|  |  |
| --- | --- |
| **DEPARTMENT OF HEALTH SERVICES**  Division of Quality Assurance  F-03082E (09/2022) | **STATE OF WISCONSIN**  Page 1 of 13 |

**SUBSTANCE USE TREATMENT PROVIDER**

**INITIAL CERTIFICATION (or) CHANGE OF OWNERSHIP APPLICATION**

**DHS 75.53 – Transitional Residential Treatment Service**

**DHS 75.54 – Medically Monitored Residential Treatment Service**

**DHS 75.55 – Medically Managed Inpatient Treatment Service – if NOT approved as a hospital under DHS 124**

**DHS 75.56 – Adult Residential Integrated Behavioral Health Stabilization Service**

**DHS 75.57 – Residential Withdrawal Management Service**

**DHS 75.58 – Residential Intoxication Monitoring Service**

|  |
| --- |
| Questions regarding this form may be directed to the Division of Quality Assurance (DQA), Behavioral Health Certification Section (BCHS) at [DHS DQA Mental Health AODA](mailto:DHSDQAMentalHealthAODA@dhs.wisconsin.gov) or **608-261-0656**.  Submission of this information is required by Wis. Stat. §§ 50.065 and 51.45 and Wis. Admin. Code chs. DHS 75. Failure to provide complete and accurate information may result in denial of the application and/or delay in the process. |
| **STEP 1 – PLAN REVIEW** |
| Do you have an existing DHS 83 Community-Based Residential Facility (CBRF) license or DHS 124 Hospital license at this location?  YES  NO  If “yes”, provide license number.  If “no”, are you applying for a CBRF or hospital license at this same time?  YES  NO  If “no”, the building plan must submitted for approval to the [Office of Plan Review and Inspection](https://www.dhs.wisconsin.gov/regulations/plan-review/index.htm) to determine compliance with Wis. Admin. Codes §§ DHS 75.45 and DHS 75.46. Building review can take up to 45 working days for completion. |
| **STEP 2 – ENTITY CAREGIVER BACKGROUND CHECKS (ECBC Not applicable if adding a service to existing certificate)** |
| The applicant submits background information documents and fee directly to the Office of Caregiver Quality (OCQ).   * NOTE: Background materials should not be submitted with the certification application. * ECBCs must be completed for entity owners, whether or not the owner has direct client contact. Certification will not be issued until the ECBC has cleared and results are approved. * For information on how to complete the ECBC, visit [Regulated Entity Background Check Process.](https://www.dhs.wisconsin.gov/misconduct/entity.htm) * For assistance completing this form, call OCQ at 608-261-8319. |
| **STEP 3 – COMPLETED APPLICATION** |
| The applicant submits all applicable documents listed in this section and the BCHS staff will review to ensure compliance with applicable regulations.  A completed application includes each of the following:   1. This application form, fully completed and signed by the entity owner or board member. 2. All supporting documentation as specified in the application. 3. Fees as specified in the application. 4. The entity owner background check process in Step 1 is completed and the final report is available to the Behavioral Health Certification Section. 5. The department verifies applicant is not liable for delinquent taxes or delinquent unemployment insurance contributions as specified in Wis Stat. § 51.032(4). 6. If a building review was needed in Step 1, approval for the building to be used as a DHS 75 residential or inpatient treatment location has been issued.   Email application to [DHS DQA Mental Health and Substance Use Certification](mailto:dhsdqamentalhealthandsubstanceusecertification@dhs.wisconsin.gov) and mail the appropriate fees to the address below. You also may print and mail the completed applications and mail the appropriate fees to the address below.  **DHS/DQA/Behavioral Health Certification Section**  **PO Box 2969**  **Madison, WI 53701-2969** |
| **STEP 4 – ONSITE SURVEY** |
