

**EMERGENCY MENTAL HEALTH SERVICE
 RECERTIFICATION APPLICATION
 DHS 34**

- This application is to verify that the emergency mental health service complies with DHS 34, Wis. Admin. Code. By completing and submitting this form, the clinic indicates that it is in compliance with the program standards as required by state statutes.
- The checkboxes denote a required response, form, or attachment to the application
- **Each abstract should be limited to one page in length.**
- Label each application page with the identifying question number / letter.

| | | | | | | | | | |
|---------------------------------------|--|--|--|--|--|----------|--|--------|--|
| Name - Facility | | | | | Certification Number | | | | |
| | | | | | | | | | |
| Address – Physical | | | City | | State | Zip Code | | County | |
| Telephone Number () | | | E-mail Address <input type="checkbox"/> <i>May be published in Provider Directory.</i> | | | | | | |
| Fax Number () | | | Internet Address <input type="checkbox"/> <i>May be published in Provider Directory.</i> | | | | | | |
| Name - Contact Person | | | Telephone Number () | | E-mail Address <input type="checkbox"/> <i>May be published in Provider Directory.</i> | | | | |
| Name – Person Who Completed this Form | | | Telephone Number () | | E-mail Address <input type="checkbox"/> <i>May be published in Provider Directory.</i> | | | | |

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 crisis services.

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|----------------------|--|-------------|--|--|--|
| SIGNATURE – Director | | Date Signed | | Full Name – Director (<i>Print or type.</i>) | |
| | | | | | |

- 1. DHS 34.11 (1) General**
- YES NO The emergency mental health service complies with the requirements for a basic emergency service as described in DHS 34.11.

- 2. DHS 34.11 (2) Personnel**
- This service complies with requirements in DHS 75.03 that apply to prevention services.
- a. Complete and attach a current "Treatment Staff" form to this application.
 - b. If your agency is contracted with a 51.42 Board, provide a list of contracted counties.
 - c. Provide an abstract of volunteer personnel orientation and training plans. Include the name of a regular staff member that is available at all times to assist with the volunteers.
 - d. Provide names of those available for medical consultations available to all staff members at all times.
 - e. Provide names of those available for psychiatric consultation available to all staff members at all times.
 - f. Please have available for review, copies of degrees, certificates, and/or licenses.

- 3. DHS 34.11 (3) Program Operation and Content**
- YES NO
- YES NO
- a. Emergency services are available 24 hours a day, seven days a week.
 - b. A 24-hour a day crisis telephone services is available.
 - c. Indicate who answers the emergency telephone.
 - Mental health professionals**
 - Paraprofessionals**
 - Trained mental health volunteers**
 - d. Provide an **abstract of written guidelines for referrals and schedules of professional staff** to serve as back-up when paraprofessional/volunteers answer the phones.
 - e. Provide an **abstract of face-to-face contact** for crisis intervention services that you provide.
 - f. Provide an **abstract of client transfer policies, procedures, and names of facilities** with which you share your emergency services.

EMERGENCY MENTAL HEALTH TREATMENT STAFF LISTING

| | | | |
|-----------------|-----------------------------------|------|----------|
| Name – Facility | Facility Address – Street Address | City | Zip Code |
|-----------------|-----------------------------------|------|----------|

| Name | Position | Verification Signature * | Date | Degree | Knowledge of Applicable Parts of Chapters 48, 51, 55 |
|------|----------|--------------------------|------|--------|--|
| | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
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| | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
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| | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

* **VERIFICATION SIGNATURE** – Verifies that the above experience and knowledge factors are correct and that there is a criminal record check on file.

I affirm that the above statements are correct to the best of my knowledge.

| | | |
|-------------------------------|---|-------------|
| SIGNATURE – Facility Director | Name – Facility Director (Print or type.) | Date Signed |
|-------------------------------|---|-------------|