# MENTAL HEALTH OR SUBSTANCE USE TREATMENT PROVIDER INITIAL CERTIFICATION APPLICATION – DHS 40 and DHS 50

Questions regarding this form may be directed to the Division of Quality Assurance (DQA), Behavioral Health Certification Section (BHCS) at **608-261-0656.**

Submission of this information is required by Wis. Stat. §§ 50.065 and 51.45 and Wis. Admin. Code chs. DHS 40 and 50. Failure to provide complete and accurate information may result in denial of the application and /or delay in the process. An application is considered complete when all applications are received with accurate information, signatures, and supporting documentation, and when the background check report resulting from Step 1 is available for review by the Behavioral Health Certification Section.

## STEP 1 – ENTITY CAREGIVER BACKGROUND CHECKS (ECBC)

- The applicant submits background information documents and fee directly to the Office of Caregiver Quality (OCQ). See below.
- **NOTE: Background materials should *not* be submitted with the certification application.**
- ECBCs must be completed for entity owners, whether or not the owner has direct client contact. Certification will not be issued until the ECBC has cleared and results are approved.
- For information on how to complete the ECBC, visit http://dhs.wisconsin.gov/caregiver/entity.htm.
- For assistance completing this form, call OCQ at 608-261-8319.

## STEP 2 – COMPLETED APPLICATION

The applicant submits all applicable documents listed in this section and the BHCS staff will review to ensure compliance with applicable regulations.

A completed application includes each of the following

1. This application form, fully completed and signed by the entity owner or board member
2. All supporting documentation as specified in the application
3. Fees as specified in the application

Mail the completed application to: **DHS / DQA / Behavioral Health Certification Section**
**PO Box 2969**
**Madison, WI 53701-2969**

## STEP 3 – ONSITE SURVEY

- A BHCS surveyor will contact you to arrange a date and time for an onsite survey.
- Refer to DQA publication P-63174, *Survey Guide: Behavioral Health Certification for Mental Health and Substance Abuse Services*.
- Review applicable checklists for each administrative rule at the DQA webpage, *Mental Health Treatment Programs: Certification Information*.
- If the surveyor identifies significant changes that would result in a denial decision, the applicant will be afforded an opportunity to make necessary changes and submit those changes for review.

## STEP 4 – APPROVAL OR DENIAL DECISION

- The surveyor will make the certification decision and send the survey results to notify the provider of the decision.
- If approved, BHCS staff will mail a formal certificate to the provider for posting at the primary clinic location.

# I. GENERAL INFORMATION – ENTITY / ENTITY OWNER REQUESTING CERTIFICATION

☐ **Initial Certification** ☐ **Change of Ownership** – *Provide current certification number.*: _____

## A. Entity Contact Information

| Name – Program | Will program obtain Medicaid certification? ☐ Yes ☐ No |
|---|---|

| Telephone No. | Fax No. | Web Address (if any) |
|---|---|---|
| | | |

| Physical Address – Street | City | County | State | Zip Code |
|---|---|---|---|---|
| | | | | |

**DESIGNATED MAIL RECIPIENT**

*Provide name and contact information of person to whom **ALL** mail from DHS / DQA is to be addressed.*

| Name – Designated Mail Recipient | Title | Email Address |
|---|---|---|
| | | |

| Mailing Address – Street or PO Box *(if different from above)* | City | State | Zip Code |
|---|---|---|---|
| | | | |

## B. Entity Owner Information

Type of Entity *(Check only one.)*

☐ Church ☐ Government – County ☐ Tribal ☐ Partnership
☐ Corporation – Business ☐ Government – State ☐ Limited Liability Corp (LLC) ☐ Other – *Specify below:*
☐ Corporation – Non Profit ☐ Government – Other ☐ Proprietorship (Individual)

| Name – Owner (Individual / Partnership Names) or Corporation (Legal Entity) | FEIN* – Legal Entity |
|---|---|
| | |

| Name – Owner / Board Member | SSN* – Owner or Board Member |
|---|---|
| | |

| Address – Street | City | State | Zip Code |
|---|---|---|---|
| | | | |

| Telephone – Owner / Board Member | Fax – Owner / Board Member | Email Address – Owner / Board Member |
|---|---|---|
| | | |

** Collection of the applicant's Social Security number (SSN) and Federal Employer Identification number (FEIN), if applicable, is required per Wis. Stat. § 73.0301 to verify compliance with Wis. Stat. § 51.032. Failure to supply the number may result in denial of the application. This number will only be disclosed to the Department of Revenue for use in collection of tax delinquencies.*

## C. Program Information

| Name | Telephone No. | Fax No. | Email Address |
|---|---|---|---|
| Program Contact | | | |
| Client Rights Specialist | | | |
| Program Director / Administrator | | | |
| Clinical Coordinator | | | |
| Record Custodian | | | |

☐ Yes ☐ No Have you informed your clients (both former and present) that they may be contacted by the DQA surveyor?

