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| **DEPARTMENT OF HEALTH SERVICES**Division of Quality AssuranceF-03082B (08/2022)  | **STATE OF WISCONSIN** |
| **SUBSTANCE USE TREATMENT PROVIDER****INITIAL CERTIFICATION (or) CHANGE OF OWNERSHIP APPLICATION****DHS 75.59- Opioid Treatment Program**Questions regarding this form may be directed to the Division of Quality Assurance (DQA), Behavioral Health Certification Section (BHCS) at DHSDQAMentalHealthAODA@dhs.wisconsin.gov or 608-261-0656**.**Submission of this information is required by Wis. Stat. §§ 50.065 and 51.45 and Wis. Admin. Code chs. DHS 75. 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).* 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 [Regulated Entity Background Check Process](https://www.dhs.wisconsin.gov/misconduct/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.
4. The entity owner background check process in Step 1 is completed and the final report is available to the Behavioral Health Certification Section.
5. The department verifies applicant is not liable for delinquent taxes or delinquent unemployment insurance contributions as specified in Wis Stat. § 51.032(4).

Email application to DHS DQA Mental Health and Substance Use Certification and mail the appropriate fees to the address below. You also may print and mail the completed applications and mail the appropriate fees to the address below. **DHS / DQA / Behavioral Health Certification Section** **PO Box 2969****Madison, WI 53701-2969** |
| **STEP 3 – ONSITE SURVEY** |
| * The BHCS Surveyor will contact you with 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](https://www.dhs.wisconsin.gov/publications/p6/p63174.pdf).
* 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.
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| **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 and at all branch office and/or medication unit locations. |
| **I. GENERAL INFORMATION – ENTITY / ENTITY OWNER REQUESTING CERTIFICATION** |
| [ ]  Initial Certification[ ]  Change of Ownership– *Provide current certification number*:       |
| **FACILITY GENERAL INFORMATION** |
| Facility Name (Should match signage and Medicaid enrollment, if applicable)      |
| Facility Street Address      | Location – Street Address / Room No.      | City      | Zip Code      | County      |
| Facility Phone Number      | Facility Fax Number      | Facility Web Address           |
| 1. **FACILITY CONTACT INFORMATION**
 |
| Name Contact Person      | Will the facility obtain Medicaid certification? [ ]  Yes [ ]  No | Facility NPI Number (if known)      |
| Contact Phone Number      | Contact Email Address      |
| Physical Street Address      | City      | County      | State      | Zip Code      |
| 1. **DESIGNATED MAIL RECIPIENT**
 |
| Check and provide requested information for all that apply. |
| Name – Designated Mail Recipient      | Title      | Email Address      |
| Mailing Address – Street or PO Box (if different from above)      | City      | State      | Zip      |
| 1. **ENTITY OWNER INFORMATION**
 |
| Type of Entity (Check only one.) |
| [ ]  Church[ ]  Corporation – Business[ ]  Corporation – Non Profit | [ ]  Government – County[ ]  Government – State[ ]  Government – Other | [ ]  Tribal[ ]  Limited Liability Corp (LLC)[ ]  Proprietorship (Individual) | [ ]  Partnership[ ]  Other – *Specify below:* |
|  |  |  |       |
| Name – Direct Owner, Legal Entity) | FEIN\* – Legal Entity     NPI Number      |
| 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      |
| Signature | Title      |

**If partnership, complete for 2nd owner.**

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| Name – (Direct Owner, 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      |
| Signature | Title      |

\* *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.*

Are you accredited by any organizations, other than DQA? [ ]  YES [ ]  NO

If “yes,” identify accreditation organization and provide accreditation identification.

Does your agency have a contract with the Wis. Stat. *§* 51.42 Board? [ ]  YES [ ]  NO

If “yes,” identify county / counties.

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? [ ]  YES [ ]  NO

If “yes,” explain and provide relevant information.

List any other DHS/DQA certifications or licenses and provide identification (cert number, name, etc.) and relevant information.

