MENTAL HEALTH DAY TREATMENT PROGRAM
INITIAL CERTIFICATION APPLICATION

Chapter DHS 61.75

- By completing and submitting this form, the clinic indicates that it is in compliance with the program standards as required by state statutes and with Chapter DHS 61.75, Wisconsin Administrative Code.
- After review of the submitted application, a preliminary determination will be made as to the unit's eligibility for certification. If eligibility appears feasible, an on-site visit will be scheduled and certification status determined.
- If no significant deficiencies are found by the site visit, a certificate will be issued. If significant deficiencies are identified, the applicant will be afforded an opportunity to develop a plan of correction to complete compliance.

To Program Personnel:

- Read these instructions carefully before completing this questionnaire.
- The relevant standard is printed immediately preceding the corresponding questionnaire item.
- Respond to **every** item carefully. Do not omit a response to any item.
- Where "verification" is required in the questionnaire, **list** the type of document or materials that will be presented to verify the statement in question. **DO NOT** forward the actual documents or material with the questionnaire, but be sure they are available for review at the time of the on-site survey.

Name - Facility				
Address – Physical	City	State	Zip Code	County
Telephone Number ( )	E-mail Address ☐ *May be published in Provider Directory.*			
Fax Number ( )	Internet Address ☐ *May be published in Provider Directory.*			
Name - Contact Person	Telephone Number ( )	E-mail Address ☐ *May be published in Provider Directory.*		
Name – Person Who Completed this Form	Telephone Number ( )	E-mail Address ☐ *May be published in Provider Directory.*		

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 alcohol and other drug abuse intervention services.

SIGNATURE – Director	Date Signed	Full Name – Director *(Print or type.)*

Day treatment is a basic element of the mental health program, providing treatment while the patient is living in his own community. Its services shall be closely integrated with other program elements to ensure easy accessibility, effective utilization, and coordinated provision of services to a broad segment of the population. Day treatment provides treatment services for patients with mental or emotional disturbances who spend only part of the 24-hour period in the services. Day treatment is conducted during day or evening hours.

REQUIRED PERSONNEL

a. Day treatment staff shall include various professionals, composing a mental health team. They shall be directly involved in the evaluation of patients for admission to the service, determining plan of treatment and amount of time the patient participates in the service and in evaluating patients for changes in treatment or discharge

1. Documentation of Staff

   Complete the Staff List on page 6 of this form. *(If additional pages are need, copy before using and attach additional pages.)* Also have available for review copies of degrees, certification and/or license numbers, as well as an organization chart.

2. Who are the persons responsible for evaluating patients who come to your service for admission?

   Name: _____ Title: _____

3. Who determines the plan of treatment and amount of time that patients receive your service?

   Name: _____ Title: _____

4. Who evaluates patients for changes in treatment or for discharge?

   Name: _____ Title: _____

b. A qualified mental health professional shall be on duty whenever patients are present.

5. Who is on duty when patients are present?

   Name: _____ Title: _____

6. ☐ Yes ☐ No Do you have a psychiatrist present at least once a week and on a scheduled basis?

   Name: _____ Schedule: _____

c. A psychiatrist shall be present at least weekly on a scheduled basis and shall be available on call whenever the day treatment service is operating.

7. ☐ Yes ☐ No Further, is he/she on call during all the hours that the day treatment is open?

d. A social worker shall participate in program planning and implementation.

8. ☐ Yes ☐ No Do you have a social worker who takes part in your program planning and implementation?

   Name: _____

e. A psychologist shall be available for psychological services, as indicated.

9. ☐ Yes ☐ No Do you have a psychologist available when needed?

   Name: _____

f. A registered nurse and a registered activity therapist shall be on duty to participate in program planning and to carry out the appropriate part of the individual treatment plan.

10. ☐ Yes ☐ No Do you have a registered nurse on duty?

Name: _____ When? _____

☐ Yes ☐ No a. Does he/she participate in program planning and help carry out the appropriate part of the individual treatment plan?

Specify areas: _____

11. ☐ Yes ☐ No Do you have a registered activity therapist on duty?

Name: _____ When? _____

☐ Yes ☐ No a. Does he/she participate in program planning and help carry out the appropriate part of the individual treatment plan?

Specify areas: _____

f. Additional personnel may include licensed practical nurses, occupational therapy assistants, other therapists, psychiatric aides, mental health technicians of other paraprofessionals, educators, sociologists, and others, as applicable.

12. Indicate any additional staff that you have.

☐ Licensed Practical Nurses ☐ Occupational Therapy Assistants ☐ Other Therapists *(Specify below.)*

Specify other therapists: _____

☐ Psychiatric Aides ☐ Mental Health Technicians ☐ Other Paraprofessionals *(Specify below.)*

Specify other paraprofessionals: _____

☐ Educators ☐ Sociologists

h. Volunteers may be used in day treatment and programs are encouraged to use the services of volunteers.

13. ☐ Yes ☐ No Do you have many volunteers in your program? How many? _____

SERVICES

a. A day treatment program shall provide services to meet the treatment needs of its patients on a long or short term basis as needed. The program shall include treatment modalities as indicated by the needs of the individual patient. Goals shall include improvement of interpersonal relationships, problem solving, development of adaptive behaviors, and establishment of basic living skills.

14. How does your program provide services for the needs of your patients on both a long and short term basis?

15. Do your goals include:

☐ Yes ☐ No a. Improvement in interpersonal relations?
☐ Yes ☐ No b. Problem solving?
☐ Yes ☐ No c. Development of adaptive behavior?
☐ Yes ☐ No d. Establishment of basic living skills?

16. What are the hours that your day treatment services are in operation to receive patients? _____

17. Who is responsible for coordination of services not directly provided by your agency?

Name: _____

18. ☐ Yes ☐ No Do you have a written policy for the integration of services with other program elements?

19. Indicate the institutions with which your services integrate.

☐ Schools ☐ Nursing Homes ☐ Courts ☐ Public Agencies (DVR, etc.)
☐ Hospitals ☐ Crisis Clinics ☐ Public Welfare ☐ Other *(Specify below.)*

_____

b. There shall be a written individual plan of treatment for each patient in the day treatment service. The plan of treatment shall be reviewed no less frequently than monthly.

20. ☐ Yes ☐ No Do you have a written individual treatment plan for each patient?

21. ☐ Yes ☐ No Do you review the patient's treatment plan at least once a month? Who reviews it?

Name _____

☐ Yes ☐ No Is this done together with the patient?

c. There shall be a written individual current record for each patient in the day treatment service. The record shall include individual goals and the treatment modalities used to achieve these goals.

22. ☐ Yes ☐ No Do you maintain a written individual current record for each patient?

23. ☐ Yes ☐ No Does this record contain individual goals and the treatment plan to achieve these goals? Explain below:

24. ☐ Yes ☐ No Is confidentiality safeguarded with respect to patients' records?

25. ☐ Yes ☐ No Are files locked and secure?

26. ☐ Yes ☐ No Do you have a written policy for release of information and a procedure for obtaining information from outside agencies and resources?

Mental Health Day Treatment Program Initial Certification Application – Chapter DHS 61.75

STAFF LIST

Have available for review: copies of degrees, certificates and/or license numbers, as well as the organization chart.

Name and Title	Hours Per Week Employed	Degree	Certification and/or License No.	For Surveyor Use Only