DDA PROVIDER APPLICATION

I. BACKGROUND INFORMATION

A. Application is for (*select one*)**:**

○ **Individual Applicant** *(Sole Applicant registered with SDAT proposing to render waiver services and Applicant has no employees)*

○ **Agency** *(An entity registered with SDAT with 1 or more employees, excluding the owner)*

B. Application is for (*check all that apply*)**:**

☐ **An initial (new) provider**

☐ **A renewal (current provider renewing a license or DDA approval to render current services)**

☐ **A current provider seeking approval to render a service(s) which has not already been approved**

☐ **A current provider seeking to serve participants in another waiver**

☐ **Other – please explain:** ______________________________

C. Services will be provided in the *(check all that apply)***:**

☐ **Community Pathways Waiver** *(CPW)*

☐ **Community Supports Waiver** *(CSW)*

☐ **Family Supports Waiver** *(FSW)*

D. CPW Services are proposed for: ○ **Children** *(Aged 21 and under)* ○ **Adults** ○ **Both children and adults**

CSW Services are proposed for: ○ **Children** *(Aged 21 and under)* ○ **Adults** ○ **Both children and adults**

FSW *will serve participants attending school and children of all ages*

E. Applicant's Name or Name of Agency *(See Attachment 1)*

____

F. Applicant or Agency Address

____

G. Phone Number ______________________________

H. Email Address ______________________________

I. Do you have a National Provider Identifier? ○ Yes ○ No ***If yes****, provide number:* ______________________________
(See Attachment 2)

J. Do you have a DDA Medicaid Provider Identifier? ○ Yes ○ No ***If yes****, provide number:* ______________________________
(See Attachment 3)

K. Do you have a Business Tax ID Number? ◯ Yes ◯ No ***If yes,*** *provide number:* ______________________
(See Attachment 4)

L. How is your Agency organized? ◯ For profit ◯ Non-profit

M. Is your Agency incorporated? ◯ Yes ◯ No ***If yes,*** *please attach a copy of the Articles of Incorporation or Articles of Organization for your agency (See Attachment 5).*

N. Is your Agency registered as a Minority Owned Business (MBE)? ◯ Yes ◯ No

O. Is your Agency registered as a Disadvantaged Business Enterprise (DBE)? ◯ Yes ◯ No

P. Primary Contact Information

1. Director/CEO

Name and Position

____

Address

____

Phone Number ______________________ Fax Number ______________________

Email Address

____

2. Billing Contact/CFO

Name and Position

____

Address

____

Phone Number ______________________ Fax Number ______________________

Email Address

____

3. Board of Directors Chairperson/President

Name and Position

____

Address

____

Phone Number ______________________ Fax Number ______________________

Email Address

____

II. PROPOSED AND CURRENT SERVICES

Note: Effective 1/1/2018, providers may only be approved to render new supports and services in DDA's waivers in locations/sites which meet the Community Settings Rule. In order to provide licensed services to participants in DDA's Community Pathways Waiver, a provider operating a site which does not comply with the federal Community Settings Rule must have a transition plan approved by DDA. Site visits will continue to occur to provider operated sites as part of DDA's approval process. New licensed sites and all sites providing services to Community and Family Supports Waiver participants must be in compliance with the federal Community Settings Rule.

A. Check the Services/Supports for which DDA approval is sought.

1. Certified (Non-Licensed) Services *(Certified services are provided in the community but not in provider operated sites)*

☐ **Behavioral Supports**
- Behavioral Assessment
- Behavioral Plan
- Behavioral Consultation
- Brief Support Implementation Services

☐ **Career Exploration Services**
- ☐ Large Group
- ☐ Small Group

☐ **Community Development Services**

☐ **Employment Services**
- ☐ Co-Worker Employment Services
- ☐ Discovery
- ☐ Follow-Along Supports
- ☐ Job Development
- ☐ Ongoing Job Supports
- ☐ Self-Employment Development Supports

