State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES
INTOXICATED DRIVING PROGRAM
P.O. BOX 365
TRENTON, NJ 08625-0365

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

ELIZABETH CONNOLLY
Acting Commissioner

VALERIE L. MIELKE, MSW
Assistant Commissioner

January 19, 2016

Dear Potential Intoxicated Driver Resource Center (IDRC) Affiliated Provider:

Enclosed are the IDRC Affiliation Agreement Coversheet and IDRC Affiliation Agreement for the July 1, 2016 - June 30, 2017 cycle to be completed for each site and level of care by interested **ambulatory** substance use disorder treatment providers. The coversheet provides instructions on the required attachments that must be included with your completed affiliation agreement when submitting to your county IDRC for the upcoming cycle.

The IDRC Affiliation Agreement Coversheet and IDRC Affiliation Agreement are applicable to all interested Department of Human Services (DHS) licensed substance use disorder ambulatory treatment providers that were **NOT** affiliates in the July 1, 2015 through June 30, 2016 cycle, as well as for **all non-DHS licensed private agencies** wishing to affiliate or re-affiliate for the July 1, 2016- June 30, 2017 cycle.

All County IDRC's must be contacted prior to submitting materials to ensure that a complete package, including any county specific IDRC materials that may also be required and not included in these enclosures, are mailed to the appropriate address. County IDRC Directors can be contacted by accessing their information on the State Intoxicated Driving Program (IDP) website at: www.state.nj.us/humanservices/dmhas/resources/services/treatment/addictions/IDRC_Directory.pdf.
Any IDRC Affiliation Agreement Coversheet and IDRC Affiliation Agreement questions should be posed to the County IDRC Director in which your ambulatory treatment site is located. Thank you.

Sincerely,

Andrea Connor
Chief

Enclosures

IDRC AFFILIATION AGREEMENT COVERSHEET

INSTRUCTIONS

- *Complete one Affiliation Agreement and IDRC Affiliation Agreement Coversheet for **EACH AMBULATORY** treatment site location. Be sure to complete Sections A, B, C, D, and E in their entirety.*
- *All information submitted on the Affiliation Agreement and IDRC Affiliation Agreement Coversheet must be identical in spelling and punctuation as indicated on your license (e.g. Agency Name, Address, etc.)*
- *Be sure to label all Affiliation Agreement attachments appropriately as defined in the IDRC Affiliation Agreement Coversheet. Unsorted/mislabeled documents may be rejected or returned.*
- *Type or use block letters on all entries on the Affiliation Agreement and IDRC Affiliation Agreement Coversheet. Illegible documents may be rejected or returned.*
- *All documents are to be returned to the County IDRC for initial review. The County IDRC will complete Section F prior to submitting to the Intoxicated Driving Program for final approval.*
- *Additional guidance is provided in italics throughout the document.*

SECTION A - TREATMENT SITE AND CONTACT INFORMATION

(If treatment site is licensed by the DHS, use name, spelling, and punctuation as listed on the Office of Licensing (OOL) license):

Agency Name/Affiliate Provider Applicant: _____

Treatment Site County: _____

Treatment Site Street 1: _____

Treatment Site Street 2: _____

Site City: _____ Site Zip: _____

Treatment Site Phone #: _____

Treatment Site Fax #: _____

Treatment Site E-mail: _____

If the site is licensed by the DHS, enter OOL License #: _____

If the agency has a NJSAMS account, enter NJSAMS #: _____

Treatment Site Admissions Contact

Name: _____ Title: _____

E-Mail: _____ Phone #: _____

Treatment Site Administrative Contact 1

Name: _____ Title: _____

E-Mail: _____ Phone #: _____

Treatment Site Administrative Contact 2

Name: _____ Title: _____

E-Mail: _____ Phone #: _____

Treatment Site Administrative Contact 3

Name: _____ Title: _____

E-Mail: _____ Phone #: _____

SECTION B - TREATMENT AGENCY INFORMATION

(If operating as a LLC, enter the authorized managing member. If the provider is a Sole-Proprietorship or unincorporated partnership, enter the individual signing the Affiliation Agreement.)

