



Connecticut 1115 SUD Demonstration ASAM Residential Levels of Care Certification

In April 2022, The State of Connecticut Department of Social Services (DSS), working in collaboration with the Department of Mental Health and Addiction Services (DMHAS) and the Department of Children and Families (DCF), was approved by the Centers for Medicare & Medicaid Services (CMS) for a demonstration waiver under Section 1115 of the Social Security Act for substance use disorder (SUD) treatment for adults and children. Under Connecticut’s 1115 SUD Demonstration [fee-for-service payment rates](#) were developed within Connecticut’s Medical Assistance Program (CMAP) for substance use treatment. In alignment with the milestones of the Demonstration. SUD treatment services provided in the Medicaid fee-for-service (FFS) delivery system will comply with the current American Society of Addiction Medicine’s (ASAM) criteria for activities including authorizations, utilization review decisions, multi-dimensional assessments and individualized treatment plans.

Continued access to Medicaid fee-for-service payment rates for the residential levels of care and procedure codes outlined below is contingent on substance use providers adopting and becoming certified in the current edition of the ASAM criteria adopted by the State for the treatment of addictive, substance-related, and co-occurring conditions and the standards outlined in Connecticut’s Substance Use Disorder Services Policy and Clinical Assumptions for the levels of care provided.

ASAM Level of Care Description	Procedure Codes and Modifiers
3.7 WM - Medically Monitored Inpatient Withdrawal Management	Tx: H0011 R&B: H0047 HW
3.2 WM - Clinically Managed Residential Withdrawal Management	Tx: H0010 R&B: H0047 HG
3.7 - Medically Monitored Intensive Inpatient Treatment	Tx: H2036 HV R&B: H0047 HV
3.7 RE - Medically Monitored Intensive Inpatient Treatment – Co-occurring Enhanced	Tx: H2036 HE R&B: H0047 HE
3.5 - Clinically Managed High Intensity Residential (Adults) Clinically Managed Medium Intensity Residential (Adolescents)	Tx: H2036 R&B: H0047
3.5 PPW - Clinically Managed Population-Specific High Intensity Residential – Pregnant and Parenting Women	Tx: H2036 HD R&B: H0047 HD
3.3 - Clinically Managed High-Intensity Residential - Population Specific	Tx: H2036 HI R&B: H0047 HI
3.1 - Clinically Managed Low-Intensity Residential Services	Tx: H2034 R&B: H0047 HF

Completed forms and acknowledgement should be submitted to Advanced Behavioral Health’s 1115 Demonstration Unit at 1115Waiver@abhct.com. Application status will be communicated within 45-days of a provider agency’s receipt of application completeness communication.



**CONNECTICUT 1115 SUD DEMONSTRATION
RESIDENTIAL LEVEL OF CARE CERTIFICATION ACKNOWLEDGEMENT**

Organization Name: Click or tap here to enter text.

Organization Tax ID#: Click or tap here to enter text.

On behalf of the organization and its programs listed below, I wish to apply for certification for the following residential substance use treatment programs under Connecticut’s 1115 SUD Waiver Demonstration through the State of Connecticut Department of Social Services, Department of Mental Health and Addiction Services and/or Department of Children and Families.

To qualify for certification, I acknowledge that each of the programs listed below meet the following criteria:

		Criteria
<input type="checkbox"/>	Yes	1. Each of the programs listed above maintains an active facility license not suspended, under consent order or other corrective action plan for the ASAM level of care with the State of Connecticut Department of Public Health and, as applicable, with the Department of Children and Families for which certification is sought.
<input type="checkbox"/>	No	
<input type="checkbox"/>	Yes	2. The organization has policies identifying use and application of the current edition of American Society of Addiction Medicine criteria for all programs listed above.
<input type="checkbox"/>	No	
<input type="checkbox"/>	Yes	3. The organization currently has policies and procedures related to monitoring of medication(s) and toxicology screenings that are in place for all programs listed below as applicable.
<input type="checkbox"/>	No	

I acknowledge, with my signature below, that the information above is accurate and true to the best of my knowledge.

