**MENTAL HEALTH DAY TREATMENT SERVICE FOR CHILDREN PROGRAM**

**INITIAL CERTIFICATION APPLICATION**

**Chapter DHS 40**

* This application is to verify that the emergency mental health service program complies with Chapter DHS 40, Wisconsin Administrative Code.
* After review of the submitted application, a preliminary determination will be made as to the unit’s eligibility for certification. If eligibility appears feasible, an onsite visit will be scheduled and certification status determined.
* If no significant deficiencies are found by the site visit, a certificate will be issued. If significant deficiencies are identified, the applicant will be afforded an opportunity to develop a plan of correction to complete compliance.

**To Program Personnel:**

* Read these instructions carefully before completing this questionnaire.
* The relevant standard is printed immediately preceding the corresponding questionnaire item.
* Respond to **every** item carefully. Do not omit a response to any item.
* Where “verification” is required in the questionnaire, **list** the type of document or materials that will be presented to verify the statement in question. With the exception of the Plan for Coordination of Services (DHS 34.22), **DO NOT** forward the actual documents or material with the application unless requested to do so, but be sure that they are available for review at the time of the onsite survey.

|  |
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| **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      |
| Address – Physical      | City      | State    | Zip Code      | County      |
| Telephone Number      | E-mail Address *[ ]  May be published in Provider Directory*      |
| Fax Number      | Internet Address *[ ]  May be published in Provider Directory*      |
| Name – Contact Person      | Telephone Number      | E-mail Address *[ ]  May be published in Provider Directory*      |
| Name – Person Who Completed this Form      | Telephone Number      | E-mail Address *[ ]  May be published in Provider Directory*      |
| Type of Organization *[See Chapter DHS 40.03(4)(10)(23) for definitions.]* [ ]  Community-based Program [ ]  Hospital-based Program [ ]  School-based Program | Levels of Service [ ]  Level I [ ]  Level II [ ]  Level III |
| Average Number of Clients Per Week      | Hours per Day in Operation per 5 Day Week *[See Chapter DHS 40.07(4)]*      |
| Have you informed your clients (both former as well as present) that they may be contacted by the DQA surveyor?  [ ]  Yes [ ]  No  |
| Is there evidence that all program staff have knowledge regarding: |
|  DHS 40: [ ]  Yes [ ]  No  |  DHS 92: [ ]  Yes [ ]  No  |  DHS 94: [ ]  Yes [ ]  No  |
| How is this evidence manifested?      |  |  |
| Does your agency have a contract with a 51.42 Board? [ ]  Yes [ ]  No If “yes,” indicate with which county(ies).      |
| **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 alcohol and other drug abuse intervention services.** |
| **FULL SIGNATURE** – Director | Date Signed | Full Name – Director *(Print or type.)*      |
| **Checkboxes indicate a required response. To avoid delays in certification, respond to each item.** |
| **Chapter DHS 40.06 (1) Written Personnel Policies**  |
|  | A mental health day services program shall have written personnel policies. |
| [ ]  Yes [ ]  No | 1. Does your program have written personnel policies? |
| [ ]  Yes [ ]  No | 2. For each program employee, do you have on file, at least two character references? |
| [ ]  Yes [ ]  No | 3. For each program employee, do you have on file written letters of references from previous employers or educational institutions? |
| [ ]  Yes [ ]  No |  If “no,” do you have a written record of verbal contact giving dates, person make the contact, persons contacted, and contact content? |
| [ ]  Yes [ ]  No | 4. Does your employment personnel policy include checking relevant and available conviction records? |
| **Chapter DHS 40.06 (5) Written Policy for Clinical Supervision** |
|  | Each program shall develop and implement a written policy for clinical supervision of all staff who provide treatment for children in the program. |
| [ ]  Yes [ ]  No | 1. Who provides the clinical supervision? |
| [ ]  Yes [ ]  No | 2. Is the clinical supervision provided to each program staff member? |
| [ ]  Yes [ ]  No | 3. Does the recipient of the clinical supervision receive feedback on how well he or she is doing and what improvements are needed? |
| [ ]  Yes [ ]  No | 4. Is the clinical supervision provided to each staff person on a face-to-face basis? |
| [ ]  Yes [ ]  No | 5. How many hours per month of clinical supervision is provided to each mental health professional? |
| [ ]  Yes [ ]  No | 6. Is there clinical supervision documented in writing? |
|  | Where? |
|  |       |
| **Chapter DHS 40.06 (a) Orientation Program** |
|  | Each program shall develop and implement and orientation program which all new staff and regularly scheduled volunteers shall complete. |
