



NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE
PO Box 11117 " Chicago, Illinois 60611 " (773) 880-1460

Application for
Opioid Treatment Program (OTP) Accreditation

OTP Name (applicant): _____

Correctional Facility: _____

Correctional facility is a [] prison [] jail in (city) _____ (state) _____

We hereby apply to the National Commission on Correctional Health Care (NCCHC) for the accreditation of the Opioid Treatment Program (OTP) named above, for which we are legally authorized to contract for this service. We understand that the OTP will be surveyed by NCCHC for compliance with its *Standards for Opioid Treatment Programs in Correctional Facilities*.

We agree to abide by NCCHC's accreditation policies and to permit, at the time of the site survey, private and confidential interviews with administrators, correctional officers, inmates/residents, and health care personnel. Further, we agree to allow NCCHC surveyors to review all relevant documentation, including but not limited to OTP patient records, and to tour the facility.

We understand and agree that NCCHC will forward the results of the accreditation survey to SAMHSA, which may use the results in its certification of the OTP.

We agree that if the OTP is accredited by NCCHC, the OTP will comply with the standards throughout its period of accreditation. We agree to allow NCCHC to come on site at any time to verify compliance. We agree to notify NCCHC in writing of any substantive change in the management, policies, or practices of the OTP within 30 days of such occurrence. Further, we agree to submit an Annual Affirmation of Compliance or other documentation required by NCCHC.

We understand that we will be billed for an initial site visit and, if accredited, annually thereafter. An estimate of charges will be made available to us in advance of the site visit, if we request it. We agree to pay all NCCHC invoices within 30 days, and understand that failure to pay such invoices may result in denial or withdrawal of accreditation. We understand that we may terminate our participation in the NCCHC OTP Accreditation Program at any time upon written notice to NCCHC. A \$250 nonrefundable application fee will be submitted with this application.

Signature of Person Legally Responsible for OTP Date

Name and Title (printed or typed)

Signature of Person Legally Responsible for Correctional Facility Date

Name and Title (printed or typed)

OPIOID TREATMENT PROGRAM (OTP) INFORMATION

1. _____
Telephone Number Fax Number E-mail Address
2. _____
Mailing Address
3. _____
City State ZIP
4. Does the OTP have multiple operational sites? [] No [] Yes
If yes, list sites by name and location: _____
5. Does the OTP have SAMHSA Certification*? [] No [] Yes
If yes, date current federal certification expires: _____

*A copy of SAMHSA's Letter of Transitional Certification, Letter of Extension or Full Certification Letter must either accompany this application or be available at the time of the on-site survey, if applicable.

BILLING INFORMATION

6. Invoices for the OTP accreditation should be sent to the following:
- _____
- | | | |
|---------|-------|-----|
| Name | Title | |
| _____ | | |
| Address | | |
| _____ | | |
| City | State | ZIP |

CONTACT INFORMATION

7. _____ (_____) _____
Correctional Facility Administrator Telephone Number
8. _____ (_____) _____
OTP Administrator Telephone Number
9. _____ (_____) _____
OTP Medical Director Telephone Number
10. Are the health services in the correctional facility contracted? [] No [] Yes
If yes, name of contractor: _____
11. Are mental health services at the correctional facility under different authority than the medical services? [] No [] Yes
If yes, who provides mental health services: _____

20. Is the OTP currently involved in either of the following:

- A. Legal action alleging inadequate medical or other health care for inmates?
 No Yes If yes, when was the action filed? _____

Please (1) submit summary information about the case(s); and (2) furnish a copy of any judgment, order or decree entered by the court, and all master, monitor or facility reports filed in the last twelve months pursuant to such order, judgment or decree. If no reports have been issued within the last twelve months, please provide a copy of the last such substantive report issued.

Summary description: _____

- B. Action by a community, government or quasigovernment/public agency or group to review, investigate or look into health services provided within the OTP?
 No Yes

If yes, please state the name of the group and describe its purpose. If any reports have been issued by this group, please provide a copy with your application.

I certify that the above is true and correct to the best of my knowledge and belief.

Signature of Person Legally Responsible for Program (as given on first page)

Date

ENCLOSURES

- SAMHSA Letter of Transitional Certification, Extension or Full Certification, if applicable (see #5)
- Information regarding legal action, if applicable (see #20)
- \$250 nonrefundable application fee payable to the National Commission on Correctional Health Care