

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
DEPARTMENT OF BEHAVIORAL HEALTH



**2025 APPLICATION  
FOR CERTIFICATION AS A  
DEPARTMENT OF BEHAVIORAL HEALTH  
CERTIFIED PROVIDER**

Return completed application to Certification Division electronically to [dbh.certification@dc.gov](mailto:dbh.certification@dc.gov). When submitting your typed application, please keep all pages in sequence.

|                     |                   |       |
|---------------------|-------------------|-------|
| PROGRAM             | NAME:             |       |
|                     | ADDRESS:          |       |
|                     | CITY, STATE, ZIP: |       |
|                     | TELEPHONE:        |       |
|                     | FAX NUMBER:       |       |
|                     | AGENCY E-MAIL:    |       |
| PARENT ORGANIZATION | NAME:             |       |
|                     | ADDRESS:          |       |
|                     | CITY, STATE, ZIP: |       |
|                     | TELEPHONE:        | WARD: |

**NAMES OF EXECUTIVE STAFF – MHRs AND SUD APPLICANTS ONLY**

|                             |        |
|-----------------------------|--------|
| CHIEF EXECUTIVE OFFICER:    | EMAIL: |
| PROGRAM DIRECTOR:           | EMAIL: |
| CLINICAL DIRECTOR:          | EMAIL: |
| MEDICAL DIRECTOR:           | EMAIL: |
| CHIEF FINANCIAL OFFICER:    | EMAIL: |
| QUALITY IMPROVEMENT OFFICER | EMAIL: |

**NAMES OF EXECUTIVE STAFF – FSMHC APPLICANTS ONLY**

|                              |        |
|------------------------------|--------|
| CHIEF EXECUTIVE OFFICER:     | EMAIL: |
| PSYCHIATRIST                 | EMAIL: |
| ADMINISTRATOR                | EMAIL: |
| CORPORATE COMPLIANCE OFFICER | EMAIL: |

## 2. DISCLOSURES

When answering the following questions the word “you” refers to the CEO, Program Director-or any other title given the administrator(s) with fiduciary and programmatic responsibility for the organization.

1. Are you a Maryland Service Provider wanting to provide Community Support for the residents of the District of Columbia?  
 Yes  No *If yes, please answer questions 2-5.*
  
- 1b. Are you a Maryland Service Provider applying for Certification as a DBH Core Service Agency?  
 Yes  No *If yes, according to the DBH Provider Certification for Out-of-State Applicants (see Policy 340.3), you are **ineligible** to apply for Certification as a DBH Core Service Agency Provider.*

---

2. Have you or your organization ever lost or had suspended a professional certification, accreditation, licensure, or contract for failure to maintain required standards, misconduct, or any other reason?  
 Yes  No *If yes, please explain on a separate sheet.*

---

3. Do you or any member of the executive staff have any past (within 7 years) or pending conviction(s)?  
 Yes  No *If yes, please explain on a separate sheet.*

---

4. Do you or the organization have any past (within 7 years) or pending litigation(s)?  
 Yes  No *If yes, please explain on a separate sheet.*

---

5. Have you or your organization ever been involved in any federal, state or local investigation?  
 Yes  No *If yes, please explain on a separate sheet.*

---

6. Do you or the organization owe any debt to the IRS, the District of Columbia, or any other state or local government?  
 Yes  No *If yes, please explain on a separate sheet.*

---

7. Are you or your organization licensed or certified to conduct business in any other state?  
 Yes  No *If yes, please provide details and provide a copy of your license or certification.*

---

8. Is your agency non-profit?  Yes  No *If yes, you must have a board of directors.*  
Is your agency for-profit?  Yes  No

## 3. NATIONAL ACCREDITATION

Please select which National Accrediting body your agency is accredited with  the Commission Accreditation of Rehabilitation Facilities (CARF)  the Council on accreditation (COA)  The Joint Commission (TJC)

Please provide a **current** copy of your National Accreditation certificate along with your most recent accreditation report with your application.

## 4. REQUEST FOR EXEMPTION FROM CERTIFICATION STANDARDS

Providers seeking certification may request exemption from certification standards that may interfere with service provision. Prepare one (1) form for each exemption requested. [Duplicate this form as needed.]

Will you be seeking an exemption from any certification standard(s)? No  Yes

If “yes”, please specify the certification standard from which exemption is sought, provide your reasoning for seeking the exemption, and explain why it is appropriate.

STANDARD/CITATION:

JUSTIFICATION FOR EXEMPTION:

**5. OWNER(S), OFFICERS OR AGENTS**

Please note: You may reference an attachment if it includes all the information requested below.

1) Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Title \_\_\_\_\_ Telephone # \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

2) Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Title \_\_\_\_\_ Telephone # \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

3) Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Title \_\_\_\_\_ Telephone # \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

4) Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Title \_\_\_\_\_ Telephone # \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

5) Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Title \_\_\_\_\_ Telephone # \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

**6. MEDICAID INFORMATION**

**National Provider Identifier (NPI) Number:**

|                                       |   |                            |
|---------------------------------------|---|----------------------------|
| Current or Pending Medicaid Provider? | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | Medicaid #:                |
| Previous Medicaid Provider?           | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | Medicaid #:                |
| Suspended or Revoked?                 | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | Date Suspended or Revoked: |

*If yes, specify and explain:*

---

---

---

---

---

|  |   |                            |
|--|---|----------------------------|
| Reinstated?                                  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | Date of Reinstatement:     |
| Current Medicaid Provider in another state?  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | State, Medicaid #:         |
| Previous Medicaid Provider in another state? | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | State, Medicaid #:         |
| Suspended or Revoked?                        | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | Date Suspended or Revoked: |

*If yes, specify and explain:*

---

---

---

---

---

|   |   |                        |
|---|---|------------------------|
| Reinstated?   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | Date of Reinstatement: |
| Are there any other Medicaid programs for which you or your organization is certified for (e.g., Free Standing Mental Health Clinic)? | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | Medicaid #:            |

*If yes, please describe and provide Medicaid number:*

---

---

---

---

---

**7. TYPE OF CERTIFICATION SOUGHT**

Check below all services that apply. State the service type or level of care provided and the number of patients that can be served when operating at capacity.

**PROGRAM TYPE (Check all that apply)**

- Substance Use Disorder Treatment Services
- Recovery Support Services
- Mental Health Rehabilitation Services
- Free Standing Mental Health Clinic

**Demographics (Check all that apply)**

- Youth
- Adults
- Both

**For currently certified DBH Providers ONLY**

Are you applying to add a new service(s)?  Yes  No

**SERVICES (Select all that apply)**

| <b>Substance Use Disorder Treatment Level of Care &amp; Specialty Services (select all that apply)</b>   | <b>Capacity</b> |
|--|-----------------|
| <input type="checkbox"/> Level 1 Outpatient  |                 |
| <input type="checkbox"/> Level 2.1 Intensive Outpatient Program  |                 |
| <input type="checkbox"/> Level 2.5 Day Treatment   |                 |
| <input type="checkbox"/> Level 3.1 Clinically Managed Low-Intensity Residential  |                 |
| <input type="checkbox"/> Level 3.3 Clinically Managed Population-Specific High-Intensity Residential   |                 |
| <input type="checkbox"/> Level 3.5 Clinically Managed High-Intensity Residential (Adult) or Clinically Managed Medium-Intensity Residential (Youth)                  |                 |
| <input type="checkbox"/> Level 3.7 WM Medically Monitored Intensive Inpatient Withdrawal Management  |                 |
| <input type="checkbox"/> <b>Specialty Services (Note: Some specialty services are required at certain levels of care)</b>  |                 |
| <input type="checkbox"/> Adolescent – Community Reinforcement Approach (ACRA)  |                 |
| <input type="checkbox"/> Medication Assisted Treatment (MAT)   |                 |
| <input type="checkbox"/> Medication Management   |                 |
| <input type="checkbox"/> Parents with Children   |                 |
| <input type="checkbox"/> Supported Employment (SUD)  |                 |
| <input type="checkbox"/> Motivational Enhancement Therapy/Cognitive Behavioral Therapy (MET/CBT) (Youth)   |                 |
| <b>Recovery Support Services (select all that apply) *For providers who only want to provide Recovery Support and are NOT certified for any other Level of Care*</b> | <b>Capacity</b> |
| <input type="checkbox"/> Level RSS   |                 |
| <input type="checkbox"/> Environmental Stability (Optional)  |                 |

