

DUIIP NEW PROVIDER/NEW SERVICE FACILITY MORATORIUM

Potential Providers

ITEM 1

New Provider applications will be accepted for service to be rendered in any county in the state of Georgia only if the provider/service facility meets one or more of the following criteria:

- Services will be offered in a language other than English
- The service site is at a Community Service Board
- The service site is at a DUI Court or Drug Court

ITEM 2

New Provider applications will also be accepted if the service site is located in a county that is considered underserved by the Office of DUIIP.

(Click on link to access: [Underserved Counties](#))

Existing Providers

ITEM 1

Providers currently listed on the DUIIP Registry may add a facility to their registry listing in any county in the state of Georgia if the provider/service facility meets one or more of the following criteria:

- Services will be offered in a language other than English
- The service site is at a Community Service Board
- The service site is at a DUI Court or Drug Court

ITEM 2

Providers currently listed on the DUIIP Registry may also add a facility to their registry listing if the service site is located in a county that is considered underserved by the Office of DUIIP.

(Click on link to access: [Underserved Counties](#))

ITEM 3

If an existing provider has a service site in a county that is not considered underserved and their site is removed from the registry by choice, due to inactivity, or other reasons, the provider will not be able to re-establish service in the county unless the service site offers service in a language other than English, the service site is at a Community Service Board, or the service site is at a DUI Court or Drug Court.

(Click on link to access: [Underserved Counties](#))

ITEM 4

It will be allowed for an existing provider that currently has a service site in an over-served county to close a service site and to request to open another service site in the same county. This would be considered “replacing” and not “adding” as long as the replacement is done within six (6) months of the closing. However, changing the service site to another over-served county will not be allowed.

(Click on link to access: [Underserved Counties](#))

Effective 1-15-2014; Revised 6-9-2014



Georgia Department of Behavioral Health & Developmental Disabilities

*Frank W. Berry, Commissioner
Cassandra Price, Director*

Division of Addictive Diseases ~~~ DUI Intervention Program
Two Peachtree Street, NW, Suite 22, Atlanta, Georgia 30303-3142 ~ 404-657-2331

APPLICATION FOR
REGISTRY TO
PROVIDE SERVICES TO DUI
OFFENDERS AS A
CLINICAL
EVALUATOR
AND/OR
TREATMENT
PROVIDER
(Who will only be providing ASAM
Level I) DUI INTERVENTION
PROGRAM
DIVISION OF ADDICTIVE
DISEASES

**DEPARTMENT OF BEHAVIORAL HEALTH & DEVELOPMENTAL
DISABILITIES**

**2 Peachtree Street, NW,
22nd Floor Atlanta,
Georgia 30303-3171
(404) 657-6433**

TP?

Are you an existing provider on the DUIIP Registry as a CE or

YES

NO

If yes, please check one.

- Applying to Add TP** **Applying to**
 Add CE Re-Application

What is your Provider ID #?

Equal Opportunity
Employer



Georgia Department of Behavioral Health & Developmental Disabilities

Frank W. Berry, Commissioner

Cassandra Price, Director

Division of Addictive Diseases. Office of DUI Intervention Program

Two Peachtree Street, NW, Suite 22.275, Atlanta, Georgia 30303-3142 ~ 404-657-6433

New Provider Application Check-list	
Personal Information Completed (Pg. 8)	<input type="checkbox"/>
Submitted Photograph and Resume	<input type="checkbox"/>
Professional Credentials Section (with attached documents, Pg. 9)	<input type="checkbox"/>
Completed CE and/or TP Section (pages 12 and/or 13, with all attached documents) NOTE: please read these pages carefully to ensure all requested attachments are submitted with the application.	<input type="checkbox"/>
Completed CE/TP Statement of Compliance <u>and</u> notarized (Pgs. 14 and/or 15)	<input type="checkbox"/>
CE Facility Information Form (if applicable, Pg. 17)	<input type="checkbox"/>
TP Facility Information Form (if applicable, (Pg. 18)	<input type="checkbox"/>
Addendum A - 20 Hours Substance Abuse Continuing Education (with attached documents) (Pgs. 19,20)	<input type="checkbox"/>
CE Verification of Work, Addendum B (Pg.22)	<input type="checkbox"/>
TP Verification of Work, Addendum B (Pg. 23)	<input type="checkbox"/>
All initials and notarized signatures completed within the application	<input type="checkbox"/>
Payment enclosed (\$100-CE, \$150-TP or \$250 for both)	<input type="checkbox"/>
Submit electronic application	<input type="checkbox"/>

NOTE: New Provider Training is **ONLY** during the months of **JUNE** and **DECEMBER**. Once your application is approved, you will receive an email from our office announcing the date. Only individuals with an approved application will be notified of the training dates and location. This training is **mandatory** before you can legally begin to provide evaluation or treatment.