|  | 1. Is there written evidence that each new staff or volunteer is familiar with: |
| [ ]  Yes [ ]  No | a. Your policies and procedures |
| [ ]  Yes [ ]  No | b. The job responsibilities of staff persons in your program? |
| [ ]  Yes [ ]  No | c. Basic mental health treatment concepts applicable to providing day services for children and their families? |
| [ ]  Yes [ ]  No | d. Techniques and procedures for providing non-violent crisis management for individuals or for groups of children? |
| **Chapter DHS 40.06 (6)(b) Training Program** |
|  | Each program shall develop and implement a training program for all staff. |
| [ ]  Yes [ ]  No | 1. Is there time set aside for in-service training? |
| [ ]  Yes [ ]  No | 2. Are there presentations by community resource staff from outside agencies? |
| [ ]  Yes [ ]  No | 3. Is staff allowed to attend conferences and workshops? |
| [ ]  Yes [ ]  No | 4. Are there presentations of current principles and methods of treatment for children with mental illness? |
|  | 5. How many in-service / training hours does each staff person receive? |       |
| [ ]  Yes [ ]  No |  Is there written documentation of these hours? |
| **CHAPTER DHS 40.07 (1)(a), (b) and (c) Required Personnel and Services**  |
|  | **Level I Programs (1)(a)** |
|  | A program operating at Level I shall make available at least the following hours of direct clinical services provided either by program staff or professionals under contract to the program: |
| [ ]  Yes [ ]  No | 1. Is one hour / week of psychiatric or psychological consultation provide for every four full-time clients? |
| [ ]  Yes [ ]  No | 2. Is one hour / week of services by a registered nurse or physician provided for every four full-time clients? |
| [ ]  Yes [ ]  No | 3. When clients are present, is there provision for emergency and other necessary medical and nursing services? |
| [ ]  Yes [ ]  No | 4. Do you provide one hour / week of individual or family therapy by either a clinician or a clinical psychologist for each full-time client? |
| [ ]  Yes [ ]  No | 5. Is one hour / week of social work services provided for every two full-time clients? |
| [ ]  Yes [ ]  No | 6. Are two hours / week of occupational therapy services provided by registered occupational therapists or structured recreational or vocational services provided by specialists in specific areas of therapeutic assistance provided for each full-time client? |
| [ ]  Yes [ ]  No | 7. Are two hours / week of individual or group counseling by a qualified mental health professional for each full-time  client? |
|  | **Level II Programs (1)(b)** |
|  | A program operating at Level II shall make available at least the following hours of direct clinical services provided either by program staff or professionals under contract to the program: |
| [ ]  Yes [ ]  No | 1. Is one hour / week of psychiatric or psychological consultation provided for every two full-time clients? |
| [ ]  Yes [ ]  No | 2. Is one hour / week of services by a registered nurse provided for each full-time client? |
| [ ]  Yes [ ]  No | 3. When clients are present, is there provision for emergency and other necessary medical and nursing services? |
| [ ]  Yes [ ]  No | 4. Do you provide two hours / week of individual or family therapy by either a clinician or a clinical psychologist for each full-time client? |
| [ ]  Yes [ ]  No | 5. Is one hour / week of social work services provided for every two full-time clients? |
| [ ]  Yes [ ]  No | 6. Are three hours / week of occupational therapy services provided by registered occupational therapists or structured recreational or vocational services provided by specialists in specific areas of therapeutic assistance provided for each full-time client? |
| [ ]  Yes [ ]  No | 7. Are three hours / week of individual or group counseling by qualified mental health professionals provided for each full-time client? |
|  | **Level III Programs (1)(c)** |
|  | A program operating at Level III shall make available at least the following hours of direct clinical services provided either by program staff or professionals under contract to the program: |
| [ ]  Yes [ ]  No | 1. Is one hour / week of psychiatric of psychological consultation provided for every full-time client? |
| [ ]  Yes [ ]  No | 2. Is there a registered nurse on duty at all times that clients are present? |
| [ ]  Yes [ ]  No | 3. Do you provide three hours / week of individual or family therapy by either a clinician or a clinical psychologist for each full-time client? |
| [ ]  Yes [ ]  No | 4. Is one hour / week of social work services provided for every full-time client? |
| [ ]  Yes [ ]  No | 5. Are four hours / week of occupational therapy services provided by registered occupational therapists or structured recreational or vocational services provided by specialists in specific areas of therapeutic assistance provided for each full-time client? |