|  | Capacity |
|--|----------|
| <b>Mental Health Rehabilitation Services</b> <i>(select all that apply)</i>      |          |
| <b>Provider Type</b>   |          |
| <input type="checkbox"/> Core Services Agency                                    |          |
| <input type="checkbox"/> Child Choice  |          |
| <input type="checkbox"/> Health Home <i>(Please See Addendum)</i>                |          |
| <input type="checkbox"/> Subprovider   |          |
| <input type="checkbox"/> Specialty Provider                                      |          |
| <b>Services</b>  |          |
| <input type="checkbox"/> Diagnostic/Assessment                                   |          |
| <input type="checkbox"/> Medication-Somatic Treatment                            |          |
| <input type="checkbox"/> Counseling and Psychotherapy                            |          |
| <input type="checkbox"/> Community Support                                       |          |
| <input type="checkbox"/> Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)    |          |
| <input type="checkbox"/> Child-Parent Psychotherapy for Family Violence (CPP-FV) |          |
| <input type="checkbox"/> Supported Employment (MHRS)                             |          |
| <input type="checkbox"/> Stabilization Program <i>(Please See Addendums)</i>     |          |
| <input type="checkbox"/> Comprehensive Psychiatric Emergency Program (CPEP)      |          |
| <input type="checkbox"/> Psychiatric Crisis Stabilization                        |          |
| <input type="checkbox"/> Adult Mobile Crisis and Outreach                        |          |
| <input type="checkbox"/> Youth Mobile Crisis                                     |          |
| <input type="checkbox"/> Rehabilitation/Day                                      |          |
| <input type="checkbox"/> Intensive Day Treatment                                 |          |
| <input type="checkbox"/> Trauma Recovery Empowerment Model (TREM)                |          |
| <input type="checkbox"/> Trauma System Therapy (TST)                             |          |
| <input type="checkbox"/> Community-Based Intervention                            |          |
| <input type="checkbox"/> Level I (Multi-Systemic Therapy-(MST)                   |          |
| <input type="checkbox"/> Level II  |          |
| <input type="checkbox"/> Level III   |          |
| <input type="checkbox"/> Level IV (Functional Family Therapy-(FFT)               |          |

- |  |  |
|--|--|
| <input type="checkbox"/> Assertive Community Treatment (ACT) |  |
| <input type="checkbox"/> Transitional Planning               |  |
| <input type="checkbox"/> Clubhouse                           |  |
| <input type="checkbox"/> Intensive Care Coordination (ICC)   |  |

### 8. EVIDENCE BASED PRACTICES

DBH Certification to provide evidence based practices, or services like Health Homes, may require a provider to obtain training and certification from the Department or outside accrediting bodies, such as the national organization that oversees particular evidence based practice. Applications for those certifications (e.g. as a CBI provider providing Functional Family Therapy) must include that information.

Do you provide Evidence Based Practice?  Yes  No

If yes, please describe and include certificates, licenses or training records to demonstrate proficiency.

---

---

---

### 9. PROGRAM DESCRIPTION

Please provide a detailed description of each program for which you are seeking certification. The description should include detailed information about your prospective consumer/client populations, your staffing plan (including the functional role of each position) for each program, and your clinical expertise and philosophy of treatment. Your program description must comply with the requirements detailed in the regulations governing the certification you are seeking. *(Please attach separate sheets as necessary.)*

Hours of Operation: \_\_\_\_\_ Days \_\_\_\_\_  
Projected Capacity: \_\_\_\_\_

Age range of children accepted to your Parents with Children SUD program: \_\_\_\_\_

Describe program and population targeted for service (treatment model, program curriculum):

---

---

---

Describe staffing plan, including how staffing will be handled if you have multiple sites:

---

---

---

Describe services planned at each site, and how your program will meet DBH requirements for service delivery:

---

---

### 10. ACCESSIBILITY

Providers must have the means to provide translation services and accessibility under the American with Disabilities Act.

Check box if your organization offers: *(check all that are applicable)*

- Language Line Services for limited or non-English speaking consumers
- Live Interpreters for limited or non-English speaking consumers
- On-site American Sign Language interpretation, or Video remote interpreting (VRI),
- Document translation as necessary for limited or non-English speaking consumers.
- TDD/TTY (Telecommunications Device for the Deaf or hard of hearing)
- Relay Access for the Deaf or Hard of Hearing
- Report quarterly on Non-English Proficient/Low English Proficient encounters
- Wheelchair and restroom accessible facilities or in at least one facility if operating more than one location with similar services.
- Handicapped parking (if parking is provided)

### 11. ADDITIONAL ORGANIZATION INFORMATION

The following are not services directly reimbursed by the Department. Check box if your organization offers: (check all that are applicable)

- Childcare services (Parents with Children programs are required to make this available)
- Private Transportation
- Food and clothing support

### 12. SERVICES OFFERED THROUGH REFERRAL OR AFFILIATION AGREEMENTS

***\*Required for sub-providers ONLY\**** Describe the program/agency with which you have an agreement and indicate the type of services offered to your clients. *Attach a copy of the Affiliation Agreement between your agency and the DBH certified agency.*

DUPLICATE THIS PAGE AS NECESSARY.

