|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **DEPARTMENT OF HEALTH SERVICES**  Division of Quality Assurance  F-00785 (08/2016) | | | | | | | | **STATE OF WISCONSIN**  Wis. Admin. Code ch. DHS 35  Page 1 of 7 | | | | | | | | | | | | |
| **OUTPATIENT MENTAL HEALTH CLINIC**  **RECERTIFICATION APPLICATION – DHS 35** | | | | | | | | | | | | | | | | | | | | |
| This recertification application is to verify that the outpatient mental health clinic complies with Wis. Admin. Code ch. DHS 35. 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 | | | | | | | | | | | | | | | | | Certification No. | | | |
|  | | | | | | | | | | | | | | | | |  |  |  |  |
| Address – Physical | | | | | City | | | | | | State | Zip Code | | | | County | | | | |
| Accreditation  JCAHO  COA  CARF  Other – *Specify:* | | | | | |  | | | | Date - Accreditation End | | | | Date – Last Accreditation Visit | | | | | | |
| Telephone No. – Facility | | | | Email Address  *May be published in Provider Directory.* | | | | | | | | | | | | | | | | |
| Fax No. – Facility | | | | Internet Address  *May be published in Provider Directory.* | | | | | | | | | | | | | | | | |
| Name – Clinic Administrator | | | | Telephone No. | | | | | Email Address  *May be published in provider directory* | | | | | | | | | | | |
| Name – Person Completing Form | | | | Telephone No. | | | | | Email Address  *May be published in provider directory* | | | | | | | | | | | |
| **FACILITY CONTACT PERSON** | | | | | | | | | | | | | | | | | | | | |
| Name – Contact Person | | | | Telephone No. | | | | | | Email Address  *May be published in provider directory* | | | | | | | | | | |
| Mailing Address – Contact Person | | | | | | | City | | | | | | State | | | Zip Code | | | | |
| **AGREEMENT FOR ELECTRONIC TRANSMISSIONS** | | | | | | | | | | | | | | | | | | | | |
| **This applicant agrees to permit and cooperate with the Department in using electronic transmissions to communicate official business, including applications, survey findings, statements of deficiencies, and plans of correction.** | | | | | | | | | | | | | | | | | | | | |
| The official email address is: | | |  | | | | | | | | | | | | | | | | | |
| **ATTESTATION** | | | | | | | | | | | | | | | | | | | | |
| I hereby attest that all statements made in this application and in any attachments are correct to the best of my knowledge and that I will comply with all laws, rules, and regulations governing mental health outpatient services. | | | | | | | | | | | | | | | | | | | | |
| **SIGNATURE** – Clinic Administrator | | | | | | | | | | | | | | | Date Signed | | | | | |
| **INSTRUCTIONS**   * Applicants must answer each question. Affirm “Yes” if the requirement was met; check “No” if the requirement was not met. * Attach additional narrative, status report, or plans for improvement for every “No” response. * For each branch office requested, attached DQA form F-00191, *Certified Outpatient Clinic Request for a Branch Office*, with this application. Access the form at: <https://www.dhs.wisconsin.gov/forms/index.htm> * Mail (1) appropriate fee, (2) this application form, and (3) branch office application (if applicable) to:   **DHS / Division of Quality Assurance**  **BHS / Behavioral Health Certification Section**  **P.O. Box 2969**  **Madison, WI 53701-2969** | | | | | | | | | | | | | | | | | | | | |
|  | **DHS Code** | **Clinic Administrator’s Responsibilities** | | | | | | | | | | | | | | | | | | |
| Yes  No | **35.07** | Clinic Administrator is primarily located at the main clinic. | | | | | | | | | | | | | | | | | | |
| Yes  No | **35.09** | Notify the Department of any changes in administration, ownership, main clinic and branch locations, clinic name, and any change in the clinic’s policies and practices that may affect clinic compliance by no later than the effective date of the change. | | | | | | | | | | | | | | | | | | |
| Yes  No | **35.123** | Oversee the clinic operations; ensure the main clinic and all branch offices are in compliance with this chapter and other applicable state and federal law and regulations. | | | | | | | | | | | | | | | | | | |
| Yes  No | **35.123** | Ensure minimum staffing requirement and sufficient number of qualified staff members to provide outpatient mental health services. | | | | | | | | | | | | | | | | | | |
| Yes  No | **35.123** | Verify mental health professional’s license, competency, and scope of practice. Maintain documentation of staff’s practice limitations and restrictions. Employ/contract only qualified mental health professionals. | | | | | | | | | | | | | | | | | | |
| Yes  No | **35.127** | Ensure clinical supervision provided to qualified treatment trainee. | | | | | | | | | | | | | | | | | | |
| Yes  No | **35.14** | Oversee all staff job performances; require staff members to adhere to all applicable laws and regulations. | | | | | | | | | | | | | | | | | | |