| [ ]  Yes [ ]  No | 6. Are four hours / week of individual or group counseling by qualified mental health professionals provided for each full-time client? |
| **Chapter DHS 40.07 (2)(a) Staffing Levels**  |
|  | At all times that clients are present at a program, the program shall have a minimum of two staff persons qualified under ch. DHS 40.06(4) on duty, at least one of whom shall be a qualified mental health professional. |
|  | 1. Names of staff on duty at all times: |
|  |       |
| **Chapter DHS 40.07 (2)(b) Additional Staff Level I** |
|  | If more than 10 clients are present at a program operating at Level I, an additional staff person qualified under ch. DHS 40.06(4) shall be present for every 10 additional clients or fraction thereof. |
|  | 1. Name(s) of additional staff on duty at all times:  |
|  |       |
| **Chapter DHS 40.07 (2)(c) Additional Staff Level II and Level III** |
|  | If more than 10 clients are present at a program operating at Level II and III, an additional staff person qualified under ch. DHS 40.06(4) shall be present for every five additional clients or fraction thereof. |
|  | 1. Name(s) of additional staff on duty at all times:  |
|  |       |
| **Chapter DHS 40.08 Admission (1) and (2) Criteria and Procedures**  |
|  | A program shall establish written criteria and procedures to be used when screening children referred for admission. |
| [ ]  Yes [ ]  No | 1. Does your admission policy identify the sources from which referrals may be accepted? |
| [ ]  Yes [ ]  No | 2. Does your admission policy identify the process used for making referrals? |
| [ ]  Yes [ ]  No | 3. Does your admission policy identify the procedures used to screen and assess children who have been referred? |
| [ ]  Yes [ ]  No | 4. Does your admission policy identify any funding restrictions which are applied to admissions? |
| [ ]  Yes [ ]  No | 5. Does your admission policy identify the age range of children the program will serve? |
| [ ]  Yes [ ]  No | 6. Does your admission policy identify any diagnostic or behavioral requirements utilized when selecting clients for admission? |
| [ ]  Yes [ ]  No | 7. Does your admission policy identify any client characteristics for which the program has been specifically designed, including the level or levels of service to be provided, whether male or female clients, or both may be admitted, the nature or severity of disorders which can be managed within the program, and the length of time that services may be provided to the client? |
| [ ]  Yes [ ]  No | 8. Does your admission policy identify any priorities which may be applied in selecting children referred for admission? |
| **Chapter DHS 40.08(3) Criteria for Admission** |
| [ ]  Yes [ ]  No | 1. Does your admission criteria require the child to have a primary psychiatric diagnosis of mental illness or severe emotional disorder? |
| [ ]  Yes [ ]  No | 2. Does your admission criteria state that the child would be unable to obtain sufficient benefit from a less restrictive treatment program? |
| [ ]  Yes [ ]  No | 3. Does your admission criteria state that, based on the information available at the time of referral, there shall be a reasonable likelihood that the child will benefit from the services? |
|  | 4. Does your admission criteria state that the child: |
| [ ]  Yes [ ]  No | a. Exhibit significant dysfunction in two or more of the basic domains of his/her life? |
| [ ]  Yes [ ]  No | b. Is in need of transition from a hospital, residential treatment center, or other institutional setting? |
| [ ]  Yes [ ]  No | c. Is in a period of acute crises or other severe stress and would be at high risk of hospitalization or other institutional placement? |
| **Chapter DHS 40.08 (4) Referral for Admissions** |
| [ ]  Yes [ ]  No | 1. Is admission to your program arranged through the program director, clinical coordinator, or designee? |
| [ ]  Yes [ ]  No | 2. If other than the program director or clinical coordinator, is the designation in writing? |
| **Chapter DHS 40.08 (5) Admission Decision** |
| [ ]  Yes [ ]  No | 1. Do you notify the referring agency of your admission decision, by letter, within 30 days after date of referral? |
| **Chapter DHS 40.08 (6) Admission Priorities** |
| [ ]  Yes [ ]  No | 1. Do you have a written policy on the acceptance of children for admission but for whom space is not yet available? |
| [ ]  Yes [ ]  No | 2. Have you ever had a waiting list? |
| **Chapter DHS 40.08 (7) Admission Summary** |
| [ ]  Yes [ ]  No | 1. When you have completed the screening and have decided to admit the child into your program, do you prepare a written report summarizing the reasons for admission? |
| [ ]  Yes [ ]  No | 2. If “yes,” does the report identify services to be offered while the initial assessment and treatment plan are being prepared? |
| [ ]  Yes [ ]  No | 3. Does the report identify a date on which a client may begin attending the program? |
