**S T A T E O F C O N N E C T I C U T**

**DEPARTMENT OF SOCIAL SERVICES**

**Division of Health Services**

**Connecticut Medical Assistance Program (CMAP)**

**PSYCHIATRIC HOSPITALS PROVIDING INPATIENT SUBSTANCE USE DISORDER (SUD) SERVICES**

**ACKNOWLEDGMENT OF DEADLINE FOR FULL COMPLIANCE WITH ASAM GUIDELINES**

**Effective Date: April 1, 2022**

On behalf of the provider listed below (Provider), I, as the Chief Executive Officer (CEO), Executive Director or equivalent, acknowledge that one of the conditions of a psychiatric hospital providing, billing, and being paid for inpatient SUD services in CMAP is aligning with and maintaining full compliance with applicable edition of American Society of Addiction Medicine (ASAM) clinical criteria adopted by the state no later than twenty-four (24) months after the effective date of this acknowledgment document. This acknowledgement is pursuant to the SUD Demonstration Waiver pursuant to section 1115 of the Social Security Act (Demonstration). For currently enrolled providers, this acknowledgement must be signed and submitted to the State’s Medicaid Management Information System (MMIS) vendor prior to submitting any CMAP inpatient SUD claims for services newly authorized for coverage by the Demonstration.

I acknowledge that, if the Provider does not achieve full compliance on or before 24months after the effective date of this acknowledgement and maintain such compliance on an ongoing basis, then the Provider will no longer be able to bill and be paid by CMAP for providing inpatient SUD services and the Provider will not receive CMAP payment for such services provided after that date.

Provider Name:

Provider Address:

Provider NPI:

Provider CMAP Number:

**Acknowledged and Agreed to:**

Provider Name:

By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Duly Authorized

Print Name:

Title:

Date Signed: