SUBSTANCE USE DISORDER OUTPATIENT PROVIDER
STATE APPROVAL APPLICATION

Applicant Information:

Provider Name: _____

MT Professional License Number: _____

Mailing Address: _____

Primary Physical Address: _____

City:_____State/Zip:_____

Telephone Number:_____FAX:_____

E-mail:_____

Website Address: _____

Days of Operation_____ Hours of Operation_____

Indicate type of service to be State Approved (mark all that apply)

☐ DUI Educational Services
☐ MIP Educational Services
☐ Adult Outpatient (ASAM 1.0)
☐ Adolescent Outpatient (ASAM 1.0)

Proposed Service Area

Provide a list of each county where the Applicant proposes to provide SUD Outpatient services under this State Approval application. (listing telehealth to all counties will not be accepted)

County:_____

Site Address:_____

Phone Number:_____

County:_____

Site Address:_____

Phone Number:_____

If you are applying for multiple counties, please submit a separate document with that provides site address, phone number, and hours of operation.

Please include the following with the application:

- Copy of certificate of general liability insurance and professional liability insurance per ARM 37.27.120 (1)(h)

- At minimum, there must be policies and procedures that address the following:
  - Program organization and management (ARM 37.27.120);
    - Individual LAC assumes sole legal responsibility. LAC private office are not a facility and cannot bill for licensure candidates or other staff.
  - Acceptance of persons for treatment (ARM 37.27.115);
  - Client rights (ARM 37.27.116);
  - Communicable Disease Control (ARM 37.27.118)
  - Confidentiality (ARM 37.27.117 & 42 CFR Part 2);
  - Targeted populations (45 CFR 96.126 – 131)
  - Abuse or Neglect (ARM 37.27.119); and
  - Detailed description of program services.

- Documentation demonstrating local need *for each county* in application (see application supplement)

- Projected services form *for each county* in application (see applicationsupplement)

Application materials can be sent to bhddapprovalapps@mt.gov

I certify that all information I have submitted to DPHHS is true and correct. I have reviewed Administrative Rules of Montana (ARM) 37.27.101 through 37.27.138 and ensure substantial compliance with applicable requirements. This Application for Substance Use Disorder Individual Outpatient Treatment Provider State Approval is hereby submitted under the provision of Montana Code Annotated Sections 53-24-101 through 53-24-306.

I understand the application and possible issuance of a Letter of State Approval for Substance Use Disorder Prevention Services does not entitle any provider listed in this application to a contract for services or other funding available for Substance Use Disorder Outpatient Treatment Provider State Approval services.

Signature:_____ Date:_____

Printed Name:_____

Address:_____ City:_____ State/Zip:_____