Days/Hours of Operation: \_\_\_\_\_ Capacity: \_\_\_\_\_  
Identify agency and address:

---

---

Population targeted for service and service(s) provided:

---

---

---

**13. SPECIFIC QUALIFICATIONS, TRAINING, AND EXPERIENCE OF STAFF**

For: **All** staff including the Executive Staff. The information in the top half of the form must be supplied for all staff. The information in the bottom half of the form **(b.) must** be supplied for all licensed staff. Providers may also supply a complete staff list with resumes containing all of the identified information in **(a.)** rather than using this form. Applicants applying for any part of the Stabilization Program, please skip section 13 but please be sure to complete addendum(s).

Duplicate this page as necessary. **a. One (1) page for each staff person.**

|  |                                      |  |
|--|--------------------------------------|--|
| Last Name  | First Name                           | Middle Name                              |
|  |                                      |  |
| Title  |                                      |  |
| Fulltime Employee <input type="checkbox"/><br>Part-time <input type="checkbox"/><br>(No. of Hours/week):           | Supervisory <input type="checkbox"/> | Non-Supervisory <input type="checkbox"/> |
| Duties:  |                                      |  |
| Communicable disease testing/vaccinations (as required) <input type="checkbox"/> yes <input type="checkbox"/> no   |                                      |  |
| Employed or a volunteer at another DBH Certified Provider <input type="checkbox"/> yes <input type="checkbox"/> no |                                      |  |
| Name of Program:   |                                      |  |

**b. The following section is to be completed for staff requiring licensure/ certification**

| Degree(s)   | Date Received | Name and Location of Institution |
|---|---------------|----------------------------------|
|   |               |                                  |
|   |               |                                  |
|   |               |                                  |
| Certificates, Licenses, Registrations (attach copies) | Number        | Expiration                       |
|   |               |                                  |
|   |               |                                  |
|   |               |                                  |

Background and Professional Experience

---

---

---

---

**14. LICENSES, CERTIFICATIONS, AND OTHER REQUIRED DOCUMENTS**

Check each that applies and ATTACH A COPY

| Type   | License/Registration or Certificate Number | Expiration Date |
|--|--|-----------------|
| <b>REQUIRED DOCUMENTS</b>  |  |                 |
| A complete current staff list which includes hire date and PT or FT status   |  |                 |
| Current licenses under other District of Columbia law or regulation, i.e., Basic Business License: (Please specify)  |  |                 |
| Certificate of Good Standing/Clean Hands Form issued by Office of Tax and Revenue – Certificate of Clean Hands is NOT valid if it is more than <b>30 days</b> old.   |  |                 |
| Proof of insurance coverage as indicated in 3413.32, 6311.11, or 3004.9  |  |                 |
| Client’s Rights Statement  |  |                 |
| Notice of Privacy Practices  |  |                 |
| Confidentiality Forms and Releases   |  |                 |
| Certificate of Need (For Residential Treatment Programs)   |  |                 |
| Equal Employment Opportunity Compliance Documents (Mayor’s Order 85-85, dated June 10, 1985)   |  |                 |
| Certificate of Occupancy (Not needed for Re-Certification unless new sites have been added)  |  |                 |
| DCRA Inspection for new Residential facilities, as outlined in 6325.6  |  |                 |
| DCRA permits and post-inspection report for any work done in the past 12 months that required DCRA approval.   |  |                 |
| Certificate of compliance from the District of Columbia Department of Fire and Emergency Medical Services  |  |                 |
| For all unlicensed staff members, attach a copy of the criminal background check results contained in D.C. Official Code §44-551 <i>et seq.</i> , Unlicensed Personnel Criminal Background Check - <a href="https://www.fbi.gov/services/cjis/identity-history-summary-checks/list-of-fbi-approved-channelers-for-departmental-order-submissions">https://www.fbi.gov/services/cjis/identity-history-summary-checks/list-of-fbi-approved-channelers-for-departmental-order-submissions</a> . Background check must not be older than 45 days of the person’s hire date |  |                 |
| For all programs serving children, attach a copy of the criminal background check requirements contained in the Criminal Background Checks for the Protection of Children Act of 2004 and the Emergency Amendment of 2006 *Must be completed annually for District of Columbia and or State of Residency <b>*Not optional for FSMHC applicants*</b>  |  |                 |

**Version: FY-25 (Previous versions of this application are invalid)**

|  |  |  |
|--|--|--|
| FSMHC applicants only: Identification of the psychiatrist(s) who will provide clinical and administrative direction, and provide direct services as outlined in 3005.2 |  |  |
| FSMHC applicants only: A signed contract or attestation letter for all clinical staff as outlined in 3002.18 (c) 2   |  |  |
| For Medication Assisted Treatment applicants: SAMHSA Certification and accreditation by a national accreditation body that has been approved by SAMHSA.                |  |  |
| For Medication Assisted Treatment applicants: Current DEA registration   |  |  |
| For Medication Assisted Treatment applicants: Current registration under DCMR Title 22B Chapter 10   |  |  |
| CPEP applicants only: A signed attestation letter as outlined in 8025.15 and 8015.5  |  |  |
| CPEP applicants only: A signed and submitted contract with a licensed and bonded security company  |  |  |

### **National Accreditation**

|   |  |  |
|---|--|--|
| Current certification from the Commission Accreditation of Rehabilitation Facilities (CARF) |  |  |
| Current certification from the Council on Accreditation (COA)                               |  |  |
| Current certification from the Joint Commission (TJC)                                       |  |  |
| Other National Accreditation Body   |  |  |

**All of the following must be included with your application. Please mark with a *v* to indicate your submission.**

### **Ownership and Governance**

- List of Board members and titles
- DC 1513 Form-Ownership Statement
- Organization chart that reflects lines of authority with governing body
- Copies of referral or affiliation agreements, or written agreements with any DBH certified provider providing program services (MHRS and SUD applicants only)

### **Financial Information**

- Annual audit by a certified public accounting firm. *Applies only to agencies 1) with revenue at or above three hundred thousand dollars (\$300,000.00); and 2) agencies that have been in operation for more than one year.*
- Anticipated or actual program budget, along with Board-approved financial reports explaining variations in budgeted activity.
- Documented evidence adequate funding to provide the services for which you seek Certification – which includes a Line of Credit sufficient to support ninety (90) days of operating expenses and or last 4 months (120 days) of consecutive financial bank statements from a verified banking institution
- Proof of insurance for residential programs as described in 6311.11.

### **Human Resources**

- Health Professional Licensing Administration (HPLA) License Verification <https://app.hpla.doh.dc.gov/Weblookups/> & a copy of current paper license for all licensed staff.
- History of professional license revocation or admitting privilege revocation for all staff (Not needed for

**Version: FY-25 (Previous versions of this application are invalid)**

- Re-certification Applications unless has changed since Initial Certification).
- Office of the Inspector General (OIG) Medicaid Exclusion checks for all staff and Board Members. (<https://exclusions.oig.hhs.gov/>)
  - CPR certification as per 6319.2 for at least two staff members (one staff member for RSS applicants) who will be present during all hours of operation.
  - Licensed dietician or nutritionist license for residential treatment programs.

**15. REQUIRED POLICIES & PROGRAM DOCUMENTS**

*Please note, while DBH regulations stipulate these documents are not mandatory for submission, we reserve the right to request any of the listed documents as deemed necessary.*

|  | SUD/RSS | MHRS | FSMHC | CPEP |
|--|---------|------|-------|------|
| Abuse or Neglect (consumers) Policy (6308.2; 3413.37, 3413.39; 8018.g)   | X       | X    |       | X    |
| Access to records (8022.6c;d)  |         |      |       | X    |
| Admission, Exclusion, Transfer, and Discharge Policy (6313.2d, 6313.3 a,b; 6313.2d; 3413.11; 3006.4a; 8012.3a;b) | X       | X    | X     | X    |
| Advance Instruction Policy (3409.7, 3409.8)  |         | X    |       |      |
| Affiliation Agreement (8012.1j)  |         |      |       | X    |
| Affiliated Provider Policy / Collaboration Policy (6313.1l; 3415.7; 8012.1j)                                     | X       | X    |       |      |
| Anti-Discrimination Policy (6320.1k; 3413.27, 3006.4c)   | X       | X    | X     |      |
| Assertive Community Treatment Organizational Plan (3426.8)   |         | X    |       |      |
| Assertive Community Treatment Service Policy (3426.4)  |         | X    |       |      |
| Billing and Payment Policy (3413.34; 3006.4d)  |         | X    | X     |      |
| Care Coordination Policy (3006.4e)   |         |      | X     |      |
| Child Care & Monitoring Policy (6326) (PWC programs only)  | X       |      |       |      |
| Clinical Records Maintenance and Storage Policy (3006.4f)  |         |      | X     |      |
| Community Based Intervention Organizational Plan (3425)  |         | X    |       |      |
| Community Support Organizational Policy (3421)   |         | X    |       |      |
| Community Support Service Policy (3421)  |         | X    |       |      |
| Complaint and Grievance Policy (6320.4; 3409.4; 3006.4g; 8019.4)   | X       | X    | X     | X;   |
| Consent to Treatment Policy (6329.6; 3409.5; 3006.4h)  | X       | X    | X     |      |
| Consumer and Family Education Policy (CSAs Only) (3414.5)  |         | X    |       |      |
| Consumer Privacy Release of Information Policy (3006.4s)   |         |      | X     |      |
| Client Conduct Policy (6313.3j)  | X       |      |       |      |

|   |   |   |   |   |
|---|---|---|---|---|
| Client/Consumer Rights & Choice Policies (6320, 6321; 3410; 3006.4n; 8012.3j; 8020.1) | X | X | X | X |
| Collaboration Policy (Subproviders and Specialty Providers Only) (3415.6)             |   | X |   |   |
| Continuity of Care Policy (6307; 3405)  | X | X |   |   |
| Continuity of Operations Plan (6314.1; 3413.10; 8013.1 and DBH Policy 651.2)          | X | X |   | X |
| Contractor Policy (8012.1i)   |   |   |   | X |
| Control of Stock Pharmaceuticals (8015.26)  |   |   |   | X |
| Control Substance Policy (8007.15; 80012.3)   |   |   |   | X |
| Corporate Compliance Plan (6310.5e; 3413.39;)   | X | X |   |   |
| Counseling Service Policy (6342; 3413.13)   | X | X |   |   |
| Crisis/Emergency Service Policy (6341; 3422)  | X | X |   |   |
| Crisis Intervention/Medical Emergency Service Policy (8012.3e)                        |   |   |   | X |
| CSA Affiliation Policy (Subproviders Only) (3415)                                     |   | X |   |   |
| CSA Referral Policy (Specialty Only) (3415)   |   | X |   |   |
| Cultural Competency Policy (3413.10; 3006.4i; 8012.2a; b)                             |   | X | X | X |
| Diagnostic/Assessment Service Policy (6339; 3418)                                     | X | X |   |   |
| Disaster Evacuation Plan (8013.1)   |   |   |   | X |
| Disaster Recovery Plan (3006.4j)  |   |   | X |   |
| Drug and Alcohol Policy (6308.14)   | X |   |   |   |
| Drug Testing and Screening Policy (6343.4)  | X |   |   |   |
| Environmental/Safety Policy (6315.1 a-g; 6315.6; 6315.10a,g; 6315.14)                 | X |   |   |   |
| Employee Conduct Policy (6309)  | X |   |   |   |
| Fiscal Management Policy (6311; 8010.2)   | X |   |   | X |
| Gender Specific (6313.4)  | X |   |   |   |
| Grievance Policy (6320.4; 3409.4)   | X | X |   |   |
| Group education Policy (group size and group leader) (6342)                           | X |   |   |   |
| Hazardous Environmental Conditions Policy (6313.3 d; 6315)                            | X |   |   |   |
| Individualized Services Policy (6313.2a)  | X |   |   |   |
| Infection Control & Universal Precautions Policy (6313.3d; 3413.29j;                  | X | X | X | X |

|   |   |   |   |   |
|---|---|---|---|---|
| 3006.4k; 8018.3e)   |   |   |   |   |
| Intensive Day Treatment Organizational Plan (6332; 3424)                | X | X |   |   |
| Intensive Day treatment Service Policy (3424)                           |   | X |   |   |
| Interpreter Policy (6320.1w; 3413.23-25; 3006.4l; 8025.11)              | X | X | X | X |
| Interpreter Language Access Policy (8025.11)                            |   |   |   | X |
| IRP/IPC Review Policy (CSAs Only) (3411)                                | X | X |   |   |
| Least Restrictive Setting Policy (6313.2c)                              | X |   |   |   |
| Major Unusual Incident Policy & Investigation Policy (6308.2)           | X |   |   |   |
| Medical Waste Policy (6315.11)  | X |   |   |   |
| Medication & Controlled Substance Policy (6313.3o; 3413.29l)            | X | X |   |   |
| Medication Management (8015.2)  |   |   |   | X |
| Medication Storage and Administration Policy (3006.4m)                  |   |   | X |   |
| Medication Policy (8012.3n)   |   |   |   | X |
| Natural Settings Policy (3413.26; 8012.2c)                              |   | X |   | X |
| Nutritional Standards Policy (6318)                                     | X |   |   |   |
| On-Call System Policy (3414; 3006.4o; 8007.14c)                         |   | X | X |   |
| Outreach Policy (6313.3c; 3414.6g)                                      | X | X |   |   |
| Patient Funds Policy (6311.10)  | X |   |   |   |
| Performance Review Policy (6308.10; 3413.6; 3006.4p; 8007.14)           | X | X | X | X |
| Personnel Policies & Procedures (6308.13a, c; 8007.14)                  | X |   |   | X |
| Plan of Care Policy (3006.4v)   |   |   | X |   |
| Program Mission Statement, philosophy, purpose, and values<br>(6313.1a) | X | X |   |   |
| Primary Care Provider Communication Policy (3413.14; 3006.4q)           |   | X | X |   |
| Privacy Policy (6315.15; 6320.1h)                                       | X |   |   |   |
| Quality Improvement Policy (6310; 3413.28; 3006.4r; 8009.1)             | X | X | X | X |
| Records Management Policy (6323; 3413.16; 8012.3g)                      | X | X |   | X |
| Record Retention Policy (6323; 3413.31)                                 | X | X |   |   |
| Rehabilitation/Day Organizational Policy (3423)                         |   | X |   |   |
| Rehabilitation/Day Service Policy (3423)                                |   | X |   |   |
| Release of Consumer Information Policy (6322)                           | X |   |   |   |

