1115 SUD Waiver Facility Application Form

1	Agency Name: Date:
2	Physical address: (Location of this facility where services are provided)
3	Mailing address:
4	Program Contact: Phone: E-Mail:
5	Indicate what 1115 Waiver Services the facility will be providing at this location (check all that apply for services the agency will be **implemented immediately** upon approval of this application. Services not yet ready to be implemented, must have a separate 1115 waiver facility application): ☐ 1.0 Outpatient Services ☐ 2.1 Intensive Outpatient ☐ 2.5 SUD Partial Hospitalization ☐ Community Recovery Support Services (CRSS) ☐ 23 Hour Crisis Stabilization Observation ☐ 3.1 Clinically Managed Low Intensity Residential ☐ 3.3 Clinically Managed High Intensity Residential (Population Specific) ☐ 3.5 Clinically Managed High Intensity Residential Adult ☐ 3.5 Clinically Managed Medium Intensity Residential Adolescent ☐ 3.7 Medically Monitored Intensive Inpatient Services ☐ 4.0 Medically Managed Intensive Inpatient Services ☐ 1.0 Ambulatory Withdrawal Management (With/Without Extensive Onsite Monitoring) ☐ 3.2 Clinically Managed Residential Withdrawal Management ☐ 3.7 Medically Monitored Inpatient Withdrawal Management ☐ 4.0 Medically Managed Intensive Inpatient Withdrawal Management ☐ SUD Care Coordination Services (known as MAT Care Coordination) ☐ Intensive Case Management Services (ICM) ☐ Peer Based Crisis ☐ Mobile Outreach & Crisis Response ☐ Treatment Plan Development/Review ☐ Crisis Residential Stabilization
6	What is the target date to begin services at this location: Note: Medicaid enrollment after Department approval requires up to four weeks when processing new applications and backdating enrollment files is prohibited.
7	Would Medicaid be billed for eligible recipients who receive services at this facility location? ☐ Yes ☐ No
8	Choose the National Accreditation Agency that will accredit the location & services: ☐ CARF ☐ Joint Commission ☐ COA ☐ Alternative Accreditation ☐ Unknown
9	I understand that for this location, our agency must collect and report the statistics, service data, and other information requested by the department: ☐ Yes ☐ No

Certification Statement:

I certify that the responses in this request and the information in the attached documents are accurate, complete, and current. I understand the information may be verified by Division of Behavioral Health (Division) staff upon on-site evaluations. I understand the Division has the authority and discretion to grant this approval in the absence of an updated Community Action Plan if it will enhance the continuum of services for the service area.

Name (print): ______________________ Signature: ______________________

(Administrator or Authorized Person)

Date: ______________________