User ID : 15
Program Name : Ringgold Treatment Center, LLC
Name of employee that has registered and/or completed the MOUD/WDT training : Dana Johnson
Program Clinical Director/ credential : Dana Johnson
Program Address: 8292 HWY 41 Ringgold, GA 30736
Office Phone: 706-952-2800
Email: danaj1510.rtc@gmail.com

III. PROVIDER PROFILE QUESTIONS

PLEASE ATTACH A DETAILED EXPLANATION FOR ANY QUESTIONS BELOW THAT WERE ANSWERED "YES."

A. Please answer the following questions regarding your organization's programs:

1. Has the organization, or any other Provider Entity, had its professional liability or malpractice insurance refused, revoked, declined, or accepted on special terms in the past five (5) years?: No
2. Has any government agency suspended, revoked, or taken other action against the organization's license in the past five years?: No
3. Have any accreditations or memberships been revoked, reduced, denied, or suspended in the past five years, or are any actions now underway?: No
4. Has any Owner, Managing Employee, officer, or shareholder of the organization ever been convicted of a crime? : No
5. Has the organization ever been denied acceptance into or withdrawn from GA DBHDD or GA Collaborative ASO network participation? : No
6. Has the organization had any settled claims or judgments relating to sexual misconduct or civil rights violations in the past five years? : No
7. Has the organization had any settled claims or judgments relating to any other matter not disclosed above? : No
8. Has the organization been a defendant in five (5) or more lawsuits in the past five (5) years? : No
9. Does the organization employ or contract with individuals listed on the Office of Inspector General's List of Excluded Individuals/Entities? : No
10. Has the organization filed for Bankruptcy in the past five years? : No

CARELINK OF GEORGIA OPIOID TREATMENT PROVIDERS OF GEORGIA GRANT ATTESTATION

By executing this attestation, the undersigned verifies the following with respect to its application to participate in the Opioid Treatment Providers (OTPG),Department of Behavioral Health & Developmental Disabilities (DBHDD) Grant. I hereby attest that my staff, agents, contractors, subcontractors, billing agents, and I have reviewed and agree to comply with the terms and conditions set forth in the applicable DBHDD and Department of Community Health(DCH) Provider Manuals.

My program agrees to provide Medication for Opioid Use Disorder (MOUD)Treatment Services to individuals who meet the admission and continued stay criteria in accordance with The Department of Behavioral Health & Developmental Disabilities

PROUD Identification Form

Indentifying Information:
First Name:
Middle Initial:
Last Name:
Email Address:
Additional Email if applicable:

Physical Address:
Physical Address Continued:
City:
State/Province:
Postal Zip Code:
Country:
Home Phone Number:
Work Phone Number:
Date of Birth:

List any relative state/national licenses and/or certifications:
Please define all acronyms.

Gender: Optional
Ethnicity:
Candidate Id=Last 4 digits of SS#:
Reason for Taking Exam:
Special Accomodations:
Disability (ADA) Needs:
ADA Contact Name if applicable:

Would you like to purchase the PROUD Study Guide for $45.00?
This guide is updated periiodically and may differ from others. The guide is specified for your particular test.

Do you represent an OTPG Membership Program? If Yes, please list the name of the program. If No, you may still take this exam, however, OTPG Membership will be required for additional PROUD exams.

(DBHDD) Provider manual definition of Medication Assisted Treatment located at: http://dbhdd.org/files/Provider-Manual-BH.pdf.

I understand and acknowledge that the policies and procedures manuals are amended (generally on a quarterly basis) when either Department finds it necessary or appropriate to do so, and that it is my responsibility to check periodically for any revisions pertaining to the delivery of or reimbursement for services rendered to eligible individuals.

I further understand that failure to abide by either DBHDD or DCH policies and procedures will result in adverse consequences including, but not limited to the denial of payment, termination of contract, and reduction of reimbursement.

I certify and attest that I have reviewed the entire contents of the completed application and that the information provided is accurate and complete. I understand that inaccurate, incomplete or omitted data may lead to adverse consequences including, but not limited to the denial of payment, termination of contract, and reduction of reimbursement.

I attest that my program will share patient program data as requested by CareLink or DBHDD. I certify and attest that my program is not currently a recipient of grant funding from any other DBHDD grant for MOUD treatment services.

I hereby declare under penalty of perjury that the foregoing is true and correct. I do hereby affirm that I am the authorized agent to complete this document, and that information contained herein this document is complete, true, and correct to the best of my knowledge. I understand that material misrepresentation and/or falsification of any information containedherein shall result in the immediate removal of further consideration for participation.

Executed on Feb, 28, 2025 in Cartersville (city), GA (state).

Signature of Authorized Officer or Agent

Dana Johnson

Printed Name and Title of Authorized Officer or Agent

SUBSCRIBED AND SWORN BEFORE ME
ON THIS THE 28 DAY OF Feb, 2025.

NOTARY PUBLIC
My Commission Expires: Nov 25, 2028

JENNIFER SIMMONS NOTARY PUBLIC CATOOSA COUNTY EXPIRES GEORGIA Nov. 25, 2028