☐ **Family Supports Provider**
- ☐ Family and Peer Mentoring Supports
- ☐ Family Caregiver Training and Empowerment Services
- ☐ Participant Education, Training and Advocacy Supports

☐ **Fiscal Management Services**

☐ **Housing Supports**

☐ **Nursing Support Services**

☐ **Organized Health Care Delivery System Services**
- ☐ Assistive Technology and Services
- ☐ Environmental Assessment
- ☐ Environmental Modifications
- ☐ Live-in Caregiver Supports
- ☐ Transition Services
- ☐ Transportation Services
- ☐ Vehicle Modification Services

☐ **Personal Supports**

☐ **Remote Support Services**

☐ **Respite Care**
- ☐ Respite Care Services
- ☐ Respite Care Services – Camp

☐ **Shared Living**
- Matching Services
- Host Home Stipend

☐ **Support Broker Services**

☐ **Supported Living**

2. Licensed Services *(Licensed services are provided in sites operated by providers and licensed by OHCQ)*

☐ **Adult Residential Services**
- Community Living – Group Home
- Community Living – Group Home Trial Experience

☐ **Adult Residential Services - Enhanced Supports**
- Community Living – Enhanced Supports
- Community Living – Enhanced Supports Trial Experience

☐ **Children Residential Services**
- Community Living – Group Home

☐ **Career Exploration Service - Non-CSR Compliant**
☐ Large Group
☐ Small Group

☐ **Career Exploration Services - CSR Compliant**
CSR Compliance is required for Community Supports and Family Supports Waiver participants' sites and all new provider sites
☐ Large Group
☐ Small Group

☐ **Day Habilitation Services**
☐ CSR Non-compliant
☐ CSR Compliant
CSR Compliance is required for Community Supports and Family Supports Waiver participants' sites and all new provider sites.

☐ **Targeted Case Management Services**

Other Existing Services *(to be phased out)*
☐ Supported Employment
☐ Employment Discovery & Customization

B. Do you have an application pending approval to provide services/supports to DDA waiver participants?
○ Yes ○ No ***If yes****, please indicate proposed licensed, OHCDS, and/or DDA-certified services.*

C. Please list the licensed, OHCDS, and DDA-certified services you have already been authorized to provide and/or are currently providing to DDA waiver participants:

D. Check the area(s) where services/supports (current and proposed) will be provided *(check all that apply)*:

Central Maryland
- ☐ Anne Arundel County
- ☐ Baltimore City
- ☐ Baltimore County
- ☐ Harford County
- ☐ Howard County

Eastern Shore Maryland
- ☐ Caroline County
- ☐ Cecil County
- ☐ Dorchester County
- ☐ Kent County
- ☐ Somerset County
- ☐ Talbot County
- ☐ Queen Anne's County
- ☐ Wicomico County
- ☐ Worcester County

Southern Maryland
- ☐ Calvert County
- ☐ Charles County
- ☐ Montgomery County
- ☐ Prince George's County
- ☐ St. Mary's County

Western Maryland
- ☐ Allegany County
- ☐ Carroll County
- ☐ Frederick County
- ☐ Garrett County
- ☐ Washington County

III. EXPERIENCE AND TRAINING

Individual Applicants must complete this section or attach a resume which includes the information below. Agencies must submit resumes for Chief Executive Officers, Directors, Managers and Supervisors overseeing waiver services which demonstrate education and/or experience requirements are met.

A. Applicant's Education, Relevant Work/Life Experiences and Training

Do you have a high school diploma? ○ Yes ○ No? or GED? ○ Yes ○ No

Name of High School or GED program ______________________ Dates Attended ________ to ________

Address ______________________

Name of College or University ______________________ Dates Attended ________ to ________

Address ______________________

Major ____________ # of Credits ________ Degree earned ○ Yes ○ No Type of Degree ____________

(Submit copy as Attachment 6)

Name of College or University ______________________ Dates Attended ________ to ________

Address ______________________

Major ______________ # of Credits ______ Degree earned ○ Yes ○ No Type of Degree ______________ (Submit copy as Attachment 6)

B. Relevant Work and/or Life Experiences and Skills

Please list all relevant work and life experiences starting with your most recent experience. If more space is required, you may attach additional pages and/or your resume to this application. DDA will consider whether experience was full or part time, based on the number of years, and nature and intensity of needs of persons served against applicable eligibility criteria.

