Department of Medicaid Services
275 East Main St. 6W-A
Frankfort KY 40601

Email: DMS.Issues.ky.gov
Phone: (502) 564-6890

GENERAL INSTRUCTIONS

Complete ALL items on the form unless otherwise instructed.

Attest to ALL levels of care (LOC) you are applying for. If attesting to more than one LOC, include supporting documentation to clearly delineate between levels, including staffing and therapies.

Each DMS provisionally certified program is expected to obtain the American Society of Addition Medicine (ASAM) Level of Care (LOC) Certification for each attested LOC **prior to** the provisional certification end date.

Attestation should be submitted to DMS.Issues@ky.gov mailbox. with subject line "Specific Facility Name: SUD Residential Provisional Certification Attestation"

Prior to completing attestation, please view the following information regarding ASAM LOC Certification:

DMS Attestation Materials
ASAM LOC Certification
ASAM LOC 2023 Rating Element Updates
ASAM LOC Certification - Facts and FAQs
ASAM LOC Certification - Other Resources

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A. ENTITY INFORMATION

1. Legal Entity Name / Provider Name:

2. Residential Program Name (If different than Legal Entity Name used to identify the program):

3. Residential Program Street Address (Physical location/address where the program operates):

3a. City

3b. State/Zip

5. Mailing Address (If different than Program Address)

5a. Mailing City

5b. Mailing State/Zip

6. Contact Name

6a.Title

6b. Contact Email

6c. Contact Phone

7. National Provider Identifier (NPI)

8. Medicaid ID (If Applicable)

9. Tax ID

10. AODE Residential License#

10a. # of Licensed Beds

10b. Average Daily Residential Census

Additional Information:

11. Have you applied for the ASAM Level of Care Certification?

***Note: National Accreditation and ASAM LOC certification are two separate certifications**

11a. If yes, please include scheduled survey date.

12. Please indicate the following ASAM LOC Certification Resources utilized to prepare for certification:

- ☐ ASAM LOC Certification Manual
- ☐ ASAM LOC Certification Preparation Workbook
- ☐ ASAM LOC Certification Training Modules
- ☐ The ASAM Criteria

Program Types

Select the appropriate ASAM Level(s) Of Care for which you are seeking DMS Provisional Certification. By checking this LOC you attest the program has received the appropriate licensure and that you are compliant with all applicable State regulations for the LOC indicated.

Please Note: ASAM LOC Certification must be obtained by the end of the Provisional Period for each attested LOC.

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B. Program Description	ASAM LOC	Attesting For:
Clinically Managed Low-Intensity Residential Services: 24-hour supervised residence that provide at least 5 hours of clinical service per week (not intended to describe recovery residences where clinical treatment services are not provided). 3.1 Programs provide opportunity to develop and practice interpersonal and group living skills who required structured daily activities as individuals work toward community reintegration. *Allowable in PT 03 or PT 30	3.1	☐
Clinically Managed High-Intensity Residential Services: 24-hour care that requires stabilization of intensive therapies provided by licensed therapist. 3.5 programs provide a safe and stable environment so that individuals refrain from relapse. **Allowable in PT 03, PT 06 or PT 30*	3.5	☐
Medically Managed High-Intensity Residential Services: 24-hour professionally directed evaluation, medical monitoring, and addiction treatment in an inpatient setting. 3.7 programs do not require the full resources of an acute care general hospital or a medically managed inpatient treatment program. **Allowable in PT 06, PT 26 treating SUD, or PT 30 with CDTC License*	3.7	☐

C. ASSESSMENT / TREATMENT PLAN	Check all that apply
13 Duration of stay is based on recipients progress, not predetermined.	☐
14 Physical examinations and policies for each patient address:	
Completion by provider(s) employed or contracted by the program	☐
Admissions on weekends and holidays	☐
What should be included in the physical examination	
Documentation of the exam in the patient record	☐
As needed integration into the treatment plan of services to address identified medical needs	☐
Completion of physical exam with 48 hours (24 hours for ASAM Level 3.7) of admission	☐
If or when an exam would be accepted from an external physician	☐
15 Procedures for nursing address (*ASAM Level 3.7 Only*) :	
Alcohol or other drug-focused nursing assessment of each patient that is conducted at admission.	☐
Provision of nursing services 24/7 and reflected on staffing schedule.	☐
16 Admission criteria includes:	
The ASAM 6 dimensional criteria	☐
DSM/ICD diagnosis	☐
Medical and psychiatric needs/conditions that would exclude admission into level of care assessed.	☐
17 Written procedures for biopsychosocial assessments specify:	
Qualifications of providers who can conduct the assessment	☐
Timeframe for completion of the assessment	☐
18 Treatment Planning procedures includes:	
Patient participation	☐
Plan is individualized	☐
Timeframes for initial development of plan, review and modification of the plan at least weekly (more frequently as needed for ASAM Level 3.7)	☐
Reflects current issues and maintained relevance	☐
Reviewed by an interdisciplinary team with knowledge about addiction treatment	☐
19 Program provides care coordination, at minimum to include:	
Referral to appropriate community services	☐
Facilitation of medical and behavioral health follow up	☐
Linking the recipient to the appropriate level of substance use treatment within the continuum to provide ongoing supports	☐

D. SUPPORT SYSTEMS	Check all that apply

20	Policy includes procedures to respond to urgent medical **and** psychiatric situations 24 hours a day, 7 days a week that address: a. Access to medical personnel b. When to call 911	☐ ☐
21	Program has direct affiliation or close coordination with other levels of care programs	☐