☐ Yes ☐ No Are you accredited by any organizations, other than DQA? *If "yes," identify accreditation organization and provide accreditation identification.*

☐ Yes ☐ No Does your agency have a contract with the 51.42 Board? *If "yes," identify county / counties.*

☐ Yes ☐ No Have you every operated a residential facility, health care facility, or day care program for adults or children in Wisconsin or in any other state? *If "yes," explain and provide relevant information.*

## D. Disclosure of Ownership

**Required Supporting Documentation –** *Submit these required documents, when applicable:*

☐ 1. List of names, principal business address, and percentage of ownership interest of all officers, directors, stockholders owning 5% or more of stock, members, partners, or others having authority or responsibility for the operation of the organization. For non-profit or governmental organizations, list the names and principal business addresses of all officers and board members.

☐ 2. A diagram reflecting the ownership structure and names of any affiliate organization associated with the entity owner (parent corporations, other LLC, partnership, etc.)

☐ **If there are no additional owners, check here.**

## E. Entity Owner Attestation

I hereby attest that all staff know and understand the rights of the clients that they serve and the procedures of informal and formal resolution and have read Wis. Admin. Code chs. DHS 92 and 94. The above-named program has appropriate policies to meet Wis. Admin Code chs. DHS 92 and 94 to ensure patient rights, patient records, confidentiality, and informed consent. The program has a designated client rights specialist who is trained in compliance with the requirements of Wis. Admin. Code chs. DHS 92 and 94, Wis. Stat. ch. 51, and federal HIPAA requirements in 45 CFR 164 Part E and 42 CFR Part 2, as applicable.

I attest, under penalty of law, that the information provided in this application and in attached application materials is truthful and accurate to the best of my knowledge and that knowingly providing false information or omitting information may result in a fine of up to $10,000 or imprisonment not to exceed six years, or both (Wis. Stat. § 946.32).

I attest that I will comply with all laws, rules, and regulations governing program certification in Wisconsin.

| **SIGNATURE** – Owner or Board Member *(Full signature is required.)* ➢ | Date Signed |
|---|---|
| Name – Owner or Board Member *(Print or type.)* | Title – Owner or Board Member |

## F. Entity Owner Transfer of Responsibility to Request Future Changes and Clinical Operations

The individual in the role specified below is given full authority to request initial services and branches, service additions and deletions, staff changes, branch location additions and deletion, and all operational changes submitted to the department.

*Check applicable role*: ☐ Program Contact ☐ Program Director / Administrator ☐ Clinical Coordinator

| **SIGNATURE** – Owner or Board Member *(Full signature is required.)* ➢ | Date Signed |
|---|---|
| Name – Owner or Board Member *(Print or type.)* | Title – Owner or Board Member |

## II. INITIAL SERVICES CERTIFICATION

*Indicate which services will be offered; review and complete the section fully; and, submit the specified additional documentation.*

### ☐ DHS 40 – Mental Health Day Treatment Services for Children

**A. Type of Organization** *(See Wis. Admin. Code §§ DHS 40.03(10) and (20) for definitions.)*

☐ Community-based program ☐ Intensive hospital-based program

**B. Required Supporting Documentation** *(Submit these required documents specific to Wis. Admin. Code ch. DHS 40.)*

☐ Program description outlining each item listed in Wis. Admin. Code § DHS 40.04(1)(b)2.c

☐ Policies and procedures that meet the requirements of Wis. Admin. Code § DHS 40.07(1)

The following documents showing compliance with Wis. Admin Code chs. SPS 361-366 per Wis. Admin. Code § DHS 40.04(1)(b)2.c.6:

***If existing building:***

☐ Municipal zoning approval documentation or occupancy permit

***If new building construction or newly remodeled building:***

☐ 1. State agency or municipal agent **plan review approval letter** (written, signed) that specifically identifies compliance with the Wisconsin Commercial Building Code (Wis. Admin. Code chs. SPS 361-366) and accessibility requirements (ADA). Link to Wisconsin Municipalities with Commercial Buildings Delegated Authority

☐ 2. State agency or municipal agent **inspection report** (written, signed) that specifically identifies compliance with the Wisconsin Commercial Building Code (Wis. Admin. Code chs. SPS 361-366) and accessibility requirements (ADA).