NOTICE

TO ALL APPLICANTS

ALL APPLICATIONS SUBMITTED TO THE DEPARTMENT OF BEHAVIORAL HEALTH & DEVELOPMENTAL DISABILITIES BECOME A PERMANENT RECORD OF THE DEPARTMENT. THEREFORE, PLEASE BE ADVISED THAT **THE AGENCY CANNOT RETURN ANY PART OF THIS APPLICATION.**

Keep a copy of the application and all attachments for your file.

Please carefully read the DBHDD Rules and Procedures Manual for Clinical Evaluators and Substance Abuse Treatment for DUI Offenders (290-4-13). These documents can be seen at www.mop.uga.edu.

Read all instructions for completing the application and make sure you have the proper credentials before completing the application.

RETURN THE APPLICATION IN ITS **ORIGINAL ORDER WITH NO DELETIONS OR ALTERATIONS.** Any additional information required should be included as attachments. Addendum B should be sent directly to DBHDD by the person or persons verifying your work experience (if applicable).

BE CERTAIN THAT YOUR APPLICATION IS COMPLETE. Complete applications are processed promptly. Incomplete applications will automatically go into pending status, and delay processing.

APPLICATION FEES: \$100 Clinical Evaluator; \$150 Treatment Provider. If you are applying for both you must pay \$250.00. Please make checks payable to **Department of Behavioral Health & Developmental Disabilities.** These fees are not refundable.

SEND APPLICATIONS TO:

**Georgia Department of Behavioral Health and Developmental Disabilities
Division of Addictive Diseases
Office of DUI Intervention Program
2 Peachtree Street, NW
22nd Floor
Atlanta, GA 30303-3171
ATTN: Dr. Scott Dunbar**

Applications received without the application fee will not be processed until payment is received. THANK YOU! You will receive an email response within two weeks after the application is received by the DUI Intervention Program.

ALSO NOTE THAT:

New Applications are no longer being accepted from the seven Metro Counties (DeKalb, Fulton, Gwinnett, Cobb, Clayton, Hall, Clarke and Henry)

IMPORTANT UPDATE REGARDING APPLICATION SUBMISSION AND NEW PROVIDER TRAINING

Effectively immediately:

GEORGIA DEPARTMENT OF BEHAVIORAL HEALTH & DEVELOPMENTAL DISABILITIES

- 1) The mandatory New Provider Training will only be offered to Clinical Evaluator and Treatment Provider applicants that have **completed the application process and received acknowledgement from the Office of DUI Intervention program that their application is complete and accepted**
- 2) **There will no longer be open registration for mandatory New Provider Training.** The Office of DUI Intervention Program will send the specified individuals the training dates/times.
- 3) The training will still occur in December and June.
- 4) The deadline to submit an application in an effort to attend the December training will be November 1st.
- 5) The deadline to submit an application in an effort to attend the June training will be May 1st.
- 6) Existing providers that had their account deactivated due to non-activity will be allowed to attend New Provider training.
- 7) Existing providers that are currently active on the registry are NOT allowed to attend. Existing providers may attend the Provider Refresher training sessions that will be scheduled periodically throughout the year.
- 8) The format of the New Provider training has been modified:
 - a. For applicants applying as a Clinical Evaluator OR Treatment Provider, they must attend two (2) days of training offered by the Office of DUI Intervention Program
 - b. For applicants applying as a Clinical Evaluator AND Treatment Provider, they must attend three (3) days of training offered by the Office of DUI Intervention Program
- 9) Anyone that was not sent an invitation to training will not be allowed to attend the session.
- 10) All **new** treatment provider **applicants** must show evidence that they are certified to use an evidence-derived, protocol-driven, standardized treatment program that integrates Cognitive Behavioral Therapy, Motivational Interviewing, Contingency Management, Persuasion Protocols, Lifestyle Risk Reduction Model, and the Transtheoretical Model. Treatment providers will use this ASAM Level 1 Treatment Program and maintain their certification to do so. Currently the Department contracts with PRI Inc. to provide such material and certifications. They can be contacted at www.primeforlife.org.

FOR APPROVED PROVIDERS: An approved provider, who has attended new provider training must begin practicing within 6 months of being added to the registry. A new provider must activate their account within 60 days of receiving their CETP Login information. If not, two things will happen: (1) the provider will be suspended from the Registry due not entering their monthly report or (2) will be deactivated and completely removed from the registry after 6 months of inactivity for treatment providers and 12 months for clinical evaluators.

