Name: ____________________________ NPI #: ____________________________ 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, to include statement regarding if you became incapacitated how client’s records will be resolved

**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 Nicole.M.Robbins@dhhs.nh.gov or call Nicole Robbins 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

<table>
<thead>
<tr>
<th>Practitioner Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email address:</td>
</tr>
<tr>
<td>County:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Billing Information</th>
<th>Service Site 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Address:</td>
</tr>
<tr>
<td>Phone:</td>
<td>Phone:</td>
</tr>
<tr>
<td>Fax:</td>
<td>Fax:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Site 2</th>
<th>Service Site 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Address:</td>
</tr>
<tr>
<td>Phone:</td>
<td>Phone:</td>
</tr>
<tr>
<td>Fax:</td>
<td>Fax:</td>
</tr>
</tbody>
</table>

II. Primary Contact Information

<table>
<thead>
<tr>
<th>Primary Contact Person:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email:</td>
</tr>
<tr>
<td>Phone:</td>
</tr>
</tbody>
</table>

BDAS Provider Application Rev. 08/2022
### III. Service Information

Please indicate the services you are applying for:

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual Outpatient</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Group Outpatient</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Intensive Outpatient</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>IDSP Recovery Support</strong></td>
<td>(IDSP Provider Applicants ONLY): Any services within the certified recovery support worker scope of practice described in RSA 330-C:13.</td>
</tr>
</tbody>
</table>

### 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)
- ☐ Community-based (not faith-based)

Type of religious denomination:
- ☐ 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
Rules of Use for the New Hampshire Web Information Technology System (WITS)

These “Rules of Use” apply to all participants in WITS, a web-based system.

The NH Web Information Technology System (WITS) provides a secure, 24/7 accessible web-based information technology system for the purpose of storing client demographic information (e.g. client first and last name, date of birth, address, phone numbers). WITS is a Stage 1 Ambulatory Meaningful Use Certified Electronic Health Record (EHR) originally built by SAMHSA and focused on Substance Use Disorder services. WITS assists in tracking and managing clients, staff, facilities, and agencies collecting treatment, prevention, and recovery data. WITS is also used also to capture the Treatment Episode Data Set (TEDS) required for Federal Block Grant reporting requirements and Centers for Disease Control (CDC) National Outcomes Measurement System data submission.

The WITS Security and Authentication Modules are built upon three sets of guiding rules: HIPAA, 42 CFR pt. 2 (which is more rigid than HIPAA), and 28 CFR pt. 23 (Criminal Justice data security rules). FEI designed the software to strictly adhere to these rules at the framework level; therefore, all modules, which are effectively built on top of the framework, inherit these constraints.

These Rules of Use establish access, disclosure and modification standards that are the foundation of a successful security plan. WITS users are responsible for reporting to the Provider System Administrator and the Bureau of Drug and Alcohol System Administrator (BDAS) any unauthorized access or disclosure of WITS data.

Participant Responsibilities

1. Participants will not attempt to avoid or circumvent the security measures set up to protect the WITS system from unauthorized use (e.g., sharing User ID or Password).

2. Participants must provide a full name and email information to the WITS System Administrator or Provider System Administrator and permit the use of this information in order to register the user for access to the WITS system.

3. Participants will notify the WITS System Administrator or Provider System Administrator of any change in job position or responsibilities to allow for the evaluation of the appropriateness of continued status as a registered user.

4. Participants acknowledge that a change in job position or responsibilities may make them ineligible for further access to the WITS system.

The Department of Health and Human Services' Mission is to join communities and families in providing opportunities for citizens to achieve health and independence.
5. Participants acknowledge that the information received via the WITS system is privileged and confidential. This information can only be shared with those co-workers who need this information in order to perform their client consented job responsibilities, and will not be shared with anyone outside their office, unless approved by their immediate supervisor and is in accordance with the agency’s release of information policies and complies with HIPAA, 42 CFR pt. 2 regulations.

6. Participants will limit the amount of information that they download or print from the WITS system to only those items that are essential to the performance of their professional duties. Downloaded data containing protected health information will be stored only in secure and protected locations on the computer. Downloaded data containing protected health information shall not be stored on portable electronic devices such as laptops and may only be stored on portable storage devices (flash drive, CD-ROM, etc.) if absolutely necessary to complete a work task and only if the device is secured in the same manner confidential paper records are stored (in a locked file cabinet, etc.). Such devices cannot be removed from the work location unless secured and in accordance with the agency's confidentiality policy and applicable State/Federal Laws.

7. Participants agree to destroy all information downloaded and/or printed from the WITS system (electronic and hard copy) as soon as it is no longer needed.

8. Participants will limit the photocopying of information obtained from the WITS system, and will destroy photocopies when no longer needed.

9. Participants will submit information to the WITS system that is accurate to the best of their knowledge at the time of submission, and update the system when they become aware of changes to the information contained there.

I have been granted access to the WITS system as a registered user due to my current status as a BDAS contracted service provider, BDAS approved provider, BDAS duly authorized user, or BDAS approved State of New Hampshire Employee. I understand that as a WITS user, I will have access to sensitive and confidential information, and this information has been shared with me in a strictly professional capacity, in order to assist me in the performance of my official professional responsibilities.

**Acknowledgement and Agreement**

I

__________________________________________

Name (Please print)  Agency

__________________________________________

Position/Title  Agency Address

As an authorized WITS user acknowledge receipt of, understand my responsibilities, and will comply with the Rules of Use for the WITS System.

__________________________________________

Sign

Please sign and date this completed form, scan it and email to:

bruce.blaney@dhhs.nh.gov or kristy.l.mcdonald@dhhs.nh.gov
Required Information Sheet for a new WITS User in the system

Person making this request: Agency: __________________________/BDAS __________________________

New WITS USER Name: ____________________________________________________________

Background checks / Policies & Procedures / Performance review completed: Y _____/N _____

Login name requested: ____________________________ (if available)

Agency: ______________________________________________________

Facility Assignment(s): ____________________________________________

Email Address: ____________________________________________

Job Title: ____________________________________________________

Staff Member Type: (i.e. Administrative / Clinical / Clerical) ____________________________

Employment Type: (i.e. permanent / contractual / part time) ____________________________

Employment Date: ____________________________________________

Add Access Category: Adult _______ and/or Child _______

Phone Number: ____________________________________________

Relationship to this Staff member: (i.e. Clinical Supervisor / Manager) ____________________________

  a) Related Staff Member: ____________________________________________

License(s) Information: (i.e. MLADC / LADC / MSW) ____________________________

Degree(s) Information: (i.e. Masters / Bachelors / Associates) ____________________________

  a) In what discipline: (i.e. Arts / Science / Nursing / Counseling) ____________________________

Certification(s): (i.e. Basic Life Saving / other certifications) ____________________________

Roles & Accesses: (what will they be doing) ____________________________

Please scan and email completed form to: bruce.blaney@dhhs.nh.gov or kristy.mcdonald@dhhs.nh.gov

**Please complete the next page of questions if you are applying for “Agency” status as well.

NOTE: We must have the signature page from the, “WITS – Rules of Use” security form before an account can be activated.
Complete only if you have received approval to be applying for a new Agency

Agency Name: ____________________________________________________________

National Provider ID: ________________________________

Address: ________________________________________________________________

County: ________________________________

Phone number: ________________________________

Facility #1 name: _________________________________________________________

Address: ________________________________________________________________

County: ________________________________

Phone number: ________________________________

I-BHS#: ________________________________

Facility #2 name: _________________________________________________________

Address: ________________________________________________________________

County: ________________________________

Phone number: ________________________________

I-BHS#: ________________________________