☐ 3. DQA form F-62495, *Compliance Statement*, completed by the owner and representative design professional that specifically identifies compliance with the Wisconsin Commercial Building Code (Wis. Admin. Code chs. SPS 361-366) and accessibility requirements (ADA).

**C. Attestation**

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 DHS 40 services, including Wis. Admin. Code chs. DHS 92 and 94 and Wis. Stat. ch. 51. The signatory of this document is duly authorized by the licensee / certificate holder to sign this agreement on its behalf. The certificate holder hereby accepts responsibility for knowing and ensuring compliance with all licensing, operational, and requirements for this facility.

I attest under penalty of law that the information provided above is truthful and accurate to the best of my knowledge.

I understand that knowingly providing false information or omitting information may result in denial of licensure, a fine of up to $10,000 or imprisonment not to exceed six years, or both (Wis. Stat. § 946.32).

| **SIGNATURE** – Entity Owner, Representative, or Authorized Representative Specified Above ➢ | Date Signed |
|---|---|
| Full Name *(Print or type.)* | Title |

## ☐ DHS 50 – Youth Crisis Stabilization Facility (YCSF)

***Note:*** *Per Wis. Stat. § 51.042(2)(a), the department may limit the number of certifications it grants to operate a YCSF. Before applying for certification, perspective providers must receive approval from the Division of Care and Treatment Services (DCTS).*

### A. Required Supporting Documentation *(Submit these required documents specific to Wis. Admin. Code ch. DHS 50.)*

- ☐ **DCTS approval letter**
- ☐ A program statement, as specified under Wis. Admin. Code § DHS 50.05
- ☐ A copy of the YCSF's policies and procedures, as specified under Wis. Admin. Code DHS 50.06
- ☐ A floor plan of the YCSF specifying dimensions, exits, and planned room usage *[See §§ DHS 50.15(2) and (6).]*
- ☐ All inspection reports completed during the last 12 months, as defined in Wis. Admin. Code §§ 50.15-50.18
  - ☐ 1. If private water supply, annual well water test results *[See Wis. Admin. Code § DHS 50.15(3)(a)2.]*
  - ☐ 2. If private sewer system, sewer test results indicating system is sized appropriately for intended use *[See Wis. Admin. Code § DHS 50.15(3)b.]*
  - ☐ 3. Annual inspection of smoke detection system *[See Wis. Admin. Code § DHS 50.17(1).]*
  - ☐ 4. Annual fire inspection *[See Wis. Admin. Code § DHS 50.17(4).]*
- ☐ Proof of building insurance *[See Wis. Admin. Code § DHS 50.03(2)(h).]*
- ☐ Proof of risk and liability insurance *[See Wis. Admin. Code § DHS 50.03(2)(h).]*
- ☐ Proof of vehicle insurance, if transporting youth *[See Wis. Admin. Code § DHS 50.03(2)(h).]*
- ☐ Payment of any forfeitures, fees, assessments related to any licenses or certifications issued by the department to the applicant, or a written statement signed by an authorized representative stating that no fees, forfeitures, assessments are owed

The following documents showing compliance with Wis. Admin. Code chs. SPS 361-366 per Wis. Admin. Code DHS 50.15(1):

***If existing building:***

- ☐ Municipal zoning approval documentation or occupancy permit

***If new building construction or newly remodeled building:***

- ☐ 1. State agency or municipal agent **plan review approval letter** (written, signed) that specifically identifies compliance with the Wisconsin Commercial Building Code (Wis. Admin. Code chs. SPS 361-366) and accessibility requirements (ADA). Link to Wisconsin Municipalities with Commercial Buildings Delegated Authority
- ☐ 2. State agency or municipal agent **inspection report** (written, signed) that specifically identifies compliance with the Wisconsin Commercial Building Code (Wis. Admin. Code chs. SPS 361-366) and accessibility requirements (ADA)
- ☐ 3. DQA form F-62495, *Compliance Statement*, completed by the owner and representative design professional that specifically identifies compliance with the Wisconsin Commercial Building Code (Wis. Admin. Code chs. SPS 361-366) and accessibility requirements (ADA)

### B. Attestation

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 DHS 50 services, including Wis. Admin. Code chs. DHS 92 and 94 and Wis. Stat. ch. 51. The signatory of this document is duly authorized by the licensee / certificate holder to sign this agreement on its behalf. The certificate holder hereby accepts responsibility for knowing and ensuring compliance with all licensing, operational, and requirements for this facility.

I attest under penalty of law that the information provided above is truthful and accurate to the best of my knowledge.