Date:

Signature:

Print Name:

Title:



**State of Connecticut 1115 Substance Use Disorder Demonstration
Residential Level of Care Certification Application Form**

Directions: Please utilize this form to identify all service locations where the following ASAM level of cares and services are being provided. All residential levels of care offered at each listed location must be identified and all sections must be completed.

ASAM Level of Care Description	Procedure Codes and Modifiers
3.7 WM- Medically Monitored Inpatient Withdrawal Management	Tx: H0011 R&B: H0047 HW
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3.7 - Medically Monitored Intensive Inpatient Treatment	Tx: H2036 HV R&B: H0047 HV
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3.5 - Clinically Managed High Intensity Residential (Adults) Clinically Managed Medium Intensity Residential (Adolescents)	Tx: H2036 R&B: H0047
3.5 PPW - Clinically Managed Population-Specific High Intensity Residential – Pregnant and Parenting Women	Tx: H2036 HD R&B: H0047 HD
3.3 - Clinically Managed High-Intensity Residential - Population Specific	Tx: H2036 HI R&B: H0047 HI
3.1 - Clinically Managed Low-Intensity Residential Services	Tx: H2034 R&B: H0047 HF

Completed forms should be submitted with the attached acknowledgement to Advanced Behavioral Health’s 1115 Demonstration Unit at 1115Waiver@abhct.com.



Agency Information		
Agency Name: Click or tap here to enter text.		Date: Click or tap to enter a date.
Agency Corporate Address: Click or tap here to enter text.		
Agency Contact: Click or tap here to enter text.	Phone: Click or tap here to enter text.	Email: Click or tap here to enter text.
Site		
Site Name: Click or tap here to enter text.	DPH Facility License Number: Click or tap here to enter text. DCF Facility License Number (if applicable): Click or tap here to enter text. Medicaid Provider ID: Click or tap here to enter text.	
Site Address: Click or tap here to enter text.		
Site Contact: Click or tap here to enter text.	Site Phone: Click or tap here to enter text.	Site Contact Email: Click or tap here to enter text.
Requested ASAM Level of Care for Certification:		
<input type="checkbox"/> Level 3.7 WM - Medically Monitored Inpatient Withdrawal Management <input type="checkbox"/> Level 3.2 WM- Clinically Managed Residential Withdrawal Management <input type="checkbox"/> Level 3.7 - Medically Monitored Intensive Inpatient Services <input type="checkbox"/> Level 3.7RE - Medically-Monitored Intensive Inpatient Services, Co-Occurring Enhanced <input type="checkbox"/> Level 3.5 - Clinically Managed High-Intensity Residential Services (Adults) <input type="checkbox"/> Level 3.5 - Clinically Managed Medium Intensity Residential Services (Adolescents) <input type="checkbox"/> Level 3.5PPW - Clinically Managed Population-Specific High Intensity Residential – Pregnant and Parenting Women* <input type="checkbox"/> Level 3.3 - Clinically Managed, High-Intensity Residential - Population Specific <input type="checkbox"/> Level 3.1 - Clinically Managed Low-Intensity Residential Services		
Population(s) Served:		
<input type="checkbox"/> Women/Girls <input type="checkbox"/> Adults <input type="checkbox"/> Men/Boys <input type="checkbox"/> Adolescents <input type="checkbox"/> Gender-Inclusive		
Number of beds: Click or tap here to enter text.		
*As of 3/1/2023 the flex bed model is not permitted for this level of care		

Agencies submitting requests for more than one site should use additional copies of this page to submit information for each site.



Section A- SUPPORTING DOCUMENTATION AND DESCRIPTIONS

Supporting documentation required by all applicants. Items with an * should be submitted for each site on the application request.

