OHIO STATE DENTAL BOARD

77 South High Street, 17th Floor, Columbus, OH 43215-6135 · (614) 466-2580 · www.dental.ohio.gov

Application For Approval as a Treatment Provider for Impaired Practitioners

Dear Treatment Provider:

This application must be completed by any provider of chemical dependency treatment services that wish to obtain approval from the Ohio State Dental Board to provide treatment for impaired practitioners in accordance with Section 4715.301, Ohio Revised Code.

Thoroughly read the instructions and Ohio Administrative Code Chapter 4715-21-01 prior to completing this application. By applying for approval, you agree to keep the Ohio State Dental Board apprised of any changes to the information contained herein, in writing, within thirty (30) days.

If you have any questions regarding this application, please contact Barb Yehnert, Dental Board Enforcement Officer, at (614) 466-2580.

Application For Approval as a Treatment Provider for Impaired Practitioners

Application Materials Checklist

☐ **Application:** Complete the entire application and attach all required documentation. An application submitted with questions left bland or with documentation missing will be considered an incomplete application and will not be processed by the Ohio State Dental Board. (Please note there is NO FEE for this application.)

☐ **Program Site Form:** Please complete the Program Site form for each individual site operated by the applicant. If multiple sites are operated the form may be copied and attached to the application.

☐ **Verification of State Certification:** Please complete the applicant's portion of the VERIFICATION OF STATE CERTIFICATION Form and mail it to the Ohio Department of Alcohol and Drug Addiction Services, or, if the applicant is located outside Ohio and not certified by the Ohio agency, to the appropriate certifying agency in the state where treatment services are provided. After receiving verification from the proper agency, enclose the form with the completed application. (NOTE: The applicant is responsible for any fees associated with verification of certification.)

☐ **Affidavit and Release of Applicant:** Ensure that the applicant's chief executive officer and medical director properly executed the Affidavit and Release and that their signatures have been notarized.

Please return the completed application to:

OHIO STATE DENTAL BOARD
77 South High Street, 17th Floor
Columbus, Ohio 43215-6135

PROGRAM SITE FORM

(where treatment services are delivered)

Please provide the following information for each individual program site operated by the applicant. This page may be copied and attached when multiple programs sites are operated.

Name: _____

Street Address: _____

_____

City: _____ State: _____ Zip: _____ County: _____

Telephone Number: _____ Fax Number: _____

Contact Name: _____ Title: _____

Contact Number: _____ Contact Email: _____

Please attach a table of organization and a list of the names and position titles of all licensed physicians on staff.

Place a check mark in the box of each service listed below that is available at this program site:

- ☐ Intensive inpatient treatment (Medical, nursing care, and therapy are provided. Patients are not permitted to leave facility.)
- ☐ Residential treatment (Patients reside in facility or other accommodations, but are permitted to leave while accompanied by other patients.)
- ☐ Intensive outpatient treatment (Patients spend days or nights at the facility and are permitted to leave facility each day.)
- ☐ Hospital detoxification
- ☐ Methadone administration
- ☐ Aftercare
- ☐ 72-hour evaluation to determine treatment needs
- ☐ Fitness to return to practice evaluations

Please list other services provided at this program site: _____

_____

_____

_____

Describe in detail the medical and nursing services the applicant provides for patients in each stage of treatment, including detoxification treatment:

_____

_____

_____

_____

TREATMENT PROVIDER FOR IMPAIRED DENTAL PRACTITIONERS
VERIFICATION OF STATE CERTIFICATION FORMS

The below named applicant is applying for a Certificate of Good Standing to provide treatment to impaired practitioners in accordance with Section 4715.301, Ohio Revised Code. The Ohio State Dental Board requires that the applicant's status with your agency be certified. Please complete this form and return it to the applicant.

To Be Completed by Applicant

(If more than two program sites are certified, list additional addresses on a separate sheet and attach.)

Name of Applicant: _____

Complete Mailing Address of Program Site Certified: _____

_____

Complete Mailing Address of Program Site Certified: _____

_____

To Be Completed by Verifying Agency

NOTE: The applicant is responsible for payment of any fees charged for the completion of this form.

State Agency Title: _____

Complete Mailing Address: _____

_____

Telephone Number: _____

The above named applicant holds a current certificate or certificates to provide treatment for substance abuse/addiction at the following sites on the dates indicated below:

Site Address: _____ Date Certified: _____

_____

Site Address: _____ Date Certified: _____

_____

Signature: _____

Affix Agency Seal
Not Valid Without Seal

Title: _____

Date: _____

APPLICATION FOR APPROVAL AS A TREATMENT PROVIDER FOR IMPAIRED PRACTITIONERS

Applicant Contact Information

Treatment Provider (Applicant) Name: _____

Street: _____

City: _____ State: _____ Zip: _____

Telephone Number: Fax Number:

Treatment Provider Owner Contact Information

Name of Treatment Provider Owner:
(If sole proprietor, give full name) _____

Street: _____

City: _____ State: _____ Zip: _____

Telephone Number: Fax Number:

General Questions

1.	Does the applicant base its philosophy and individualized treatment plan on the disease concept of chemical dependency?	☐ Yes	☐ No
2.	Does the applicant base its model of treatment on a twelve-step program such as Alcoholics Anonymous?	☐ Yes	☐ No
3.	Does the applicant adhere to the principle that treatment of chemical dependency requires total abstinence from alcohol and other mind-altering drugs?	☐ Yes	☐ No
4.	Is the applicant subject to the confidentiality requirements of Title 42, Part 2, of the Code of Federal Regulation?	☐ Yes	☐ No
5.	Is the applicant able and willing to examine individuals under the jurisdiction of the Ohio State Dental Board, including the requirement of 72 hours inpatient monitoring as applicable?	☐ Yes	☐ No
6.	Is the applicant able and willing to provide patients under the jurisdiction of the Ohio State Dental Board with at least 28 days of inpatient or residential treatment by a Board approved treatment provider?	☐ Yes	☐ No
7.	Is the applicant willing and able to provide outpatient assessments for those individuals so ordered under the jurisdiction of the Ohio State Dental Board?	☐ Yes	☐ No
8.	Is the applicant able and willing to provide services to those individuals who qualify for intensive outpatient treatment?	☐ Yes	☐ No
9.	Is the applicant accredited by JCAHO to provide substance abuse treatment? (Attach a copy of JCAHO accreditation certificate and JCAHO reports reflecting the most recent review of inspection.)	☐ Yes	☐ No
10.	If you answered NO to the previous question, have you applied for JCAHO accreditation?	☐ Yes	☐ No

11. Are costs of the patients' treatment program covered by most insurance policies that provide coverage for alcohol/substance abuse treatment? ☐ Yes ☐ No
12. Is the applicant willing to bill the insurance company up front and allow the patient to pay the balance? ☐ Yes ☐ No
13. Do you offer a sliding fee? ☐ Yes ☐ No
14. Do you offer payment plans? ☐ Yes ☐ No

15. Describe the applicant's procedures to arrange payment plans for treatment costs not covered by insurance.

16. Describe in detail the evaluation process and procedures used to identify patterns, progressions, and stages of recovery during treatment.

17. Describe in detail the medical and nursing services the applicant provides for patients in each state of treatment, including detoxification treatment.

18. Describe how the applicant involves family and significant others in the patient's treatment.

19. Describe any services available to family and significant others.

20. Describe any procedures the applicant uses to assess treatment success rates (e.g. surveys of former patients).

21. List all agencies and professionals to which the applicant refers patients and significant others to meet needs which exceed the applicant's expertise or available facilities.

22. Is the applicant willing, if necessary, to provide evidence and/or testify on behalf of the Dental Board in a Dental Board administrative licensure proceeding? If no, please explain. ☐ Yes ☐ No

AGREEMENT OF APPLICANT

By execution of the Affidavit and Release of Applicant, the applicant agrees that upon issuance of approval as a treatment provider for impaired practitioners:

1. It shall be bound by and comply with the requirements contained in Chapter 4715., Ohio Revised Code and Chapter 4715-21-01, 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 Ohio State Dental Board (Board) the written statements and notices required by the Board; and

4. It shall immediately notify the Ohio State Dental Board if changes occur which could affect its eligibility for approved status under Section 4715.301, Ohio Revised Code, or Chapter 4715-21-01, Ohio Administrative Code; and

5. It shall notify the Ohio State Dental Board of any transfer of ownership of the program or change in location or locations of the program prior to such transfer or change becoming effective.

AFFIDAVIT AND RELEASE OF APPLICANT

The affidavit and release below must be completed by BOTH the chief executive officer and the medical director of the applicant treatment 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 treatment 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 4731.25, 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 treatment 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 treatment 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 Title

(NOTARY SEAL)

_____ _____

Signature of Medical Director Title

Subscribed and sworn to before me this _____ day of _____ 20_____

_____

Notary Public Signature

_____

Date Commission Expires