I understand that knowingly providing false information or omitting information may result in denial of licensure, a fine of up to $10,000 or imprisonment not to exceed six years, or both (Wis. Stat. § 946.32).

| **SIGNATURE** – Entity Owner, Representative, or Authorized Representative Specified Above | Date Signed |
|---|---|
| ➢ | |
| Full Name *(Print or type.)* | Title |
| | |

## Mental Health or Substance Use Treatment Provider Initial Certification Application – DHS 40 and DHS 50
## QUALIFIED STAFF ROSTER – MAIN LOCATION

**NOTE:** 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 and direct contact with clients of the entity.

| Name | Position Title (e.g., Clinical Administrator) | Professional Credential (e.g., LCSW) | DSPS License No. (if applicable) | Hours Per Week Per Service Type | |
|---|---|---|---|---|---|
| | | | | DHS 40 | DHS 50 |
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## III. BRANCH LOCATIONS

*If applying for certification for multiple branch locations, submit a separate copy of this page and a separate roster page for each branch location.*

***NOTE: A school district may not be named as a branch location**. Each physical school location providing services must be listed as a branch. Tier 3 school branch surveys will be conducted virtually when possible.*

### A. Branch Information – DHS 40 ONLY

| Name – Branch Location | | Telephone No. | |
|---|---|---|---|
| Street Address | City | State | Zip Code |

Intensity

☐ Tier 1 (less than 20 treatment hours per week)
☐ Tier 2 (20 or more treatment hours per week)
☐ Tier 3 (certified school)
☐ Tier 4 (non-certified school)

Distance from Main Office

_____ Miles

### B. Tier 3 Only: School District Information

Name – School District

| Street Address – School District Administrative Office | City | State | Zip Code |
|---|---|---|---|

### C. Required Supporting Documentation *(Submit these required documents specific to each branch.)*

☐ Schedule indicating days and hours when this branch office is open for psychotherapy or substance abuse counseling

☐ Documentation describing how consumer records are stored

☐ Description of the policies of oversight for the clinic administrator and of the policies for collaboration and/or supervision in the branch office

☐ **Tier 3 School Branch Only:** Memorandum of understanding between certified clinic and the school delivery service site which addresses points 1-12 in DQA Memo 13-020, *Addendum to Division of Quality (DQA) Assurance Outpatient Mental Health and Substance Abuse Program Branch Office Policy*

### D. Attestation

I attest that all statements made on this form are true and correct to the best of my knowledge.

| **SIGNATURE** – Entity Owner, Representative, or Authorized Representative Specified Above<br>➢ | Date Signed |
|---|---|
| Full Name *(Print or type.)* | Title |

## Mental Health or Substance Use Treatment Provider Initial Certification Application – DHS 40 ONLY

## QUALIFIED STAFF ROSTER – BRANCH LOCATION

- *If applying for certification for multiple branch locations, submit a separate copy of this page and a separate copy of page 8 for each branch location.*
- ***NOTE:*** *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 and direct contact with clients of the entity.*

Name – Branch Location

| **Name** | **Position Title** (e.g., Clinical Administrator) | **Professional Credential** (e.g., LCSW) | **DSPS License No.** (if applicable) | **Hours Per Week at This Branch** |
|---|---|---|---|---|
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## IV. BIENNIAL FEES

- Submit check with application materials.
- Make checks payable to: **DHS / Division of Quality Assurance**
- All fees are non-refundable.

| Service Type | Number of Branch Locations | Fees *(See fee tables below.)* |
|---|---|---|
| DHS 40 ***or*** DHS 50 | | $ |
| DHS 40 ***and*** DHS 50 | | $ |
| Tier 1 Branch Location(s) | | $ |
| Tier 2 Branch Location(s) | | $ |
| Tier 3 Branch Location(s) * | | $ |
| Tier 4 branch locations are not certified, but will be listed as requested. There is no fee for listing Tier 4 locations. | | |
| | **TOTAL FEES DUE** | $ |

***** At the biennial recertification, there will be a discount for school branch fees based on number of active Level 3 branches.

| Biennial Fee Table<br>Initial DHS Services / Programs | |
|---|---|
| DHS 40 ***or*** DHS 50 | $ 1,100.0 |
| DHS 40 ***and*** DHS 50 (2) | $ 1,600.00 |

| Biennial Fee Table<br>Initial Branch Locations | |
|---|---|
| Tier 1 Branch | $ 400.00 each |
| Tier 2 Branch | $ 1,000.00 each |
| Tier 3 School Branch | $ 400.00 each |