Treatment Agency Executive Director Name: _____

Title: _____

E-Mail: _____ Phone #: _____

Address *(If different from treatment site)*: _____

_____

If the treatment agency's mailing address is different from site address, enter the agency address:

Agency Street 1: _____

Agency Street 2: _____

Agency City: _____ Agency State: _____ Agency Zip: _____

SECTION C - AFFILIATION LEVEL OF CARE INFORMATION

*Indicate all level(s) of care for which the treatment site is affiliating (DHS licensed agencies **MUST** include a copy of their OOL license for **EACH** level of care indicated in their submission):*

___ Assessment ___Detoxification

___ Level I Standard Outpatient ___Short-Term Residential

___ Level II Intensive Outpatient ___Long-Term Residential

___ Level II.5 Partial Care ___Halfway House

SECTION D - AFFILIATION AGREEMENT ATTACHMENTS

*The following attachments **MUST** be included and labeled with your Affiliation Agreement when submitting to the County IDRC. Each should be labeled appropriately as Attachment 1, Attachment 2, Attachment 3, etc.*

Attachment 1: Written and **signed** statement by the agency's Executive Director or owner that the agency will conform to and abide by the following as amended and supplemented by any rules adopted:

- N.J.S.A. 39:4-50 et seq., DUI Statute
- N.J.A.C. 10:162, Intoxicated Driving Program Regulations
- 40A:9-22 et seq. Local Government Ethics Law
- N.J.A.C. 10:161, Division of Mental Health and Addiction Services Outpatient Regulations
- 45:2D-1 et seq., Division of Consumer Affairs
- 26:2H-1 et seq., Department of Health Regulations

Agency Name_____

_____ _____

Executive Director or Owner Signature Date

_____ _____

Print Name Title

Attachment 2: Fee schedule for **EACH** Level of Care indicated in Section C, including sliding scale fee or no-fee statement and identifying other funding sources (i.e. Fee-for-service (FFS), health insurance, etc.). (*See below)*

FEES AND SLIDING SCALE SCHEDULE FOR AFFILIATED LEVELS OF CARE INCLUDING:

- Levels of Care
- Service Descriptions—Group/Individual
- Rate per Service
- Sliding Fee Scale*
- Urine Drug Screen
- Other

Methods of Payment
Self-pay: _____ (List payment types, e.g. MasterCard, Visa, Check, Cash, etc.)
Private Insurance: _____ (List supported insurers, e.g. HBCBS, Aetna, etc.)
Medicaid: _____
Medicare: _____
DMHAS FFS Network: _____ (List eligible programs, e.g. DUII, Drug Court, etc.)
Other: _____

*If no sliding fee scale is offered, include 10% no-charge statement signed by the Executive Director/Owner: PROVIDER AGREES TO ACCEPT UP TO 10% OF IDRC REFERRED CLIENTS AT NO COST.

Attachment 3: Written descriptive process for **EACH** Level of Care seeking affiliation, including policies for:

- Treatment Philosophy
- Assessment Process
- Treatment Planning
- Self-Help
- Family Treatment Resources
- Discharge Planning
- Continuum of Care Process

Attachment 4: Treatment site hours of operation to include **Day, Evening** and **Weekend hours** for group sessions for each level of care indicated. *(See example below.)*

TREATMENT SITE ADMINISTRATIVE HOURS OF OPERATON
Ex. M –F 8-5
Sat/Sun by appointment

Level of Care	*Service Description*	*MON*	*TUE*	*WED*	*THU*	*FRI*	*SAT*	*SUN*
ex. Level I	*Individual Session*	*9-11*	*9-12*	*9-11*	*9-12*	*12-2*	*N/A*	*N/A*
ex. Level I	*Group Session*	*N/A*	*12-1:30*	*N/A*	*12-1:30*	*12-1:30*	*9-11*	*N/A*

Attachment 5: Provider policies including written policies for Clinical Supervision, Urine Drug Screen/Oral, and/or Medication Assisted Treatment.

Attachment 6: Current copy of **Commercial** liability insurance listing treatment **SITE** address.

Attachment 7: **Current** copy of **Professional** liability insurance.

Attachment 8: List of staff including resumes and copies of **ALL** current credentials/licenses. (*Downloads from the State Board of Marriage and Family Therapy Examiners are **not** acceptable for this purpose.)*

Attachment 9 (If Applicable): Submit documented proof of education and hours of experience, including the "Proposed Plan of CADC/LCADC and Internship Agreement" for counselor interns leading to CADC or LCADC status, or to another health professional license that includes work of an alcohol and drug counseling nature within its scope of practice, without regard to changes in employment.

Attachment 10 (optional): Agency/provider wanting to indicate additional services may indicate those services below.

SECTION E - AGENCY / PROVIDER CERTIFICATION

Initial here _____ to indicate that all documentation has been reviewed, completed, and is included in the Affiliation Agreement packet, including a site specific Affiliation Agreement, IDRC Affiliation Agreement Coversheet and Attachments 1-10 (10 optional).