| **Chapter DHS 40.08 (8) Consent for Admission** |
| [ ]  Yes [ ]  No | 1. Is there written evidence in the client chart of consent for admission to your program by the appropriate person(s)? |
| **Chapter DHS 40.08 (9) Case Management** |
|  | Upon admission to a program, a child shall be assigned a case manager. |
| [ ]  Yes [ ]  No | 1. Is there written evidence that a case manager has been assigned to every child? |
| [ ]  Yes [ ]  No | 2. Is there written evidence that the case manager has provided the client and the parents or guardian (if they are available) a thorough explanation of the nature and goals of the program, the initial assessment, treatment planning and reviews, and the rights and responsibilities of clients and their families? |
| [ ]  Yes [ ]  No | 3. Is there written evidence that the case manager supervises and facilitates the client’s initial assessment, the development and implementation of the treatment plan, ongoing case reviews, discharge plans, and the implementation of an aftercare program? |
| [ ]  Yes [ ]  No | 4. Is there written evidence that the case manager coordinates the client’s program with other agencies and schools serving the client? |
| [ ]  Yes [ ]  No | 5. Is there written evidence that the case manager maintains contact with the client’s family and facilitates the family’s participation in the treatment plan? |
| [ ]  Yes [ ]  No | 6. Does the case manager serve as an advocate for the client and his/her family with other agencies? |
| [ ]  Yes [ ]  No | 7. Does the case manager act as a mediator regarding disputes that may arise between the client or the client’s family and the program or with other programs or agencies? |
| **Chapter DHS 40.09 Initial Assessment (1) Multi-disciplinary Team** |
|  | 1. Does your team include: |
| [ ]  Yes [ ]  No | a. The case manager? |
| [ ]  Yes [ ]  No | b. The clinical coordinator? |
| [ ]  Yes [ ]  No | c. An occupational therapist, clinical social worker, or registered nurse? |
| [ ]  Yes [ ]  No | d. An educational professional from the client’s school? |
| [ ]  Yes [ ]  No | e. The client to the degree that the client is willing and able to participate? |
| [ ]  Yes [ ]  No | f. The client’s parent or guardian if available and willing? |
| [ ]  Yes [ ]  No | g. Representatives of other professions / agencies identified in the referral materials / intake screening? |
| [ ]  Yes [ ]  No | h. The assigned social worker if the client has been placed by a county pursuant to a juvenile court order? |
| **Chapter DHS 40.09 (2) Elements of the Initial Assessment** |
| [ ]  Yes [ ]  No | 1. Does the initial assessment include: |
| [ ]  Yes [ ]  No | a. Obtaining and reviewing any existing evaluation? |
| [ ]  Yes [ ]  No | b. Completing any new test or evaluation necessary for the development of an effective treatment plan? |
| [ ]  Yes [ ]  No | c. Completing an evaluation of the client’s mental health status by a psychiatrist or psychologist and the clinical coordinator? |
| [ ]  Yes [ ]  No | d. The client’s use of alcohol/drugs? |
| [ ]  Yes [ ]  No | e. The client’s level of academic functioning? |
| [ ]  Yes [ ]  No | f. The client’s level of social and behavioral functioning in the home, school, and community? |
| [ ]  Yes [ ]  No | g. For clients 15 years of age and older, the vocational and independent living skills and needs? |
| [ ]  Yes [ ]  No | h. The client’s relationship with his/her family including both strengths and weaknesses? |
| [ ]  Yes [ ]  No | i. Any other assets and needs of the client and his/her family which affect the client’s ability to participate effectively in the home, school, and community? |
| [ ]  Yes [ ]  No | j. Completing an evaluation for determining the level of risk of suicide and risk of harm resulting from a dangerous reaction to psychotropic medication? |
| [ ]  Yes [ ]  No | k. Completing an evaluation of procedures for assessing and monitoring the effects and side effects of psychotropic medications, for dealing with the results of possible medication overdose, an error in medication administration, an unanticipated reaction to the medication, or the effects of a concurrent medical illness or condition occurring while the person was receiving the medication? |
| [ ]  Yes [ ]  No | l. Completing an evaluation of the criteria for deciding when the level of risk of suicide or a reaction to a psychotropic medication requires a face-to-face response, use of mobile services, or hospitalization. |
| [ ]  Yes [ ]  No | m. Completing an evaluation of the procedures to be used to notify those around the person that he or she may be at risk of harming him or her self? |
| [ ]  Yes [ ]  No | n. Completing an evaluation of the procedures for obtaining a more thorough mental status examination or other form of in-depth assessment, when necessary, based on the results of the initial emergency assessment? |
