**APPLICATION FOR NEW**

**Alcohol/Drug Treatment Program**

*Complete one application per Program Location*

**Organization/Corporate Information *Please Print Legibly***

Please check if you are applying for a Licensure  or a Certification

Legal Name of Organization/Corporation:

National Provider Identification (NPI) #

Organization/Corporation Office Address:

City:       State:       Zip:

Corporate Office Telephone:       Fax:

Executive Director of Alcohol and Drug Program:

Executive Director Mailing Address:

City:       State:       Zip:

Telephone:       Email:

**Board President Name** *if applicable***:**

Telephone:       Email:

**Website:**

**Program Location Information *Please Print Legibly***

Program Name:

Program’s Street Address:      

City:       State:       Zip:

Program’s Telephone:       Fax:

Name of Program Director:

***The Program Director receives site visit summaries, scheduling letters & mass emails from the State in email format.***

His/Her Mailing Address:

City:       State:       Zip:

Telephone:       Email:

**Program Information**

Program Hours of Operation: A.M.       P.M.

Other: (please specify)

**PTOTENTIAL Funding Sources** (check all that apply): Medicaid  AAPS

SB123  4th Time DUI  Private Pay

**Special program type**:

Faith Based SB 123 (program is receiving funds from DOC)

DUI Evaluations: Please complete an attestation for each individual and the DUI Evaluator spreadsheet

**Populations Served:**

*Please check all that apply*

Adolescents

Adult Men

Seniors or Older Adults

Women w/ Children

Adult Women

Pregnant or Postpartum Women

Co-Occurring

Persons with HIV or AIDs

Hearing Impaired

Native American

Gays or Lesbians

Criminal Justice

**Languages Available:**

*Please check all that apply for this program*

Spanish

Korean

Vietnamese

American Sign Language (ASL)

Other: (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Program Services Provided and number of beds, if applicable**.

Number of Beds

Acute Detox

Inpatient

Social Detoxification

Therapeutic Community

Intermediate

Reintegration

Total Number of Beds:

Outpatient: Intensive

Outpatient: Counseling Treatment

Early Intervention/Interim Services

Opioid Maintenance Treatment: **MEDICAL DIRECTOR**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol & Drug Assessment & Referral Program *(****Required by all programs****)*

**Required Signatures:**

Name/Title of person completing this application Date

Executive Director of Alcohol & Drug program Date

Please return the completed application with all required materials to:

*Stephanie.Simpson@ks.gov* ***Or***

KDADS/ Survey Certification & Credentialing / *Attention: Stephanie Simpson*

612 S. Kansas Avenue, Topeka, KS 66603

**APPLICATION PACKET AND REQUIRED MATERIALS CHECKLIST**

**Application-** an application is NOT considered complete until all required materials are received. KDADS has 90 days from the date of a COMPLETED application submission to make a determination.

**Application Fee** (enclose a fee of $100.00 per Program Location. Make checks payable

to: The Department for Aging & Disability Services/Survey Certification & Credentialing.)

**Complete Program Policy and Procedure Manual** (Written Policy and Procedures must include applicable statues and regulations. Those standards which read “A licensee shall develop, implement and comply with…” are required to be specific to that program and location. General policies and procedures or copies of the standards will not be accepted)

**Complete list of employees, job titles and BSRB credentials (if applicable)**

**Organizational chart including the agency board**

**Proof of liability and malpractice insurance**

**Fire and safety inspection conducted by the STATE fire marshal**

**Client admission paperwork*-***Please put together a “new client” admission packet to include:

* ***Client Rights***
* ***Grievance policy and procedure***
* ***HIV, transmission, high risk behavior and infectious pulmonary tuberculosis client information***
* ***Confidentiality policy***
* ***Treatment Service fees***
* ***Consent to treatment***
* ***Alcohol/drug testing, if applicable.***

**A copy of the program assessment tool used, if not using the KCPC**

**A copy of the additional Substance abuse assessment tool used (SASSI, MAST, etc..)**

**Treatment forms to include:** Treatment Plan, Treatment Plan Update, Discharge Plan, Discharge Summary,

**Release of Information forms to be used**

**If providing adolescent services-** Criminal and abuse or neglect background checks.

**If providing** **Early Intervention/Interim treatment-** Curriculum information that will be used. Or a description of how the program will meet the needs of their clients through this level of care.

**If making electronic entries,** signed password protection and security agreement by each staff member.

**If completing DUI Evaluations**

Attestations for each individual who will be completing the evaluations

Completed DUI Evaluator Spreadsheet

Required Security information, found at <https://webapps.kdads.ks.gov/LSOBP18/f?p=101:210>

1) The KDADS security agreement- the embedded on-line submission form on this page.

2) The EAS Citrix security form

3) The DCF security form

4) The awareness training (cyber) & submission of the certificate at the end.

5) If your computer doesn’t already have the KCPC, then you will need to complete the computer questionnaire.

\*\*Please advise that an application is considered complete when **all** required information has been received and approved. All standards relevant to services provided must be met before an application will be approved and a license issued. \*\*