DIRECTIONS FOR COMPLETING THE APPLICATION

Experience/Continuing Education

PART I

Personal Information:

Complete and include one recent photo. Initial as indicated. Attach resume.

PART II

Professional Credentials:

Complete and include a photocopy of EACH license and credential you wish considered. Only those credentials listed in DBHDD Rules and Regulations will be accepted. Initial as indicated.

PART III

Professional Practice:

Complete and initial where indicated.

PART IV/SECTION 1

Clinical Evaluator Applicants ONLY:

Complete and include a copy of each instrument or instrument contract, your interview form or guidelines or an anonymous SA patient/client interview record sample. If you provide drug screening tests, include a copy of the laboratory contract or the request form, which is used by the lab and pre-addressed to you. Initial where indicated.

PART IV/SECTION II

Treatment Provider Applicants ONLY:

Complete and attach documents 1 through 6 as indicated. **Initial** as indicated.

PART V

Applicant's Statement of Compliance:

Initial, Sign, and Notarize the appropriate statement. If you are applying for both Clinical Evaluator & Treatment Provider, you must complete BOTH statements.

PART VI

Registry Information:

Complete the Registry Information for the appropriate application, Clinical Evaluator & Treatment Provider respectively. If you are applying for both, you must complete BOTH Registry Information forms. Initial as indicated.

Applicants Requiring Documentation of Experience/Continuing Education.

Complete Addendum A

Include copies of certificates, transcripts, or signed reports as verification. **Initial** as indicated.

Complete Addendum B

Arrange for the appropriate form to be completed. If you are applying for BOTH Clinical Evaluator & Treatment Provider, you must arrange for **BOTH** forms in Addendum B to be completed appropriately.

QUALIFYING CONDITIONS FOR APPLICANTS

APPLICANTS WITH SPECIFIC SUBSTANCE ABUSE CERTIFICATION

Applicants Who Hold One of the Following Certification (A-G)

- a) Certification as an addiction medicine specialist by the American Society of Addiction Medicine: (ASAM)
- b) Certification in addiction psychiatry by the American Board of Psychiatry and Neurology; (CAP)
- c) Certification by the Georgia Addiction Counselors Association as a Certified Addiction Counselor II (CACII); Certified Clinical Supervisor (CCS)
- d) Certification by the National Association of Alcoholism and Drug Abuse Counselors Association as a National Certified Addiction Counselor, Level I (NCAC I); National Certified Addiction Counselor, Level II (NCAC II); NAADAC-Master Addiction Counselor (MAC)
- e) Certification by the National Certification and Reciprocity Consortium; (NCRC, ICRC)
- f) Certification by the Alcohol and Drug Abuse Certification Board of Georgia as a Georgia Certified Alcohol and Drug Abuse Counselor II (GCADC II); Georgia Alcohol and Drug Abuse Counselor III (GCADC III); Certified Advanced Alcohol and Drug Counselor (CAADC)
- g) Certificate of Proficiency in the Treatment of Alcohol and Other Psychoactive Substance Use Disorders from the American Psychological Association’s College of Professional Psychology; (APA-CP)

Copies of all licenses and credentials must be included with your application. If you do not see your certification listed, please contact our office to inquire if we accept that particular certification.

TRAINING & CONTINUING EDUCATION

All clinical evaluators and treatment providers listed on the registry **are required to attend either one or two days of training and orientation** as sponsored by the department within six months before being placed on the registry. You will be notified by email of the next available training after your application is processed.

All clinical evaluators and treatment providers shall complete, every two years, **20 contact hours** of continuing education in **substance abuse** approved by the department. The department will not accept more than five hours of in-service training in each two-year period **and no more than 10 of the hours should be from courses completed online.**

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Initial Here: _____

If you do NOT hold one of the above listed credentials continue on with the next page.

QUALIFYING CONDITIONS FOR APPLICANTS

APPLICANTS WHO DO NOT HOLD SPECIFIC SUBSTANCE ABUSE CREDENTIALS

If you are NOT certified by one of the Certifying Boards (A-F) Identified in Section II, YOU MUST HAVE LICENSURE UNDER O.C.G.A. Title 43. As a physician, psychologist, professional counselor (LPC), social worker, marriage and family therapist, advanced practice nurse, registered nurse with a bachelor's degree in nursing or certification as an employee assistance professional.

Copies of all licenses and credentials must be included with your application.