Dates ________ to ________ Years ______ Months ______ ○ Full-time ○ Part-time

Company Name and Address ______________________

Supervisor's Name and Job Title ______________________

Phone Number ______________ Email Address ______________________

Duties

Dates ________ to ________ Years ______ Months ______ ○ Full-time ○ Part-time

Company Name and Address ______________________

Supervisor's Name and Job Title ______________________

Phone Number ______________________ Email Address ______________________________________

Duties

C. Relevant Licenses, Certifications and Specialized Trainings

Provide type, number, expiration date(s), and grantor. Submit this information and submit copies as Attachment 7. Also see specific information which should be provided in the Instructions for Completing DDA Provider and Re-Enrollment Applications for DDA Approval DDA as a Qualified Supports/Services Provider ("QSP"), page 3.

IV. ADDITIONAL INDIVIDUAL OR AGENCY APPLICANT INFORMATION

A. Are you the sole owner of the Agency?
◯ Yes ◯ No ◯ Not applicable (Agency is incorporated) ***If yes****, provide a copy of your social security card.* ***If no****, please indicate your role and provide the full legal names, dates of birth, addresses, telephone numbers, email addresses, and social security numbers for each direct or indirect owner. Label information requested as Attachment 8.*

B. Have you obtained three (3) professional letters of reference attesting to your ability and your manager(s) and supervisors' ability to deliver the service/support in which approval is sought?
◯ Yes ◯ No ◯ Not applicable ***If yes****, please submit each professional reference as Attachment 9. Existing DDA agencies are exempt from this requirement.*

C. Is your Agency credentialed, accredited or certified?
◯ Yes ◯ No ◯ Not applicable ***If yes****, provide the name of accrediting body, license or certification number, state that issued the credential, accreditation, or certification, and service(s) that is accredited, and submit as Attachment 10.*

D. Do you or the Agency have general commercial liability insurance?
◯ Yes ◯ No ***If yes****, please specify the vendor, policy number, and coverage dates, or a price quote for Applicants. Submit this information and copies of coverage or quotes and label as Attachment 11.*

E. Do you have automobile insurance for all cars which will be used to conduct business?
◯ Yes ◯ No ***If yes****, specify the vendor, policy number, and coverage dates. Submit this information and copies of coverage as Attachment 12.* ***If no****, please explain.*

F. Are you or the Agency currently approved or licensed, or have you or the Agency been approved or licensed in the last five (5) years to provide services with any other state of Maryland or out-of-state agency?

○ Yes ○ No ***If yes****, please specify approved/licensed services, population served, and submit a copy of license(s). Also submit current and prior licensing reports issued within 10 years from any in-state or out-of-state entity, including deficiency reports and compliance records and label as Attachment 13.*

Note: During evaluation of your application, DDA may request that you provide for review OHCQ deficiency reports regarding DDA licensed services which were funded during the last 10 years.

G. Have you or the Agency been awarded any contracts and/or funding to provide licensed or non-licensed services/supports in the last five (5) years to any state of Maryland or out-of-state agency?

○ Yes ○ No ***If yes***, please specify the nature, amount of services, population served and term dates, if applicable. If you or the Agency has provided services in Maryland and another state, but no longer do so, please explain why you no longer provide those services.

H. Aside from the governing body required by COMAR 10.22.02/08, do you have any additional boards appointed to make decisions related to your Agency's operations?

