|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DEPARTMENT OF HEALTH SERVICES**  Division of Care and Treatment Services  F-00203 (07/2024) | | | | | | | | | | | | **STATE OF WISCONSIN** | | | |
| **COMMUNITY RECOVERY SERVICES (CRS) COUNTY / TRIBAL AGENCY APPLICATION** | | | | | | | | | | | | | | | | |
| Completion of this form is voluntary; however, failure to complete will result in not being a certified provider of CRS | | | | | | | | | | | | | | | | |
| Send completed application to: [DHSDCTSCRS@dhs.wisconsin.gov](mailto:DHSDCTSCRS@dhs.wisconsin.gov) | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | Date of Application | | | | |
|  | | | | | | | | | | | |  | | | | |
| **I. COUNTY / TRIBAL AGENCY INFORMATION** | | | | | | | | | | | | | | | | |
|  | Name of Agency | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | |
|  | Official Address for Correspondence | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | |
|  | Name – Program Primary Contact Person | | | | | Phone Number | | | | | Fax Number | | | | | |
|  |  | | | | |  | | | | |  | | | | | |
|  | Address (Primary Contact Person) | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | |
|  | Email Address | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | |
|  | **Type of Agency**  County department of community programs (51.42 and 51.42/.437 boards)  County department of human services  County department of social services  Tribal agency | | | | | | | | | | | | | | | |
| **II. SERVICE AREA, CONSUMER ENROLLMENT, AND COUNTY COLLABORATION** | | | | | | | | | | | | | | | | |
|  | Please enter the geographic area to be served, and an estimate of the number of consumers to be served in the first year of implementation. If your county is collaborating with other counties to deliver CRS, please explain how enrollment, service delivery, billing, and quality oversight will occur. | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | |
| **III. CONFLICT OF INTEREST PROTECTIONS** | | | | | | | | | | | | | | | | |
|  | CMS requires that states assure the independence of persons performing evaluations, assessments, and plans of care. Provide an overview of the agency’s CRS program structure and how this approach will assure that the agency has taken adequate measures to reduce possible conflicts of interest. | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **IV. AGENCY COMMUNITY RECOVERY SERVICES MEDICAID AND FUNCTIONAL ELIGIBILITY PROCESSES** | | | | | | | | | | | | | | | | |
|  | 1. Medicaid Eligibility. Describe the agency process that will be used to determine that potential CRS consumers meet Medicaid eligibility for CRS services and assure potential CRS consumers live in their home or in the community. Who in the county or tribe will be responsible for this process? | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
|  | 1. Functional Eligibility. Describe how the county or tribe will provide the independent evaluation (on an annual basis) of the potential client’s functional eligibility through the Use of the Mental Health and Substance use Disorder (MH/SUD) or Children’s Functional Screen. Describe the county or tribe’s required qualifications of the individuals completing the Functional Screens. Who will assure that all screeners meet the required qualifications? How will the agency assure the quality of the MH/SUD or Children’s Functional Screening process? | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
|  | 1. Comprehensive Assessment Development. Describe the agency’s plan for completing an initial comprehensive assessment with consumers and how assessments will be updated throughout treatment. Include who will be developing the assessment and how they will involve CRS consumers. What are the agency’s required qualifications for the persons completing comprehensive assessments? | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
|  | 1. Service Plan Development. Describe the agency’s plan for developing and implementing service plans for a potential CRS client. Who will be responsible for developing the service plan and how will the CRS consumer be involved? How will the agency ensure that CRS consumers enrolled in other programs (i.e. CCS, CSP, Crisis, etc.) are not receiving duplicative services? | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
|  | 1. Program Staff Duties. Describe the other roles and responsibilities that CRS county staff will have (i.e. CCS, CSP, Crisis, etc.). | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **V. SERVICE PLAN QUALITY** | | | | | | | | | | | | | | | | |
|  | Describe how the agency will ensure that all CRS Service Plans are updated every 6 months and thoroughly reviewed annually. Additionally, describe the process for ensuring service plans evolve throughout treatment and goals and objectives change to meet the consumer’s recovery path. | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
| **VI. COMMUNITY RECOVERY SERVICES AND PROVIDER NETWORK** | | | | | | | | | | | | | | | |
|  | 1. Provider Quality. Describe how the CRS agency will ensure that the providers meet the training and documentation requirements. | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
|  | 1. Medicaid Provider Agreements. Describe the agency’s process, including who will be responsible, for executing and ensuring that Medicaid provider agreements for all CRS service providers will be on file at the county agency. | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **VII. AGENCY PUBLIC EXPENDITURES** | | | | | | | | | | | | | | | | |
|  | Certification of Public Expenditures. According to the terms of reimbursement for CRS, Wisconsin Medicaid will reimburse only the federal share (less state administrative costs) for CRS. Counties or tribes are responsible for the state share of the payment for services. The state share must be appropriated from non-federal public funds and must be sufficient to cover the Medicaid payments received. Please describe the source of the non-federal public funds that will be used to pay the non-federal share for CRS services. Describe the county/tribe’s current status of the approval process from the appropriate county board for use of these funds for CRS services. | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | |
|  | 1. Annual Cost Report Process. The county or tribal agency providing CRS services will be required to file an annual cost report, through WIMCR, covering services delivered in the prior calendar year that is the following year. Describe the county agency’s process and/or capacity to provide the actual indirect and direct costs related to CRS services. | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
|  | 1. Agency Contact Person for Annual CRS Cost Reporting Process | | | | | | | | | | | | | | |
|  | | | Name – Agency Contact Person | | | | | Title | | | | | | | |
|  | | |  | | | | |  | | | | | | | |
|  | | | Address | | | | | | | | | | | | |
|  | | |  | | | | | | | | | | | | |
|  | | | Email Address | | | | | | | Phone Number | | | | | |
|  | | |  | | | | | | |  | | | | | |
| **VIII. COUNTY ASSURANCE** | | | | | | | | | | | | | | | |
|  | The CRS agency hereby attests that it will follow requirements from the Center for Medicare and Medicaid Services and the Wisconsin Department of Health Services’ regulations, standards, and policy regarding CRS. The CRS agency shall retain on file duly executed documentation that demonstrates these requirements are met. The CRS agency attests that it will provide the non-federal share of the costs for all CRS. | | | | | | | | | | | | | | |
|  |  | | |  |  | | | | | | | |  |  | |
|  | SIGNATURE – Authorized County Official | | |  | Title | | | | | | | |  | Date Signed | |
| FOR DHS USE ONLY  Application indicates agency meets CRS standards.  Application does not indicate agency meets CRS standards at this time and additional information is required. | | | | | | | | | | | | | | | |
|  | |  | | | | |  | |  | | | | | |  |
|  | | SIGNATURE – CRS Coordinator | | | | |  | | Date Signed | | | | | |  |
| Additional information has been received and applicant meets the CRS standards at this time. | | | | | | | | | | | | | | | |
|  | |  | | | | |  | |  | | | | | |  |
|  | | SIGNATURE – CRS Coordinator | | | | |  | | Date Signed | | | | | |  |