OUTPATIENT MENTAL HEALTH CLINIC RECERTIFICATION APPLICATION – DHS 35

This recertification application is to verify that the outpatient mental health clinic complies with Wis. Admin. Code ch. DHS 35. By completing and submitting this form the clinic indicates that it is in compliance with the program standards as required by state statutes.

Name –Facility					Certification No.
Address – Physical	City	State	Zip Code	County	
Accreditation ☐ JCAHO ☐ COA ☐ CARF ☐ Other – *Specify:*		Date - Accreditation End		Date – Last Accreditation Visit	
Telephone No. – Facility	Email Address ☐ *May be published in Provider Directory.*				
Fax No. – Facility	Internet Address ☐ *May be published in Provider Directory.*				
Name – Clinic Administrator	Telephone No.	Email Address ☐ *May be published in provider directory*			
Name – Person Completing Form	Telephone No.	Email Address ☐ *May be published in provider directory*			

FACILITY CONTACT PERSON

Name – Contact Person	Telephone No.	Email Address ☐ *May be published in provider directory*	
Mailing Address – Contact Person	City	State	Zip Code

AGREEMENT FOR ELECTRONIC TRANSMISSIONS

This applicant agrees to permit and cooperate with the Department in using electronic transmissions to communicate official business, including applications, survey findings, statements of deficiencies, and plans of correction.

The official email address is:

ATTESTATION

I hereby attest that all statements made in this application and in any attachments are correct to the best of my knowledge and that I will comply with all laws, rules, and regulations governing mental health outpatient services.

SIGNATURE – Clinic Administrator	Date Signed

INSTRUCTIONS

- Applicants must answer each question. Affirm "Yes" if the requirement was met; check "No" if the requirement was not met.
- Attach additional narrative, status report, or plans for improvement for every "No" response.
- For each branch office requested, attached DQA form F-00191, *Certified Outpatient Clinic Request for a Branch Office*, with this application. Access the form at: https://www.dhs.wisconsin.gov/forms/index.htm
- Mail (1) appropriate fee, (2) this application form, and (3) branch office application (if applicable) to:

DHS / Division of Quality Assurance
BHS / Behavioral Health Certification Section
P.O. Box 2969
Madison, WI 53701-2969

	DHS Code	Clinic Administrator's Responsibilities
☐ Yes ☐ No	**35.07**	Clinic Administrator is primarily located at the main clinic.
☐ Yes ☐ No	**35.09**	Notify the Department of any changes in administration, ownership, main clinic and branch locations, clinic name, and any change in the clinic's policies and practices that may affect clinic compliance by no later than the effective date of the change.
☐ Yes ☐ No	**35.123**	Oversee the clinic operations; ensure the main clinic and all branch offices are in compliance with this chapter and other applicable state and federal law and regulations.
☐ Yes ☐ No	**35.123**	Ensure minimum staffing requirement and sufficient number of qualified staff members to provide outpatient mental health services.
☐ Yes ☐ No	**35.123**	Verify mental health professional's license, competency, and scope of practice. Maintain documentation of staff's practice limitations and restrictions. Employ/contract only qualified mental health professionals.
☐ Yes ☐ No	**35.127**	Ensure clinical supervision provided to qualified treatment trainee.
☐ Yes ☐ No	**35.14**	Oversee all staff job performances; require staff members to adhere to all applicable laws and regulations.
☐ Yes ☐ No	**35.21**	Identify treatment approaches and implement the role of clinical supervision and clinical collaboration in the treatment approaches.
	DHS Code	**Policies and Procedures**
☐ Yes ☐ No	**35.13**	Establish and implement written personnel policies and procedures including compliance of caregiver background check and caregiver misconduct reporting. Maintain a personnel records for each clinic staff.
☐ Yes ☐ No	**35.14**	Establish and implement clinical collaboration and clinical supervision policies and procedures.
☐ Yes ☐ No	**35.15**	Establish and implement orientation and training policies and procedures. Maintain orientation and training record for each clinical staff.
☐ Yes ☐ No	**35.16**	Establish and implement written admission criteria. Maintain a written recommendation for psychotherapy documentation in the clinical record.
☐ Yes ☐ No	**35.19(4)**	Establish and implement written policies and procedures for referring clients to other service providers as needed. Maintain a list of outside resources for referrals.
☐ Yes ☐ No	**35.165**	Establish and implement written emergency service policies and procedures.
	DHS Code	**Clinical Documentation**
☐ Yes ☐ No	**35.14**	Maintain clinical collaboration and clinical supervision records.
☐ Yes ☐ No	**35.17**	Comprehensive assessment is completed by qualified clinical staff and a written assessment report is maintained in the clinical record.
☐ Yes ☐ No	**35.18**	Signed informed consent for treatment and medication (if applicable), cost for services, and acknowledgment of client rights, grievance procedures, emergency services, and discharge policy are maintained in the clinical record.
☐ Yes ☐ No	**35.19**	Treatment plan is maintained in the clinical record and meets the following criteria: • Treatment plan is based on the client's diagnosis and symptoms description from the comprehensive assessment. It reflects client's current needs. • Client's strengths are incorporated in the treatment plan. • Treatment outcomes are measurable. • Increase client's ability to function independently. • Client's developmental needs are considered. • Include schedules, frequency, and nature of services recommended. • Include client's signature and guardian's signature (if applicable).
☐ Yes ☐ No	**35.19**	Regular treatment plan review documentation is maintained in the clinical record.
☐ Yes ☐ No	**35.20**	Medications are listed in the clinical record. When appropriate, refer clients to receive psychotherapy to meet their treatment needs.

☐ Yes ☐ No	**35.215**	Monitor group therapy size and staff to consumer ratio.
☐ Yes ☐ No	**35.22**	Discharge summary is completed within 30 days of the discharge and is maintained in the clinical record.
☐ Yes ☐ No	**35.23**	Maintain a confidential, factual, accurate, and legible clinical record for each client. Maintenance, retention, disposal, and transfer of paper or electronic clinical record are consistent with all applicable law and regulations.
☐ Yes ☐ No	**35.24**	Establish and implement client rights policies and procedures consistent with all applicable law and regulations.
☐ Yes ☐ No	**35.25**	Fax a death determination report to the Department within 24 hours of learning of a reportable death.

1. Briefly describe changes in facility policies and procedures since last recertification visit. *(Attach additional pages, if necessary.)*

2. Describe innovations the facility has created or employed as they relate to the services since the last recertification visit. *(Attach additional pages, if necessary.)*

3. Describe facility needs (e.g., problems, supports, or enhancement needs), which your facility has identified, including hiring qualified staff, training availability, or other technical assistance. *(Attach additional pages, if necessary.)*

4. Describe special burdens or challenges that your facility faces. *(Attach additional pages, if necessary.)*

OUTPATIENT SERVICES PROVIDED IN A SCHOOL SETTING

- Copy and complete pages 5 and 6 **FOR EACH SCHOOL LOCATION.**
- **NOTE:** Wis. Admin. Code § DHS 35.09 states, "The clinic shall notify the department of any changes in administration, ownership or control, office location, clinic name, or program, and any change in the clinic's policies or practices that may affect clinic compliance by no later than the effective date of the change."

MAIN CLINIC INFORMATION

Name – Main Clinic	Certification No.

SCHOOL DISTRICT ADMINISTRATION OFFICE INFORMATION

Name – School District

Street Address	City	State	Zip Code

Contact Person

Name	Telephone No.	Fax No.	Email Address – Contact Person

SCHOOL LOCATION AND CONTACT PERSON

Name – School Site	County

Street Address	City	State	Zip Code

Contact Person

Name	Telephone No.	Fax No.	Email Address – Site Contact Person

Is this site a certified branch office? ☐ Yes ☐ No

If "yes," no additional site information is required on this form. Complete DQA form F-00191A, *Certified Outpatient Clinic School Branch Office Request.*

OUTPATIENT SERVICES PROVIDED AT THIS SITE

☐ Mental Health ☐ Substance Use ☐ Other *(Describe below.)*

DAYS AND HOURS SERVICES ARE PROVIDED AT THIS SITE

DAY	Monday	Tuesday	Wednesday	Thursday	Friday
HOURS					

STAFF ROSTER FOR THIS SITE

Name	License No.	Hours Available Per Week

MEMORANDUM OF UNDERSTANDING

Is there a memorandum of understanding (MOU) in effect between the certified clinic and this school delivery site?

☐ Yes ☐ No If “yes,” attach a copy.

RECORDS

Are consumer records kept at this school site? ☐ Yes ☐ No

If “yes,” describe how records are stored.

OVERSIGHT

Briefly describe the policies of oversight for the clinic administrator and the policies for collaboration and/or supervision for services delivered at this school site.

OUTPATIENT MENTAL HEALTH CLINIC STAFF ROSTER

Pursuant to Wis. Stat. § 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.

PRINT ADDITIONAL PAGES, AS NEEDED.

Name – Facility	Certification No.

Name – Client Rights Specialist	Telephone No. – Client Rights Specialist	Mailing Address – Client Rights Specialist

LICENSED STAFF				Hours Per Week at Main Clinic	Caregiver Criminal Background Check			
Name (Last, First)	**Position Description** (Example: Clinic Administrator)	**Profession** (Example: LPC)	**DSPS Lic. No.** (Ex: 1111-125)		**BID Form (mm/yy)**	**DOJ Report (mm/yy)**	**DHS/IBIS Letter (mm/yy)**	**Background Reviewed within Last 4 Yrs**
								☐ Yes
								☐ Yes
								☐ Yes
								☐ Yes
								☐ Yes
								☐ Yes
								☐ Yes
								☐ Yes

NON- LICENSED STAFF (In-home providers shall list all staff, including non-licensed staff.)

Name	Position Description	Degree	Same as above				
							☐ Yes
							☐ Yes
							☐ Yes
							☐ Yes
							☐ Yes
							☐ Yes