

<p>DEPARTMENT OF HEALTH AND HUMAN SERVICES SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION CENTER FOR SUBSTANCE ABUSE TREATMENT</p> <p>Application for Approval as Accreditation Body Under 42 CFR § 8.3(b)</p>	<p>Form Approved: OMB Number XXXX-XXXX Expiration Date: xx/xx/xxxx See OMB Statement on Reverse</p> <p><b>DATE OF SUBMISSION</b></p>
<p><b>Note:</b> This form is required by 42 CFR § 8.3(b) pursuant to Sec. 303, Controlled Substances Act (21 USC 823) and the Drug Abuse Prevention and Control Act of 1970 (42 USC 275 (a)). Failure to report may result in the suspension or revocation of the accreditation body approval.</p>	
<p><b>1. NAME OF ACCREDITATION BODY</b></p>	<p><b>2. PURPOSE OF APPLICATION</b></p> <p>New <input type="checkbox"/>      Renewal <input type="checkbox"/></p>
<p><b>3. ADDRESS OF ACCREDITATION BODY</b> (Include ZIP Code)</p>	<p><b>4. TELEPHONE NUMBER</b> (Include Area Code)</p> <p><b>5. E-MAIL ADDRESS</b></p>
<p><b>6. NAME AND ADDRESS OF RESPONSIBLE OFFICIAL</b> (Include ZIP Code)</p>	<p><b>7. TELEPHONE NUMBER</b> (Include Area Code)</p> <p><b>8. E-MAIL ADDRESS</b></p>
<p><b>9. APPLICATION</b></p> <p>Center for Substance Abuse Treatment Division of Pharmacologic Therapies Substance Abuse and Mental Health Services Administration Attention: OTP Certification Program 5600 Fishers Lane Rockville, MD 20857</p> <p>Overnight: 5600 Fishers Lane Rockville, MD 20857</p> <p>Dear Sir/Madam</p> <p>As the official responsible for the accreditation body, I submit this application for approval to serve as an accreditation body under 42 CFR Part 8.</p> <p>A. I have a copy of, or access to 42 CFR Part 8, Certification of Opioid Treatment Programs, including 42 CFR § 8.4, Accreditation Body Responsibilities. I have read, understand and will comply with these regulations which address the accreditation of opioid treatment programs (OTPs) that treat narcotic addiction with approved opioid drugs.</p> <p>B. I have a copy of, or access to 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records. I have read and understand the requirements to maintain the confidentiality of alcohol and drug abuse treatment patient records. I agree to protect the identity of all patients in accordance with the regulations and agree to maintain records of accreditation activities for 5 years from the creation of the record.</p> <p>C. Attached is evidence of the accreditation body's nonprofit status (i.e., of fulfilling Internal Revenue Service requirements as a nonprofit organization) if the accreditation body is not a State governmental entity or political subdivision.</p> <p>D. Attached is a set of accreditation elements and a detailed discussion showing how the proposed accreditation elements will ensure that each OTP surveyed by the accreditation body is qualified to meet or is meeting each of the Federal opioid treatment standards set forth under 42 CFR § 8.12.</p> <p>E. Attached is a detailed description of the accreditation body's decision making process, including: procedures for initiating and performing onsite accreditation surveys of OTPs, procedures for assessing OTP personnel qualifications; copies of an application for accreditation, guidelines, instructions, and other materials that the accreditation body will send to OTPs during the accreditation process; policies and procedures for notifying OTPs of deficiencies and for suspending or revoking an OTP's accreditation; policies and procedures for ensuring the timely processing of accreditation applications, and a description of the accreditation body's appeals process to allow OTPs to contest adverse accreditation decisions.</p> <p>F. Attached are the policies and procedures established by the accreditation body to avoid conflicts of interest, or the appearance of conflicts of interest, by the accreditation body's board members, commissioners, professional personnel, consultants, administrative personnel, and other representatives.</p> <p>G. Attached is a description of the education, experience, and training requirements for the accreditation body's professional staff, accreditation survey team membership, and the identification of at least one licensed physician on the accreditation body's staff, along with a description of the accreditation body's training policies and survey fee schedules with supporting cost data.</p> <p>H. Attached is an assurance that the accreditation body will comply with the accreditation body responsibilities set forth under 42 CFR § 8.4, including a contingency plan for investigating complaints under 42 CFR § 8.4(e).</p> <p>I. Attached are the policies and procedures that the accreditation body has established to protect confidential information that the accreditation body will collect or receive in its role as an accreditation body.</p> <p>As the responsible official, I certify that the information submitted in this application is truthful and accurate.</p>	

RESPONSIBLE OFFICIAL (Signature)

DATE

FORM SMA-163 (revised 2016) (FRONT)

*The preferred method for submitting this form to CSAT/DPT is online at the MAT Web site, <http://dpt2.samhsa.gov/sma163/>. The Web site contains complete instructions for preparing and submitting your request. Additional detail is provided here: <http://www.samhsa.gov/medication-assisted-treatment/opioid-treatment-accrediting-bodies>. Online submission is highly encouraged, however, if you are unable to do so, the form may be e-mailed as an attachment to [otp@samhsa.hhs.gov](mailto:otp@samhsa.hhs.gov) or sent by traditional mail to the mailing address below.*

*If unable to apply online, please send this form and all attachments to:*

Center for Substance Abuse Treatment  
Division of Pharmacologic Therapies  
Substance Abuse and Mental Health Services Administration  
Attention: OTP Certification Program  
5600 Fishers Lane  
Rockville, MD 20857

Overnight:

5600 Fishers Lane  
Rockville, MD 20857

#### Paperwork Reduction Act Statement

Public reporting burden for this collection of information is estimated to average 2 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (XXXX-XXXX); 5600 Fishers Lane, Rockville, MD 20857. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is XXXX-XXXX.

FORM SMA-163 (revised 2016) (BACK)