DSAMH Provider Enrollment Questions & Answers

To be completed prior to Meet and Greet

Please answer all the following questions and return the document prior to your scheduled meeting.

Date: _____

1. Provider Name (Company Name): _____
   Representative Name: _____
   Representative Title: _____
   a. Do you currently provide services in or out of the state of Delaware?
      (If yes, please provide a list of services):
      _____

   b. What is your interest in Delaware?
      (Please provide background as to your choice to begin providing services or expand services in the State.)
      _____

   c. Which DSAMH-licensed services are you interested in providing?
      (please check all that apply)

☐ **Outpatient Treatment Services:** Outpatient Services ASAM Level 1
☐ **Outpatient Treatment Services:** Intensive Outpatient Treatment ASAM Level 2.1*****
☐ **Outpatient Treatment Services:** Outpatient Services ASAM Level 1 and Intensive Outpatient Treatment ASAM Level 2.1
☐ **Opioid Treatment Services:** Opioid Treatment Program (OTP) ASAM Level 1
☐ **OTP with mobile unit --** include VIN# of mobile unit(s):
☐ **OTP with medication unit --** include address of medication unit:
☐ **Co-Occurring Outpatient Services:** Partial Hospitalization Program (PHP): Co-Occurring Treatment Services ASAM Level 2.5
☐ **Ambulatory Detoxification:** WM Ambulatory Withdrawal Management ASAM Level 2
☐ **Ambulatory Detoxification Services:** WM Ambulatory Withdrawal Management with Extended On-site Monitoring ASAM Level 2
☐ **Residential Detoxification Services:** WM-23 Hour Ambulatory Withdrawal Management with Extended On-site Monitoring ASAM Level 2
☐ **Residential Detoxification Services:** WM Medically Monitored Inpatient Withdrawal Management ASAM Level 3.7
☐ **Transitional Residential Treatment:** Clinically Managed Low-Intensity Residential Treatment ASAM Level 3.1
☐ **Residential Treatment:** Clinically Managed High Intensity Residential Treatment

ASAM Level 3.5

☐ **Residential Treatment:** Medically Monitored Intensive Inpatient Treatment ASAM Level 3.7

d. Which DSAMH-certified services are you interested in providing? (please check all that apply)

☐ ACT (PROMISE)
☐ ICM (PROMISE)
☐ ACT Plus (PROMISE)
☐ Personal Care Service (PROMISE)
☐ Peer Service (PROMISE)
☐ Group Home (PROMISE)
☐ Facility Based Crisis Intervention
☐ Mobile Crisis Intervention
☐ OTHER: _____

e. Provider readiness for licensure/certification:
   i. Do you have policies and procedures as required for Licensure and Certification for services identified?
      ☐ Yes ☐ No

   ii. Do you have a facility location in mind?
      ☐ Yes ☐ No
      1. County: _____
         Address: _____
      2. Is facility ADA Compliant?
         ☐ Yes ☐ No
      3. Is facility zoned for appropriate use?
         ☐ Yes ☐ No

   iii. Do you have a Delaware Business License?
      ☐ Yes ☐ No

   iv. Do you have a staffing model commensurate with the services identified?
      ☐ Yes ☐ No

   v. To your knowledge, does your selected program model require other certifications or licenses from the DEA, SAMHSA, DHCQ, or other entities?
      ☐ Yes ☐ No

If yes, are they in process already or are you preparing this step currently?

☐ In Process Already ☐ Preparing This Step Currently

f. Will your program have an electronic health record?

☐ Yes ☐ No

i. If yes, which electronic health record are you currently using or considering using?

_____

g. Do you have planned hours and days of operation?

☐ Yes ☐ No

(If yes, what are the days and hours)

_____

h. To what degree will telehealth be utilized, if at all?

_____

i. What are your expected funding sources?

_____

j. What is your timeline for opening your program?

_____