| * The BHCS Surveyor will contact you with a date and time for an onsite survey. * Refer to DQA Publication [P-63174, Survey Guide: Behavioral Health Certification for Mental Health and Substance Abuse Services.](https://www.dhs.wisconsin.gov/publications/p6/p63174.pdf) * If the surveyor identifies significant changes that would result in a denial decision, the applicant will be afforded an opportunity to make necessary changes and submit those changes for review. |
| **STEP 5 – APPROVAL OR DENIAL DECISION** |
| * The surveyor will make the certification decision and send the survey results to notify the provider of the decision. If approved, BHCS staff will mail a formal certificate to the provider for posting at the primary clinic location and at all branch office and/or medication unit locations. |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. **GENERAL INFORMATION – ENTITY/ENTITY OWNER REQUESTING CERTIFICATION** | | | | | |
| Initial Certification  Change of Ownership – *Provide current certification number:*  Adding Service to Existing Certificate – *Provide current certification number:*  **SERVICE APPLYING FOR:**  DHS 75.53 – Transitional Residential Treatment Service  DHS 75.54 – Medically Monitored Residential Treatment Service  DHS 75.55 – Medically Managed Inpatient Treatment Service – *if approved as a hospital under DHS 124, submit information under Section A only.*  DHS 75.56 – Adult Residential Integrated Behavioral Health Stabilization Service  DHS 75.57 – Residential Withdrawal Management Service  DHS 75.58 – Residential Intoxication Monitoring Service | | | | | |
| **FACILITY GENERAL INFORMATION** | | | | | |
| Facility Name (Should match signage and Medicaid enrollment, if applicable) | | | | | |
| Facility Street Address | | City | State | County | Zip Code |
| Facility Phone Number | Facility Fax Number | | | | |
| Facility Web Address | | | | | |
| Number of Beds/Capacity | | | | | |
| Identify Genders Served – (select one)  Male  Female  Both Male and Female | | | | | |
| Choose ambulatory status of clients - (select one)  Semi-ambulatory  Ambulatory  Non-ambulatory | | | | | |
| Are services provided to minors (per DHS 75.35)?  Yes  No | | | | | |
| Are minors allowed to reside with the parent/guardian while the parent/guardian received treatment services per DHS 75.36?  Yes  No | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. **FACILITY CONTACT INFORMATION** | | | | | | | | | | | | | | | | |
| Name Contact Person | | Will program obtain Medicaid certification?  Yes  No | | | | | | | | Facility NPI Number (if known) | | | | | | |
| Contact Phone Number | | | | Contact Email Address | | | | | | | | | | | | |
| Facility Street Address | | | | City | | | | | State | | | | County | | | Zip Code |
| 1. **DESIGNATED MAIL RECIPIENT** (Provide name and contact information of person to whom **ALL** mail from DHS/DQA is to be addressed) | | | | | | | | | | | | | | | | |
| Name – Designated Mail Recipient | | | Title | | | | | Email Address | | | | | | | | |
| Mailing Address – Street or PO Box (if different from above) | | | | | | | City | | | | State | | | | Zip Code | |
| 1. **ENTITY OWNER INFORMATION** | | | | | | | | | | | | | | | | |
| Type of Entity(Check only one). | | | | | | | | | | | | | | | | |
| Church  Corporation – Business  Corporation – Non-profit | Government – County  Government – State  Government – Other | | | | Tribal  Limited Liability Corp (LLC)  Proprietorship (Individual) | | | | | | | | | Partnership  Other – *Specify below:* | | |
| Name – Direct Owner, Legal Entity | | | | | | FEIN\* - Legal Entity | | | | | | | | | | |
| Name – Owner/Board Member | | | | | | SSN\* - Owner/Board Member | | | | | | | | | | |
| Address – Street | City | | | | | State | | | | | | Zip Code | | | | |
| Phone – Owner/Board Member | | | Fax – Owner/Board Member | | | | | | Email Address – Owner/Board Member | | | | | | | |
| Signature | | | | | | Title | | | | | | | | | | |