***ADDENDUM A** (Form for Addendum A is included separately)

Clinical Evaluator & Treatment Provider Applicants:

- Document the completion of at least **20 hours** of continuing education in the field of substance abuse, with not more than five of these hours consisting of in-service training **AND no more than 10 of these hours completed as online training** in the **two-year period prior to application**.
- These 20 contact hours or 2 CEU's **must be substance abuse specific**, for example, Counseling the Substance Abuser, Dual Diagnoses, Adolescent Substance Abuse, Narcotic Addiction, Alcoholism and Depression, Anger and Addiction, etc.

Include the completed form for Addendum A and copies of all certificates or other written verification of the hours claimed, with your application.

***ADDENDUM B** (form for Addendum B is included separately)

1) Clinical Evaluator Applicants:

Document at least **2,000 hours** of clinical experience **in the treatment** of persons who are addicted to alcohol or other drugs, with at least **500 hours** of that experience in the actual administration of substance abuse **clinical evaluations**. **(If you do not have this experience, do not send the application)**

2) Treatment Provider Applicants:

- Document at least **2,000 hours** of clinical experience in the treatment of persons who are addicted to alcohol or other drugs.
- **ADDENDUM (B) MUST BE COMPLETED BY A PROFESSIONAL WHO IS OR HAS BEEN EITHER YOUR SUPERVISOR OR COLLEAGUE AND HOLDS ONE OF THE CREDENTIALS LISTED IN RULE 290-4-13:04.**

The completed Addendum B must be sent directly by the supervisor/colleague to the **DBHDD Office**. Completed originals included with the **application will not** be accepted.

TRAINING & CONTINUING EDUCATION

All clinical evaluators and treatment providers listed on the registry are **required to attend either one or two day of training and orientation** sponsored by the department within six months of being placed on the registry. You will be notified of the next available training when your application is processed.

All clinical evaluators and treatment providers shall complete, every two years, **20 contact hours** of continuing education in substance abuse approved by the department. The department will not accept more than five hours of in-service training in each two-year period.

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**Part I PERSONAL
INFORMATION**

(HOME ADDRESS & HOME TELEPHONE NUMBER IS CONFIDENTIAL AND WILL NOT BE RELEASED UNDER THE OPEN RECORDS ACT, UNLESS THEY ARE ALSO YOUR BUSINESS ADDRESS. SOCIAL SECURITY NUMBER IS CONFIDENTIAL)

MUST BE COMPLETED INDIVIDUALLY
BY
ALL CLINICAL EVALUATOR APPLICANTS
AND
TREATMENT PROVIDER APPLICANTS WHO PROVIDE ONLY ASAM LEVEL I
(Please Type or Print)

1. NAME: _____
(Last) (First) (MI)
2. HOME ADDRESS: _____
(Street Address)

(City) (State) (Zip) (County)
3. CELL PHONE NUMBER: _____
4. DATE OF BIRTH: _____ 5. Social Security Number _____
6. EMAIL ADDRESS: _____ (for correspondence related to this application)
7. OCCUPATION: _____
(Main Source of Current Employment Income)
- EMPLOYED BY: _____

EMPLOYED BY: _____

ATTACH RESUME

ATTACH ONE RECENT PHOTOGRAPH SHOWING A FULL VIEW OF THE FACE, NECK, SHOULDERS AND UNCOVERED HEAD. (SUCH AS A PASSPORT PHOTO) PHOTO COPIES NOT *ACCEPTED*.

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Part II PROFESSIONAL CREDENTIALS
 REQUIRED BY ALL CLINICAL EVALUATOR APPLICANTS
 AND

ALL TREATMENT PROVIDER APPLICANTS WHO ARE NOT LICENSED BY DBHDD'S OFFICE OF REGULATORY SERVICES

1. List the licenses and/or credentials you presently hold: (Attach a photocopy of each Lic/Cred. Listed)

LICENSE/CREDENTIAL	LICENSE CREDENTIAL #	DATE RECEIVED	EXPIRATION DATE

2. Have any of the above Licenses/Credentials ever been suspended or revoked?
YES_____ **NO**_____

If yes, explain:

3. EDUCATION:

NAME OF COLLEGE	CITY/STATE	DATES ATTENDED MO/YR	MAJOR	DIPLOMA/DEGREE

4. I am applying to be listed in the registry as a (check as many as apply):

Clinical evaluator Treatment provider

I am applying as a clinical evaluator ONLY, but I am also on staff at, or subcontract with, a treatment facility practice.

NAME OF FACILITY: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

(If you work for more than one treatment program, attach additional pages.)

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PART III PROFESSIONAL PRACTICE

Clinical Evaluator and ASAM Level I Only Treatment Provider
(Note: Services may not be delivered in a private residence)

1. I will be providing the clinical evaluator services for DUI offender, as part of a: (check one)

- Community Service Board** **Private Treatment Facility**
 Private Practice **Other Public Agency**

If Private Practice or facility, please complete the following:

- Sole Proprietorship Corporation Partnership
 For Profit Non Profit

I will be providing Level I treatment services for DUI Offenders, as listed in the registry as part of a:
(check one)

- CSB** **Other Public Agency**
 Private Practice **Public Agency** **Private Treatment Facility**

If Private Practice or facility, please complete the following:

- Sole Proprietorship Corporation Partnership
 For Profit Non Profit

*** INFORMATION ABOUT PRACTICE ***

3. **The Name of Your Practice/Facility/Business (Main/Central Office)**

Business Name:

Address:

City/State/Zip:

Mailing Address: (if different)

Business Telephone #: ()

2nd Business #: ()

FAX Number: ()

EMAIL Address (Mandatory)

4. **Are you establishing a new practice in order to provide services as a clinical evaluator or treatment provider?** **YES** **NO**

If no, how long has your practice been in existence? _____

5. Briefly describe your existing clientele and type of practice:

6. What percentage of your practice, if any, has been devoted to providing substance abuse services to DUI offenders or other criminal justice clients?

7. Does your practice/facility/business provide SA services in any languages other than English?

YES NO

If yes, list the other languages here: _____

8. FOR ALL APPLICANTS: Have you had any experience in the last 5 years providing substance abuse evaluations and treatment to DUI offenders or other criminal justice clients? YES NO

If yes, briefly describe this experience:

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**PART IV
SECTION I
CLINICAL EVALUATOR APPLICANTS ONLY**

1. **DBHDD Rules require face to face interview as part of the clinical evaluation**, and you are required to use the "Case Presentation Format" that has the 6 dimensions, the DSM IV diagnosis and ASAM level. Attach the following forms, formats and examples of your clinical evaluations to complete this part of the application process (your application will not be reviewed beyond this section without the examples requested).

- a) Copy of your interview form, interview guidelines or format(s)
- b) Copy of your last or most recent clinical evaluation done on a substance abuse client (with the identifying client information blacked out).

2. **Also, attach the screening instruments you use.**

3. **Do you include a drug screen (urine test)?** **YES** **NO**
(If yes, include a copy of the laboratory's contract of the request form which is used.)

4. **DBHDD Rules require that treatment recommendations be made according to ASAM Patient Placement Criteria.**

Have you participated in ASAM patient placement criteria training? **YES** **NO**

Are you familiar with the ASAM criteria? **YES** **NO**

Have you used the ASAM patient placement criteria? **YES** **NO**

5. **Do you have experience using the DSM IV Criteria for Substance Abuse, Substance Dependence and Substance-Induced Disorders?** **YES** **NO**

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If you are ALSO applying for your business/practice/facility to be on the registry as a **TREATMENT SITE** complete **PART IV** for Treatment Providers.

If you are applying as a Clinical Evaluator *ONLY*.....**PROCEED TO PART V**

INITIAL HERE _____

**PART IV
SECTION II**

TREATMENT PROVIDER APPLICANTS ONLY

1. List any individuals providing direct client care within your program under the supervision of the Clinical Supervisor.

NAME	CURRENT CREDENTIALS	CREDENTIALS/CERTIFICATION SOUGHT

Clinical Supervisor: _____ Credentials: _____

Telephone Number: () _____

2. List any ongoing subcontractors who provide direct substance abuse client services through your program:

NAME	ADDRESS	CITY	COUNTY	TELEPHONE #

All **new** treatment provider **applicants** must show evidence that they are certified to use an evidence-derived, protocol-driven, standardized treatment program that integrates Cognitive Behavioral Therapy, Motivational Interviewing, Contingency Management, Persuasion Protocols, Lifestyle Risk Reduction Model, and the Transtheoretical Model. Treatment providers will use this ASAM Level 1 Treatment Program and maintain their certification to do so. Currently the Department contracts with PRI Inc. to provide such material and certifications. They can be contacted at www.primeforlife.org.