**Version: FY-25 (Previous versions of this application are invalid)**

|  |   |   |   |   |
|--|---|---|---|---|
| Residential Program House Rules (6323.6-7)   | X |   |   |   |
| Safe Workplace Policy (6313.3g)  | X |   |   |   |
| Special Needs Policy (client & population) (6312.2b)   | X |   |   |   |
| Staff Development & Training & Orientation Policies (8007.13)                                |   |   |   | X |
| Staff Selection or Human Resources Policy (6308.7; 3413.4; 8007.9)                           | X | X |   | X |
| Staff Relationships (8008.1d)  |   |   |   | X |
| Subcontractor Policy (3414.5)  |   | X |   |   |
| Supervision and Peer Review Policy (6308.11; 3413.7; 3006.4t; 8007.12 and DBH Policy 710.38) | X | X | X | X |
| Supported Employment Organizational Plan (Supported Employment Applications only) (3701.3)   |   | X |   |   |
| Supported Employment Service Policy (Supported Employment Applications only) (3701.3)        |   | X |   |   |
| Staff Development, Training & Orientation Policies (6319; 3413.10; 3413.11)                  | X | X |   |   |
| Training Policy (3006.4b; 8018)  |   |   | X | X |
| Treatment Philosophy & approach (6313.1g)  | X |   |   |   |
| Unscheduled Service Access Policy (3413.15)  |   | X |   |   |
| Vehicle Use and Safety Policy (6317.1)   | X |   |   |   |
| Volunteer Policy (6308.13d, 6313.1m, 6313.3e; 8012.3d)                                       | X |   |   | X |

*I certify, under penalty of perjury, that the information contained in this application is accurate and complete to the best of my knowledge.*

Name:

\_\_\_\_\_  
Owner, Officer, or Agent

Title:

\_\_\_\_\_

Signature:

\_\_\_\_\_  
Owner, Officer, or Agent

Date:

\_\_\_\_\_

**ADDENDUM  
FOR HEALTH HOME SERVICES**

**PLEASE COMPLETE ONE PAGE FOR EACH TEAM**

Number of Teams: \_\_\_\_\_

Capacity: \_\_\_\_\_

**LIST STAFFING PATTERN FOR EACH TEAM**

TEAM 1

Number of Consumers: \_\_\_\_\_

Health Home Director's Name: \_\_\_\_\_

|                    |                                     |
|--------------------|-------------------------------------|
| Full-time Employee | Part-time Employee (how many hours) |
|--------------------|-------------------------------------|

Nurse Care Manager's Name: \_\_\_\_\_

|              |      |    |
|--------------|------|----|
| License Type | APRN | RN |
|--------------|------|----|

Expiration Date: \_\_\_\_\_

Nurse Care Manager's Name: \_\_\_\_\_

|              |      |    |
|--------------|------|----|
| License Type | APRN | RN |
|--------------|------|----|

|                 |  |
|-----------------|--|
| Expiration Date |  |
|-----------------|--|

**NEEDED FOR EVERY 500 CONSUMERS**

Primary Care Liaison's Name: \_\_\_\_\_

|              |      |    |
|--------------|------|----|
| License Type | APRN | MD |
|--------------|------|----|