○ Yes ○ No *Individual Applicants should skip this question.* ***If yes****, please explain.*

I. Do all locations in which new supports/services are proposed to be provided meet the federal Community Settings Rule (CSR)? ○ Yes ○ No ○ Not applicable *If you are a current provider with existing sites which do not meet the CSR, please check no and indicate if you have a transition plan approved by the DDA and date of approval. Please attach your approval letter to this application as Attachment 19. If you checked not applicable because you do not currently have any licensed sites or a proposed community location to render a certified service, please specify how you will ensure your eventual sites or community location will meet the federal CSR?*

J. Provide your Agency mission statement and describe how you will support individuals with developmental disabilities to live a life as diverse and enriching as others living in their communities. *Existing DDA agencies can skip this question. Add additional pages if needed. If you are applying as an individual behavior supports or an individual nursing professional, please describe what should be considered when supporting participants with challenging behaviors, co-occurring illnesses, and significant health needs.*

K. Describe how you or the Agency will ensure that individuals will have input regarding the services/supports that you provide. *Please skip this question if you are an Agency Applicant and completed the Agency Questionnaire and Information Form.*

L. Are you or is your Agency in good standing with the IRS and/or the Maryland State Department of Assessments and Taxation?

○ Yes ○ No ***If no****, please explain. If application is for renewal of DDA Approval or License to render current services and supports, attach completed IRS Form 990 for the previous year if business is a non-profit, or a completed Form 1120 if business is a for-profit. Label all information as Attachment 14. Information will be kept confidential and may be disclosed only in accordance with the provisions of the Maryland Public Information Act, General Prov. Art., Title 4, MD Ann. Code.*

M. Do you or your Agency have any outstanding debts to or disallowances from DDA, or other state and/or federal agencies?

○ Yes ○ No ***If yes****, please explain.*

N. Have you, your Agency, CEO, Executive Director, owner(s), manager(s) and/or supervisor(s) ever been disciplined in a manner which has resulted in sanctions, a reprimand, suspension, and/or expulsion from providing DDA-funded services or from participating in a state, federal, or local program or contract (i.e., Medicaid and/or Medicare), or private program?

○ Yes ○ No ***If yes**, please explain.*

O. Have you, your Agency, CEO, Executive Director, owner(s), manager(s) and/or supervisor(s) ever been affiliated with any program providing health care that has been placed on the Medicaid exclusion list?

○ Yes ○ No ***If yes**, please explain.*

P. Have you, your Agency, CEO, Executive Director, owner(s), manager(s) and/or supervisor(s) ever been convicted of a criminal offense, including any program under Title 18, 19 or 20 of the Social Security Act?

○ Yes ○ No ***If yes**, please explain providing detailed information about the conviction including but not limited to: date, state, county, court, nature, and type of offense or violation, and penalty imposed.*

Q. Are the required CJIS background or criminal history checks for the Applicant or Agency CEO, Executive Director, manager(s) and/or supervisor(s), behavioral supports professional(s), and owner(s) included in this application?

○ Yes ○ No *Please attach the required CJIS background or criminal history checks as Attachment 15.*

R. If you propose to serve children, do you or your Agency CEO, Executive Director, manager(s) and/or supervisor(s), and owner(s) of your Agency who will have direct access to children have child protective clearance(s)?

○ Yes ○ No ○ Not applicable *Please attach Child Protective Clearance(s), if applicable, and label Attachment 16.* ***If no**, please explain.*

V. DISCLAIMER

I hereby affirm under the penalties of perjury that the information given by me in this application is true and complete to the best of my knowledge and belief. I understand that to falsify information is grounds for disapproval of my application and for discharge as a provider should DDA be made aware of information contrary to which has been provided in this application. I authorize DDA to request and receive information from any person, organization or company listed on this application regarding my previous employment, education and qualifications to provide services and support under DDA's Family Support and/or Community Supports Waivers.

Privacy Notice – The information in your application is not routinely shared with other governmental agencies. However, by accepting this notice of privacy, I understand that the Maryland Department of Health's Medicaid Program, auditors, inspectors and other government officials may review it.

