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| **DEPARTMENT OF HEALTH SERVICES**  Division of Quality Assurance  F-00059 (06/2024) | **STATE OF WISCONSIN**  Wis. Admin. Code ch. DHS 35  Page 1 of 6 | |
| **DHS 35 OUTPATIENT MENTAL HEALTH CLINICS** | | **Internal Use Only** |
| **INITIAL CERTIFICATION APPLICATION** | | Date Received: |
| Questions regarding this form may be directed to the Division of Quality Assurance (DQA), Behavioral Health Certification Section (BHCS) at [DHS DQA Mental Health and Substance Use Certification](mailto:dhsdqamentalhealthandsubstanceusecertification@dhs.wisconsin.gov).  Submission of this information is required by Wis. Stat. §§ 50.065 and 51.45 and Wis. Admin. Code ch. DHS 35. Failure to provide complete and accurate information may result in denial of the application and/or delay in the process. An application is considered complete when all applications are received with accurate information, signatures, and supporting documentation, and when the background check report resulting from Step 1 is available for review by the Behavioral Health Certification Section. | | |
| **STEP 1 – ENTITY OWNER BACKGROUND CHECKS (ECBC)** | | |
| * The applicant submits background information documents and fee directly to the Office of Caregiver Quality (OCQ). See below. * **Note: Background materials should not be submitted with the certification application**. * ECBCs must be completed for entity owners, whether or not the owner has direct client contact. Certification will not be issued until the ECBC has cleared and results are approved. * For information on how to complete the ECBC, visit <http://dhs.wisconsin.gov/caregiver/entity.htm>. * For assistance completing this form, call OCQ at 608-261-8319. | | |
| **STEP 2 – COMPLETED APPLICATION** | | |

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| The applicant submits all applicable documents listed in this section and the BHCS staff will review to ensure compliance with applicable regulations.  A completed application includes each of the following:   1. This application form, fully completed and signed by the entity owner or board member 2. All supporting documentation as specified in the application 3. Fees as specified in the application   Email application and supporting documents to: [DHS DQA Mental Health and Substance Use Certification](mailto:DHSDQAMentalHealthandSubstanceUseCertification@dhs.wisconsin.gov)  Mail the required fees with “Initial App [Provider Name] DHS 35” in the memo line to: | | |
|  | **DHS/DQA/BAL/Behavioral Health Certification Section**  **PO Box 2969**  **Madison, WI 53701-2969** | |
| **Please Note:** The application will not be processed until a completed application, supporting documents, and all fees are received in full. All fees are non-refundable. | | |
| Fees for New Provider: | | Biennial Fee - $1,100.00. |
| Fees for Existing Provider: | | If adding this service, please reach out via email to determine your current cycle and correct fees. Please include your current certification number on the [email](mailto:DHSDQAMentalHealthandSubstanceUseCertification@dhs.wisconsin.gov). |

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| **STEP 3 – ONSITE SURVEY** |
| * A BHCS surveyor will contact you to arrange a date and time for an onsite survey after all materials and fees are processed. * Refer to DQA publication [*P-63174, Survey Guide: Behavioral Health Certification for Mental Health and Substance Abuse Services*](https://www.dhs.wisconsin.gov/publications/p6/p63174.pdf)*.* * If the surveyor identifies significant changes that would result in a denial decision, the applicant will be afforded an opportunity to make necessary changes and submit those changes for review. |
| **STEP 4 – APPROVAL OR DENIAL DECISION** |
| * The surveyor will make the certification decision and send the survey results to notify the provider of the decision. * If approved, BHCS staff will email a formal certificate to the provider for posting at the primary clinic location. |

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| 1. **GENERAL INFORMATION – ENTITY / ENTITY OWNER REQUESTING CERTIFICATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Initial Certification  Change of Ownership** – *Provide current certification number*: | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |
| **Adding Service to Existing Certificate** – *Provide current certification number*: | | | | | | | | | | | | | | | | | |  | | | | | | | | | |  | | | |
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| **Facility General Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Facility Name (Should match signage and Medicaid enrollment, if applicable) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Facility Street Address | | | | | | Location – Street Address / Room No. | | | | | | | | | | City | | | | | | | | ZIP Code | | | | | | County | |
| Facility Phone Number | | | | | | Facility Fax Number | | | | | | | | Facility Web Address | | | | | | | | | | | | | | | | | |