ATTACH THE FOLLOWING DOCUMENTS:

1. Description/outline of your treatment program.
2. Current fee schedules given to patient/clients.
3. Statement of confidentiality given to patient/clients.
4. Statement of patient/client rights given to patients/clients.
5. HIV antibody/AIDS status confidentiality given to patients/clients.
6. An anonymous patient/client sample record, including treatment plan

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PROCEED TO PART V**

Initial Here _____

GEORGIA DEPARTMENT OF BEHAVIORAL HEALTH & DEVELOPMENTAL DISABILITIES

**PART V.I
CLINICAL EVALUATOR
APPLICANT'S STATEMENT OF COMPLIANCE**

This is to certify that I am applying for approval to be included on the Department of Behavioral Health & Developmental Disabilities Registry of Clinical Evaluators and that all of the information contained on this application and the attached documents are true and correct. I have read the Rules and Regulations for Clinical Evaluation and Substance Abuse Treatment for DUI Offenders and understand that I am responsible for complying with all requirements.

I FURTHER UNDERSTAND AND AGREE:

In accordance with O.C.G.A. 16-10-20, to knowingly make a false statement or conceal a material fact in this application will result in the denial of my application or removal of my name from the Department's Registry.

INITIALS_____

I understand that I may only conduct clinical evaluations at the locations specified within my application and approved by the Department.

INITIALS_____

I understand that clinical evaluations may not be conducted in a private residence.

INITIALS_____

All client records shall be confidential and shall be maintained and disclosed in accordance with the provisions of Volume 42 of the code of Federal regulations, 42 Part 2, "Confidentiality of Alcohol and Drug Abuse Patient Records".

INITIALS_____

I understand that, as a Clinical Evaluator, I may not evaluate and treat the same client.

INITIALS_____

I understand that any and all fees for clinical evaluation must be within the range provided on my application and approved by the Department, and that I may not increase the fees for evaluation without prior notification to the Department. Upon approval of an increase in fee range, the new fee may not be charged until it appears on the Registry located on the DUIIP website.

INITIALS_____

I agree to submit all reports and information to the Department as specified in the Rules and Regulations and maintain all client records, at the location specified on my application and provide access to the Department during the hours indicated on my application.

INITIALS_____

I understand that I must use the DBHDD "Case Presentation Format" for each client that I evaluate, or a substitute format officially approved by DBHDD. That includes the 6 Dimensions, DSM and ASAM.

INITIALS_____

I hereby authorize the release to DBHDD of any information necessary for the determination of my application for approval as a Clinical Evaluator. I understand that this information will be used only for the purpose of processing my application. Photocopies of this authorization will be valid for the purpose of obtaining requested information.

APPLICANT'S SIGNATURE

SIGNATURE OF PRINCIPAL OFFICER OF GOVERNING BODY

Sworn to before me on this _____ day _____ 20_____

Notary _____ (Seal Required) _____

**PART V.2
TREATMENT PROVIDER APPLICANT'S
STATEMENT OF COMPLIANCE**

This is to certify that I am applying for approval to be included on the Department of Behavioral Health and Developmental Disabilities Registry of Treatment Providers and that all of the information contained on this application and the attached documents are true and correct. I have read the Rules and Regulations for Treatment Provider and Substance Abuse Treatment for DUI Offenders and understand that I am responsible for complying with all requirements.

I/WE FURTHER UNDERSTAND AND AGREE:

In accordance with O.C.G.A. 16-10-20, to knowingly make a false statement or conceal a material fact in this application or removal of the name from the Department's Registry.

INITIALS_____

I understand that **I** may only provide substance abuse services at the ASAM Levels of Treatment for which I have been approved for inclusion on the Registry and only at the locations specified within the application.

INITIALS_____

I understand that each substance abuse professional who provide services under this program must complete, every two years, a minimum of 20 contact hours of continuing education in the field of substance abuse approved by the department. Documentation of Said continuing education will be kept in staff personnel files.

INITIALS_____

All client records shall be confidential and shall be maintained and disclosed in accordance with the provisions of Volume 42 of the Code of Federal Regulations, 42 Part 2, "Confidentiality of Alcohol and Drug Abuse Patient Records."

INITIALS_____

I understand that, as a Treatment Provider, **I** may not evaluate and treat the same client.

INITIALS_____

I agree to submit all reports and information to the Department as specified in the Rules and Regulations and maintain all client records at the location specified on the application and provide access to the Department during the hours indicated on the application.

INITIALS_____

I hereby authorize the release to DBHDD of any information necessary for the determination of the application for approval as a Treatment Provider. **I** understand that this information will be used only for the purpose of processing the application. Photocopies of this authorization will be valid for the purpose of obtaining requested information.

APPLICANT'S SIGNATURE

SIGNATURE OF PRINCIPAL OFFICER OF GOVERNING BODY

Sworn to before me on this _____ day _____ 20_____

Notary _____ (Seal Required) _____

PART VI REGISTRY

INFORMATION

If you are applying for both Clinical Evaluator and Treatment Provider, please complete both forms.