Applicant's Signature ____________________________ Date ____________________

Applicant's Title ____________________________

VI. REQUIRED INFORMATION ATTACHMENTS FOR ALL PARTICIPANTS:

A. Previous trade name and documentation for "doing business as," if applicable, labeled as Attachment 1;

B. Verification of the National Provider Identifier in the form of a document generated by the National Plan and Provider (NPPES), if applicable, labeled as Attachment 2;

C. Letter or document verifying DDA Medicaid Provider Number, if assigned, labeled as Attachment 3;

D. Letter from IRS verifying Business Tax ID number labeled as Attachment 4;

E. A copy of the Articles of Incorporation, if applicable, labeled as Attachment 5;

F. Copies of college degree(s) and resume(s) for all initial Applicants labeled as Attachment 6 (This attachment is not required for renewal Applicants);

G. Copies verifying relevant licenses, certifications and trainings for all initial Applicants. Renewal Applicants should provide updated licenses, certifications and evidence of training. Documents should be labeled as Attachment 7;

H. A copy of initial Applicant's social security card and owner(s) social security numbers and information labeled as Attachment 8;

I. Three letters of professional references, if an initial Applicant, labeled as Attachment 9;

J. Agency Credentials, Accreditations, or Certifications, if applicable, labeled as Attachment 10;

K. Copy of General Commercial Liability Insurance Coverage, or price quote for initial Applicants, labeled as Attachment 11;

L. Copy of Automobile Coverage pages labeled as Attachment 12;

M. Other State or Agency license(s) and prior licensing reports issued within the previous 10 years from any in-state or out-of-state regulatory office, including deficiency reports and compliance records (excluding OHCQ deficiency reports for DDA licensed services) labeled as Attachment 13;

N. Completed IRS Form 990 if non-profit, or Form 1120 if for-profit, for the previous year of business labeled as Attachment 14;

O. Required CJIS criminal background checks and for agencies, a current Table of Organization which identifies CEOs, Executive Directors, Managerial and Supervisory staff names and the waiver services this staff oversee. Please label these documents as Attachment 15**.** ***Note: See page 3 of the Instructions for completing and submitting required background checks for the DDA Provider Application;***

P. Child Protective Clearance(s), if applicable, labeled as Attachment 16;

Q. CSR transition plan approved by the DDA, if applicable, as Attachment 17;

R. Conditions of Participation form; and

S. Application Checklist.

STOP HERE IF YOU ARE AN INDIVIDUAL APPLICANT

VII. AGENCY QUESTIONARE AND INFORMATION FORM

This form should be completed in its entirety for initial Agency applications and Agencies seeking to renew DDA Certification and/or licensure. Current providers should indicate how information has changed since the previous application and provide current dates as applicable.

A. If applying for a license, has your Agency developed policies and procedures which meet requirements in COMAR 10.22.02.10?

○ Yes ○ No ○ Not applicable *If DDA approves your application, policies and procedures must be submitted to the OHCQ within 30 days of the date of approval of the application.*

B. Do you have worker's compensation insurance coverage?

○ Yes ○ No *Submit copy of document verifying your worker's insurance compensation vendor, coverage and term dates and label as Attachment 17.*

C. Do you have unemployment insurance coverage?

○ Yes ○ No *Submit copy of document verifying your unemployment insurance coverage vendor, coverage and term dates and label as Attachment 18.*

D. Do you have a policy which includes Governing Members' qualifications, role, frequency of meetings, minutes, etc.?

○ Yes ○ No ○ Not applicable *Licensed providers must complete the Governing Body Board of Directors' form and meet requirements in COMAR 10.22.08.*

E. Program Service and Quality Assurance Plans

All initial Agency Applicants (including those proposing to render non-licensed, DDA-certified services only) must have a Program Service and a Quality Assurance Plan. Applicants seeking to renew their licenses or DDA Certification to render services must submit Program Service and Quality Assurance Plans with signatures and dates which reflect approval and annual review from their Governing Body Members, the CEO or an administrator (as applicable), respectively. Renewal Applicants must also submit their Annual QAP Data Approval letter from DDA.

