

**Comprehensive Community Services (CCS)
 for Persons with Mental Disorders and Substance Use Disorders
 RECERTIFICATION APPLICATION – DHS 36**

By completing and submitting this form the clinic indicates it is in compliance with the program standards as required by Wis. Stat. §§ 49.45(30e)(b) and 51.42(7)(b).

This application was completed by:

Name – Agency				Certification Number			
Street (Physical) Address		City		State	County		Zip Code
Mailing Address			City		State	Zip Code	
Telephone Number			Fax Number				
Website <input type="checkbox"/> <i>May be published in Provider Directory</i>			Email Address <input type="checkbox"/> <i>May be published in Provider Directory</i>				
Name – Contact Person			Date Application Completed (MM/dd/yyyy)				

I hereby attest or affirm 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 Comprehensive Community Services (CCS) for persons with mental disorders and substance use disorders programs.

SIGNATURE – Director		Name – Director (<i>Print or type.</i>)		Date Signed
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I. CERTIFICATION MATERIALS (DHS 36.04)

Application Materials

The following materials must accompany the CCS recertification application:

- Required fees
- A return copy of this application and the materials developed in response
- A complete CCS staff listing
- A copy of any previously approved waiver or variance
- Any other information required by the department

Application Instructions

- The check-boxes () denote a required response, form, or attachment to the application.
- **Each abstract is limited to one page in length.**
- Label each application page with the name of the CCS program and the question number.

Copies

Send:

- One **signed copy** of all application materials to: **DHS / Division of Quality Assurance
BHS / Behavioral health Certification Section
P.O. Box 2969
Madison, WI 53701-2969**
or
dhsdqamentalhealthaoda@dhs.wisconsin.gov
- One **email copy** of the application to: **Division of Mental Health and Substance Abuse Services**
dhsdmhsasccs@dhs.wisconsin.gov

II. CCS PLAN (DHS 36.07)

1. Provide an abstract of **revisions to the CCS quality improvement plan.**
2. Attach copies of **new or revised CCS Policies and Procedures.**
3. The complete CCS plan and its components are maintained on-site.

III. COORDINATION COMMITTEE (DHS 36.09)

4. Attach the **recommendations of the Coordination Committee** for revising the CCS plan.
5. Attach the **written response by the CCS** to the Coordinating Committee's recommendations.
6. Minutes of the Coordination Committee meetings and membership list are on-site.

IV. PERSONNEL (DHS 36.10 – 36.12)

7. Complete a current form of **CCS employees and contract Providers.**

Submit pages related to employees only. For contracted service providers, review and maintain the pages on-site. **Note:** Include all service providers with face-to-face consumer contact.

8. Provide an abstract of the **CCS personnel orientation and training plans.**
9. Attach a **description or list of the program's training needs.**

10. Complete program personnel policies and files, including credentials, background checks, and supervision and clinical collaboration records, are maintained on-site and subject to review.

V. CONSUMER SERVICES (DHS 36.13 – 36.15)

During the past year:

- 11. The **Functional Screen** was completed for the following number of persons: _____
- 12. **Comprehensive assessments** were completed for the following number of persons: _____
- 13. **Abbreviated assessments** were completed for the following number of persons: _____
- 14. Enter the number of **enrolled consumers** in this table.

GENDER	AGE				
	0 – 17	18-24	25-44	45-64	65 +
Male					
Female					

- 15. Provide an **abstract of progress on outreach and service delivery to all target groups**.

VI. ASSESSMENT PROCESS (DHS 36.16)

- 16. The assessment process and summary incorporates the **consumer’s perspective and language**, especially in the desired outcomes and measurable service goals to the greatest extent possible.
- 17. Complete assessments and assessment policies and procedures are maintained on-site.

VII. SERVICE PLANNING AND DELIVERY PROCESSES (DHS 36.17)

- 18. Provide a copy of the **array of services** identifying which are provided or contracted by the CCS.
- 19. Provide an **abstract of any change in the methods used to identify and decide** when a service is needed and of any change in the means by which it is to be provided.

VIII. CONSUMER SERVICE RECORDS (DHS 36.18)

- 20. Consumer service records are maintained on-site under confidentiality standards.

CCS STAFF LISTING

See instructions on page 5.

Name – Program						Certification No.			
NAME (Last, First, MI)	POSITION DESCRIPTION	CREDENTIALS / LICENSE NUMBER	FUNCTIONS*	MINIMUM QUALIFICATIONS*	FTE %**	CAREGIVER MISCONDUCT BACKGROUND CHECKS***			
						BID (mm / yy)	DOJ (mm / yy)	DHS IBIS (mm / yy)	Reviewed Last 4 Years
					<input type="checkbox"/> E <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> E <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> E <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> E <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> E <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N
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					<input type="checkbox"/> E <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N
					<input type="checkbox"/> E <input type="checkbox"/> C				<input type="checkbox"/> Y <input type="checkbox"/> N

***FUNCTIONS / MINIMUM QUALIFICATIONS**
 1 – MH Professional..... 1 – 8
 2 – Administrator..... 1 – 14
 3 – Service Director..... 1 – 8
 4 – Service Facilitator..... 1 – 21
 5 – Services Array..... Any

****FULL-TIME EQUIVALENT (FTE) %**
E = Employed (full or part time)
C = Contracted

*****CAREGIVER MISCONDUCT BACKGROUND CHECKS**
BID = Background Information Disclosure (DHS form F-82064)
DOJ = Department of Justice Wisconsin Criminal History
IBIS = Integrated Background Information Systems, DHS

CCS STAFF LISTING INSTRUCTIONS

- Complete for each CCS employee and contract service provider who provides psychosocial rehabilitation services, including clinical, student, and volunteers.
- Wis. Admin. Code § DHS 36.10 requires staff credentials, descriptions of provider role/function, minimum qualifications, and caregiver background assurances as defined.
- Record whether the staff are employed or contracted and their full-time equivalent (FTE) percentage. Enter the percentage of FTE contracted for CCS for every staff member who provides face-to-face service.
- The caregiver backgrounds are documented through Background Information Disclosure (BID) (DHS form F-82064), Department of Justice (DOJ) Wisconsin Criminal History, and the DHS Integrated Background Information Systems (IBIS) and require updating every four (4) years.

Name – Program						Certification No.			
NAME (Last, First, MI)	POSITION DESCRIPTION	CREDENTIALS / LICENSE NUMBER	FUNCTIONS*	MINIMUM QUALIFICATIONS*	FTE %**	CAREGIVER MISCONDUCT BACKGROUND CHECKS***			
						BID (mm / yy)	DOJ (mm / yy)	DHS IBIS (mm / yy)	Reviewed Last 4 Years
Samples, William C.	Psychiatrist	MD XXXXX-020	1, 3, 5	1	60 % <input type="checkbox"/> E <input checked="" type="checkbox"/> C	04/03	05/03	05/03	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N

Dr. Samples is contracted at 60% time. He serves two CCS program functions, as mental health professional and the service director, under DHS 36.10(e)(1) and (3). He does so while qualified as a psychiatrist, under 36.10(g)(1) and as evidenced by his DRL licensed credentials. His background disclosure form was completed and signed by him on April 2003. The Department of Justice criminal history report was returned in May as was the DHS IBIS letter detailing any suspensions of licensure. The agency has reviewed the Caregiver Background materials and assures they were all within the past four years.

Model, Marilyn	Program Director	LCSW XXXX-123	1, 2, 5	5	100 % <input checked="" type="checkbox"/> E <input type="checkbox"/> C	09/03	10/03	09/03	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N
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Ms. Model is a full-time employee of the CCS program with two functions. She is a mental health professional and an administrator under DHS 36.10(e)(1) and (2) and is qualified for both as an LCSW under 36.10(g)(5), as evidenced by her DRL licensed credentials. The caregiver background processes and assurances are affirmed.

<p>*FUNCTIONS / MINIMUM QUALIFICATIONS</p> <p>1 – MH Professional 1 – 8 2 – Administrator 1 – 14 3 – Service Director 1 – 8 4 – Service Facilitator 1 – 21 5 – Services Array Any</p>	<p>**FULL-TIME EQUIVALENT (FTE) %</p> <p>E = Employed (full or part time) C = Contracted</p>	<p>***CAREGIVER MISCONDUCT BACKGROUND CHECKS</p> <p>BID = Background Information Disclosure (DHS form F-82064) DOJ = Department of Justice Wisconsin Criminal History IBIS = Integrated Background Information Systems, DHS</p>
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