| [ ]  Yes [ ]  No | o. Completing an evaluation of the procedures for gathering as much information as possible, given the nature and circumstances of the emergency, about the person’s health, any medication prior incidents of drug reaction or suicidal behavior, and any other information? |
| **Chapter DHS 40.09 (3) Written Report on Initial Assessment** |
|  | The multi-disciplinary team shall prepare a written report on the initial assessment. |
| [ ]  Yes [ ]  No | 1. Does the report describe the client’s current mental health status? |
| [ ]  Yes [ ]  No | 2. Does the report describe the client’s level of functioning both in terms of assets and problems which are to be addressed through treatment? |
| [ ]  Yes [ ]  No | 3. Does the report provide current baseline data regarding the severity, duration, and frequency with which mental health symptoms or problem behaviors have been observed? |
| [ ]  Yes [ ]  No | If “no,” does the report describe the data as being reported as part of the client’s history. |
| [ ]  Yes [ ]  No | 4. Does the report establish primary treatment goals and objectives? |
| [ ]  Yes [ ]  No | 5. Does the report express the goals / objectives in measurable terms? |
| [ ]  Yes [ ]  No | 6. Do the goals / objectives identify the conditions or behaviors which the client will be helped to achieve? |
| [ ]  Yes [ ]  No | 7. Is there an anticipated date by which the client can be expected to achieve the goals / objectives? |
| **Chapter DHS 40.10 Treatment Plan (1) Requirement** |
|  | The multi-disciplinary team shall prepare a written treatment plan for a client based upon the written report under ch. DHS 40.09(3) or the initial assessment of the client. |
| [ ]  Yes [ ]  No | 1. Is the treatment plan prepared within 30 calendar days after admission for preparation and approval of a Level I or Level II treatment plan? |
| [ ]  Yes [ ]  No | 2. Is the treatment plan prepared within 10 calendar days after admission for preparation and approval of a Level III treatment plan? |
| [ ]  Yes [ ]  No | 3. Does the treatment plan list the specific services which will be provided? |
| [ ]  Yes [ ]  No | 4. Does the treatment plan include a summary of services the client will receive from his/her school or other educational resource? |
| [ ]  Yes [ ]  No | 5. Does the treatment plan include a summary of services the client will receive from other involved agency(ies)? |
| [ ]  Yes [ ]  No | 6. Does the treatment plan indicate how the services from outside agencies will be coordinated with services provided by the program? |
| [ ]  Yes [ ]  No | 7. Does the treatment plan include a statement of program staff actions/interventions to be provided to the client/family, their frequency, and the staff responsible? |
| [ ]  Yes [ ]  No | 8. Does the treatment plan describe the procedure for monitoring and managing any identified suicide risk? |
| [ ]  Yes [ ]  No | 9. Does the treatment plan include short-term and long-term treatment objectives? |
| [ ]  Yes [ ]  No | 10. Does the treatment plan include criteria for measuring the effectiveness/appropriateness of the treatment plan? |
| [ ]  Yes [ ]  No | 11. Does the treatment plan include criteria to determine when the client has met the treatment plan objectives? |
| [ ]  Yes [ ]  No | 12. Does the treatment plan identify any medication the client will be receiving, the physician prescribing the medication, the purpose of the medication, and the plan for monitoring the medication administration/effects? |
| [ ]  Yes [ ]  No | 13. Who signs the treatment plan? Name(s): |       |
| [ ]  Yes [ ]  No | 14. In the event the client / parent / guardian / legal custodian refuses to sign the treatment plan or indicates a disagreement with the plan, is this refusal / disagreement documented in the treatment plan? |
| [ ]  Yes [ ]  No | 15. Does program staff document the steps which will be taken to attempt to resolve the conflict noted in the above question? |
| [ ]  Yes [ ]  No | 16. Does the psychiatrist or psychologist review, approve, and sign the treatment plan? |
| **Chapter DHS 40.10 (5) Review of Case Progress** |
|  | The case manager shall reconvene the multi-disciplinary treatment planning team according to the following schedule to assess the progress of the case. |
|  | **Level I Services** |
| [ ]  Yes [ ]  No | 1. Level I Services. Does the multi-disciplinary team assess the progress within 30 calendar days following approval of the treatment plan and every month thereafter? |
|  | **Level II Services** |
| [ ]  Yes [ ]  No | 1. Does the multi-disciplinary team assess the progress within 30 calendar days following approval of the treatment plan and every month thereafter? |
|  | **Level III Services** |
| [ ]  Yes [ ]  No | 1. Does the multi-disciplinary team assess the progress within 14 calendar day after approval of the treatment plan and every month thereafter? |