**If partnership, complete for 2nd owner.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name – (Direct Owner, Legal Entity) | | | FEIN\* - Legal Entity | | | |
| Name – Owner/Board Member | | | SSN\* - Owner or Board Member | | | |
| Address – Street | | City | | | State | Zip Code |
| Phone – Owner/Board Member | Fax – Owner/Board Member | | | Email Address – Owner/Board Member | | |
| Signature | | | Title | | | |

\* *Collection of the applicant’s Social Security number (SSN) and Federal Employer Identification Number (FEIN), if applicable, is required per Wis. Stat. § 73.0301 to verify compliance with Wis. Stat. § 51.032. Failure to supply the number may result in denial of the application. This number will only be disclosed to the Department of Revenue for use in collection of tax delinquencies.*

Are you accredited by any organizations, other than DQA?  YES  NO

If “yes,” identify accreditation organization and provide accreditation identification.

Does your agency have a contract with the Wis. Stat. § 51.42 Board?  YES  NO

If “yes,” identify county/counties.

Have you ever operated a residential facility, health care facility, or day care program for adults or children in Wisconsin or in any other state?  YES  NO

If “yes,” explain and provide relevant information.

List any other DHS/DQA certifications or licenses and provide identification (cert number, name, etc.) and relevant information.

|  |  |
| --- | --- |
| 1. **DISCLOSURE OF OWNERSHIP** | |
| **Required Supporting Documentation – Submit these required documents, when applicable:** | |
|  | 1. List of names, principal business address, and percentage of ownership interest of all officers, directors, stockholders owning 5% or more of stock, members, partners, or others having authority or responsibility for the operation of the organization. For non-profit or governmental organizations, list the names and principal business addresses of all officers and board members. |
|  | 1. A diagram reflecting the ownership structure and names of any affiliate organization associated with the entity owner (parent corporations, other LLC, partnership, etc.). |
|  | 1. If there are no additional owners, check here. |

Licensee Representative

Must be Individual Owner, both partners if Partnership, or Board Member Representative as specified and signed on Page 3 and as applicable on Pages 3, 6, and 10

**Note: This representative(s) must submit an entity background check with ‘Licensee’ role selected as specified in Step 2 on Page 1**

Name of Business Organization *(if any)* that owns the Direct Owner of Certified Entity below

Note: Often referred to as the ‘grandparent’ level owner

List of Board Members, may refer to separate list supplied in #1 above

Note: Not applicable to Individual or Partnership Owners

If needed, list on separate document

Direct Owner of Facility listed on Page 3 as the Direct Owner, Legal Entity

Type of Entity: Individual, Partnership, LLP, LLC, Corporation, Nonprofit, etc. listed on Page 3

List of other entities owned and licensed/certified by DHS Division of Quality Assurance as requested on Page 4

If known, supply license/certificate number

If needed, list on separate document

Name of Certified Entity which matches the Facility Name specified on Page 2, Facility General Information. Facility NPI number as supplied on Page 3

*(This is the name of main location of program requesting certification and match signage used by clients and patients)*

