



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: _____
4. Executive Director/CEO: _____ Title: _____
Phone: _____ Fax: _____ TTY: _____
E-Mail: _____
5. ATR-specific contact person at your organization (SPOC) Single Point of Contact:
Name: _____ Title: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____ TTY: _____
E-Mail: _____
6. Will ATR services be provided at other locations than the one above? Yes No
7. If yes, please list program, facility, address, and phone:
 - a. _____

 - b. _____

 - c. _____

INFORMATION TECHNOLOGY REQUIREMENTS

8. 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
9. To use the Electric Services Management System (Falling Colors) 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.

10. 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.

11. National Provider Number (NPI): _____ Federal Tax ID#: _____

APPLICABLE LICENSES/APPROVALS/ACCREDITATIONS AND INSURANCE

12. 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.*
13. 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

14. Current Fiscal Year Operating Budget for the organization: \$ _____
15. Last Fiscal Year Operating Budget for the organization: \$ _____
16. 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
17. Is any officer, owner or executive staff of this organization <u>currently</u> doing business with the Department of Public Health, Bureau of Substance Abuse Services or Advocates for Human Potential (AHP) under a different name?		
18. Has any officer, owner or executive staff of this organization <u>previously</u> done business with the Department of Public Health, Bureau of Substance Abuse Services or Advocates of Human Potential (AHP) under a different name?		
19. Is there any current investigation or litigation pending against the organization or its employees?		
20. Has the organization had monies recouped from DPH or AHP?		
21. Has any government agency investigated, suspended, revoked or taken any other action against the organizations license to do business?		
22. 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

23. 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)

24. **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

25. 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)

26. 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) 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

27. 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.

28. How does the program verify these licenses continue to be in good standing with the RMV? Please describe.

29. Attach Proof of Insurance for all vehicles that will be used to transport ATR clients.

30. How will the organization ensure that drivers are not using illegal substances or driving under the influence of alcohol or other drugs? Please explain.

31. Are all vehicles used for client transport well maintained, safe and in good condition? Yes No

32. Please include your policies and procedures relating to routine inspection and maintenance of vehicles.

EMPLOYMENT AND TRAINING

33. Please describe your training program and curriculum. Include the number of weeks for the program and note if there are different sessions for classroom vs. internship/on-the-job (e.g. 6-week program; 8-week program has two 4-week sessions, first classroom then internship), the learning goals of the program and what types of jobs participants can apply for at the end of the program and job placement efforts that will be made. Note any credentials/certifications that will be provided at the end of the course, or if the participant will be prepared to take any particular tests/certifications.

34. Does your organization conduct follow up measures with your graduates? If so, would it be possible to share job placement outcomes related to ATR participants with us?

RECOVERY COACHING

35. 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.
- 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?	Confidentiality Pledge Attached?	Name of Recovery Coach Supervisor
<i>Example: John Doe</i>	<i>Johndoe@agency.org</i>	<i>413-555-0314</i>	<i>Yes</i>	<i>Yes</i>	<i>Jane Doe</i>

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

ATTESTATIONS AND SIGNATURES

36. 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). 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.
37. 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 the completed and signed application and attachments to Suzannah Kratz.

Email: skratz@ahpnet.com

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

Office phone: 978-460-2064