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| **DEPARTMENT OF HEALTH SERVICES**  Division of Care and Treatment Services  F-00944 (09/2016) | | | | | | |  | | **STATE OF WISCONSIN** |
| **REQUEST FOR APPROVAL COMPREHENSIVE COMMUNITY SERVICES (CCS) REGIONAL SERVICE MODEL** | | | | | | | | | |
| This form is intended to be used by counties and tribes to complete the first step: to obtain approval of the CCS Regional Service Model from the Department of Health Services-Division of Care and Treatment Services (DHS-DCTS). Please view the accompanying [Info/Action Memo](https://www.dhs.wisconsin.gov/dcts/memos/Info/2014-01InfoMemo.pdf) for more information.  **NOTE:** Counties and Tribes interested in providing CCS and accessing the state payment of the non-federal share of CCS Medicaid costs must complete these three steps:   1. Obtain approval of the CCS Regional Service Model from DHS-DCTS by completing this form, 2. Obtain CCS certification from the Division of Quality Assurance (DQA), and 3. Enroll in the Medicaid program and obtain approval from the Division of Health Care Access and Accountability (DHCAA) to bill the Medicaid program for CCS services. | | | | | | | | | |
| List Counties/Tribes part of this CCS Regional Service Model | | | | | | Indicate Effective Date (start date) for each County/Tribe | | | |
| List Counties/Tribes | | | | | | Enter Dates | | | |
| Name of Consortium (Required) | | | | | | | | | |
| Enter Name | | | | | | | | | |
| Indicate by checking a box below the CCS Regional Service Model by which the CCS program proposes to operate. For more information, see publication [P-00602 CCS Regional Service Models Document](http://www.dhs.wisconsin.gov/publications/P0/P00602.pdf).  For counties/tribes selecting *Tribal Nations: Options* from the publication [P-00602 CCS Regional Service Models Document](http://www.dhs.wisconsin.gov/publications/P0/P00602.pdf), select which regional service model would be used. | | | | | | | | | |
|  | Population Based | |  | Multi-County Services Model | | | | | |
|  | Shared Services | |  | 51.42 Model | | | | | |
| Complete the Following Questions by Providing a Narrative Response | | | | | | | | | |
| 1. CCS Governance: | | | | | | | | | |
| * Please attach a fully executed legal agreement (signed by all business partners) for the regional operation of CCS; this may take the form of an intergovernmental agreement (ss 66.0301), a contract or memorandum of understanding. | | | | | | | | | |
| * Administration of CCS; Who is the CCS Administrator, CCS Service Director, Care and Treatment Professionals? Include an organizational chart that depicts the CCS program’s administrative structure. | | | | | | | | | |
| Enter Narrative | | | | | | | | | |
| * Lead Agency; Will one agency serve as the lead agency for the regional program? If yes, identify this agency. | | | | | | | | | |
| Enter Narrative | | | | | | | | | |
| * CCS Coordinating Committee; Does the CCS Coordinating Committee currently exist? What is the current and/or proposed membership? How is the Committee used in governance functions? How does the Committee represent or involve all the regional partners? | | | | | | | | | |
| Enter Narrative | | | | | | | | | |
| 1. CCS Access Plan: | | | | | | | | | |
| * CCS Access for the Lifespan; Will all populations (children, adults, elders) have access to CCS at the onset of the program? If not, what is the expansion schedule? | | | | | | | | | |
| Enter Narrative | | | | | | | | | |
| * CCS Access in the Region (for current and proposed CCS programs); how is CCS made available across the region (throughout multiple counties/tribes)? Are there any components of CCS programming restricted to one area, the lead agency, or select counties/tribes? | | | | | | | | | |
| Enter Narrative | | | | | | | | | |
| * CCS Access to Mental Health and Substance Abuse Programming; CCS offers both mental health and substance abuse treatment. Describe specifically how mental health and substance abuse services are available in CCS. Are there any geographic limitations to the provision of mental health and/or substance abuse services in the region? | | | | | | | | | |
| Enter Narrative | | | | | | | | | |
| 1. CCS Shared Services Regional Models:   DHS has identified the following examples of CCS components that can be shared among regional partners, please check which services will be shared among regional partners: | | | | | | | | | |
|  | | Program Administration | | | | | | | |
|  | | Staff or Providers | | | | | | | |
|  | | Clinical Supervision | | | | | | | |
|  | | Training | | | | | | | |
|  | | Electronic Health Records or Program | | | | | | | |
|  | | Documentation | | | | | | | |
|  | | Billing / Claims | | | | | | | |
|  | | Quality Improvement Plan | | | | | | | |
|  | | Facilities | | | | | | | |
|  | | Other (please describe) | | | Enter Description | | | | |
| Describe how the indicated services/functions of CCS will be shared among regional partners. | | | | | | | | | |
| Enter Description | | | | | | | | | |
| Describe efficiencies and/or estimate savings anticipated through the shared services model | | | | | | | | | |
| Enter Description | | | | | | | | | |
|  | | | | | | | | | |
| DHS-DMHSAS has defined the following performance requirements for providers of CCS: | | | | | | | | | |
|  | * CCS will be provided to eligible consumers including children, adults, and elders with diagnoses of mental health and/or substance abuse disorders. * CCS programs will complete initial and annual functional screens on all enrolled participants. * CCS programs will engage consumers in surveys to assess perceptions of quality. DHS will identify the survey instrument and frequency of administration. * CCS programs will report outcome data through the functional screen reviews and submitting service information at designated intervals via the Program Participation System (PPS). CCS providers agree to cooperate with DHS in developing performance measures to assess CCS outcomes. * CCS programs will notify DHS of any significant change in the design of the Regional Service Model, including changes in counties/tribes participating in the program. | | | | | | | | |
| **Submitting this Request for Approval of the CCS Regional Service Model declares the affiliated providers agree to comply with these performance requirements.** | | | | | | | | | |
| Please provide contact information for questions about the proposed Regional Service Model outlined in this document: | | | | | | | | | |
| County/Tribe Name | | | | | Contact Name | | | Title | |
| Enter County/Tribe Name | | | | | Enter Contact Name | | | Enter Title | |
| Contact Phone Number | | | | | Email Address | | | | |
| Enter Area Code and Phone Number | | | | | Enter Email Address | | | | |
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| Submit Form To: Email: [Kenya.Bright@wisconsin.gov](mailto:Kenya.Bright@wisconsin.gov)  Fax #: 608-267-4865, ATTN: Kenya Bright  Mailing Address: Department of Health Services  Division of Care and Treatment Services  ATTN: Kenya Bright, Room 951  P.O. Box 7851  Madison, WI 53707 | | | | | | | | | |