If you are an Agency seeking approval for certified services which do not require a license, does your quality assurance plan explain how your Agency is governed, identify individuals' roles, and explain how your quality assurance plan was developed? *Please check not applicable if an initial or renewal and you are proposing to provide licensed services.*

○ Yes ○ No ○ Not applicable

F. Is there a quality assurance plan included in this application?

○ Yes ○ No *Submit the Quality Assurance Plan and label as Attachment 19.*

G. Please check if the quality assurance plan includes the following required components:

1. Methods for ensuring that participants' preferences and choices are honored, and there are personal contacts with participants.

○ Yes ○ No

2. Describes how the Agency will support participants with developmental disabilities to participate in integrated community activities.

○ Yes ○ No *Licensed providers can indicate yes if a policy was previously submitted and approved by OHCQ addressing this.*

3. Person-centered plans for participants with measurable outcomes.

○ Yes ○ No

4. Activities involving collection and evaluation of data, analyzing trends, and appropriate interventions (which address incident reporting, evaluating and meeting behavior supports and/or health needs of participants, and use of restrictive interventions).
   ○ Yes ○ No

5. Goals and proactive strategies for accomplishing goals for delivery of quality services and supports.
   ○ Yes ○ No

6. Methods which ensure the following:

   a. All employees providing direct services with participants with developmental disabilities have required criminal background checks.
      ○ Yes ○ No

   b. Current and prospective employees convicted of crimes posing a risk to participants with developmental disabilities do not provide direct services and/or are assigned duties which require them to work alone with individuals.
      ○ Yes ○ No

   c. Current and prospective employees will meet statutory and regulatory requirements in the DDA policy of reportable incidents and investigations, rights of individuals afforded in annotated code of Maryland, Health-General, 7-1002 and required training in COMAR 10.22.02.
      ○ Yes ○ No

7. Describe in detail your experience operating a business. If you do not have this experience, please describe how you will obtain this expertise**.** *Please skip this question and check "not applicable" if you are a renewal Applicant.*
   ○ Not applicable

H. Proposed Budgets

If a DDA license and/or certification is granted to your Agency, payment for services and supports may not be received for up to 180 days from the date of service initiation. You will incur operating expenses during this period. Initial Applicants must submit the Agency's proposed budget for the first year of services and a projected budget for the next year. Agencies renewing a DDA-certification or license must submit their current budget and fiscal verification forms. All Applicants must also ensure submission of tax documents indicated in *Attachment 14.*

1. Are there current and/or proposed budgets included in this application as required? ○ Yes ○ No
   Submit budgets and fiscal verification forms as Attachment 20.

2. Please check if budgets include the following required components:

   a. Costs incurred from specified positions and employee salaries, taxes, equipment, insurance, space, transportation/travel, training, supplies, etc.
      ○ Yes ○ No

b. Sources and amounts of start-up funds for initial Applicants. Information provided must include verification of income in the form of a current letter (within 30 days of submission of application) from an accredited bank or other financial institution documenting a line of credit, business loan, or availability of funds in the owner's name.
○ Yes ○ No ○ Not applicable (current provider)

c. All sources of income, and details for any fundraising activities.
○ Yes ○ No

I. Please explain how the Agency will ensure sound fiscal operations?

J. Does the Agency have any outstanding debts to or disallowances from DDA, other state and/or federal agencies?
○ Yes ○ No ***If yes,*** *please explain.*

K. Organized Health Care Delivery System
Agencies designated as Organized Health Care Delivery System (OHCDS) may subcontract with Medicaid and Non Medicaid providers to allow individuals to receive services approved in their Person Centered Plan in the manner which best suits their needs and results in the more complete fulfillment of their plans. To qualify as an OHCDS, an Applicant must:

1. Provide at least one Medicaid service such as:
   a. Support services designated by the department
   b. Day Services
   c. Employment Services
   d. Residential Services
   e. Any other services designated by the department;

