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| **DEPARTMENT OF HEALTH SERVICES**Division of Quality AssuranceF-01216 (11/2019) | **STATE OF WISCONSIN**Wis. Admin. Code ch. DHS 36Wis. Stat. §§ 49.45(30e)(b) and 51.42(7)(b)Page 1 of 4 |

**COMPREHENSIVE COMMUNITY SERVICES (CCS)**

**FOR PERSONS WITH MENTAL DISORDERS AND SUBSTANCE USE DISORDERS**

**REGIONAL MODEL SUPPLEMENTAL APPLICATION - DHS 36**

**READ INSTRUCTIONS ON PAGE 4 BEFORE COMPLETING THIS FORM.**

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

1. **COUNTY AGENCY INFORMATION**

|  |  |
| --- | --- |
| Regional Name      | Certification No.      |
| **LEAD OR SINGLE COUNTY AGENCY (as applicable to regional model)** |
| Name - Lead or Single County Agency      | Name – CCS Administrator      |
| Street (Physical Address for Lead Agency)      | City      | County      | State   | Zip Code      |
| Mailing Address (if different from above)      | City      | State   | Zip Code      |
| Telephone Number      | Fax Number      | Estimated Start Date      |
| Regional Model *(Check one.)*  [ ]  Population-based [ ]  Multi-county [ ]  Shared Services [ ]  51.42 [ ]  Tribal Nations: Options  |
| **COUNTIES INCLUDED IN THE REGION** *(List all below.)* |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
| **ATTESTATION** |
|  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 for Persons with Mental Disorders and Substance Use Disorders. |
| **SIGNATURE** – CCS Administrator | Date Signed      |

1. **BRANCH OFFICE**

If branch office locations exist within the region, copy and complete this page for **EACH BRANCH OFFICE LOCATION** within the region.

|  |  |
| --- | --- |
| Regional Name       | Certification No.      |
| **BRANCH OFFICE LOCATION AND CONTACT INFORMATION** |
| Name – Branch Office      | County      |
| Name - Site Contact Person      | Email Address – Site Contact Person      |
| Street Address      | City      | State   | Zip Code      |
| Telephone No.      | Fax No.      |
| **BRANCH OFFICE DESCRIPTION** |
| Distance from Lead County Agency      | Service Intensity  [ ]  Tier 1: Less than 20 consumer treatment hours per week ($200)  [ ]  Tier 2: 20 or more hours per week ($500) |
| **CONSUMER RECORDS** |
| Are consumer records kept in at this branch office? [ ]  No [ ]  Yes  | If “yes,” identify the county agency that maintains the records.       |

1. **COUNTIES WITHIN REGION**

 Copy and complete this page for **EACH COUNTY** within the region.

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| **INDIVIDUAL COUNTY INFORMATION** |
| Regional Name       | County      | Certification No.      |
| **CONSUMER SERVICES BY COUNTY (for recertification only)** |
| The Functional Screen was completed for the following number of persons:  |       |
| Comprehensive assessments were completed for the following number of persons:  |       |
| Abbreviated assessments were completed for the following number of persons:  |       |

 Enter the number of Enrolled Consumers in this table.

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

**INSTRUCTIONS**

This form accompanies DQA form F-00482, *CCS for Persons with Mental Disorders and Substance Use Disorders Initial Certification Application – DHS 36,* or DQA form F-00475, *CCS for Persons with Mental Disorders and Substance Use Disorders Recertification Application – DHS 36.*

* **Item I, County Agency Information** (page 1). This section is used to gather general information about the lead or single county agency, as applicable to the regional model. It includes the CCS Administrator attestation.

**NOTE:** By completing and submitting this form the agency indicates it is in compliance with the program standards as required under ss. 49.45(30e)(b) and 51.42(7)(b), Wis. Stats.

* **Item II, Branch Office** (page 2). This section is used to gather specific information for each CCS branch office. If there are one or more branch offices within the region, copy and complete this page for each branch office.
* **Item III, Counties within Region** (page 3). This section is used to gather specific information for each county within the region.
* **Supplemental Information**

Submit documents listed below and label each document with the regional name, program certification number, and date. Programs seeking initial certification will not have a program certification number.

* A copy of the Division of Mental Health and Substance Abuse Services Regional Model Approval letter.
* Policies and Procedure addressing CCS administrator/director(s) oversight of the region and other responsibilities with respect to all branch office sites, given the location of the program’s offices within the region and their distance from the lead agency.

**NOTE:** All DHS 36 CCS policies and procedures shall adequately address administrative code requirements within the context of the selected regional service model. Technical assistance is available from the Division of Mental Health and Substance Abuse Services at: DHSDMHSASCCS@wisconsin.gov

* If counties within the region are not contiguous, a description of how services will be provided and monitored.
* If telehealth will be utilized, a description of how telehealth will be used.
* After completing the Regional Model Supplemental Application, return all requested information with the appropriate certification application and fee to the DQA Central Office at:

**Division of Quality Assurance**

**BHS / Behavioral Health Certification Section**

**PO Box 2969**

**Madison, WI 53701-2969**