Expiration Date: \_\_\_\_\_

Care Coordinator(s)

|       |    |    |
|-------|----|----|
| Name: | BS | MS |
|-------|----|----|

|       |    |    |
|-------|----|----|
| Name: | BS | MS |
|-------|----|----|

|       |    |    |
|-------|----|----|
| Name: | BS | MS |
|-------|----|----|

|       |    |    |
|-------|----|----|
| Name: | BS | MS |
|-------|----|----|

|       |    |    |
|-------|----|----|
| Name: | BS | MS |
|-------|----|----|

|       |    |    |
|-------|----|----|
| Name: | BS | MS |
|-------|----|----|

**ADDENDUM  
FOR  
COMPREHENSIVE PSYCHIATRIC EMERGENCY PROGRAM (CPEP)**

Capacity:

**NAMES OF EXECUTIVE STAFF**

|                                |                   |
|--------------------------------|-------------------|
| CPEP PROGRAM DIRECTOR:         | EMAIL:            |
| CLINICAL DIRECTOR:             | NUMBER:           |
| PSYCHIATRIST:                  | EMAIL:            |
| QUALITY COORDINATOR:           | NUMBER:           |
| DESIGNATED PRIVACY OFFICER:    | EMAIL:            |
| MEDICAL RECORDS ADMINISTRATOR: | NUMBER:           |
| SECURITY COMPANY/GUARD(S):     | EMAIL:<br>NUMBER: |
| SECURITY COMPANY/GUARD(S):     | EMAIL:<br>NUMBER: |
| SECURITY COMPANY/GUARD(S):     | EMAIL:<br>NUMBER: |

Describe security and safety services, staffing plan and evidence of security and safety services that will be present 24hrs/day 7days/week.

---

---

---

---

---

---

---

---

---

---

**Attestation Letter attached**

**ADDENDUM  
FOR  
PSYCHIATRIC CRISIS STABILIZATION**

Capacity:

**NAMES OF EXECUTIVE STAFF**

|                                |                   |
|--------------------------------|-------------------|
| PROGRAM DIRECTOR:              | EMAIL:<br>NUMBER: |
| CLINICAL DIRECTOR:             | EMAIL:<br>NUMBER: |
| PSYCHIATRIST:                  | EMAIL:<br>NUMBER: |
| QUALITY COORDINATOR:           | EMAIL:<br>NUMBER: |
| DESIGNATED PRIVACY OFFICER:    | EMAIL:<br>NUMBER: |
| MEDICAL RECORDS ADMINISTRATOR: | EMAIL:<br>NUMBER: |

**ADDENDUM  
FOR  
YOUTH/ADULT MOBILE CRISIS AND OUTREACH**

Adult    Youth    Both   Capacity:

**NAMES OF EXECUTIVE STAFF**

|                                |                   |
|--------------------------------|-------------------|
| PROGRAM DIRECTOR:              | EMAIL:<br>NUMBER: |
| CLINICAL DIRECTOR:             | EMAIL:<br>NUMBER: |
| PSYCHIATRIST:                  | EMAIL:<br>NUMBER: |
| QUALITY COORDINATOR:           | EMAIL:<br>NUMBER: |
| DESIGNATED PRIVACY OFFICER:    | EMAIL:<br>NUMBER: |
| MEDICAL RECORDS ADMINISTRATOR: | EMAIL:<br>NUMBER: |

**ADDENDUM  
FOR  
TRANSITIONAL PLANNING**

Medicaid ID Number:

Location of where services are being held:

Capacity of Program:

Name of qualified Supervisor according to §6510.9:

Names of line staff according to §6510:

Program Description:

**ELIGIBLE PROVIDERS MUST BE ENROLLED IN MEDICAID (§6507.1) AND IN ACCORDANCE WITH THE REQUIREMENTS OF TITLE 29 CHAPTER 94, AS A(N): PLEASE SELECT ONE OF THE FOLLOWING WHICH QUALIFIES YOUR AGENCY ALONG WITH EVIDENCE IN WHICH IT PERTAINS TO:**

- Mental Health Rehabilitation Services (MHRS) provider; or
- Adult Substance Abuse Rehabilitative Services (ASARS) provider; or
- Free Standing Mental Health Clinic (FSMHC); or
- Federally Qualified Health Center (FQHC)

**Other Requirements:**

- A transition planning provider shall participate through a formal agreement with a registered Health Information Exchange (HIE) entity of the DC Health Information Exchange (DC HIE), defined in Title 29 DCMR Chapter 87 (§6507.9).
- Evidence of how the agency meets each of the requirements according to §6507.2 (a-e)
- Submit evidence of training according to §6510.8 (e)

**Required Policies**

The following provider policies shall be submitted for review:

- Client/Consumer Rights Policy;
- Language Access Policy; and
- Client/Consumer Choice Policy.