State of Connecticut
Department of Social Services, Division of Health Services
Connecticut Medical Assistance Program (CMAP)

ADDENDUM TO PROVIDER ENROLLMENT AGREEMENT FOR SUBSTANCE USE DISORDER (SUD) PROVIDERS – OUTPATIENT AND RESIDENTIAL LEVELS OF CARE

The Provider wishes to participate in the Connecticut Medical Assistance Program as a Substance Use Disorder (SUD) services provider. The Connecticut Medical Assistance Program is administered by the State of Connecticut Department of Social Services ("DSS"). Except as otherwise specifically provided in this Addendum to Provider Enrollment Agreement (the "Addendum"), all provisions of the Provider Enrollment Agreement (the "Agreement") remain in full force and effect. This Addendum is incorporated by reference into the Agreement as if fully set forth therein and DSS may enforce this Addendum pursuant to all applicable authority, including, but not limited to, all authority specified in the Agreement. In addition to all representations and agreements made in the Agreement, the Provider also agrees as follows:

1. To the full extent applicable to the Provider, comply with all requirements set forth in, as applicable and each as amended from time to time, the DSS operational policy, regulations, guidance, bulletins, and manuals that apply to the provision of SUD services, including provisions that apply broadly to CMAP providers and also including the DSS Standards for SUD Services (the "Standards"), including, but not limited to, staff qualifications, minimum staffing, and supervision requirements.
2. To comply with all requirements applicable to the Provider as set forth in the approved Medicaid State Plan regarding SUD services and the approved demonstration waiver, terms and conditions, and implementation plan under section 1115 of the Social Security Act, each as amended from time to time.
3. To comply with all applicable requirements set forth in the documents referenced above, including, but not limited to, compliance with requirements associated with the American Society of Addiction Medicine ("ASAM") level or levels of care performed by the provider, within each timeframe applicable to the requirement. Compliance includes maintaining all applicable certifications required from DSS, Department of Mental Health and Addiction Services (DMHAS), the Department of Children and Families (DCF), any combination thereof, or the authorized agent of one or more of such agencies for each ASAM level of care for which the provider is providing services and for which certification is required (which is currently required for all levels of care other than ASAM 1 – Outpatient Services). **The Provider specifically understands and agrees that, to the extent applicable, the deadlines for obtaining provisional and then full certification, as established by DSS, for complying with SUD services requirements, including, but not limited to, the Standards and ASAM clinical criteria, are mandatory and that failing to comply on time may result in immediate termination of the Provider's participation in CMAP as an SUD Services provider for those levels of care not certified. Failure to maintain certification on an ongoing basis for each ASAM level of care requiring certification for which the provider is enrolled will result in termination of the Provider's participation in CMAP for that level of care.**
4. To comply with all requests from DSS or its designees for information, documentation, and reports and to fully participate in training, monitoring, and evaluation conducted by or on behalf of DSS.

THE UNDERSIGNED, BEING THE PROVIDER OR HAVING THE SPECIFIC AUTHORITY TO BIND THE PROVIDER TO THE TERMS OF THIS ADDENDUM TO PROVIDER ENROLLMENT AGREEMENT, AND HAVING READ THIS ADDENDUM AND UNDERSTANDING IT IN ITS ENTIRETY, DOES HEREBY AGREE, BOTH INDIVIDUALLY AND ON BEHALF OF THE PROVIDER AS A BUSINESS ENTITY, TO ABIDE BY AND COMPLY WITH ALL OF THE STIPULATIONS, CONDITIONS, AND TERMS SET FORTH HEREIN.

Provider Name:
Provider Address:

Provider NPI:
Provider CMAP Number:

Acknowledged and Agreed to:

Provider Name:

By: _____________________________________, Duly Authorized
Print Name:
Title:
Date Signed: