CERTIFIED OUTPATIENT CLINIC – SCHOOL BRANCH OFFICE REQUEST

Instructions

- Page 1 of this form is designed to gather general information about the main clinic and the school district administrative office. It also includes the clinic administrator attestation.
- Page 2 gathers specific information for an individual school branch office. After completing, submit with page 1. If there is more than one school branch office, make copies of page 2, complete page 2 for each school branch office, and attach all to page 1.

Contact Information

- The fee for each addition of a school branch office is $200.00. All fees are non-refundable.
- Return completed form(s) and fee(s) to the DQA Central Office at: **DHS / Division of Quality Assurance**
  Behavioral Health Certification Section
  PO Box 2969
  Madison, WI 53701-2969
- If you have questions regarding this form, contact Behavioral Health Certification staff at **608-261-0656.**

References

- Branch Office Policy information on page 2 of DQA form, F-00191, *Certified Outpatient Clinic Request for a Branch Office*
- DQA Memo 13-020, *Addendum to Division of Quality Assurance (DQA) Outpatient Mental Health and Substance Abuse Program Branch Office Policy*

I. MAIN CLINIC INFORMATION

Name – Main Clinic			Certification No.
Street Address	City	State	Zip Code
Telephone No.	Fax No.	Email Address – Contact Person	

II. SCHOOL DISTRICT ADMINISTRATIVE OFFICE INFORMATION

Name – School District			
Street Address	City	State	Zip Code
Telephone No.	Fax No.	Email Address – Contact Person	

III. ATTESTATION

I attest that all information provided on this form and all accompanying materials are, to the best of my knowledge, true and correct.

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

IV. INDIVIDUAL BRANCH OFFICE INFORMATION

Name – Main Clinic	Certification No.

A. Description

Clinic – Type(s): ☐ MH ☐ AODA ☐ Both

B. Location and Contact Information

Name – Branch Location

Street Address	City	State	Zip Code

Telephone No.	Fax No.	Email Address – Contact Person

C. List of All Days and Hours Open for Psychotherapy or Substance Abuse Counseling

DAY	Monday	Tuesday	Wednesday	Thursday	Friday
HOURS					

D. List of All Staff Providing Mental Health or Substance Abuse Services at this Location *(Add additional pages, if necessary.)*

Name	License No.	Hours Available Per Week

E. MOU

☐ Yes ☐ No Is there a memorandum of understanding in effect between the certified clinic and this school delivery service site which addresses points 1-12 in DQA Memo 13-020?

F. Records

☐ Yes ☐ No Are consumer records kept in this branch office? If "yes," describe how records are stored. Attach additional pages, if necessary.

G. Oversight

Briefly describe the policies of oversight for the clinic administrator and the policies for collaboration and/or supervision in this branch office. Attach additional pages, if necessary.