| 1. **Facility Contact Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name Contact Person | | | | | | | | Will program obtain Medicaid certification?  Yes  No | | | | | | | | | | | | | | | Facility NPI Number (if known) | | | | | | | | |
| Contact Phone Number | | | | | | | | Contact Email Address | | | | | | | | | | | | | | | | | | | | | | | |
| Physical Address – Street | | | | | | | | City | | | | | | | | | County | | | | | | | | | | State | | | | ZIP Code |
| 1. **Designated Mail Recipient** *(Check and provide requested information for all that apply)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name – Designated Mail Recipient | | | | | | | Title | | | | | | | | Email Address | | | | | | | | | | | | | | | | |
| Mailing Address – Street or PO Box *(if different from above)* | | | | | | | | | | | City | | | | | | | | | | | | | | | State | | | ZIP Code | | |
| 1. **Entity Owner Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Type of Entity *(Check only one)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Church  Corporation – Business  Corporation – Non Profit | | | | Government – County  Government – State  Government – Other | | | | | | Tribal  Limited Liability Corp (LLC)  Proprietorship (Individual) | | | | | | | | | | | | | | | Partnership  Other – *Specify below:* | | | | | | |
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| Name – Owner (Individual/Partnership Names) or Corporation (Legal Entity) | | | | | | | | | | | | | | | | | | | | | | FEIN\* – Legal Entity | | | | | | | | | |
| Name – Owner/Board Member | | | | | | | | | | | | | | | | | | | | | | SSN\* – Owner or Board Member | | | | | | | | | |
| Address – Street | | | | | | | | | | City | | | | | | | | | | | | | | | | State | | | ZIP Code | | |
| Telephone – Owner/Board Member | | | | | Fax – Owner/Board Member | | | | | | | | Email Address – Owner/Board Member | | | | | | | | | | | | | | | | | | |
| *\* Collection of the applicant’s Social Security number (SSN) and Federal Employer Identification number (FEIN), if applicable, is required per Wis. Stat. § 73.0301 to verify compliance with Wis. Stat. § 51.032. Failure to supply the number may result in denial of the application. This number will only be disclosed to the Department of Revenue for use in collection of tax delinquencies.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Program Information** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Name** | | | | | **Telephone Number** | | | | **Fax Number** | | | | | | | | | | **Email Address** | | | | | | | | | | | | |
| Program Contact | | | | |  | | | |  | | | | | | | | | |  | | | | | | | | | | | | |
| Client Rights Specialist | | | | |  | | | |  | | | | | | | | | |  | | | | | | | | | | | | |
| Program Director/Administrator | | | | |  | | | |  | | | | | | | | | |  | | | | | | | | | | | | |
| Clinical Coordinator | | | | |  | | | |  | | | | | | | | | |  | | | | | | | | | | | | |
| Record Custodian | | | | |  | | | |  | | | | | | | | | |  | | | | | | | | | | | | |
| Yes  No | | | Have you informed your clients (both former and present) that they may be contacted by the DQA surveyor? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No | | | Are you accredited by any organizations, other than DQA? *If “yes,” identify accreditation organization and provide accreditation identification.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Yes  No | | | Does your agency have a contract with the 51.42 Board? *If “yes,” identify county / counties.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Yes  No | | | Have you every operated a residential facility, health care facility, or day care program for adults or children in Wisconsin or in any other state? *If “yes,” explain and provide relevant information.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. **Disclosure of Ownership** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Required Supporting Documentation –** *Submit these required documents, when applicable:* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | 1. List of names, principal business address, and percentage of ownership interest of all officers, directors, stockholders owning 5% or more of stock, members, partners, or others having authority or responsibility for the operation of the organization. For non-profit or governmental organizations, list the names and principal business addresses of all officers and board members. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | 1. A diagram reflecting the ownership structure and names of any affiliate organization associated with the entity owner (parent corporations, other LLC, partnership, etc.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | **If there are no additional owners, check here.