Program Staffing Data: All program staff who provide direct client services and/or oversee the program must be included. Please provide date of hire and valid credentials including effective and expiration dates.

Detailed Monthly Program Schedule: Provide a copy of the weekly schedule of activities designed to meet individualized treatment needs in alignment with the minimum required treatment hours outlined in the Connecticut SUD Services Policy and Clinical Assumptions Grid.

Program Staffing Policy: Provide a copy of the program's policy or procedures related to 24-hour staffing coverage and on-call services.

Program Medical/Behavioral Health Emergency Policy: Provide a copy of the program's policy or procedures related to addressing medical, psychiatric or behavioral health emergencies and crisis intervention.

Assessment and Treatment Plan Procedures: Provide a copy of agency policies for completing intake, biopsychosocial assessments, treatment and discharge plans that incorporate the ASAM Dimensional criteria.

Medication Policy and Procedures: Provide a copy of the program's medication policies and procedures including those that outline how the program introduces, educates, refers and supports individuals with medications for opioid use disorder and alcohol use disorder needs.

Weekly Activities Schedule: Provide the program's full weekly schedule of services. Weekly schedules should include all treatment services provided within the facility. These services should align with the Service Components outlined in State Plan Amendment 22-0020 which are Assessment and Individualized Plan Development, Therapy, Health Services and Medication Management, Peer Support Services, Service Coordination, Skill Building and Psychoeducation. On the schedule, please indicate the total number of service hours provided per week and the credentials of the staff person completing the service. Please indicate on the weekly schedule which service type is being provided by utilizing the following codes:

Assessment	A
Individualized Plan Development/Review	IP
Group Therapy	GT
Family therapy	FT
Individual Therapy	IT
Health Services	HS
Medication Management	MM
Peer Support Services	PS
Service Coordination	SC
Skill Building	SB
Psychoeducation	PE



Program’s Level of Care Assessment: Provide a copy of the program’s LOC Assessment used to determine the appropriate level of care for a resident. The LOC Assessment must incorporate the ASAM Criteria®, which includes a comprehensive biopsychosocial assessment addressing each of the six dimensions with rating, rationale, strengths and needs. All programs participating in the Connecticut 1115 SUD Demonstration should utilize the most recent edition of the American Society of Addiction Medicine Treatment Criteria for Addictive, Substance-Related and Co-occurring disorders (Currently Connecticut's Demonstration is utilizing the 3rd edition). Clinical documentation should support and justify placement within this level of care and provide clear evidence that the individual's needs were assessed for each of the six dimensions.

Sections B-D

This section must be completed by all applicants.

This portion of the application is a self-assessment of the residential facility. Please answer all questions regarding the program services, staffing, support systems, and assessment/treatment plan review.

Section B – Program Services

Is the program providing medication for opioid use disorder and alcohol use disorder? (MOUD/MAUD)	<input type="checkbox"/> Yes
	<input type="checkbox"/> No
Does the program preclude admissions of individuals based on MAT profile and active medication prescriptions?	<input type="checkbox"/> Yes
	<input type="checkbox"/> No
Does the agency employ a physician, currently licensed in the State of Connecticut, designated to direct the medical services of the facility, appropriate for the LOC that you seek?	<input type="checkbox"/> Yes
	<input type="checkbox"/> No
Does the program employ a physician (or NP/PA) that reviews all admissions, indicates agreement with the level of care recommended and documents this in the individual’s medical record?	<input type="checkbox"/> Yes
	<input type="checkbox"/> No
Have all Clinical Supervisors, Masters Level Behavioral Health Providers and Non-licensed staff, providing therapeutic services, completed the following ASAM Trainings?	
<i>Introduction to the ASAM Criteria</i>	<input type="checkbox"/> Yes
	<input type="checkbox"/> No
<i>From Assessment to Service Planning and Level of Care</i>	<input type="checkbox"/> Yes
	<input type="checkbox"/> No
<i>Multi-Dimensional Assessment</i>	<input type="checkbox"/> Yes
	<input type="checkbox"/> No

If no, please provide a training plan for these personnel to receive the required trainings through the Change Companies.



Section B – Program Services (Continued)

Have all Clinical Supervisors, Masters Level Behavioral Health Providers, and Non-licensed staff providing therapeutic services completed the Motivational Interviewing and Stages of Change Trainings provided by the Change Companies or equivalent trainings by an accredited continuing education provider within the last three years?

Motivational Interviewing Yes
 No

Transtheoretical Stages of Change Yes
 No

If no, please provide a training plan for these personnel to receive the required trainings through the Change Companies or an accredited continuing education provider.

Section C – Support Systems

Does the program offer telephone or in person consultation with a physician, physician assistant or nurse practitioner and are emergency services available 24/7? Yes
 No

Does the program have direct affiliations with other levels of care (e.g. such as IOP for purposes of discharge planning)? Yes
 No

Select all levels of care for which the program has direct affiliations with below:

- | | |
|---|---|
| <input type="checkbox"/> 0.5 Early Intervention | <input type="checkbox"/> 1.0 Outpatient Services |
| <input type="checkbox"/> 2.1 Intensive Outpatient Services | <input type="checkbox"/> 2.5 Partial Hospitalization Services |
| <input type="checkbox"/> 3.1 Clinically Managed Low-Intensity Residential Services | |
| <input type="checkbox"/> 3.3 Clinically Managed Population-Specific High-Intensity Residential Services | |
| <input type="checkbox"/> 3.5 Clinically Managed High-Intensity Residential Services (Adults)
Clinically Managed Medium Intensity Residential (Adolescents) | |
| <input type="checkbox"/> 3.5PPW Clinically Managed High-Intensity Residential Services Pregnant and Parenting Women | |
| <input type="checkbox"/> 3.5RE Medically Monitored Intensive Inpatient Services, Co-Occurring Enhanced | |
| <input type="checkbox"/> 3.7 Medically Monitored Intensive Inpatient Services | |
| <input type="checkbox"/> 3.7RE Medically Monitored Intensive Inpatient Services, Co-Occurring Enhanced | |
| <input type="checkbox"/> 4.0 Medically Monitored Intensive Inpatient Services, Co-Occurring Enhanced | |
| <input type="checkbox"/> 1-WM Ambulatory Withdrawal Management without Extended On-site Monitoring | |
| <input type="checkbox"/> 2- WM Ambulatory Withdrawal Management with Extended On-site Monitoring | |
| <input type="checkbox"/> 3.2-WM Clinically Monitored Residential Withdrawal Management | |
| <input type="checkbox"/> 3.7-WM Medically Monitored Inpatient Withdrawal Management | |
| <input type="checkbox"/> 4.0-WM Medically Managed Intensive Inpatient Withdrawal Management | |

Please indicate which services are offered through referrals:

- | | |
|---|---|
| <input type="checkbox"/> Medical Services | <input type="checkbox"/> Psychiatric Services |
| <input type="checkbox"/> Mental Health Services | <input type="checkbox"/> MAT Services |
| <input type="checkbox"/> Laboratory Services | <input type="checkbox"/> Toxicology Services |

Please indicate which services are offered onsite or co-located:

- | | |
|---|---|
| <input type="checkbox"/> Medical Services | <input type="checkbox"/> Psychiatric Services |
| <input type="checkbox"/> Mental Health Services | <input type="checkbox"/> MAT Services |
| <input type="checkbox"/> Laboratory Services | <input type="checkbox"/> Toxicology Services |



Section D – Assessment/Treatment Plan Review/Discharge

Does the program’s assessment and treatment plan documentation include:

A biopsychosocial assessment that clearly identifies the individual's risks, strengths and needs in each of the ASAM Six Dimensions and provides justification for placement within the program's level of care.	<input type="checkbox"/> Yes <input type="checkbox"/> No
A biopsychosocial assessment that includes behavioral health diagnoses, cognitive needs and a screening for trauma.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Initial treatment plans that demonstrate clear evidence that the risks, strengths and needs identified in each of the ASAM Six Dimensions have been incorporated and contains strengths, needs, abilities and preferences (SNAP) and reflects coordination of substance use treatment, mental health, recovery support, social housing, vocational services or integration of care as applicable.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Individualized Treatment plan(s) demonstrate evidence of discharge planning beginning at admission and ongoing dimensional need reassessments.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Documentation of a physical exam one month prior to admission or an appointment scheduled no later than five days after admission. Any individual receiving uninterrupted treatment or care in a licensed facility shall require only the documentation of the initial physical examination.	<input type="checkbox"/> Yes <input type="checkbox"/> No
An alcohol or other drug focused nursing assessment (for applicable levels of care)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there evidence that the individual participated in the treatment planning process (e.g. signature)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are assessments, initial treatment plans, treatment plan reviews and discharge plans reviewed by an interdisciplinary team?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please check the roles of those included in the program's interdisciplinary team responsible for developing and/or reviewing assessments, initial treatment plans, treatment plan reviews and discharge plans:

<input type="checkbox"/> Physician	<input type="checkbox"/> Licensed Clinical Social Worker
<input type="checkbox"/> Licensed Psychologist	<input type="checkbox"/> Licensed Marital and Family Therapist
<input type="checkbox"/> Licensed Professional Counselor	<input type="checkbox"/> Licensed Alcohol and Drug Counselor
<input type="checkbox"/> Advanced Practice Registered Nurse	<input type="checkbox"/> Physician Assistant
<input type="checkbox"/> Licensed Master Social Worker	<input type="checkbox"/> Licensed Professional Counselor Associate
<input type="checkbox"/> Licensed Marital and Family Therapy Associate	<input type="checkbox"/> Certified Alcohol and Drug Counselor
<input type="checkbox"/> Certified Peer Support Specialist	<input type="checkbox"/> Other



Does the discharge planning process include:	
ASAM Transfer/Discharge criteria are applied to discharge planning processes.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Presence of Transfer or Discharge Plan Discharge plans include obtaining necessary release(s) of information to refer to appropriate aftercare services, including clinical recovery supports.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Plans are written in conjunction with the individual and is documented in discharge plan.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Addresses original reason for referral to treatment.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Describes whether the individual's goals were met or not met.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Describes type, frequency and duration of treatment/services.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Specifies reason(s) for discharge.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Conducted/updated/signed by an independently licensed or associate licensed behavioral health staff or graduate-level intern, with credentials included.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Review and signature by independently licensed behavioral health practitioner/clinical supervisor for associate licensed or graduate level interns.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Evidence of referral to or documentation of an established connection to a MAT or pharmacotherapy provider and incorporation of ongoing or continued MAT services post-discharge.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Completed within 15 days of discharge.	<input type="checkbox"/> Yes <input type="checkbox"/> No



**State of Connecticut 1115 Substance Use Disorder Demonstration
Residential Level of Care Certification Application Form Acknowledgment**

Organization Name: Click or tap here to enter text.
Organization Tax ID#: Click or tap here to enter text.

On behalf of this organization and its programs listed in the Certification Application Form, I acknowledge, with my signature below, that the information above is accurate and true to the best of my knowledge. I also acknowledge and attest that billing for SUD services will not be effective until conditional certification is approved.

Date: _____
 Signature: _____
 Print Name: _____
 Title: _____



Residential Certification Application

Please Type or Print Clearly

Federal Tax ID (TIN): [Click or tap here to enter text.](#)

Legal Name of Organization [Click or tap here to enter text.](#)

(As Registered with the IRS): [Click or tap here to enter text.](#)

Section 1: General Business Information

1. Type & Ownership of Facility

(Please check one)

<input type="checkbox"/> General Hospital	<input type="checkbox"/> FQHC
<input type="checkbox"/> Private Psychiatric Hospital	<input type="checkbox"/> State Operated Facility
<input type="checkbox"/> Residential Treatment Center	<input type="checkbox"/> Community Health Center
<input type="checkbox"/> Outpatient Clinic (Psych or Substance Abuse)	<input type="checkbox"/> Other

2. Business Classification

Ownership:	<input type="checkbox"/> Private	<input type="checkbox"/> Public	<input type="checkbox"/> State Operated Program
Status:	<input type="checkbox"/> For-Profit	<input type="checkbox"/> Not-for-Profit	



Organization Name:

Section 2: Liability Insurance Information

Name of Liability Carrier: <input type="text" value="Click or tap here to enter text."/>	
Limits of Professional Liability: Per Occurrence	Aggregate: <input type="text" value="Click or tap here to enter text."/>
Insurance Effective Date: <input type="text" value="Click or tap to enter a date."/>	Insurance Expiration Date: <input type="text" value="Click or tap to enter a date."/>

Please enclose Certificate of Insurance with application

Section 3: Malpractice Claim History

Indicate all pending and closed cases that have occurred during the past five years by completing the malpractice claim information work sheet (see following page).

1. Has the Organization been named in any malpractice action? Yes No
2. Has the Organization had or currently have pending, any legal actions? Yes No
3. Has the Organization had professional liability insurance refused, revoked, declined or accepted on special terms? Yes No
4. Has any government agency investigated, suspended, revoked or taken other action against the Organization's license, current/former owner, officer or shareholder to conduct business? (Include Medicaid/Medicare) Yes No
5. Have any memberships in professional organizations been revoked, reduced, denied, or suspended by others or voluntarily given up by the Organization, current/former owner, officer or shareholder or are any actions now under way, which may lead to such sanctions? Yes No
6. Has any license, certification, or accreditation been revoked, denied or suspended by others or voluntarily given up by the Organization, current/former owner, officer or shareholder or are any actions now under way which may lead to such sanctions? Yes No
7. Have any current/former owners, officers or shareholders of the Organization been convicted of a crime, excluding misdemeanors? Yes No
8. Has the Organization, current/former owner, officer or shareholder been assessed a penalty, conviction, suspension, or other Sanction; or has the Organization, current/former owner, officer or shareholder currently under investigation by Medicare or Medicaid Programs? Yes No
9. Has the Organization, current/former owner, officer or shareholder ever been a defendant in any lawsuit with regard to the practice of mental health or substance abuse treatment where there has been an award or payment of \$50,000.00 (fifty thousand dollars) or more? Yes No
10. Has any claim or suit for alleged malpractice been brought against the facility/program, or are you aware of any circumstances that might lead to such a claim or suit against the facility/program? Yes No

Number of claims (check one) 0 1 2 More than 2



Organization Name: [Click or tap here to enter text.](#)

MALPRACTICE CLAIM INFORMATION WORKSHEET

If the answer to any of the questions in Section 3 on Page 3 was yes, please complete this page. Please specify to which question the detailed explanation applies.

Please complete this section for each claim identified in Section 3, Malpractice Claim History.

1. Patient's Name: Click or tap here to enter text. (if applicable)	Date of Occurrence: Click or tap to enter a date.	Date Claim Filed: Click or tap to enter a date.
Allegations: Click or tap here to enter text.		
Status of Claim: <input type="checkbox"/> Pending	<input type="checkbox"/> Settled	Date of Settlement: Click or tap to enter a date.
Case Settled: <input type="checkbox"/> In Court	<input type="checkbox"/> Out-of-Court	\$ Paid to claimant on your behalf Click or tap here to enter text.
<input type="checkbox"/> With Prejudice	<input type="checkbox"/> Without Prejudice	
The information above applies to # _____ on page 3.		

