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| **DEPARTMENT OF HEALTH SERVICES**  Division of Quality Assurance  F-02788 (04/2021) | | | | **STATE OF WISCONSIN**  Page 1 of 2 | | | |
| **CERTIFIED NARCOTIC TREATMENT SERVICE FOR OPIATE ADDICTION:**  **MEDICATION UNIT APPLICATION** | | | | | | | |
| * Questions regarding this form may be directed to the Division of Quality Assurance (DQA), Behavioral Health Certification Section (BHCS) at 608-261-0656. * Return completed form and required fee to: DHS DQA - Behavioral Health Certification Section / PO Box 2969 / Madison, WI 53701-2969. The fee for each medication unit is $500. * After the completed application and fee is received a BHCS surveyor will contact you to arrange a date and time for an onsite survey. * Medication unit means a facility established as part of a service but geographically separate from the service, from which licensed private practitioners and community pharmacists are:   1. Permitted to administer and dispense a narcotic drug.   2. Authorized to conduct biochemical monitoring for narcotic drugs. | | | | | | | |
| GENERAL INFORMATION: MAIN CLINIC | | | | | | | |
| MAIN CLINIC INFORMATION | | | | | | | |
| Name – Main Clinic | | | | | Certification Number | | |
|  | | | | |  | | |
| Phone Number | Fax Number | | | Email Address (Contact Person) | | | |
|  |  | | |  | | | |
| Street Address | | City | | County | | State | Zip Code |
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| MEDICATION UNIT INFORMATION | | | | | | | |
| If applying for certification for multiple medication unit locations, submit a separate application and fee for each one | | | | | | | |
| Medication Unit Information | | | | | | | |
| Name – Medication Unit | | | | | Phone Number | | |
|  | | | | |  | | |
| Street Address | | | City | | | State | Zip Code |
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| Distance from Main Office:       miles  Total number of patients to be served by the primary facility and medication unit:       patients  Total number of patients that will be served only at this medication unit:       patients | | | | | | | |
| Required Supporting Documentation *(submit these required documents specific to this medication unit)* | | | | | | | |
| Schedule indicating days and hours when this medication unit office is open  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 medication unit  Copy of the SMA-162 form that was submitted to SAMHSA adding a medication unit  Description of how the medication unit receives the medication supply  Diagram and description of the facilities to be used as a medication unit  Justification for need to establishing a medication unit | | | | | | | |
| Attestation | | | | | | | |
| Check to confirm agreement with each attestation statement and sign in the section below.  I attest that the medication unit is limited to administering and dispensing the narcotic treatment drug and collecting samples for drug testing or analysis  I attest that the sponsor agrees to retain responsibility for patient care  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 | | | | | Date Signed | | |
|  | | | | |  | | |
| Full Name *(Print or type)* | | | | Title | | | |
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| QUALIFIED STAFF ROSTER – MEDICATION UNIT | | | | |
| * If applying for certification for multiple medication units, submit a separate application for each unit * **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 Number**  (if applicable) | **Hours Per Week at This Med Unit** |
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