2. Be an enrolled Medicaid provider and render at least one Medicaid Service directly; and

3. Meet other requirements in COMAR 10.22.20

Are you applying to be designated as an organized health care delivery system?
○ Yes ○ No ***If yes****, please complete the Organized Health Care Delivery System Application form and submit it with your application labeled as Attachment 21.*

VIII. ADDITIONAL ATTACHMENTS FOR AGENCIES

A. Completed Agency Questionnaire and Information Form;

B. Copy of document verifying your worker's insurance compensation vendor, coverage and term dates labeled as Attachment 17;

C. Copy of document verifying your unemployment insurance vendor, coverage and term dates and labeled as Attachment 18;

D. DDA Program Service Plan for all service(s) applied for, or a current DDA PSP approval letter, Quality Assurance Plan/Information or QA approval letter, and transition plan approval letter for current provider existing licensed sites, if applicable, and label each document as Attachment 19;

E. Budgets and fiscal verification forms labeled as Attachment 20;

F. Organized Health Care Delivery System Application form, if applicable, labeled as Attachment 21.

IX. LICENSED PROVIDER INITIAL AND RENEWAL APPLICANTS – ADDITIONAL FORMS REQUIRED AND REVIEWED BY OHCQ

A. Governing Body – Board of Directors Form;

B. Staff Training Form – COMAR 10.22.02;

C. Staff Training Form – Office of Children, if applicable;

D. Staff Criminal History Form;

E. Policies and Procedures Form;

F. List of Licensed Site Locations Form (if applicable; renewals only); and

G. Addendum Application for Current License Form (to add a new site), if applicable.

X. DISCLAIMER FOR AGENCY APPLICANTS

Applicant's signature attests that all information in the Agency Questionnaire and Information Form are accurate and the required attachments are included with this application.

Applicant's Signature _______________________________ Date ________________

Applicant's Title _______________________________

XI. POLICIES REQUIRED FOR CHILDREN'S RESIDENTIAL SERVICES (COMAR 14.31.06)

A. Copies of the Program Administrator's required degrees, licenses, resume, and letter of appointment by the Board (COMAR 14.31.06.06(A)(2))

B. Description of facility, including diagram (COMAR 14.31.06.07)

C. Menu plan and Nutritional Consultant's report (COMAR 14.31.06.10.B.(2) & (9) (b))

D. Letters of support/documentation of need

E. Program service plan which addresses:

1. Philosophy of provision of services
2. Capacity of facility
3. Sex and age range of participants
4. Admission criteria
5. Client rights and grievance procedures
6. Individual service plans
7. Treatment Modalities
8. Family Involvement
9. Daily routines
10. Life needs
11. Religious activities
12. Allowances/money
13. Clothing/personal belongings
14. Personal hygiene standards
15. Sleep
16. Life skills
17. Training
18. Somatic health care
19. Child abuse and neglect
20. Discipline
21. Absent without leave (AWOL)
22. Discharge

F. Written policies and procedures as per COMAR reference noted in parenthesis, including:

1. Organization and administration (14.31.05.04)
2. Governance (14.31.06.04)
3. Personnel administration (14.31.06.05)
4. Employee duties and qualifications (14.31.06.06)
5. Emergency and General Safety, (14.31.06.08)
6. General program requirements (14.31.06.09)
7. Basic life needs (14.31.06.10)
8. Children's rights (14.31.06.11)
9. Children's services (14.31.06.12)
10. Health care (14.31.06.13)
11. Child abuse and neglect (14.31.06.14)
12. Behavioral Interventions, Strategies, and Supports (14.31.06.15)
13. Absence without leave (14.31.06.16)
14. Admission, individual service plan, behavior plan, and discharge (14.31.06.17)
15. Reports and records (14.31.06.18) and
16. Additional as required for licensure of specialized programs (14.31.07)

G. Physical plant inspection, including:

1. Report of Public Health Authority COMAR 14.31.06.07(A)(4)(a)
2. Report of Public Fire Authority COMAR 14.31.06.07(A)(4)(a)