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| **DEPARTMENT OF HEALTH SERVICES**  Division of Care and Treatment Services  F-02595 (10/2020) | |  | | | **STATE OF WISCONSIN**  Wis. Admin Code. § DHS 50.03 (4)(c) |
| **REQUEST FOR APPROVAL YOUTH CRISIS STABILIZATION FACILITIES (YCSF) CERTIFICATION APPLICATION** | | | | | |
| This form is intended to be used by all applicants to complete the first step to obtain approval to apply for certification for an YCSF from the Department of Health Services, Division of Care and Treatment Services (DHS-DCTS).  **NOTE:** Upon approval from the DHS-DCTS applicants must complete the Initial Certification application per [Wis. Admin. Code § DHS 50.03](https://docs.legis.wisconsin.gov/code/register/2019/767A2/register/emr/emr1922_rule_text/emr1922_rule_text) through the [Division of Quality Assurance](https://www.dhs.wisconsin.gov/regulations/mh/youth-crisis-stab-fac.htm) (DQA). | | | | | |
| Name of Organization (Required)  Click or tap here to enter text. | | | | | |
| If any, list certified county crisis program the YCSF will be partnered with. [(Wis. Admin. Code ch. DHS 34)](https://docs.legis.wisconsin.gov/code/admin_code/dhs/030/34) | | | Indicate effective date organization intends to provide services. | | |
| Click or tap here to enter text. | | | Click or tap to enter a date. | | |
| **Complete the Following Questions by Providing a Narrative Response** | | | | | |
| 1. **Physical Location and Current Use**  * Provide a description of the proposed YCSF location, including address if known.   Click or tap here to enter text.   * Describe the current crisis related resources within the geographical area, including any other certified YCSFs.   Click or tap here to enter text.   * How does the agency plan to coordinate and work in collaboration with the listed resources to provide a full continuum of care for youth crisis stabilization and treatment?   Click or tap here to enter text.   * Describe any other planned use of the YCSF if it is not a stand-alone facility.   Click or tap here to enter text. | | | | | |
| 1. **Program Design**  * Describe the organization’s criteria for admission.   Click or tap here to enter text.   * Describe the ages and gender of youth intended to be served and how bedrooms will be allocated.   Click or tap here to enter text.   * Describe the proposed schedule of the program. Include total hours of therapy, recreation, education, etc. each day.   Click or tap here to enter text.   * Describe the plan for utilization review and determination of length of stay within the YCSF.   Click or tap here to enter text.   * Describe the brief therapeutic interventions that will be used to stabilize the mental health crisis and support the youth in a trauma informed manner.   Click or tap here to enter text.   * How does the YCSF intend to implement trauma informed strategies, evidence-based practices and skill building initiatives to support the youth in achieving positive outcomes?   Click or tap here to enter text.   * What specific evidence-based practices will be used and how will these practices be implemented to fidelity?   Click or tap here to enter text.   * Describe the organization’s policy to address medical emergencies and safety concerns specific to the youth being served. Explain the criteria utilized and process if the YCSF is not able to meet the needs of the youth.   Click or tap here to enter text.   * How will the YCSF connect youth and their families to outside resources to establish a safe transition out of the YCSF?   Click or tap here to enter text.   * What criteria will be utilized to determine time of discharge?   Click or tap here to enter text.   * Describe the staffing plan for the YCSF under [WI Admin. Code § DHS 50.07](https://docs.legis.wisconsin.gov/code/admin_code/dhs/030/50/ii/07). Provide a description of roles, responsibilities, and scheduling. Include the type of credential and training that will be required of the positions.   Click or tap here to enter text. | | | | | |
| Please provide contact information for questions about the proposed qualification for the YCSF outlined in this document: | | | | | |
| County/Tribe/Nonprofit 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 | | | | |
| Submit Form To: Email: [dhsdctsycsf@dhs.wisconsin.gov](mailto:dhsdctsycsf@dhs.wisconsin.gov)  Mailing Address: Department of Health Services  Division of Care and Treatment Services  PO Box 7851  Madison, WI 53707 | | | | | |