

ATTESTATION FOR COMPLIANCE WITH WAIVER REQUIREMENTS TO PROVIDE MEDICATIONS FOR THE TREATMENT OF SUBSTANCE USE DISORDER

Instructions: Complete electronically using ADOBE READER. The Facility may use this form to attest that they meet the requirements of the Certificate of Waiver for substance use disorder facilities issued on 03/10/2020. Submissions may be made via email to DOHCNLBHwaivers@doh.nj.gov.

FACILITY INFORMATION									
Official Name of Facility/Program									
Facility License No.					Date Received				
Facility EIN No.									
Site Address 1									
Site Address 2									
City				State		Zip		County	
Telephone Number					Fax Number				

FACILITY CONTACTS			
Facility Administrator/ Director/CEO			
Title			Email Address
Facility Representative <i>(whose signature appears below)</i>			
Telephone Number			Email Address

The mental health facility (“Facility”) identified above submits the attached attestation to the New Jersey Department of Health (“DOH”) which is required by the Certificate of Waiver issued _____ for the Facility to prescribe, store, and/or administer medications, other than Methadone, for the treatment of substance use disorder. The Facility is in compliance with conditions I through V below.

I. LICENSE

The Facility’s license to provide outpatient mental health services pursuant to N.J.A.C. 10:37E is in good standing.

The Facility currently prescribes psychotropic medication.

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II. PROVISION OF SERVICES

The Facility provides the following services:

Prescribing medication for the treatment of substance use disorder.

Administering medication for the treatment of substance use disorder.

The Facility does not prescribe, store, and/or administer Methadone without a license pursuant to N.J.A.C. 10:161B-11 et seq.

III. STAFFING

The Facility adheres to the following staffing requirements:

- 1) The Facility's prescriber(s) are currently licensed and in good standing in the State of New Jersey;
- 2) The prescriber(s) adhere to DEA and CDS requirements for the provision of medications for the treatment of substance use disorder;
- 3) Staff who provide counseling to patients as part of their treatment plan are appropriately licensed or credentialed.

IV. POLICIES AND PROCEDURES

The Facility has developed and implemented the following policies and procedures:

- 1) The facility assesses the need to prescribe medications to treat substance use disorder;
- 2) The facility has policies and procedures for processing toxicology screening or testing and pregnancy tests prior to prescribing medication;
- 3) The facility ensures patients have abstained from opioid use prior to treatment, where required for the specific medication;
- 4) The facility ensures patients in need of inpatient withdrawal management services are referred to the appropriate level of care; and
- 5) The facility has policies and procedures to ensure continuity of care in the event the prescriber separates from the facility.

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V. MEDICATION STORAGE

The Facility does not store medications in the Facility.

The Facility stores medications in the Facility and complies with the following:

- a. All drugs are kept in locked storage areas.
- b. Drug storage and preparation areas are kept locked when not in use.
- c. All drugs are stored and administered in accordance with Federal and state law;
- d. All drugs are stored and administered under proper conditions, as indicated by the United States Pharmacopoeia, product labeling, and/or package inserts.
- e. Drugs for external use are kept separate from drugs for internal use.
- f. Drugs in single dose or single use containers which are open or which have broken seals, drugs in containers missing drug source or exact identification (such as lot number), and outdated, recalled, or visibly deteriorated medications are disposed in accordance with Federal and State laws.
- g. A declining inventory of all drugs in Schedules I through V of the Controlled Dangerous Substances Acts and amendments thereto is made at the termination of each shift and is retained wherever these drugs are maintained.

I, _____, of full age, hereby certify that I am employed with the Facility in the
[NAME]
capacity of _____; that I am duly authorized to make the representations contained
[TITLE]
within this form on behalf of the Facility and to bind the Facility thereto; and that all information supplied in
this form, including any and all attachments, is true and complete to the best of my knowledge. I am aware
that if any statement in this form or in an attachment hereto is willfully false, I and/or the Facility may be
subject to penalties in accordance with applicable laws and/or licensure enforcement activity. I attest that the
Facility is in compliance with conditions I through V.

Signature of Facility Representative: _____ **Date:** _____
[Month/Day/Year]