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Entity Owner Attestation** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I hereby attest that all staff know and understand the rights of the clients that they serve and the procedures of informal and formal resolution and have read Wis. Admin. Code chs. DHS 92 and 94. The above-named program has appropriate policies to meet Wis. Admin Code chs. DHS 92 and 94 to ensure patient rights, patient records, confidentiality, and informed consent. The program has a designated client rights specialist who is trained in compliance with the requirements of Wis. Admin. Code chs. DHS 92 and 94, Wis. Stat. ch. 51, and federal HIPAA requirements in 45 CFR 164 Part E and 42 CFR Part 2, as applicable.  I attest, under penalty of law, that the information provided in this application and in attached application materials is truthful and accurate to the best of my knowledge and that knowingly providing false information or omitting information may result in a fine of up to $10,000 or imprisonment not to exceed six years, or both (Wis. Stat. § 946.32).  I attest that I will comply with all laws, rules, and regulations governing program certification in Wisconsin. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SIGNATURE** – Owner or Board Member *(Full signature is required)* | | | | | | | | | | | | | | | | | | | | | Date Signed | | | | | | | | | | |
| Name – Owner or Board Member *(Print or type)* | | | | | | | | | | | | Title – Owner or Board Member | | | | | | | | | | | | | | | | | | | |
| 1. **Entity Owner Transfer of Responsibility to Request Future Changes and Clinical Operations** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| The individual in the role specified below is given full authority to request initial services and branches, service additions and deletions, staff changes, branch location additions and deletion, and all operational changes submitted to the department. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Check applicable role*:  Program Contact  Program Director/Administrator  Clinical Coordinator | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SIGNATURE** – Owner or Board Member *(Full signature is required)* | | | | | | | | | | | | | | | | | | | | | Date Signed | | | | | | | | | | |
| Name – Owner or Board Member *(Print or type)* | | | | | | | | | | | | Title – Owner or Board Member | | | | | | | | | | | | | | | | | | | |
| 1. **INITIAL SERVICES CERTIFICATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Review and complete the section fully; submit the specified additional documentation.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Required Supporting Documentation** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | All Policy and Procedures for DHS 35. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Proof of malpractice and liability insurance for the clinic and each staff member who provides psychotherapy or who is a prescriber [See Wis. Admin Code § DHS 35.08(1)]. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Attestation** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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 DHS 40 services, including Wis. Admin. Code chs. DHS 92 and 94 and Wis. Stat. ch. 51. The signatory of this document is duly authorized by the licensee / certificate holder to sign this agreement on its behalf. The certificate holder hereby accepts responsibility for knowing and ensuring compliance with all licensing, operational, and requirements for this facility.  I attest under penalty of law that the information provided above is truthful and accurate to the best of my knowledge.  I understand that knowingly providing false information or omitting information may result in denial of licensure, a fine of up to $10,000 or imprisonment not to exceed six years, or both (Wis. Stat. § 946.32). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SIGNATURE** – Entity Owner, Representative, or Authorized Representative Specified Above | | | | | | | | | | | | | | | | | | | | | | Date Signed | | | | | | | | | |
| Full Name *(Print or type)* | | | | | | | | | | | | Title | | | | | | | | | | | | | | | | | | | |

|  | **APPENDIX A: QUALIFIED STAFF ROSTER** | | | |  | | | | | |
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| Name – Program | | | | | | | Certification Number | | | |
| Name – Client Rights Specialist | | | | | | | Telephone Number | | | |
| **Clinic Role and Name**  (Last, First) | | **Credentials/Licenses**  (Not MA Number) | | **Hours of Usual Availability**  **per Week** | | **Caregiver Background** | | | | |
| **DHS-64 BID**  (mo/yr) | | **DOJ Report**  (mo/yr) | **DHS IBIS**  (mo/yr) | **Background Reviewed Within Last**  **4 Years** |
| Clinic Administrator | |  | |  | |  | |  |  | Yes |
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| Licensed Treatment Professional | |  | |  | |  | |  |  | Yes |
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| Licensed Treatment Professional | |  | |  | |  | |  |  | Yes |
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| **SIGNATURE –** Facility Director | | | Name –Facility Director *(Print or type)* | | | | | Date Signed | | |