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| **DEPARTMENT OF HEALTH SERVICES**  Division of Quality Assurance  F-03082F (07/2023) | | **STATE OF WISCONSIN**  Page 1 of 5 |
| **INITIAL CERTIFICATION APPLICATION for**  **DHS 75.59 Opioid Treatment Program (OTP) Mobile Unit** | | |
| Questions regarding this form may be directed to the Division of Quality Assurance (DQA), Behavioral Health Certification Section (BHCS) 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. An application is considered complete when all applications are received with accurate information, signatures, and supporting documentation is submitted. | | |
| **STEP 1 – APPLICATION** | | |
| A completed application includes all of the following:   * This application form, fully completed and signed by the entity owner or board member. * All supporting documentation as specified in the application – See Section III. * Fees as specified in the application.   E-mail application to [dhsdqamentalhealthandsubstanceusecertification@dhs.wisconsin.gov](mailto:dhsdqamentalhealthandsubstanceusecertification@dhs.wisconsin.gov) and mail the appropriate fees to the address below.  OR  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 2 – ONSITE SURVEY** | | |
| * A BHCS surveyor will contact you to arrange 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 3 – 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 main clinic location and at all Mobile Unit/branch office locations. | | |
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| 1. **GENERAL INFORMATION** | | |
| Facility Name (Main clinic location listed on DQA certificate): | Wisconsin Certificate Number: | |
| Select which services the Mobile Unit will be providing:  Unit **WILL** utilize SAMHSA’s allowances to provide the same certified services as main clinic’s certification.  Unit **WILL** **NOT** utilize SAMHSA’s allowances and only provide allowable medical services. | | |
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| 1. **MOBILE UNIT INFORMATION** | | | | |
| *If applying for certification for multiple Mobile Units, submit a separate copy of this page and a separate program staff roster page for each Mobile Unit location.* | | | | |
| Name of Mobile Unit- \**DQA will add Mobile Unit to the name for purposes of printing on the certificate and in the public directory.* | | | | |
| Overnight Parking Address | City | State | Zip Code | |

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| 1. **REQUIRED SUPPORTING DOCUMENTATION** |
| **For Mobile Unit:** |
| Policies and Procedures- different than main clinic, if any. |
| Floor Plan- Showing a detailed description of the Mobile Unit and its contents.  Travel Plan- Provide the days of the week traveling and list times at each stop(s) on the travel route for each day traveled.  Dispensing Locations- Identify the locations and times on the travel route/plan.  Storage Location – when not in use.  Policies and Procedures of Mobile Unit including:   * Including emergency Travel Plans (breakdown protocol) * Security Plan of loading and unloading medications * Dispensing Process when on location |

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| 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 mental health and substance use treatment services at this location including Wis. Admin. Code chs. DHS 75, 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). | | |
| **SIGNATURE** – Entity Owner, Representative, or Authorized Representative as designated at the main clinic location. | | Date Signed |
| Full Name *(Print or type)* | Title | |

**Mobile Unit**

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| **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.** |
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**Program Staff Roster**

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.

**Mobile Unit—Part 1 of 2**

**Mobile Unit**

**Program Staff Roster**

**Mobile Unit—Part 2 of 2**

**Example:**

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|  | DHS 75.59 | DHS 75.50 |  |  |  |  |  |  |  |
| Smith, John | 30 hours | 10 hours |  |  |  |  |  |  |  |

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| **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 *at this location*.**  **\*\* 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 |
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| 1. **BIENNIAL FEES** |
| Submit check with application materials.   * Make checks payable to: **DHS / Division of Quality Assurance.**   + Check Number:   + Amount of Fees Submitted: $ * All fees are non-refundable. |

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| **TOTAL FEES DUE:** | $ |
| Please submit separate applications for each Mobile Unit being added. | |

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| **Biennial Fee Table** | |
| Mobile Unit | $500 each |