New Hampshire Department of Health and Human Services (DHHS)
Division for Behavioral Health (DBH)
Bureau of Drug and Alcohol Services (BDAS)
105 Pleasant St, Concord NH 03301

Impaired Driver Service Provider (IDSP)
Application Instructional Checklist

Name: _____ **Date:** _____

Dear Applicant:

Enclosed you will find the BDAS Provider Application, which must be completed for inclusion as an IDSP provider in the BDAS network.

Please identify the provider type(s) for which you are requesting approval (check only the one that applies):

- ☐ Provider Applicant
- ☐ Organizational Applicant

Impaired Driver Service Provider (IDSP): Adheres to He-A 500 rules for policies, procedures, and requirements regarding the IDSP program and guidelines.

For an application to be considered complete, the following documents and information shall be submitted to BDAS along with the completed application and this provider checklist:

APPLICANTS: Please check off all items provided with this application.

Provider application must provide all items listed below.

- ☐ IDSP Provider Information checklist
- ☐ Proof of Insurance for General and Professional Liability
- ☐ Copies of relevant certifications, licenses, or other documentation that support provider's qualifications to provide services
- ☐ A narrative describing how the provider will ensure continuity of care for clients

Organization application only: Organizations must provide all items listed below.

- ☐ IDSP Provider Information checklist
- ☐ Annual income and expense statement for the most recent fiscal year
- ☐ Balance sheet for the most recent fiscal year
- ☐ Most recent agency audit or audited financial statements
- ☐ List of board members, including name, address, employment, titles, and meeting dates
- ☐ List of key agency staff, including contact information
- ☐ Certificate of Good Standing from the Secretary of State's Office
- ☐ Proof of Insurance for Worker's Compensation.

NH BUREAU OF DRUG AND ALCOHOL SERVICES
IMPAIRED DRIVER SERVICE PROVIDER (IDSP) APPLICATION

Instructions

- Thoroughly complete all applicable sections.
- Type or print legibly.
- Retain a copy of the completed application and all attachments for your files.
- Mail completed application and required attachments to:

BDAS Approved Provider Unit
105 Pleasant Street, 3rd Floor North
Concord, NH 03301

- If you have questions regarding the *IDSP application process*, please direct them to albert.willis@dhhs.nh.gov or call Al Willis at 603-271-6113.
- If you have questions regarding the WITS electronic information system process, please direct them to Bruce.Blaney@dhhs.nh.gov or call Bruce Blaney at 603-271-6102.

I. Applicant Information

Practitioner Name:	
Email address:	County:
Billing Information Address: Phone: Fax:	**Service Site 1** Address: Phone: Fax:
Service Site 2 Address: Phone: Fax:	**Service Site 3** Address: Phone: Fax:

II. Primary Contact Information

Primary Contact Person:	
Email:	Phone:

III. Service Information

Please indicate the services you are applying for:

	Individual Outpatient: An organized service, delivered in a variety of settings in which treatment staff provide professionally directed evaluation and treatment of substance related disorders to a single client.
	Group Outpatient: An organized service, delivered in a variety of settings in which treatment staff provide professionally directed evaluation and treatment of substance related disorders to a group of clients.
	Intensive Outpatient: An organized service, delivered by addiction professionals or addiction credentialed clinicians, which provides a planned regimen of treatment, consisting of regularly scheduled sessions within a structured program.
	IDSP Recovery Support *(IDSP Provider Applicants ONLY):* Any services within the certified recovery support worker scope of practice described in RSA 330-C:13.

IV. Disclosures

Within the past 5 years, have you, your organization, or an employee or volunteer been cited for ethical violations or other misconduct, failure to maintain required standards, or any other reason, that was substantiated?

☐ **Yes** ☐ **No**

If yes, please explain:

In the past 3 years have you, or your organization, breached a contract with the Department of Health and Human Services?

☐ **Yes** ☐ **No**

If yes, please explain:

Are you, or is your organization, or any employee or volunteer, facing any pending ethical violations or allegations of misconduct?

☐ **Yes** ☐ **No**

If yes, please explain:

Private Practitioners: Does your current license/credential require criminal background checks?

☐ **Yes** ☐ **No**

Organizations: Does your agency conduct criminal background checks for employees, contractors or volunteers? If so, does your organization have policies and procedures in place to guide acceptance or denial of employment, contracting work or volunteers relative to criminal background checks?

☐ **Yes** ☐ **No**

Comments:

V. Type of Organization

Place a check mark in the box that best describes your organization:

☐ **Faith-based** (Organization founded on a particular religion or spiritual belief) Type of religious denomination:	☐ **Community-based** (not faith-based) Please indicate type (select all that apply) ☐ Non-profit ☐ For-profit ☐ Grassroots (organizations with annual operating budgets of $500,000 or less) ☐ Other

VI. Information System Requirements

☐ Practice utilizes Windows Internet Explorer 7.0 or higher
☐ Practice utilizes high-speed internet access
☐ I agree to utilize the WITS system as required by the IDSP Programs

In the event that an application is incomplete or additional documentation is requested by BDAS in order to complete the process, the applicant has 30 days from the date of the request to provide all of the additional documentation or the application will be discarded.

Upon acceptance of your application, BDAS will issue a Cooperative Agreement for the provision of the services you identified. The duties, rights and obligations of the parties to this agreement shall be governed by the Cooperative Agreement Documents, which include the Special conditions, General Conditions and Application.

By signing below, I certify that the information provided in this application and attachments, is correct and true to my knowledge.

_____
Signature of applicant or applicant representative

_____ _____
Title or position Date

For BDAS office use only:	
Impaired Driver Services Coordinator Signature:	Date Application received by BDAS:
Date:	☐ Application approved