Provide the information exactly as you wish it to appear in the registry.

Fill out all the information if you are a new provider or if you are changing information on the registry.

For changes, **list your ID#, name** and only the information to be changed. Please make a note of applicable deadlines when completing **the form on the next page.**

CLINICAL EVALUATION FACILITY INFORMATION FORM

Section I - Registry Listing PRINT OR TYPE exactly as you want to appear on the registry Listing			
If New Provider: <input type="checkbox"/> If Existing Provider: <input type="checkbox"/> Date: _____			DBHDD Use only
Existing Provider UserID: _____		Provider Type: CE	
First Name: _____		MI: _____	Last Name: _____
Credentials (limit to three, e.g. CACII, LPC, LCSW):			
Name of Facility /Practice/ Business where services are provided (cannot be home address):			
Service address:			
City: _____		County: _____	Zip Code: _____
Telephone # for appointments () _____		() _____	
Email Address 1: _____		Email Address 2: _____	
Contact Person: _____		Telephone #: () _____	
Minimum Fees: \$95.00	Fee Range: \$ _____ To: \$ _____		
Other languages (List Languages)			
Comments to appear on Registry: (Limit to 125 spaces)			
Section II - Mailing address and Private Contact Information (for Internal DBHDD Use only) Will not appear on the Registry.			
Mailing Address:			
City: _____		State: _____	County: _____ Zip Code: _____
Additional telephone # where we can reach you. Such as cell phone) () _____		Fax #: () _____	
Section III – Client Records/Files Storage			
Location where DUI Records & Client files will be kept: <input type="checkbox"/> On Site <input type="checkbox"/> Other Location (Records may not be kept in a private residence)			
If other location, Name of Facility where records are kept:			
Street Address:			
City: _____		County: _____	Zip Code: _____
Contact Person (for location)		Telephone #: () _____	

Note: Please complete this form only if you are a new provider or an existing provider adding CE.

TREATMENT PROVIDER FACILITY INFORMATION FORM

Section I - Registry Listing PRINT OR TYPE exactly as you want to appear on the registry Listing			
If New Provider: <input type="checkbox"/> If Existing Provider: <input type="checkbox"/> Date: _____			DBHDD Use only
Existing Provider UserID: _____		Provider Type: <u>TP</u>	
First Name: _____		MI: _____	Last Name: _____
Credentials (limit to three, e.g. CACII, LPC, LCSW): _____			
Name of Facility /Practice/ Business where services are provided (cannot be home address): _____			
Service address: _____			
City: _____		County: _____	Zip Code: _____
Telephone # for appointments (____) _____		(____) _____	
Fee Range: \$ _____ To: \$ _____			
Email Address 1: _____		Email Address 2: _____	
Contact Person: _____		Telephone #: (____) _____	
Other languages (List Languages) _____			
Comments to appear on Registry: (Limit to 125 spaces) _____			
ASAM level (s) of Service: (Check or Circle all that apply)	Level I-(6-12 weeks) _____	ASAM Level II.1 or above II.1 II.5 III.3 III.5 III.7	ORS License #:
	Level I - (4-12 months) _____		
Section II - Mailing address and Private Contact Information (for Internal DBHDD Use only) Will not appear on the Registry.			
Mailing Address: _____			
City: _____		State: _____	County: _____ Zip Code: _____
Additional telephone # where we can reach you. Such as cell phone) (____) _____			Fax #: (____) _____
Section III – Clients Records/Files Storage			
Location where DUI Records & Client files will be kept: <input type="checkbox"/> On Site <input type="checkbox"/> Other Location (Records may not be kept in a private residence)			
If other location, Name of Facility where records are kept: _____			
Street Address: _____			
City: _____		County: _____	Zip Code: _____
Contact Person (for location)		Telephone #: (____) _____	

Note: Please complete this form only if you are a new provider or an existing provider adding TP.

