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| **DEPARTMENT OF HEALTH SERVICES**  Division of Quality Assurance  F-03308 (09/2024) | **STATE OF WISCONSIN**  Page 1 of 8 |

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| **DHS 75.58 RESIDENTIAL INTOXICATION MONITORING SERVICE** | | | | | | | | | **Internal Use Only** | | | | |
| **INITIAL CERTIFICATION (OR) CHANGE OF OWNERSHIP APPLICATION** | | | | | | | | | Date Received: | | | | |
|  | | | | | | | | |  | | | | |
| Questions regarding this form may be directed to the Division of Quality Assurance (DQA), Behavioral Health Certification Section (BHCS) at [DHSDQAMentalHealthandSubstanceUseCertification@dhs.wisconsin.gov](mailto:DHSDQAMentalHealthandSubstanceUseCertification@dhs.wisconsin.gov)**.**  Submission of this information is required by Wis. Stat. §§ 50.065 and 51.45 and Wis. Admin. Code chs. DHS 75.58. 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, and when the background check report resulting from Step 1 is available for review by the Behavioral Health Certification Section. | | | | | | | | | | | | | |
| **BEFORE SUBMITTING THIS APPLICATION** | | | | | | | | | | | | | |
| Please answer the questions below to determine if a Physical Environment Review is required: | | | | | | | | | | | | | |
| 1. | Is the building/address associated with this application, currently licensed as a DHS 83 Community Based Residential Facility (CBRF) or currently a residential service that is licensed as a DHS 124 Hospital?  Yes  No | | | | | | | | | | | | |
|  | If **“Yes”** provide license number(s): | | |  | | | | | | | | | |
| 2. | Will the above license remain active/open through the DHS 75 certification process?  Yes  No  N/A | | | | | | | | | | | | |
|  | If **“No”** to either question 1 or 2, an [Office of Plan Review and Inspection application](https://www.dhs.wisconsin.gov/forms1/f6/f62333.docx) must be submitted to the [Office of Plan Review and Inspection (OPRI](https://www.dhs.wisconsin.gov/regulations/plan-review/forms.htm)). OPRI will conduct a Physical Environment Review to determine compliance with Wis. Admin. Codes §§ DHS 75.42, 75.43, 75.45, and 75.46. Physical Environment Review can take up to 45 working days for completion. Please proceed to STEP 1 after a letter that states, “conditional approval” is provided by OPRI. | | | | | | | | | | | | |
| 3. | Are there any proposed building alterations/remodel?  Yes  No | | | | | | | | | | | | |
|  | If **“Yes”** an [Office of Plan Review and Inspection application](https://www.dhs.wisconsin.gov/forms1/f6/f62333.docx) must be submitted to the [Office of Plan Review and Inspection (OPRI)](https://www.dhs.wisconsin.gov/regulations/plan-review/forms.htm). OPRI will conduct a Physical Environment Review to determine compliance with Wis. Admin. Codes §§ DHS 75.42, 75.43, 75.45, and 75.46. Physical Environment Review can take up to 45 working days for completion. Please proceed to STEP 1 once the conditional approval is provided by OPRI. | | | | | | | | | | | | |
| 4. | If there is no current CBRF license, are you also planning to apply for a DHS 83 CBRF license for the address associated with this application?  Yes  No  If **“Yes”** an [Office of Plan Review and Inspection application](https://www.dhs.wisconsin.gov/forms1/f6/f62333.docx) must be submitted to the [Office of Plan Review and Inspection (OPRI)](https://www.dhs.wisconsin.gov/regulations/plan-review/forms.htm). Please proceed to STEP 1 once the conditional approval is provided by OPRI. | | | | | | | | | | | | |
| 5. | If there is no current Hospital license, are you also planning to apply for a DHS 124 Hospital license for the address associated with this application?  Yes  No  If **“Yes”** an [Office of Plan Review and Inspection application](https://www.dhs.wisconsin.gov/forms1/f6/f62333.docx) must be submitted to the [Office of Plan Review and Inspection (OPRI)](https://www.dhs.wisconsin.gov/regulations/plan-review/forms.htm). Please proceed to STEP 1 once the conditional approval is provided by OPRI. | | | | | | | | | | | | |
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|  | **FEES:** | | | | | | Initial Physical Environment Review Fee: | | | | |  | |
|  | Initial Physical Environment Review\* | | | | **Fees Based on Project Dollar Value**  (Fee from Table) | |  | **Fee Based on Project Dollar Value** | | |  |  | |
|  | **Estimated Cost of Work Submitted** | | **Fee** |  |
| Est. Cost: | $ |  | Less than $2,000 | | $100 |  |
|  | $2,000 – $24,999 | | $300 |  |
|  | **Please Note:** Any building that does **not** have a current/active CBRF license or current/active residential service that is licensed as a DHS 124 Hospital associated with this service application is required to comply with current building/construction requirements.  \* Separate fees apply for Physical Environment Review submission. | | | | | |  | $25,000 - $99,999 | | $500 |  |  | |
|  | $100,000 - $499,999 | | $750 |  |
|  |  | $500,000 - $999,999 | | $1,500 |  |  | |
|  | $1,000,000 - $4,999,999 | | $2,500 |  |
|  |  | $5,000,000 and Over | | $,5,000 |  |  | |
| **STEP 1 – PHYSICAL ENVIRONMENT REVIEW and CONDITIONAL APPROVAL** | | | | | | | | | | | | | |
| * Upon receipt of a letter from OPRI that states *Conditional Approval*, resume with STEP 2 to continue this Substance Use Treatment Provider Certification application (if applicable). | | | | | | | | | | | | | |
| **STEP 2 – ENTITY OWNER BACKGROUND CHECKS (ECBC) – Not applicable if adding a service to an existing certificate** | | | | | | | | | | | | | |
| * Complete an Entity Owner Background Check for the current year. For information on how to complete the EBC, visit [Regulated Entity Background Check Process.](https://www.dhs.wisconsin.gov/misconduct/entity.htm) EBC can take up to 10 business days after submission. If assistance is needed with EBC, contact the Office of Caregiver Quality (OCQ) at 608-261-8319.   \*The applicant submits background information documents and fee directly to OCQ. Background materials should not be submitted with this certification application. | | | | | | | | | | | | | |
| **STEP 3 – COMPLETED APPLICATION AND FEE REQUIREMENTS** | | | | | | | | | | | | | |
| The applicant submits all applicable documents listed in this section and the BHCS 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   Email application and supporting documents to: [DHS DQA Mental Health and Substance Use Certification](mailto:DHSDQAMentalHealthandSubstanceUseCertification@dhs.wisconsin.gov)  Mail the required fees with “Initial App [Provider Name] DHS 75.58” in the memo line to: | | | | | | | | | | | | | |
|  | | **DHS / DQA / BAL / Behavioral Health Certification Section**  **PO Box 2969**  **Madison, WI 53701-2969** | | | | | | | | | | | |
| **Please Note:** The application will not be processed until a completed application, supporting documents, and all fees are received in full. All fees are non-refundable. | | | | | | | | | | | | | |
| Fees for New Provider: | | | Biennial Fee - $1,100.00. | | | | | | | | | |
| Fees for Existing Provider: | | | If adding this service, please reach out via email to determine your current cycle and correct fees. Please include your current certification number on the [email](mailto:DHSDQAMentalHealthandSubstanceUseCertification@dhs.wisconsin.gov). | | | | | | | | | |
| **STEP 4 – 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 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 email a formal certificate to the provider for posting at the primary clinic location. | | | | | | | | | | | | | |