| [ ]  Yes [ ]  No | 2. For all three levels of service does the multi-disciplinary team reconvene and assess client progress more frequently if there is indication from any of the affected parties that there is a need to do so? |
| **Chapter DHS 40.10 (5)(b) Elements of Review** |
|  | 1. In reviewing case progress, do you: |
| [ ]  Yes [ ]  No |  a. Identify the client’s current status under each objective and assess the client’s progress, lack of progress, or regression in each area? |
| [ ]  Yes [ ]  No | b. Determine the continued appropriateness of the treatment plan and modify the objectives, proposed achievement dates, interventions, actions, or responsible staff? |
| [ ]  Yes [ ]  No | c. Request the participation or assistance of additional community programs or agencies as necessary? |
| [ ]  Yes [ ]  No | d. Prepare a written summary of the findings of the review and, if necessary, a revised treatment plan? |
| **Chapter DHS 40.10 (5)(c) Documentation** |
|  | 1. As part of the review of case progress, does the treatment team prepare a written report which includes: |
| [ ]  Yes [ ]  No | a. A description of the client’s progress, lack of progress, or regression in relation to the treatment plan objectives? |
| [ ]  Yes [ ]  No | b. Documentation of clinical client contacts and interventions required as part of the treatment plan? |
| [ ]  Yes [ ]  No | c. Identification of all days on which services were actually delivered to the client? |
|  | 2. Is the written report prepared: |
| [ ]  Yes [ ]  No | a. Each month in programs providing Level I and Level II services? |
| [ ]  Yes [ ]  No | b. Every two weeks in programs providing Level III services? |
| [ ]  Yes [ ]  No | 3. Are the written reports maintained in the client record? |
| **Chapter DHS 40.10 (6) Discharge Planning** |
| [ ]  Yes [ ]  No | 1. Does the treatment plan include a discharge planning component? |
|  | 2. When the client is approaching attainment of the treatment plan objectives, does the treatment team prepare a discharge plan: |
| [ ]  Yes [ ]  No | a. Which establishes a process for the client’s transition back into the community? |
| [ ]  Yes [ ]  No | b. Which identifies aftercare services which will be provided to assist in that transition and to support the client’s reintegration into the family, school, and community activities? |
| **Chapter DHS 40.10 (7)(a) and (b) Termination of Services** |
| [ ]  Yes [ ]  No | 1. If you terminate a client prior to the client’s attaining their goals, do you do so with the agreement of the client, the program director, the clinical coordinator, and the court if participation in the program has been required by a court order? |
| [ ]  Yes [ ]  No | 2. If “yes” --- Unless the client poses an immediate risk of harm to others, do you provide the court and the responsible social worker 14 days prior notice of your intent to end services? |
| [ ]  Yes [ ]  No | 3. If you terminate a client prior to the client’s attaining their goals, this decision is made: |
| [ ]  Yes [ ]  No | a. By determining that further participation of the client is unlikely to provide any reasonable benefit to the client? |
| [ ]  Yes [ ]  No | b. By determining that the client’s condition requires a greater or more restrictive level of care than can be provided by the program? |
| [ ]  Yes [ ]  No | c. By determining that the client’s behavior or condition is such that there is a serious risk of harm to others in the program? |
| [ ]  Yes [ ]  No | 4. If “yes,” to either a. or b. --- Do you provide the client, the parent or guardian, and other agencies providing services to the client with at least seven days prior notice of your intent to end services? |
| **Chapter DHS 40.10 (8) Reporting of Deaths** |
| [ ]  Yes [ ]  No | 1. Do you have written policies and procedures for reporting to the department deaths of clients due to suicide, psychotropic medications, or use of physical restraints? |
| **Chapter DHS 40.11 (1) and (2) Program Components** |
|  | **Level I Program** |
| [ ]  Yes [ ]  No | 1. Do you provide individual, group, and family counseling provided by qualified mental health professionals? |
| [ ]  Yes [ ]  No | 2. Do you provide a structured milieu supervised by qualified mental health professionals in which a positive pattern of social, educational, and personal behaviors and coping skills are taught, reinforced, and enhanced through a variety of individual and group activities? |
| [ ]  Yes [ ]  No | 3. Do you provide case management services? |
| [ ]  Yes [ ]  No | 4. Do you provide crisis response services for your clients when the client is not present at your program? |
| [ ]  Yes [ ]  No | 5. After discharge, do you provide aftercare services for a minimum of three months. |
|  | **Level II Program** |
| [ ]  Yes [ ]  No | 1. Do you provide all of the program components identified in Level I above? |
| [ ]  Yes [ ]  No | 2. If “yes,” do you structure the services in such a way as to meet the needs of clients for closer supervision and more severe symptomatology? |