Submitted by:

Printed Name: _____ Title: _____

Signature: _____

E-Mail: _____

Phone #: _____ Fax #: _____

Date Submitted to IDRC: _____/_____/_____

SECTION F - FOR IDRC USE ONLY

Initial here _____ to indicate that all documentation has been reviewed, completed, and is included in the Affiliation Agreement packet, including a signed site specific Affiliation Agreement, IDRC Affiliation Agreement Coversheet and Attachments 1-10 (10 optional) for affiliation with the County for the following level(s) of care:

___ Assessment	___Detoxification
___ Level I Standard Outpatient	___Short-Term Residential
___ Level II Intensive Outpatient	___Long-Term Residential
___ Level II.5 Partial Care	___Halfway House

Submitted by:

Printed Name: _____ Title: _____

Signature: _____

E-Mail: _____

Phone #: _____ Fax #: _____

Date Submitted to IDP: _____/_____/_____

INTOXICATED DRIVER RESOURCE CENTER
TREATMENT AGENCY/PROVIDER AFFILIATION AGREEMENT

IDRC _____

Treatment Agency/Provider _____

Date _____

It is agreed that the above named treatment agency or provider will accept referrals from the _____County Intoxicated Driver Resource Center (IDRC) or the Intoxicated Driving Program (IDP) of the N.J. Department of Human Services, Division of Addiction Services for the purpose of alcohol and/or drug abuse treatment. As per the Intoxicated Program Regulations, (N.J.S.A.10:162-5.1), " …All approved treatment programs shall report to the Division of Addiction Services through the Division's Alcohol and Drug Abuse Data System or any successor treatment management information system implemented by the Division".

The initial determination of treatment appropriateness will be made through the screening process accomplished by the IDRC or IDP.

"Treatment appropriate" refers to those IDRC or IDP clients who may be in need of a structured intervention into their drinking and/or drug use; or care for alcohol, drug abuse or related problems.

A treatment referral will be made by the IDRC or IDP. If from the IDRC, the Agency/Provider will communicate with the IDRC and will send the entire required forms etc. to the IDRC. If the referral is from the IDP, then the Agency/Provider will send all forms etc. to the IDP.

The Agency/Provider will be notified of the referral via the Treatment Referral form. Clients referred to the program will be given an Agreement to Participate in Treatment form by the IDRC or IDP, and they will contact the program for an intake interview **by the agreed contact date.**[1]

The Agency/Provider agrees to schedule the client for the intake interview within **30** days of the client's contact of the program.

If the client fails to make contact or appear for his appointment, the Agency/Provider will immediately inform the IDRC or IDP, as appropriate, via the Client Treatment Release form.

When the client appears, the Agency/Provider will perform an in-depth assessment and make a determination as to the client's appropriateness for the program. If the client is found not appropriate, the Agency/Provider agrees to immediately inform the IDRC or IDP, as appropriate, via the Client Treatment Release form, with supporting explanation.

If the client is treatment appropriate and is accepted for treatment with the Agency/Program, the IDRC or IDP, as appropriate, will be informed via the Client Intake form. The agency agrees to make an independent evaluation of the client's needs in treatment. **A copy of the evaluation and recommendations must be sent with the Client Intake form.** The information packet received from the IDRC shall be utilized. The Client

[1] Contact date-within 10 days of agreement signature.

Intake form and evaluation by the treatment program shall be sent to the IDRC or IDP, as appropriate, within **seven (7) working days** after the intake with the Records Release Authorization. The IDRC or IDP, as appropriate, must concur with the treatment plan prior to the start of treatment.

The Agency/Provider agrees to inform the client of his/her specific responsibility under the treatment plan and to provide a written copy of the plan to the client.

The Agency/Provider agrees to establish a contract with the client regarding the treatment plan.

The client shall sign a Records Release Authorization during the intake process. The form shall be completed to allow the Intoxicated Driver Resource Center, all New Jersey courts, the Intoxicated Driving Program, the Division of Addiction Services, the Motor Vehicle Commission, the client's attorney, and the treatment program to exchange information. A copy shall be sent the IDRC or IDP, as appropriate.

The Agency/Provider will inform the IDRC or IDP, as appropriate, of the client's participation in treatment on a monthly basis for the duration of treatment. Verification of active treatment participation will be by use of the monthly roster and Client Treatment Progress form to be **filed by the fifteenth (15) day of each month.**

When the client is released from treatment, with approval, or if the client refuses to complete treatment, the Agency/Provider agrees to inform the IDRC or IDP, as appropriate, via the Client Treatment Release form within **seven (7) days.** All forms will be supplied by the IDRC or IDP, as appropriate.

