



**APPLICATION FOR BOARD APPROVAL
AS A ONE BITE CONTINUING CARE PROVIDER
FOR IMPAIRED PRACTITIONERS**

This application must be completed by any provider of chemical dependency treatment services who wishes to have approval from the State Medical Board of Ohio to provide continuing care for impaired practitioners as part of the One Bite program in accordance with Ohio Revised Code 4731.251 and Ohio Administrative Code 4731-16-21.

This application **DOES NOT** confer approval from the State Medical Board of Ohio to provide treatment for impaired practitioners in accordance with Ohio Revised Code 4731.25. A separate application to provide treatment for said licensees may be found on the Board's website.

Board approval is valid for a period of three years.

If you have any questions regarding this application, please contact:
med.compliance@med.ohio.gov

SUBMIT BY MAIL:

State Medical Board of Ohio
Attn: Donald Davis
30 East Broad Street, 3rd Floor
Columbus, Ohio 43215

APPLICANT NAME:

TREATMENT PROVIDER NAME:

ADDRESS:

TELEPHONE:

FAX:

EMAIL:

TREATMENT PROVIDER OWNER:

PLEASE PROVIDE DETAILED ANSWERS TO THE FOLLOWING QUESTIONS:

1. Does the applicant base its philosophy and individualized treatment plan on the disease concept of chemical dependency?
2. Does the applicant base its model of treatment on a twelve-step program such as Alcoholics Anonymous?
3. Does the applicant adhere to the principle that treatment of chemical dependency requires total abstinence from alcohol and other mind-altering drugs?
4. Is the applicant subject to the confidentiality requirements of Title 42, Part 2, of the Code of Federal Regulation?
5. Is the applicant accredited by the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF) to provide substance abuse treatment? (***attach a copy of Joint Commission or CARF accreditation certificate***)
6. Does the applicant hold a current state certificate to provide treatment for substance abuse/addiction at the following sites on the dates indicated below: (***attach a copy of the certificate***)
7. Is therapy led by one of the following master's level or high qualified behavioral healthcare providers:
 - a. A board certified addictionologist, board certified addiction psychiatrist, or psychiatrist licensed under Ohio Revised Code 4731?
 - b. A licensed independent chemical dependency counsel-clinical supervisor, licensed independent chemical dependency counselor, licensed chemical dependency counselor III, or licensed chemical dependency counselor II licensed under Ohio Revised Code 4758?
 - c. A professional clinical counselor, licensed professional counselor, licensed independent social worker, licensed social worker, or marriage and family therapist licensed under Ohio Revised Code 4757?

- d. An advanced practice registered nurse, licensed as a clinical nurse specialist under Ohio Revised Code 4723, who holds certification as a psychiatric mental health clinical nurse specialist issued by the American nurses credentialing center?
 - e. An advanced practice registered nurse, licensed as a nurse practitioner under Ohio Revised Code 4723, who holds certification as a psychiatric mental health nurse practitioner issued by the American nurses credentialing center?
 - f. A psychologist, as defined in division (A) of the Ohio Revised Code 4732.01, licensed under Ohio Revised code 4732?
 - g. An advanced practice registered nurse licensed under Ohio Revised Code 4723, who holds subspecialty certification as a certified addiction registered nurse-advanced practice issued by the addiction nursing certification board?
8. Are continuing care meetings held at least one time per week, with missed meetings made up?
 9. Are continuing care meetings at least one hour in duration?
 10. Does the continuing care provider have a process to provide status reports for each participating licensee to the monitoring organization on a quarterly or greater basis?
 11. Does the continuing care provider have a process to provide reports and documentation to the monitoring organization on a quarterly or greater basis for the following:
 - a. The number and type of licensees entering into continuing care agreements?
 - b. The number and type of licensees released by the continuing care program?
 - c. The average length of the continuing care agreements?
 - d. The number and type of licensees who relapse?
 12. Does the continuing care provider provide abstinence-based education and treatment for all types of substance use disorders?
 13. Does the continuing care provider have a process to report a relapse and/or failure to comply with the terms of the continuing care agreement to the monitoring organization and the Medical Board?
 14. Does the continuing care provider have a process for the medical director of the monitoring organization to review and concur with requests for release from continuing care?
 15. Describe in detail the evaluation process and procedures used to identify patterns, progressions, and stages of recovery during continuing care. Include details regarding level of involvement with a certified addictionologist, the medical director, and treatment team.
 16. Describe any procedures used to assess continuing care success rates (e.g. - surveys of former patients, collaterals).

- 17.** List other services provided at this program site and including details regarding medical and nursing services provided for patients in each stage of treatment.
- 18.** Describe the applicant's procedures to arrange payment for treatment costs not covered by insurance.

PROGRAM SITE(S)

Please provide the following information for ***each location site*** operated by the applicant.

***You must also attach a table of organization
and a list of the names and position titles
of ALL licensed physicians on staff.***

Continuing Care Provider/Location:

Address:

Telephone:

Fax:

Email:

Medical Director:

Additionologist:

Preferred Contact:

Title:

Telephone:

Fax:

Email:

Please indicate which service(s) listed below are available at the above location:

- Residential Treatment
- Intensive Inpatient Treatment
- Intensive Outpatient Treatment
- Aftercare and/or Continuing Care
- 72-Hour Evaluations to Determine Initial Treatment Needs
- Evaluations to Determine Fitness to Return to Practice

AGREEMENT OF ONE BITE CONTINUING CARE PROVIDER APPLICANT

By execution of the Affidavit and Release of Applicant, the applicant agrees that upon Board Approval:

1. It shall be bound by and comply with the requirements contained in Chapter 4731., Ohio Revised Code, and Chapter 4731-16, Ohio Administrative Code; and
2. It shall provide appropriate training to its staff to assure compliance; and
3. It shall provide to each patient and referral source who is under the jurisdiction of the State Medical Board of Ohio the written statements and notices required by the Board; and
4. It shall immediately notify the State Medical Board of Ohio if changes occur, including, but not limited to, transfer of ownership of the program; change in location or locations of the program; or change of directorship, which could affect its eligibility for approved status under Section 4731.25, Ohio Revised Code, or Chapter 4731-16, Ohio Administrative Code.

AFFIDAVIT AND RELEASE OF ONE BITE CONTINUING CARE PROVIDER APPLICANT

The affidavit and release below must be completed by BOTH the chief executive officer and the medical director of the applicant continuing care provider. The form MUST be notarized. Failure to submit the affidavit and release completed and notarized with the application will result in the application being considered incomplete.

State of _____
County of _____

On behalf of _____, an applicant for a certificate of good standing as a One Bite continuing care provider for impaired practitioners, the undersigned hereby certify under oath that we are the duly appointed chief executive officer and medical director, respectively, of the applicant; that we submit this application under the authority of the governing body of the applicant; that all statements we have made or shall make with respect to the application are true; and that all document forms, or copies thereof furnished or to be furnished with respect to this application are strictly true in every respect.

We acknowledge that we have read and are able to provide services in compliance with Section 4731.251, Ohio Revised Code and Chapter 4731-16, Ohio Administrative Code.

We further state that by filing this application for a certificate of good standing as a One Bite continuing care provider for impaired practitioners, we hereby authorize and consent to have an investigation made as to the applicant's qualifications to provide such treatment. We agree to give any further information which may be required in reference to the applicant's qualifications or eligibility for approval.

We further understand that this application of a certificate of good standing as a One Bite continuing care provider for impaired practitioners is an ongoing process. We will immediately notify the State Medical Board of Ohio in writing of any changes to the answers of any questions contained in the application if such changes occur at any time prior to a certificate of good standing being granted by the State Medical Board of Ohio.

On behalf of the applicant, we authorize every person, hospital, clinic governmental agency (local, state, or federal), court, association, institution, or law enforcement agency having control of any documents, records, and other information pertaining to the application to furnish to the State Medical Board of Ohio any such information, documents, or records, including records regarding charges or complaints filed against the applicant, formal or informal, pending or closed, and we authorize the State Medical Board of Ohio or any of its agents or representative to inspect and make copies of such documents, records, and other information in connection with this applicant, subsequent grant of a certificate of good standing or practice thereunder.

On behalf of the applicant and acting under the authority of its governing body, we hereby release, discharge, and exonerate the State Medical Board of Ohio, its agents or representatives and any person furnishing information, of any and all liability of every nature and kind arising out of investigation made by the State Medical Board of Ohio. We authorize the State Medical Board of Ohio to release information, material, documents, order or the like relating to the applicant or to this application to any governmental agency (local, state, or federal); or to any hospital, nursing home, clinic, health maintenance organization or similar institution; or to any professional association.

We further understand the issuance of a certificate of good standing will be considered based on the truth of the statements and documents contained herein or to be furnished, which if false, can subject the applicant to denial of said certificate.

Signature of Chief Executive Officer

Signature of Medical Director

(NOTARY SEAL) Subscribed and sworn to before me this day of 20

Notary Public Signature

Date Commission Expires