| [ ]  Yes [ ]  No | 3. Do you offer individual, group, and family psychotherapy either provided by a psychiatrist, a psychologist, or a qualified Master’s degree mental health professional? |
|  | **Level III Program** |
| [ ]  Yes [ ]  No | 1. Do you provide all of the program components identified in Level II above? |
| [ ]  Yes [ ]  No | 2. If “yes,” do you provide daily medical rounds? |
| [ ]  Yes [ ]  No | 3. Do you provide occupational, speech and language therapy, and other medically prescribed therapies, as needed, pursuant to each client’s individual treatment plan? |
| **Chapter DHS 40.12 Educational Services** |
| [ ]  Yes [ ]  No | 1. Do you provide services in conjunction with local educational agencies? |
| [ ]  Yes [ ]  No | 2. If “yes,” do you execute memoranda of understanding (or other form of interagency agreement) to ensure coordinated services? |
| **Chapter DHS 40.13 Client Records (1) Individual Treatment Record** |
|  | A program shall maintain a treatment record for each client. |
| [ ]  Yes [ ]  No | 1. Do you maintain a treatment record for each client? |
|  | 2. Does the treatment record include: |
| [ ]  Yes [ ]  No | a. Initial referral materials? |
| [ ]  Yes [ ]  No | b. Notes and reports made during the screening? |
| [ ]  Yes [ ]  No | c. A copy of the letter accepting or rejecting the referral? |
| [ ]  Yes [ ]  No | d. The report of the multi-disciplinary assessment of the client and his/her family? |
| [ ]  Yes [ ]  No | e. The necessary releases or authorizations for acquiring previous reports and evaluations? |
| [ ]  Yes [ ]  No | f. Reports / evaluations used in developing the initial assessment? |
| [ ]  Yes [ ]  No | g. Results of additional evaluations / assessments performed while the client is enrolled in the program? |
| [ ]  Yes [ ]  No | h. The signed individual treatment plan? |
| [ ]  Yes [ ]  No | i. Written documentation of services provided to the client? |
| [ ]  Yes [ ]  No | j. Written documentation of client progress / lack of progress? |
| [ ]  Yes [ ]  No | k. Written summaries of the client progress review done by the multi-disciplinary team? |
| [ ]  Yes [ ]  No | l. Documentation of discharge planning? |
| [ ]  Yes [ ]  No | m. Documentation of planned aftercare services? |
| [ ]  Yes [ ]  No | n. Written consent for treatment or the court order or county department authorization pursuant to commitment? |
| [ ]  Yes [ ]  No | o. Record(s) of any grievances lodged by the client, his family, or others relating to the client’s treatment and documentation of the program’s response to each grievance? |
| [ ]  Yes [ ]  No | p. Treatment plan case conference and consultation notes? |
| [ ]  Yes [ ]  No | q. Documentation that the client and his family have been informed of their rights? |
| **Chapter DHS 40.13 (1)(k) Medication Records** |
|  | Medication records, if program staff dispense medications, including documentation of both over-the-counter and prescription medications dispensed to clients. |
| [ ]  Yes [ ]  No | 1. Does program staff dispense medications? |
|  | 2. If “yes,” does the treatment record contain documentation that the medication records: |
| [ ]  Yes [ ]  No | a. Contain documentation of on-going monitoring of the administration of medication and detection of adverse drug reactions? |
| [ ]  Yes [ ]  No | b. Contain documentation specifying the name, type and purpose, dose, route of administration, and frequency of administration of the medication? |
| [ ]  Yes [ ]  No | c. Contain documentation of the person administering and the name of the physician who prescribed the medication? |
| **Chapter DHS 40.13 (2) Education Records** |
| [ ]  Yes [ ]  No | 1. Do you keep education records of your clients? |
| [ ]  Yes [ ]  No | 2. If “yes,” are these records kept separate from the clients’ treatment records? |
| **Chapter DHS 40.13 (4), (5) and (6) Client Treatment Records** |
|  | 1. Where are client treatment records kept? |
|  |       |
| [ ]  Yes [ ]  No | 2. Are the treatment records kept in a consistent format? |
| [ ]  Yes [ ]  No | 3. Are the treatment records maintained in a secure manner to ensure that unauthorized persons do not have access to the records? |
|  | 4. In the event that your program closes, where will the treatment records be kept? |
|  |       |
| [ ]  Yes [ ]  No | 5. Is there a written memorandum / agreement with the other agency identified in 4. above, regarding the retention of client treatment records? |
| **Chapter DHS 40.14 (1) Client Rights** |
| [ ]  Yes [ ]  No | 1. Do you have written policies and procedures regarding DHS 94? |
| [ ]  Yes [ ]  No | 2. Does the case manager assist the client and the client’s parents or guardian in understanding their rights? |
| [ ]  Yes [ ]  No | 3. Does your grievance procedure accommodate any informal, as well as a formal, process for resolving complaints and disagreements? |