ADDENDUM A

**SUBSTANCE ABUSE CONTINUING EDUCATION
CONTACT HOURS**

**REQUIRED FOR ALL APPLICANTS WHO DO NOT HAVE THE SPECIFIC
CREDENTIALS LISTED IN RULE 290-4-13.04(2)(a)-(f)**

TWENTY (20) SUBSTANCE ABUSE SPECIFIC HOURS ARE REQUIRED
NOT MORE THAN FIVE (5) IN-SERVICE HOURS MAY APPLY AND
NOT MORE THAN TEN (10) HOURS COMPLETED AS ONLINE
TRAINING

ALL 20 HOURS MUST HAVE BEEN EARNED DURING THE LAST TWO YEARS
COUNTING BACK FROM THE DATE YOUR APPLICATION WAS NOTARIZED

PLEASE DO NOT SEND CONTINUING EDUCATION HOURS THAT ARE MORE THAN TWO
YEARS OLD
THEY WILL NOT BE CONSIDERED

ADDENDUM A

PLEASE LIST ONLY THE 20 HOURS, YOU ARE APPLYING
AND ATTACH CERTIFICATES, TRANSCRIPTS OR SIGNED REPORTS AS VERIFICATION

YOU MAY REPRODUCE THIS PAGE IF NECESSARY TO LIST ALL 20 CONTACT HOURS
(If you provide in excess of 20 hours, only the first 20 will be considered)

1. Title: _____ Provider Number: _____ Provider: _____ Number of Contact Hours _____ Date(s): _____
2. Title: _____ Provider Number: _____ Provider: _____ Number of Contact Hours _____ Date(s): _____
3. Title: _____ Provider Number: _____ Provider: _____ Number of Contact Hours _____ Date(s): _____
4. Title: _____ Provider Number: _____ Provider: _____ Number of Contact Hours _____ Date(s): _____
5. Title: _____ Provider Number: _____ Provider: _____ Number of Contact Hours _____ Date(s): _____
6. Title: _____ Provider Number: _____ Provider: _____ Number of Contact Hours _____ Date(s): _____

[INITIAL the lower right hand corner]

INITIAL HERE: _____

ADDENDUM B EXPERIENCE

VERIFICATION

**REQUIRED FOR ALL APPLICANTS WHO DO
NOT HAVE THE SPECIFIC CREDENTIALS
LISTED IN RULE 290-4-13.04 (2)(a)-(f)**

**CLINICAL EVALUATORS: 2000 HOURS OF DIRECT SA CLIENT SERVICES INCLUDING
NO LESS THAN 500 HOURS OF CLINICAL EVALUATION EXPERIENCES**

TREATMENT PROVIDERS: 2000 HOURS OF DIRECT SA CLIENT SERVICES

**IF YOU ARE APPLYING FOR BOTH: YOU MUST PROVIDE BOTH EXPERIENCE
VERIFICATION FORMS**

**YOU MAY MAKE AS MANY COPIES OF THE BLANK FORMS AS NECESSARY
COMPLETED ORIGINALS MUST BE SENT DIRECTLY TO DBHDD, BY THE PERSON
COMPLETING THE FORM**

Only completed originals will be accepted

**ADDENDUM B
CLINICAL EVALUATOR
VERIFICATION OF WORK EXPERIENCE
(Print or Type)**

APPLICANT'S NAME: _____		
(First Name)	(MI)	(Last Name)

Name of Person Verifying Applicant's Experience: _____
 (First Name) (MI) (Last Name)

Professional Credentials: _____ Phone # _____

Location of Work Experience You are Verifying: (Facility) _____
 (Street Address) _____
 (City, County, State, Zip) _____

Relation To Applicant During The Time Indicated: (check one):

- Facility Administrator
- Program Director
- Supervisor
- Colleague at other facility
- Colleague at same facility
- Other

Dates Of Work Experience You Are Verifying: (From) Month Year (To) Month Year

***Average number of hours per week the applicant worked in substance abuse:**
 [*These are clients whose primary diagnoses is substance abuse/dependence or who are dual diagnosed]
 (Direct Services: Client or Patient received individual or group counseling or therapy from the applicant)

Direct Service in a Alcohol and Drug Treatment Program Per Week : _____	Indirect Service in a Alcohol and Drug Treatment Program Per Week : _____	Clinical Evaluation of Clients with Alcohol and/or Drug Abuse/Dependence Per Week : _____
--	--	--

Describe Indirect Services:

I HEREBY VERIFY THAT THE INFORMATION I HAVE PROVIDED ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE AND ACCURATELY REPRESENTS THE APPLICANT'S WORK EXPERIENCE IN THE FIELD OF SUBSTANCE ABUSE, AS I HAVE KNOWN IT.

SIGNATURE: _____ DATE: _____

**PLEASE RETURN THIS FORM DIRECTLY
 TO: Dept of Behavioral Health & Developmental Disabilities
 Division of Addictive Diseases
 DUI Intervention Program Section
 2 Peachtree Street, NW, 22nd Floor
 Atlanta, Georgia 30303-3171**

**DO NOT RETURN THE ORIGINAL TO THE APPLICANT
TO DO SO WILL INVALIDATE THE INFORMATION**

