

TELEHEALTH APPLICATION – ANNUAL REVIEW OF APPROVAL

By completing and submitting this application, the program/service affirms that it is in compliance with applicable program standards as required by state statutes and DHS telehealth policy as stated in DQA Memo 15-011, *Mental Health and Substance Abuse Telehealth – Criteria for Certification*.

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 plan for improvement for every “No” response.
- Attach the current written plan for telehealth.
- Reference DQA Memo 15-011 at <https://www.dhs.wisconsin.gov/dqa/memos/15-011.pdf>.
- Return completed form and any additional materials to the DQA Central Office at: **DHS / DQA / Bureau of Health Services Behavioral Health Certification Section
 P.O. Box 2969
 Madison, WI 53701-2969**
- If you have questions regarding this form, contact your surveyor at the appropriate DQA Regional Office. Regional office contact information is available at <https://www.dhs.wisconsin.gov/regulations/mentalhealth/contactus.htm>

AGENCY INFORMATION

Name – Agency				Certification No.	
Street Address		City	County	State	Zip Code
Telephone No.		Fax No.	Email Address – Agency Contact Person		

ORIGINATING SITE / CLIENT LOCATION(S)	PROGRAMS / SERVICES USING TELEHEALTH
<input type="checkbox"/> Main Site <input type="checkbox"/> Branch Location: _____ <input type="checkbox"/> Branch Location: _____ <input type="checkbox"/> Sheet of additional branch locations is attached.	<input type="checkbox"/> Outpatient Mental Health <input type="checkbox"/> Emergency / Crisis Services <input type="checkbox"/> Outpatient AODA <input type="checkbox"/> Supervision / Collaboration <input type="checkbox"/> Day Treatment <input type="checkbox"/> Professional Consultation <input type="checkbox"/> CCS <input type="checkbox"/> <i>Other (Specify.)</i> <input type="checkbox"/> CSP

DISTANT SITE / PROVIDER LOCATION (must be located within the United States)

Name – Provider				
Street Address		City	State	Zip Code
Telephone No.		Fax No.		

TELEHEALTH EQUIPMENT

Describe any changes to telehealth hardware and software at each location since the last site visit.

Yes No Signed a HIPAA Business Associate Agreement with the software vendor.

ATTESTATION

I hereby attest that all statements and information provided 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 programs and services delivered via telehealth.

SIGNATURE – Agency Director	Name – Agency Director (<i>Print or type.</i>)	Date Signed (<i>MM/dd/yyyy</i>)
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Answer the following questions and attach additional information, as needed.

Describe orientation and on-going training completed within the past year.

Summarize information gathered from consumer satisfaction surveys.

Describe quality improvement actions or best practices implemented in response to consumer satisfaction surveys.

Summarize transmission challenges encountered and actions taken for resolution during the past year.

Briefly describe changes in telehealth policies and procedures since last site visit.

Describe special burdens or challenges faced in delivering services, consultation, or supervision / collaboration via telehealth.