2. Patient's Name: Click or tap here to enter text. (if applicable)	Date of Occurrence: Click or tap to enter a date.	Date Claim Filed: Click or tap to enter a date.
Allegations: Click or tap here to enter text.		
Status of Claim: <input type="checkbox"/> Pending	<input type="checkbox"/> Settled	Date of Settlement: Click or tap to enter a date.
Case Settled: <input type="checkbox"/> In Court	<input type="checkbox"/> Out-of-Court	\$ Paid to claimant on your behalf Click or tap here to enter text.
<input type="checkbox"/> With Prejudice	<input type="checkbox"/> Without Prejudice	
The information above applies to # _____ on page 3.		



Organization Name: Click or tap here to enter text.

3. Patient's Name: Click or tap here to enter text. (if applicable)	Date of Occurrence: Click or tap to enter a date.	Date Claim Filed: Click or tap to enter a date.
Allegations: Click or tap here to enter text.		
Status of Claim: <input type="checkbox"/> Pending <input type="checkbox"/> Settled	Date of Settlement: Click or tap to enter a date.	
Case Settled: <input type="checkbox"/> In Court <input type="checkbox"/> With Prejudice <input type="checkbox"/> Out-of-Court <input type="checkbox"/> Without Prejudice	\$ Paid to claimant on your behalf Click or tap here to enter text.	
The information above applies to # _____ on page 3.		

Please include any documentation that further explains any of the above referenced items.

If you answered yes to any questions 1-10 on page 3, please attach description of the occurrence (citing dates and other relevant information).



Residential Certification Application Checklist

To ensure timely processing of your application, please submit the following documents and the completed checklist with the application (please check boxes accordingly):

- Residential Level of Care Certification Acknowledgement signed by authorized official (original signature required)
- Proof of Certificate of Need (CON) Determination from Office of Healthcare Strategy
- Approved LP-173 Form from the Connecticut Department of Public Health or photocopy of current facility license
- As applicable for child serving programs, photocopy of current DCF license
- Supporting Documentation outlined in Section A of the Application:
 - Facility Staffing Data
 - Detailed Monthly Program Staff Schedule
 - Program Staffing Policy
 - Program Medical/Behavioral Health Emergency Policy
 - Assessment and Treatment Plan Procedures
 - Medication Policy and Procedures
 - Weekly Activities Schedule
 - Program's Level of Care Assessment
- Template of treatment plan (inclusion of SNAP, strengths, needs, abilities and preferences)
- Policy for Continued stay/transfer and discharge documentation
- Policies and procedures related to referring and supporting individuals with MOUD/MAUD needs at the program
- Discharge Summary template that includes ASAM
- Training plan for any staff who have not completed the required trainings outlined in Section B of the Application
- Completed Certification Application signed by authorized official (original signature required)
- Copy of current medical malpractice, comprehensive professional, general and/or umbrella liability insurance certificates that identifies the limits of liability and policy period
- Malpractice Claim Information Worksheet (if applicable)
- Accreditation(s):
 - JCAHO (The Joint Commission) accreditation letter and/or certificate
 - CARF (Commission on Accreditation of Rehabilitation Facilities) accreditation letter and/or certificate
 - COA (Council on Accreditation) accreditation letter and/or certificate
 - Our facility is not accredited by any of the above organizations.

Please email all materials to:

Advanced Behavioral Health, Inc.*
Email: 1115Waiver@abhct.com
213 Court St., 8th Floor
Middletown, CT 06457

We suggest you keep a copy of all completed materials!

If you have any questions, please email to 1115Waiver@abhct.com.



*Advanced Behavioral Health, Inc. is contracted by the Department of Mental Health and Addiction Services and the Department of Children and Families to assist with the certification and monitoring of programs under the 1115 SUD Demonstration Waiver