|  |  |  |
| --- | --- | --- |
| 1. **ENTITY OWNER ATTESTATION** | | |
| 1. I hereby attest that all staff know and understand the rights of the clients that they serve and the procedures of informal and formal resolution and have read Wis. Admin. Code chs. DHS 92 and 94. The above-named program has appropriate policies to meet Wis. Admin Code chs. DHS 92 and 94 to ensure patient rights, patient records, confidentiality, and informed consent. The program has a designated client rights specialist who is trained in compliance with requirements of Wis. Admin. Code chs. DHS 92 and 94, Wis. Stat ch. 51, and federal HIPAA requirements in 45 CFR 164 Part E and 42 CFR Part 2, as applicable. | | |
| 1. I hereby attest that all personnel/employees/caregivers have had a caregiver background check completed in accordance with procedures in s. 50.065 Stats. And ch. DHS 12 at the time of hire, employment, or contract, and every 4 years thereafter and records of the completed caregiver background checks shall be available upon request at the service for review by the department. | | |
| 1. I hereby attest that all personnel/employees/caregivers have a signed statement regarding confidentiality of applicable provisions of 42 CFR Part 2, 45 CFR Parts 164 and 170, ss. 51.30, 146.816 and 146.82 Stats. (DHS 75.21). | | |
| I attest, under penalty of law, that the information provided in this application and in attached application materials is truthful and accurate to the best of my knowledge and that knowingly providing false information or omitting information may result in a fine of up to $10,000 or imprisonment not to exceed six years, or both (Wis. Stat. § 946.32).  I attest that I will comply with all laws, rules, and regulations governing program certification in Wisconsin. | | |
| **Signature** – Owner or Board Member  *(Full signature is required)* | | Date Signed |
|  | |  |
| Name – Owner or Board Member | Title – Owner or Board Member | |
| **Signature** – Partner if Applicable *(Full signature is required.*  *If Partnership, both owners must sign).* | | Date Signed |
|  | |  |
| Name – Owner or Board Member | Title – Owner or Board Member | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1. **ENTITY OWNER TRANSFER OF RESPONSIBILITY TO REQUEST FUTURE CHANGES AND CLINICAL OPERATIONS** | | | | | | |
| The individual in the role specified below is given full authority to request initial services and branches, service additions and deletions, staff changes, branch location additions and deletion, and all operational changes submitted to the department. | | | | | | |
| Check applicable role: | Program Contact | Service Director | Medical Director | | Clinical Supervisor | |
| **Signature** - Owner or Board Member *(Full signature required)* | | | | | | Date Signed |
| Name – Owner or Board Member | | | | Title – Owner or Board Member | | |
| **Signature** – Partner if Applicable *(Full signature is required.*  *If Partnership, both owners must sign).* | | | | | | Date Signed |
| Name – Owner or Board Member | | | | Title – Owner or Board Member | | |