| **Chapter DHS 40.15 (1) Buildings, Grounds and Equipment** |
| [ ]  Yes [ ]  No | 1. Does the building in which your program is housed comply with all appropriate state and local codes and regulations? |
| **Chapter DHS 40.15 (2) Food Service** |
| [ ]  Yes [ ]  No | 1. Do you have any clients who are at your program’s facility for four or more hours during a day? |
| [ ]  Yes [ ]  No | 2. If “yes,” do you make food service available to those clients? |
|  | 3. If “yes,” are you aware of and do you comply with all requirements of DHS 190.09 relative to: |
| [ ]  Yes [ ]  No | a. Food service personnel? |
| [ ]  Yes [ ]  No | b. Food supply and preparation? |
| [ ]  Yes [ ]  No | c. Serving of food? |
| [ ]  Yes [ ]  No | d. Storage of food and utensils? |
| [ ]  Yes [ ]  No | e. Equipment construction? |
| [ ]  Yes [ ]  No | f. Cleanliness of equipment, utensils, and area? |
| [ ]  Yes [ ]  No | g. Refrigeration? |
| [ ]  Yes [ ]  No | h. Kitchens? |
| [ ]  Yes [ ]  No | i. Garbage and refuse? |
|  |
| **Chapter DHS 40.16 (1)(a) Program Evaluation Outcome**  |
|  | Every program shall annually evaluate the effectiveness of services provided to its clients. |
| [ ]  Yes [ ]  No | 1. Does your outcome evaluation include a statement of the program’s therapeutic, behavioral, and skill-based outcome expectations for your clients in objectively measurable terms? |
| [ ]  Yes [ ]  No | 2. Do you have a process for obtaining and recording accurate information about changes in client performance to meet these outcome expectations during and following program participation? |
| [ ]  Yes [ ]  No | 3. Do you have a process for obtaining and recording honest and accurate statements of client, family, and referral source satisfaction with program services? |
| [ ]  Yes [ ]  No | 4. Do you have a method for collecting and analyzing the objective and subjective outcome data identified in 1. and 2. above which protects the confidentiality of clients and their families? |
| **Chapter DHS 40.16 (1)(b) Annual Report** |
| Every program shall send the annual report of client service outcomes to the department office which certified that program within 60 days after receiving notification of renewal of certification under Chapter DHS 40.04(6)(b) and shall make it available for review as a public record maintained by the program. |
| **Chapter DHS 40.16 (2) Operations** |
| (a) In addition to the outcome evaluation under sub. (1) a program shall arrange for an annual review of its program operations to evaluate factors such as the appropriateness of admissions and clients’ length of stay, the efficiency of procedures for conducting initial assessments and developing treatment plans, the effectiveness of discharge and aftercare services, the functionality of the program’s interagency agreements and other factors that may contribute to effective use of the program’s resources. |
| (b) The review of program operations may be conducted by an advisory committee established by the program, by a committee of the board of directors of the organization operating the program, or by any other appropriate and objective body. |
| (c) A summary of the review of program operations shall be appended to the annual report prepared under sub. (1)(b). |
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| **MENTAL HEALTH DAY TREATMENT SERVICE FOR CHILDREN PROGRAM****STAFF LISTING** |
| **NOTE: Have available for review copies of degrees and/or applicable licenses.** |
| Name – Facility      | Facility Address – Street Address      | City      | Zip Code      |
| **Name** | **Position** | **Verification**  **Signature \*** | **Date** | **Degree** | **Number of Years of Work Experience with Children w/Mental Disorders** | **Knowledge of****Applicable Parts** **of Chapters** **48, 51, 55, 115** |
|       |       |  |       |       |       | [ ]  Yes [ ]  No |
|       |       |  |       |       |       | [ ]  Yes [ ]  No |
|       |       |  |       |       |       | [ ]  Yes [ ]  No |
|       |       |  |       |       |       | [ ]  Yes [ ]  No |
|       |       |  |       |       |       | [ ]  Yes [ ]  No |
|       |       |  |       |       |       | [ ]  Yes [ ]  No |
|       |       |  |       |       |       | [ ]  Yes [ ]  No |
|       |       |  |       |       |       | [ ]  Yes [ ]  No |
|       |       |  |       |       |       | [ ]  Yes [ ]  No |
|       |       |  |       |       |       | [ ]  Yes [ ]  No |
|       |       |  |       |       |       | [ ]  Yes [ ]  No |
|       |       |  |       |       |       | [ ]  Yes [ ]  No |
|       |       |  |       |       |       | [ ]  Yes [ ]  No |
| \* ***VERIFICATION SIGNATURE*** *– Verifies that the above experience and knowledge factors are correct and that there is a criminal record check on file.* |
| **I affirm that the above statements are correct to the best of my knowledge.** |
| **SIGNATURE** – Facility Director | Name – Facility Director *(Print or type.)*      | Date Signed |