The Agency/Provider may apply whatever treatment plan is deemed necessary for each client. If the treatment plan is acceptable to the IDRC or IDP, as appropriate, the referral agency will require the client to complete that treatment. The program may also charge the client applicable fees for treatment services rendered. The IDRC or IDP will not be responsible for the client's treatment fees. Division of Addiction Services Network Affiliated Treatment Providers may apply for funding of treatment via the Driving Under the Influence Initiative (DUII) fund, (Subchapter 10:162-10.1 through 10.4, a through e) if the client is indigent/medically indigent. [2] (When monies from the Fund are not available, the Agency/Provider shall provide treatment on a sliding scale basis or at no cost for up to 10 percent of their IDRC/IDP clients required in N.J.A.C. 10:162-6.16, b.)[3]

The undersigned hereby agrees to the terms described in this document and to the Division of Addiction Services rules and regulations found in N.J.A.C. 10:162, and N.J.S.A. 39:4-50.

The DAS-Licensed Agency/Provider agrees that all treatment will be performed or supervised by a Licensed Alcoholism or Drug Abuse Counselor (LCADC), who meets the criteria established in N.J.S.A. 45:2D et seq. and any rules adopted pursuant thereto.

The Agency/Provider agrees to notify the IDRC or IDP, as appropriate, immediately of any changes in its fee schedule, including sliding fee schedule, and information on fee payment by health insurance and other information required by N.J.A.C. 10:162.

The Agency/Provider agrees to adhere to professional standards of care and ethics and any applicable State and Federal laws and regulations. Further, the Agency/Provider certifies with this agreement that no principal or

[2] inserted for clarification –N.J.A.C. Subchapter 10:162-10.1 through 10.4, a through e
[3] inserted for clarification - N.J.A.C. 10:162-6.16, d.

employee of the treatment program is in a conflict of interest situation with this County IDRC or any other County IDRC.

The Agency/Provider agrees to provide the IDP and the IDRC with a written description of treatment philosophy, program requirements, and treatment modalities.

The Agency/Provider agrees to provide the IDRC and IDP with a statement regarding its use of chemical testing as a requirement of treatment or evaluation.

The Agency/Provider warrants that there are no real or potential conflicts of interest with respect to the IDRC or IDP and services provided.

The Agency/Provider warrants that its facilities comply with all zoning, fire, building, health, and/or other applicable regulations.

The Agency/Provider shall furnish the IDRC and IDP with copies of malpractice and commercial liability insurance and will hold the IDRC and IDP harmless from and against all claims, personal injury, or death sustained in connection with the delivery of services by the Agency/Provider and which result directly from any wrongful acts or omission, including negligence or malpractice, of any of its officers, directors, employees, agents, servants or independent contractors. The provision of this paragraph shall continue after the termination of this Agreement with respect to any liability, loss, expense or damage resulting from acts occurring prior to termination.

If the client is in need of a different treatment plan, the Agency/Provider will notify the IDRC or IDP, as appropriate. The IDRC or IDP will decide the appropriate course of action.

This agreement shall expire on the last day of June of each year, and shall not survive that date without prior written IDRC or IDP approval. The IDRC or IDP may terminate this agreement for violation of this agreement or violation of any policy, procedure, rule or regulation as prescribed in N.J.A.C. 10:162.

The Agency/Provider may terminate this agreement by providing the IDRC, IDP with at least **four (4) months** written notice.

Agency/Provider: _____

N.J.S.A.M.S. Number [4] _____

Location of Program: _____
(if more than one location, list on reverse side)

_____

Mailing Address: _____

_____

[4] current name of document

Phone Number: _____

Hours of Program: _____

Days of Week: _____

Contact Person: _____

Cost: _____

Sliding Fee Scale Available: _____Yes _____No

Third Party Payment Available: _____Yes _____No

Alcohol and/or Drug Testing: _____Yes _____No
(may be required)

List of Program Counselors with licenses, certifications, or experience, and foreign languages that will have contact with IDRC clients and identify how and in what capacity each staff member serves. (Use back of page if necessary)

_____

_____

_____

_____

Name and qualifications of person providing clinical supervision of counselors conducting treatment for DUI clients.

_____

_____

_____

Signing for the IDRC _____

Director, IDRC

_____

Date

Signing for the Agency/Provider _____

Name and Title (please print) _____

_____

Date

Signing for the IDP _____

Chief, IDP

_____

Date