|  |  |  |
| --- | --- | --- |
| 1. **REQUIRED DHS 75 FACILITY POSITIONS** | | |
| Name | Phone Number | Email Address |
| Program Contact |  |  |
| Service Director – required per DHS 75.53, 75.54, 75.55, 75.56, 75.57, 75.58 services |  |  |
| Medical Director - required per DHS 75.18(1) for DHS 75.53, 75.54, 75.55, 75.56, 75.57 services |  |  |
| Clinical Supervisor - required per DHS 75.18(2) for DHS 75.53, 75.54, 75.55, 75.56, 75.57 services |  |  |
| Client Rights Specialist – required per DHS 94.40(3) |  |  |
| Record Custodian – required per DHS 92.03(1)(c) |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| 1. **INITIAL SERVICES CERTIFICATION** | | | |
| *Indicate which services will be offered; review and complete the section fully; and, submit the specified additional documentation.* | | | |
| **DHS 75 Residential Services**  DHS 75.53 – Transitional Residential Treatment Service  DHS 75.54 – Medically Monitored Residential Treatment Service  DHS 75.55 – Medically Managed Inpatient Treatment Service – *if approved as a hospital under DHS 124, submit information under Section A only.*  DHS 75.56 – Adult Residential Integrated Behavioral Health Stabilization Service  DHS 75.57 – Residential Withdrawal Management Service  DHS 75.58 – Residential Intoxication Monitoring Service | | | |
| **Service Director – See DHS 75.18(1)(a-c)** | | | |
| Name | | Phone Number | Email Address |
| List Professional License # or Certification # if applicable: | | | |
| List Qualifications including applicable professional licenses or certifications: | | | |
| List Duties: | | | |
| **Medical Director – required for DHS 75.54, DHS 75.55, DHS 75.56, and DHS 75.57** | | | |
| Name | | Phone Number | Email Address |
| List Professional License # or Certification # if applicable: | | | |
| List Qualifications including applicable professional licenses or certifications: | | | |
| 1. **REQUIRED SUPPORTING DOCUMENTATION**(Submit these required documents specific to Wis. Admin. Code ch DHS 75.53 to DHS 75.58 – Subchapters 4-5-6) | | | |
| 1. All policies and procedures per applicable DHS 75 service choice(s) indicated above. 2. What department approved placement criteria are you using per DHS 75.23(2)?   ASAM  UPC  Other (submit copy) | | | |
| 1. **COMPLETE APPLICATION** | | | |
| *The following items must be attached to this completed application form.* | | | |
|  | A floor plan specifying dimensions of the facility, exits, and planned room usage – required per DHS 75.29(1)(a) | | |
|  | An explanation of the 24−hour staffing pattern for the service – required per DHS 75.29(1)(b) | | |
|  | A statement indicating whether the service will provide treatment services for patients that are non−ambulatory or semi−ambulatory. If a service provides treatment services for patients that are non−ambulatory or semi−ambulatory, the floor plan shall include ramped exits to grade – required per DHS 75.29(1)(c) | | |
|  | Municipal zoning approval or occupancy permit – required per DHS 75.29(1)(d) | | |
|  | The results of an approved fire inspection completed within the last 12 months – required per DHS 75.29(1)(e) | | |
|  | Fireplace and chimney inspections completed within the last 12 months, if applicable – required per DHS 75.29(1)(f) | | |
|  | The results of furnace inspection completed within the last 12 months – required per DHS 75.29(1)(g) | | |
|  | The results of smoke and heat detector inspection completed within the last 12 months – required per DHS 75.29(1)(h) | | |
|  | The results of sprinkler inspection completed within the last 12 months – required per DHS 75.29(1)(i) | | |
|  | Well water test results completed within the last 12 months, if applicable – required per DHS 75.29(1)(j) | | |
|  | Building emergency evacuation plan – required per DHS 75.29(1)(k) | | |
|  | A disaster recovery plan in the case of flood, gas leak, electrical outage, or other emergency – required per DHS 75.29(1)(l) | | |
|  | Service policies and procedures – required per DHS 75.29(1)(m) | | |
|  | Policy for service approach to assessment and treatment for concurrent tobacco use disorders – required per DHS 75.24(7) | | |
|  | Policy regarding a smoke-free environment – required per DHS 75.24(7) | | |
|  | Fit and Qualified Application, [Form F-03089,](https://www.dhs.wisconsin.gov/library/F-03089.htm) with required supporting documentation requested on form – required per DHS 75.29(1)(o) and DHS 75.30 | | |
|  | Policies and procedures. written plans for the provision of medical care for residents and written plan for providing emergency transportation for patients needing emergency medical services – required per DHS 75.37 | | |
|  | Policies and procedure regarding infection control program – required per DHS 75.40 | | |
|  | Policies and procedures regarding guests and visitors – required per DHS 75.44 | | |
| **Per DHS 75.32 – General Facility Requirements** | | | |
|  | DHS 75.32(4)- Is the facility physically separated from other entities, programs, and services?  YES  NO  Submit information accordingly. | | |
|  | Is the residential service facility’s living areas separate and secure from non-resident entry?  YES  NO  Submit information accordingly. | | |
| **Per DHS 75.35 – Residential Service for Minors** | | | |
| Will you be providing residential/inpatient treatment service to minors?  YES  NO | | | |
|  | If “yes”, submit information that the service maintains physically separate and secure living areas for minors and adults. | | |
|  | If “yes”, submit policy and procedure for addressing the educational needs of each participating minor. | | |
| **Per DHS 75.36 – Services for Parents for Minors** | | | |
| Are minors allowed to reside at the facility while a parent or guardian receives treatment?  YES  NO | | | |
|  | If “yes”, submit policies and procedures that address the safety of minors, family services and supports, and behavioral expectations and interventions for residing minors and addressing the educational needs of each residing minor. | | |
| **Per DHS 75.37 – Emergency Medical Care** | | | |
|  | Submit policies and procedures and written plan for the provision of medical care for residents. | | |