E. STAFF REQUIREMENTS

23	Program Director has: A master's degree, and Documentation of at least five (5) years of addiction treatment experience.	☐ ☐
24	There is a written contract for the medical director who is a physician **(MD or DO)**. (*ASAM 3.7 Only*)	☐
25	The program has a policy on staffing that demonstrates 24/7-365 coverage: By allied health professionals (*ASAM Level 3.1/3.5 only*) Nursing coverage, including credentials of nursing personnel (*ASAM Level 3.7 only*) Clinicians who are trained on biopsychosocial dimensions of substance use and mental health disorders and their treatment. Availability of supervisory personnel to respond to urgent situations	☐ ☐ ☐ ☐
26	At least one staff on-site, per day shift, 7 days a week to include one of the following according to DMS regulations: Approved Behavioral Health Practitioner, Approved Behavioral Health Practitioner under supervision, or Certified/Registered Peer Support Specialist, and Meet staff to patient ratio for appropriate group lead services.	☐ ☐
27	Team of licensed medical, addiction, and mental health clinicians who work with non-licensed professionals as an interdisciplinary team approach.	☐
28	Clinical staff with ability to explain purposes of psychotropic medications and interactions with SUD	☐
29	Affiliation with DEA waivered MD or APRN: (provide information)	

Provider Name: _____ NPI: _____

Contact Info: _____

License: _____ Other ID: _____

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F.THERAPIES		Check all that apply
30	Program directly provides:	
	Drug testing services	☐
	Mental Health services for co-occurring disorders	☐
	Physical Health (*ASAM Level 3.7 only*)	☐
31	Planned clinical program activities that meet ASAM LOC and statuatory requirements	☐
32	Program provides withdrawal management services.	☐
33	General medication procedures address:	
	How patients obtain medications when needed	☐
	Safe Storage	☐
	Dispensing medication	☐
	Monitoring patient adherence	☐
	Compliance with regulatory requirements pertaining to administration and storage	☐
34	Policies for **substance use disorder medications** that address:	
	How and when patients are assessed to determine need for SUD medications	☐
	How patients obtain medications when needed	☐
	For maintenance after discharge or transfer	☐
	Access to all FDA approved medications for SUD according to ASAM Level of Care Certification 2023 Rating Element Updates, and per beneficiary choice.	☐
35	Procedures for accessing psychiatric consultative services address (*ASAM Level 3.7 o* nly):	
	Response by phone within 8 hours	☐
	Response in person or via telemedicine within 24 hours or sooner	☐
36	Program schedule has evidence that shows individual **and** group therapy services provided by licensed clinicians.	☐
37	Program policies include:	
	Description of all services provided	☐
	Service objective(s)	☐
	The name and credentials of the personnel providing the service	☐
	Active treatment 7 days a week, including meaningful and intentional services on Saturday and Sunday	☐

F.THERAPIES, *continued*	Check all that apply

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38	Drug testing policy, at minimum, includes:	
	Determination of frequency	☐
	Randomization or methodology for selection	☐
	Who is qualified for ordering drug test	☐
39	Motivational enhancements and engagement strategies appropriate to the individual's stage of readiness and desire to change.	☐
40	Program offers recovery support services.	☐
41	Program offers services for patient's family and significant others.	☐
42	Program offers a range of cognitive, behavioral and other therapies adapted to the recipient's developmental stage, level of comprehension, understanding and physical abilities.	☐
43	Program offers planned community reinforcement fostering community living skills.	☐
44	Support system components include evidenced based services.	☐

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G. Attachments

List of attachments required with request for provisional certification.
****Please label all documents and keep all attachments in order.****

		Check all that apply
1	Linkage agreement(s) (if applicable) for all services not directly provided by the attested program	☐
2	Detailed weekly program schedule that includes: descriptions of the services provided, names and credentials of the personnel providing the services, the objectives of services provided, and reflects the provision of active, meaningful, intentional services 7 days a week.**If applying for more than one LOC, **program schedule needed for each level** and description of how programming is differentiated among LOC.	☐
3	Weekly staffing schedule that includes names of **ALL** staff providing services to the attested program and their credentials with coverage reflecting 24/7 staffing onsite in the facility, and on-call schedule(s)	☐
4	Certifications for ALL Non-Licensed Staff, including yearly documentation of CE trainings	☐
5	Copies of license(s) for Clinical and Medical Staff	☐
6	Example of 6 Dimensional Assessment Tool utilized for determining LOC and Treatment Plan Policy	☐
7	Admission and Physical Examination Policies and procedures	☐
8	Documentation supporting access to 24/7 emergency services for urgent medical and psychiatric situations	☐
9	Care Coordination and Discharge Planning Policy	☐
10	Medication Assisted Treatment (MAT) Policy	☐
11	Drug screen policy reflecting adherence to both DMS and ASAM expectations	☐
12	Clinical Laboratory Improvement Amendment (CLIA) Certification	☐
13	Current AODE Residential License	☐

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I hereby certify that all information contained in this document and the supporting documents is true and accurate.

I further understand that any information entered in this document that subsequently is found to be false may result in termination of any agreements that the facility has or may enter into with DMS and/or its contractors.

In compliance with the DMS Provisional Residential Certification/Attestation Form, the Facility attests that it will permit only staff members who are fully licensed and/or meet DMS program requirements to see and treat Medicaid eligible members.
I hereby give permission and consent for DMS and/or its contractors, to obtain and verify information provided in this form and consent to the release by any person, organization or other entity to DMS and/or its contractors, of all information relevant to the evaluation of the facility's ability to render addiction recovery and treatment services in a cost-effective manner and agree to hold harmless any such person or organization from any cause or
By signing this attestation, I agree that all statements are true and agree to abide by any contracted requirements for the services delivered under the authority of this agreement.

Printed Name:

Title:

Phone (if different)

Signatur

Date:

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TEAM KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES

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