MA Department of Public Health / Bureau of Substance Abuse Services

ATR NEW PROVIDER APPLICATION

IDENTIFYING INFORMATION ­– Please Provide Your Organization Information

1. LEGAL name of organization:
2. Other name (doing business as):
3. Mailing address:

 City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip:

1. Executive Director/CEO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Title:

 Phone: Fax: TTY:

 E-Mail:

1. ATR-specific contact person at your organization (SPOC) Single Point of Contact:

 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title:

 Street Address:

 City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip:

 Phone: Fax: TTY:

 E-Mail:

1. Will ATR services be provided at other locations than the one above? ❑ Yes ❑ No
2. If yes, please list program, facility, address, and phone:

 a.

 b.

 c.

Information TECHNOLOGY Requirements

1. To participate in MA ATR your organization must have the following technical capacity: please check to affirm you have the following:

 ❑ Email ❑ Fax Machine

 ❑ Secure Internet access ❑ Internet browser ❑ Adobe acrobat

1. To use the Voucher Management System a provider must have a Secure Internet Connection using the WINDOWS operating system -Windows 7 or higher and Internet Explorer 10 or higher (Also works with Chrome, Google, and Firefox browsers).

**Apple MAC computers are not compatible with the system.**

Business Information

***If you are a current “BSAS contracted agency” and your updated information is on file, check
here*** ❑***. If checked, you can skip questions 10–11.***

1. If your program/organization is subject to approval by the Massachusetts Secretary of State, please submit evidence that you are in good standing. For example, not for profits should submit 501 C (3) certificate and Incorporated Organizations should submit Articles of Incorporation or other evidence that the corporation or business is in good standing.
2. National Provider Number (NPI): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Federal Tax ID#:

Applicable Licenses/Approvals/Accreditations and Insurance

1. All providers are required to submit evidence of ***current professional and commercial general liability insurance***. Some providers may need to carry additional insurance including worker’s compensation, commercial auto and additional liability insurance. *Please attach all current certificates of insurance for your organization.*
2. Please include ***building and fire inspection certificates*** for all facilities/addresses your organization operates in (listed on the first page of this application, including additional facilities listed in #7). *Certificates must be current within the last year*.

Financial Management and Internal Controls

1. Current Fiscal Year Operating Budget for the organization: \_$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Last Fiscal Year Operating Budget for the organization: \_$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Attach your Summary Audit Letter for the organization from most recent fiscal year-end audit

History of Sanctions/Adverse Events

|  |  |  |
| --- | --- | --- |
| **QUESTIONS 17–22** | **YES** | **NO** |
| 1. Is any officer, owner or executive staff of this organization currently doing business with the Department of Public Health, Bureau of Substance Abuse Services or Advocates for Human Potential (AHP) under a different name?
 |  |  |
| 1. Has any officer, owner or executive staff of this organization previously done business with the Department of Public Health, Bureau of Substance Abuse Services or Advocates of Human Potential (AHP) under a different name?
 |  |  |
| 1. Is there any current investigation or litigation pending against the organization or its employees?
 |  |  |
| 1. Has the organization had monies recouped from DPH or AHP?
 |  |  |
| 1. Has any government agency investigated, suspended, revoked or taken any other action against the organizations license to do business?
 |  |  |
| 1. Has the organization had professional liability insurance refused, revoked, declined or accepted on special terms?
 |  |  |

**If you answer yes to 17-22**, please describe each sanction or adverse event below.

Services to be Provided Through MA-ATR

1. Please check off which services you want to provide to ATR participants.
* Purchasing/Basic Needs (i.e. Take individuals shopping, Write checks)
* Health and Wellness - Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Recovery Coaching
* Transportation (Bus passes. T passes. Charlie Cards)
* Groups – Describe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Faith Based Services – Describe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Housing Search
* Job training (either job readiness or occupational training)
1. ***Note:*** If you want to provide a Recovery Support Service that is not listed, please write-in “Proposed New ATR Service” with a detailed description of the service that you would like MA-ATR to consider including as part of the program.

Staff

1. List below the names, qualifications, and if applicable, licenses and credentials of staff providing services to ATR clients.

|  |  |  |
| --- | --- | --- |
| **NAME** | **TITLE** | **LICENSURE / CREDENTIALS / CERTIFICATES (IF APPLICABLE)** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

1. CORI certification:

I affirm that I have read 105 CMR 15.00, the EOHHS CORI Regulations (unofficial version available at [www.mass.gov/hhs/cori](http://www.mass.gov/hhs/cori)) and understand how these regulations impact my organization.       \_\_\_\_YES            \_\_\_NO

I affirm that I will act in accordance with the EOHHS CORI regulations, including but not limited to becoming CORI Certified, establishing and maintaining CORI Hiring Policies and Procedures that address new hires and existing staff. \_\_\_\_\_YES \_\_\_\_\_\_NO

SPECIFIC SERVICES

*The following sections are service-specific.
Only fill out the sections that apply to the ATR services you will provide.*

***Please respond to the sections that pertain to the services you intend to provide under the ATR Program. If you are not providing these specific services, please skip to the Attestations and Signature Page.***

TRANSPORTING CLIENTS

1. Provide a copy of the current, appropriate Driver’s License (Public Chauffer’s License or Commercial Driver’s License) for all drivers who will be transporting ATR clients.
2. How does the program verify these licenses continue to be in good standing with
the RMV? Please describe.

1. Attach Proof of Insurance for all vehicles that will be used to transport ATR clients.
2. How will the organization ensure that drivers are not using illegal substances or driving under the influence of alcohol or other drugs? Please explain.

1. Are all vehicles used for client transport well maintained, safe and in good condition? ❑ Yes ❑ No
2. Please include your policies and procedures relating to routine inspection and maintenance of vehicles.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child Care

1. Do you have a current license with EEC? ❑ Yes ❑ No

 If yes, please provide number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If no, please describe efforts to obtain applicable licenses:

1. Are there any open complaints against the licensee? ❑ Yes ❑ No

 If yes, please describe:

1. Please describe in detail the program you will be providing.

Employment and Training

1. Describe your employment training program.

1. Describe your job placement efforts.

RECOVERY COACHING

1. If your organization wants to provide Recovery Coaching as part of ATR, please read the text below carefully, fill out the table on the next page, and attach required certificates for all recovery coaches and their supervisors, signed confidentiality pledges, and bios for coaches.

**To Provide Recovery Coaching your organization must:**

* Be an approved ATR Provider through the Department of Public Health/Bureau of Substance Abuse Services and
* Provide supervision to recovery coaching staff by a supervisor who has completed the BSAS Recovery Coaching Supervisor training.

**An ATR Recovery Coach must:**

* Be trained and submit a certificate of completion from a BSAS approved Recovery Coach training program (such as the Recovery Coach Academy: http://ccar.us/training-and-products/recovery-coach-academy/)
* Work under the supervision of a supervisor who has completed the BSAS Recovery Coaching Supervisor training.
* Submit a short (1 paragraph) bio on each coach with this application that includes:
	+ Name, Gender, Race, Ethnicity
	+ Locations where they are willing to travel
	+ Languages spoken
	+ Approach to recovery coaching (i.e. 12-step, faith-based, etc.)
	+ Any additional information about themselves or their recovery story they want to share
* Read, sign and submit an ATR Confidentiality pledge

**A supervisor of a Recovery Coach must:**

* Have completed the BSAS Recovery Coaching Supervisor training and submit certificate. Click on this link to see when the next training will be held:

<http://www.cvent.com/EVENTS/Calendar/Calendar.aspx?cal=66c093dd-41d5-4c76-9dfd-dda0178086f1>

* Read, sign and submit an ATR Confidentiality Pledge
* Have supervision experience
* Understand that recovery coach supervision is different from clinical supervision

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name of Recovery Coach** | **Recovery Coach Email** | **Recovery Coach Phone Number** | **Certificate Attached?** | **Bio Attached?** | **Confidentiality Pledge Attached?** | **Name of Recovery Coach Supervisor** |
| ***Example:*** *John Doe* | *Johndoe@agency.org* | *413-555-0314* | *Yes* | *Yes* | *Yes* | *Jane Doe* |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of Recovery Coach Supervisor** | **Supervisor Email** | **Supervisor Phone** | **RC Supervisor Certificate Attached?** | **Confidentiality Pledge Attached?** |
|  |  |  |  |  |
|  |  |  |  |  |

Attestations and Signatures

1. I have read and understand the MA-ATR Provider Manual and MA-ATR Program Requirements referenced therein and on the MA-ATR website ([www.ma-atr.org](http://www.ma-atr.org)). I understand and agree that it is my responsibility to ensure that my organization and staff are at all times complying with MA ATR Program Requirements, including any and all amendments, updates or revisions.
2. I hereby attest that the foregoing answers, statements and attachments are true and correct and made under the pains and penalties of perjury. At any time, if any of the information included in or attached
to this Application changes, I will notify MPDH/BSAS. I understand that incomplete applications may be returned.

 *Signature of Executive Director/CEO* *Date*

 *Name (please print) Title*

 *Signature of ATR Single Point of Contact (SPOC) Date*

 *Name (please print) Title*

**Please email or mail the completed and signed application and attachments to Suzannah Kratz.**

Email: skratz@ahpnet.com

Address:

Suzannah Kratz

Advocates for Human Potential, Inc.

41 State Street, Suite 500

Albany, NY 12207

For questions regarding the application process and required materials, please contact Suzannah at:

Office phone: 518-729-1242