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| 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: | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |  | | | |
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| **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)  Ambulatory  Semi-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 receives 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Physical Address – Street | | | | | | | | | | City | | | | | | | | | | | County | | | | | | | | | | | | | | State | | | | ZIP Code | |
| 1. **Designated Mail Recipient**(Check and provide requested information for all that apply) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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: | | | | | | | | | |
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|  | | | |  | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |
| Name – Owner (Individual/Partnership Names) or Corporation (Legal Entity) | | | | | | | | | | | | | | | | | | | | | | | | | | | FEIN\* – Legal Entity | | | | | | | | | | | | | |
| Name – Owner/Board Member | | | | | | | | | | | | | | | | | | | | | | | | | | | SSN\* – Owner or Board Member | | | | | | | | | | | | | |
| Address – Street | | | | | | | | | | | | City | | | | | | | | | | | | | | | | | | | | | State | | | | | ZIP Code | | |
| Telephone – Owner/Board Member | | | | | Fax – Owner/Board Member | | | | | | | | | | | | Email Address – Owner/Board Member | | | | | | | | | | | | | | | | | | | | | | | |
| Signature | | | | | | | | | | | | | | | | | Title | | | | | | | | | | | | | | | | | | | | | | | |
| **If partnership, complete for second 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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| List any other DHS/DQA certifications or licenses and provide identification (cert number, name, etc.) and relevant information. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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 where they need to identify the name, role, email and/or phone number. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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 | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Medical Director | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Clinical Supervisor | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Client Rights Specialist | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Record Custodian | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| 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) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| * Attach all policies and procedures that are applicable to DHS 75 service choice(s) indicated above. To expedite the program/policy review process, please submit only the policies and procedures associated with regulatory requirements. * Physical Environment Review *Conditional Approval* Letter from OPRI (if applicable) * Staff Rosters completed | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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, refer to DHS 83.39 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | 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 to prevent 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 with Residing 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 Center** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Submit policies and procedures and written plan for the provision of medical care for residents. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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. 2. 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. 3. 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. **Attestation - (Entity Owner Representative, or Authorized Representative Specified Above)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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 | | | | |
| Name – Owner or Board Member | | | | | | | | | | | | | | Title – Owner or Board Member | | | | | | | | | | | | | | | | | | | | | | | | | |

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| 1. **Staff Roster** |

**Program Staff Roster**

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| **Name**  (Last, First) | **Position** **Title**  (Example: Service Director, Clinical Supervisor, Receptionist) | **Professional** **Credential** (Example: LCSW, CSAC, SAC-IT) | **DSPS** **License** **Number**  (as applicable) | **Hire Date** |
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**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**

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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.**  **\*\* 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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