|  |  |  |
| --- | --- | --- |
| 1. **ATTESTATION** | | |
| I hereby attest that all statements made in this application and any attachments are correct to the best of my knowledge and that I will comply with all laws, rules, and regulations governing DHS 75.60 services, including Wis. Admin. Code chs. DHS 92, DHS 94, DHS 12, DHS 13, and Wis. Stat. ch. 51. The signatory of this document is duly authorized by the licensee/certificate holder to sign this agreement on its behalf. The certificate holder hereby accepts responsibility for knowing and ensuring compliance with all licensing, operational, and requirements for this facility.  I attest under penalty of law that the information provided above is truthful and accurate to the best of my knowledge.  I understand that knowingly providing false information or omitting information may result in denial of licensure, a fine of up to $10,000 or imprisonment not to exceed six years, or both (Wis. Stat. § 946.32).  I attest that all statements made on this form are true and correct to the best of my knowledge. | | |
| **SIGNATURE** – Entity Owner, Representative, or Authorized Representative Specified Above | | Date Signed |
| Full Name | Title | |

|  |
| --- |
| 1. **Staff Roster** |

**Program Staff Roster**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name**  (Last, First) | **Position** **Title**  (Example: Service Director, Clinical Supervisor, Receptionist) | **Professional** **Credential** (Example: LCSW, CSAC, SAC-IT) | **DSPS** **Lic.** **No.**  (as applicable) | **Individual NPI No.** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Main Office – Part 1 of 2**

Pursuant to Wis. Stat. s. 50.065(1), "caregiver" means (1) a person who is, or is expected to be, an employee or contractor of an entity, (2) who is, or is expected to be, under the control of an entity, as defined by the department by rule, and (3) who has or is expected to have regular, direct contact with clients of the entity.

Examples of caregivers include: Service Director, CSAC, LCSW, Receptionist, Volunteers, Peer Specialists, Recovery Coaches, Security Guards, SAC-IT, etc.

**BHCS Program Staff Roster**

**Main Office – Part 2 of 2**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name**  (Last, First) | **List each service certified at this location in the column header. Example, DHS 75.49, DHS 75.51, DHS 75.15.**  **For each person, list the hours per week spent for each program service.**  **\*\* Align individual names with Part 1 of 2 on previous page. \*\*** | | | | | | | | |
| List Service #1 | List Service #2 | List Service #3 | List Service #4 | List Service #5 | List Service #6 | List Service #7 | List Service #8 | List Service #9 |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |

|  |
| --- |
| 1. **BIENNIAL FEES** |
| Submit check with application materials.   * Make checks payable to: **DHS/Division of Quality Assurance.** * All fees are non-refundable. * If adding a service to an already existing certificate, full application fee for one service is required if the certificate is in year 1 of the 2-year biennial fee period. Half of the one service application fee is required if the certificate is in year 2 of the 2-year biennial fee period.   Example – Biennial Fee period is currently 04/01/2022 to 03/31/2024. If a new service is being added between 04/01/2022 and 03/31/2023, the full biennial fee for a new service is due, $1,100.00. If a new service is added between 04/01/2023 and 03/31/2024, only one half of the biennial fee for a new service is required, $550.00. |

|  |  |
| --- | --- |
| **Service Type** | **Fees**  *(See fee table below.)* |
| DHS 75.53 | $ |
| DHS 75.54 | $ |
| DHS 75.55 | $ |
| DHS 75.56 | $ |
| DHS 75.57 | $ |
| DHS 75.58 | $ |
| **TOTAL FEES DUE:** | $ |

|  |  |
| --- | --- |
| **Biennial Fee Table**  **Initial DHS Services/Programs** | |
| For each service being added at initial certification of adding in year 1 of biennial fee cycle | $1,100.00 |
| For each service adding in year 2 of biennial fee cycle | $550.00 |