Application for ***Approved Program Status*** with The Kentucky Department of Corrections for Substance Use Treatment Providers

I. TYPE OF APPLICATION *(Check all that apply.)*

- ☐ Initial Approval
- ☐ Annual Re-Approval
- ☐ Addition/Change in Service
- ☐ Change of Name
- ☐ Change of Location
- ☐ Change of Ownership

II. TYPE OF AGENCY

- o Government Agency
- o Private Agency
- o Non-Profit Agency
- o Corporate Agency

III. TYPE OF SERVICES *(Check all that apply.)*

- ☐ ASAM Level 3
  - ☐ 3.7 Medically Managed Residential
  - ☐ 3.5 Clinically Managed High-Intensity Residential
  - ☐ 3.1 Clinically Managed Low-Intensity Residential
- ☐ ASAM Level 2
  - ☐ 2.7 Medically Managed Intensive Outpatient
  - ☐ 2.5 High Intensity Outpatient
  - ☐ 2.1 Intensive Outpatient
- ☐ Medication Assisted Treatment
  - o Naltrexone
  - o Buprenorphine
  - o Sublocade
  - o Methadone
  - o Does not offer, but allows_____
  - o Other _____

IV. IDENTIFICATION

AODE/BHSO License Number: _____

Name of Facility: _____

Physical Location of Facility: _____
(Street) (City)

_____
(County) (State) (Zip Code)

Mailing Address: _____
(If different from above) (Street) (City)

_____
(County) (State) (Zip Code)

Telephone Number: _____

Email Address: _____
(Primary contact for correspondence)

Site Director/Administrator Name: _____

Date facility began operating at current address: ____/____/____

Date facility began operating under current owner: ____/____/____

V. Referrals

Contact for Referrals if different than above: _____

Email:_____

Phone Number:_____

VI. OWNERSHIP *(Direct owner)*

Name of Owner: _____

Address of Owner: _____

(Street) (City)

_____

(County) (State) (Zip Code)

NOTE: Provide the following supporting documentation as an attachment to this application:

- The name, mailing address, email address, and phone number of each person or legal entity having an ownership interest in the facility.
- If owned by a corporation, the name, mailing address, email address, and phone number of each officer or director of the corporation.
- If owned by a partnership, the name, mailing address, email address, and phone number of each partner.

VII. PROGRAM EXTENTION SITES (*If more than one extension site, please attach the following information to the application.)*

a. Number of existing AODE outpatient extension location sites, excluding primary location: _____

b. Location information: (If more than one outpatient extension location exists, provide the following information as an attachment to this application.)

Name of Extension Site: _____

Physical Location: _____

(Street) (City)

_____

(County) (State) (Zip Code)

Telephone Number: _____

(Include Area Code)

Director/Administrator: _____

VIII. EVIDENCE BASED CURRICULUM

(Please include information for each evidence-based curriculum used in the program. Attach additional curriculum information to this application.)

Name of Curriculum: _____

Are staff required to receive training or become certified to facilitate? ☐ Yes ☐ No

If yes, how many staff have received the training and/or certified? _____

Length of program/Phases/Components included: _____

_____

- **If your program has a religious component please confirm that it is not required and an alternative option is offered by signing here: _____**

IX. GROUP DYNAMICS (*Check all that apply)*

Groups offered: ☐ AM ☐ Afternoon ☐ Evening

Gender Specific Groups: ☐ Yes ☐ No

X. FEE FOR SERVICES

- ○ Client Self Pay: Standard Fee _____ per group.
- ○ Client Self Pay: Standard Fee _____ per individual session.
- ○ Client Self Pay: Sliding Scale
- ○ Private Insurance
- ○ Medicaid
- ○ Medicare
- ○ Other _____

XI. ADDITIONAL DOCUMENTATION CHECKLIST (*To be attached.)*

- Copy of AODE License (*If more than one site, include all documents)*
- Documentation of all program staff education and verification of any professional license or certification related to counseling.
- List of all program staff, including administrative staff not involved in the provision of treatment.
- Example of current treatment plan.
- Section V: Additional Owner/Partner Information *(If needed)*
- Section VI: Program Extension Sites *(If needed)*
- Section VII: Additional Evidence Based Curriculum *(If needed)*
- Certification of Occupancy for each location
- Other Information About Your Agency or Program

XII. SIGNATURE OF AUTHORIZED REPRESENTATIVE

An incomplete application may result in return of the application to the applicant. A completed application should not be submitted to the Kentucky Department of Corrections at the address listed at the bottom of the document.

I understand that **any change** in the information provided within this application affecting the approval status of this agency or service will be reported to the Department of Corrections, Division of Addiction Services and a new application will be completed or supplemental information will be provided. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application may result in denial or revocation of licensure.

_____

Signature of Authorized Representative **Title** **Date**

Submit the completed application and any supportive documentation to:

Kentucky Department of Corrections
Division of Addiction Services
Bridgette Coy, Program Administrator
1101 Atkinson Hill Avenue
Bardstown, KY 40004
BridgetteR.Coy@ky.gov