| Yes  No | **35.21** | Identify treatment approaches and implement the role of clinical supervision and clinical collaboration in the treatment approaches. | | | | | | | | | | | | | | | | | | |
|  | **DHS Code** | **Policies and Procedures** | | | | | | | | | | | | | | | | | | |
| Yes  No | **35.13** | Establish and implement written personnel policies and procedures including compliance of caregiver background check and caregiver misconduct reporting. Maintain a personnel records for each clinic staff. | | | | | | | | | | | | | | | | | | |
| Yes  No | **35.14** | Establish and implement clinical collaboration and clinical supervision policies and procedures. | | | | | | | | | | | | | | | | | | |
| Yes  No | **35.15** | Establish and implement orientation and training policies and procedures. Maintain orientation and training record for each clinical staff. | | | | | | | | | | | | | | | | | | |
| Yes  No | **35.16** | Establish and implement written admission criteria. Maintain a written recommendation for psychotherapy documentation in the clinical record. | | | | | | | | | | | | | | | | | | |
| Yes  No | **35.19(4)** | Establish and implement written policies and procedures for referring clients to other service providers as needed. Maintain a list of outside resources for referrals. | | | | | | | | | | | | | | | | | | |
| Yes  No | **35.165** | Establish and implement written emergency service policies and procedures. | | | | | | | | | | | | | | | | | | |
|  | **DHS Code** | **Clinical Documentation** | | | | | | | | | | | | | | | | | | |
| Yes  No | **35.14** | Maintain clinical collaboration and clinical supervision records. | | | | | | | | | | | | | | | | | | |
| Yes  No | **35.17** | Comprehensive assessment is completed by qualified clinical staff and a written assessment report is maintained in the clinical record. | | | | | | | | | | | | | | | | | | |
| Yes  No | **35.18** | Signed informed consent for treatment and medication (if applicable), cost for services, and acknowledgment of client rights, grievance procedures, emergency services, and discharge policy are maintained in the clinical record. | | | | | | | | | | | | | | | | | | |
| Yes  No | **35.19** | Treatment plan is maintained in the clinical record and meets the following criteria:   * Treatment plan is based on the client’s diagnosis and symptoms description from the comprehensive assessment. It reflects client’s current needs. * Client’s strengths are incorporated in the treatment plan. * Treatment outcomes are measurable. * Increase client’s ability to function independently. * Client’s developmental needs are considered. * Include schedules, frequency, and nature of services recommended. * Include client’s signature and guardian’s signature (if applicable). | | | | | | | | | | | | | | | | | | |
| Yes  No | **35.19** | Regular treatment plan review documentation is maintained in the clinical record. | | | | | | | | | | | | | | | | | | |
| Yes  No | **35.20** | Medications are listed in the clinical record. When appropriate, refer clients to receive psychotherapy to meet their treatment needs. | | | | | | | | | | | | | | | | | | |
| Yes  No | **35.215** | Monitor group therapy size and staff to consumer ratio. | | | | | | | | | | | | | | | | | | |
| Yes  No | **35.22** | Discharge summary is completed within 30 days of the discharge and is maintained in the clinical record. | | | | | | | | | | | | | | | | | | |
| Yes  No | **35.23** | Maintain a confidential, factual, accurate, and legible clinical record for each client. Maintenance, retention, disposal, and transfer of paper or electronic clinical record are consistent with all applicable law and regulations. | | | | | | | | | | | | | | | | | | |
| Yes  No | **35.24** | Establish and implement client rights policies and procedures consistent with all applicable law and regulations. | | | | | | | | | | | | | | | | | | |
| Yes  No | **35.25** | Fax a death determination report to the Department within 24 hours of learning of a reportable death. | | | | | | | | | | | | | | | | | | |
| 1. Briefly describe changes in facility policies and procedures since last recertification visit. *(Attach additional pages, if necessary.)* | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| 2. Describe innovations the facility has created or employed as they relate to the services since the last recertification visit. *(Attach additional pages, if necessary.)* | | | | | | | | | | | | | | | | | | | | |
| 3. Describe facility needs (e.g., problems, supports, or enhancement needs), which your facility has identified, including hiring qualified staff, training availability, or other technical assistance. *(Attach additional pages, if necessary.)* | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| 4. Describe special burdens or challenges that your facility faces. *(Attach additional pages, if necessary.)* | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **OUTPATIENT SERVICES PROVIDED IN A SCHOOL SETTING**   * Copy and complete pages 5 and 6 **FOR EACH SCHOOL LOCATION.** * **NOTE:** Wis. Admin. Code § DHS 35.09 states, “The clinic shall notify the department of any changes in administration, ownership or control, office location, clinic name, or program, and any change in the clinic’s policies or practices that may affect clinic compliance by no later than the effective date of the change.” | | | | | | | | | | | | | |
| **MAIN CLINIC INFORMATION** | | | | | | | | | | | | | |
| Name – Main Clinic | | | | | | | | | | | Certification No. | | |
| **SCHOOL DISTRICT ADMINISTRATION OFFICE INFORMATION** | | | | | | | | | | | | | |
| Name – School District | | | | | | | | | | | | | |
| Street Address | | | | | | | City | | | | State | | Zip Code |
| ***Contact Person*** | | | | | | | | | | | | | |
| Name | | Telephone No. | | | Fax No. | | | | | Email Address – Contact Person | | | |
| **SCHOOL LOCATION AND CONTACT PERSON** | | | | | | | | | | | | | |
| Name – School Site | | | | | | | | | | | County | | |
| Street Address | | | | | | | City | | | | State | | Zip Code |
| ***Contact Person*** | | | | | | | | | | | | | |
| Name | | | Telephone No. | | Fax No. | | | | | Email Address – Site Contact Person | | | |
| Is this site a certified branch office?  Yes  No  If “yes,” no additional site information is required on this form. Complete DQA form F-00191A, *Certified Outpatient Clinic School Branch Office Request.* | | | | | | | | | | | | | |
| **OUTPATIENT SERVICES PROVIDED AT THIS SITE** | | | | | | | | | | | | | |
| Mental Health  Substance Use  Other *(Describe below.)* | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **DAYS AND HOURS SERVICES ARE PROVIDED AT THIS SITE** | | | | | | | | | | | | | |
| **DAY** | **Monday** | | | **Tuesday** | | **Wednesday** | | | **Thursday** | | | **Friday** | |
| **HOURS** |  | | |  | |  | | |  | | |  | |
| **STAFF ROSTER FOR THIS SITE** | | | | | | | | | | | | | |
| **Name** | | | | | | | | **License No.** | | | **Hours Available Per Week** | | |
|  | | | | | | | |  | | |  | | |
|  | | | | | | | |  | | |  | | |
|  | | | | | | | |  | | |  | | |
|  | | | | | | | |  | | |  | | |
|  | | | | | | | |  | | |  | | |
|  | | | | | | | |  | | |  | | |
| **MEMORANDUM OF UNDERSTANDING** | | | | | | | | | | | | | |
| Is there a memorandum of understanding (MOU) in effect between the certified clinic and this school delivery site?  Yes  No If “yes,” attach a copy. | | | | | | | | | | | | | |
| **RECORDS** | | | | | | | | | | | | | |
| Are consumer records kept at this school site?  Yes  No  If “yes,” describe how records are stored. | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **OVERSIGHT** | | | | | | | | | | | | | |
| Briefly describe the policies of oversight for the clinic administrator and the policies for collaboration and/or supervision for services delivered at this school site. | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **OUTPATIENT MENTAL HEALTH CLINIC STAFF ROSTER** | | | | | | | | | | | | | |
| Pursuant to Wis. Stat. § 50.065(1), “caregiver” means (1) a person who is, or is expected to be, an employee or contractor of an entity, (2) who is, or is expected to be, under the control of an entity, as defined by the department by rule, and (3) who has or is expected to have regular, direct contact with clients of the entity.  **PRINT ADDITIONAL PAGES, AS NEEDED.** | | | | | | | | | | | | | |
| Name – Facility | | | | | | | | | | | Certification No. | | |
| Name – Client Rights Specialist | | | Telephone No. – Client Rights Specialist | | | Mailing Address – Client Rights Specialist | | | | | | | |
| **LICENSED STAFF** | | | | | | | | **Hours Per**  **Week**  **at Main Clinic** | **Caregiver Criminal Background Check** | | | | |
| **Name**  (Last, First) | **Position Description**  (Example: Clinic Administrator) | | | **Profession**  (Example: LPC) | | | **DSPS Lic. No.**  (Ex: 1111-125) | **BID**  **Form**  **(mm/yy)** | **DOJ**  **Report**  **(mm/yy)** | | **DHS/IBIS**  **Letter (mm/yy)** | **Background**  **Reviewed within**  **Last 4 Yrs** |
|  |  | | |  | | |  |  |  |  | |  | Yes |
|  |  | | |  | | |  |  |  |  | |  | Yes |
|  |  | | |  | | |  |  |  |  | |  | Yes |
|  |  | | |  | | |  |  |  |  | |  | Yes |
|  |  | | |  | | |  |  |  |  | |  | Yes |
|  |  | | |  | | |  |  |  |  | |  | Yes |
|  |  | | |  | | |  |  |  |  | |  | Yes |
|  |  | | |  | | |  |  |  |  | |  | Yes |
| **NON- LICENSED STAFF** (In-home providers shall list all staff, including non-licensed staff.) | | | | | | | | | | | | | |
| **Name** | | **Position Description** | | | **Degree** | | | **Same as above** | | | | | |
|  | |  | | |  | | |  |  |  | |  | Yes |
|  | |  | | |  | | |  |  |  | |  | Yes |
|  | |  | | |  | | |  |  |  | |  | Yes |
|  | |  | | |  | | |  |  |  | |  | Yes |
|  | |  | | |  | | |  |  |  | |  | Yes |
|  | |  | | |  | | |  |  |  | |  | Yes |