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| 1. **Disclosure of Ownership**
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| **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.
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| [ ]  | 1. A diagram reflecting the ownership structure and names of any affiliate organization associated with the entity owner (parent corporations, other LLC, partnership, etc.).
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| [ ]  | 1. **If there are no additional owners, check here.**
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| 1. **Entity Owner Attestation**
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| 1. 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.
 |
| 1. I hereby attest that all personnel/employees/caregivers have had a caregiver background check completed in accordance with procedures in s. 50.065 Stats. and ch. DHS 12 at the time of hire, employment, or contract, and every 4 years thereafter and records of the completed caregiver background checks shall be available upon request at the service for review by the department.
 |
| 1. I hereby attest that all personnel/employees/caregivers have a signed statement regarding confidentiality of applicable provisions of 42 CFR Part 2, 45 CFR Parts 164 and 170, ss. 51.30, 146.816 and 146.82 Stats. (DHS 75.21).
 |
| 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      | Title – Owner or Board Member      |
| **Signature** – Partner if Applicable *(Full signature is required,* *If Partnership, both owners must sign).* | Date Signed      |
| Name – Owner or Board Member      | Title – Owner or Board Member      |

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| **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[ ]  Service Director[ ]  Medical Director [ ]  Clinical Supervisor[ ]  Program Sponsor |
| **Signature** – Owner or Board Member *(Full signature is required)* | Date Signed      |
| Name – Owner or Board Member      | Title – Owner or Board Member      |
| **Signature** – Partner if Applicable *(Full signature is required,* *If Partnership, both owners must sign).* | Title – Owner or Board Member      |

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| 1. **Required DHS 75 Facility Positions**
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| Name | Telephone Number | Email Address |
| Program Sponsor required per DHS 75.59(3)(q)      |       |       |
| Medical Director required per DHS 75.59(5)(b)      |       |       |
| Clinical Supervisor required per DHS 75.18(2)(a)      |       |       |
| Client Rights Specialist per DHS 94.40(3)      |       |       |
| Record Custodian per DHS 92.03(1)(c)      |       |       |

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| **II. INITIAL SERVICES CERTIFICATION** |
| DHS 75.59 service; review and complete the section fully; and submit the specified additional documentation. |
| [ ]  DHS 75.59- Opioid Treatment Program |
| Indicate populations served: [ ]  Adults (Ages over 18)[ ]  Minors (Under the age of 18)[ ]  Transitional-age youth (ages 16-24) |
| **Clinic Director - See DHS 75.59(5)(a)** |
| Name      | Telephone      | Email      |
| List Professional License # or Certification # if applicable:      |
| List Qualifications including applicable professional licenses or certifications:      |
| List Duties:      |

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| **B. Required Supporting Documentation (Submit these required documents specific to Wis. Admin. Code ch. DHS 75.59)** |
| [ ]  All policies and procedures for Prevention Service – See DHS 75.59[ ]  Provide DHS 75.50 certificate number or DHS 75.50 application submission informationWas all required information submitted to the SOTA per DHS 75.59(22)? [ ]  Yes [ ]  NoDo you have a qualified Medical Director per DHS 75.59(5)(b)? [ ]  Yes [ ]  No[ ]  If NO, submit the specific plan for the person to acquire equivalent training and skills within 4 months after beginning employment, a copy of the Federal exception approved by SAMHSA (and) the SOTA to 42 CFR 8.12(b), (h), and (i) shall be physically present at the OTP at least 40% of the time the program administers or dispenses medication in order to comply with s. DHS 94.08, assure regulatory compliance, and carry out duties specifically assigned by regulation as required by SAMHSA under 42 CFR 8.12. \*NOTE: OTPs in the first 60 days of operation may reduce the time requirement the medical directors must be present on-site to at least 20% of the time that the program administers or dispenses medications. On the 61st day of operation, the service shall be subject to the requirements of this rule.[ ]  Submit staffing information per DHS 75.59(5)( e) to demonstrate compliance with staffing ratio- 1 full-time clinician (SAC, SAC-IT, LMFT, LPC, LCSW or CSAC) at 40 hours per week for every 55 enrolled patients. Do you service minors per DHS 75.59(6)(a)(2)? [ ]  Yes [ ]  No. If YES, submit policies and procedures per DHS 75.22(6) and (7). \*What department approved placement criteria are you using per DHS 75.23(2)? [ ]  ASAM [ ]  UPC [ ]  OTHER (Please submit copy)[ ]  \*ALSO- REQUIRED PER DHS 75.59(2) – APPLY FOR DHS 75.50 service. SEE ADDITIONAL APPLICATION: <https://www.dhs.wisconsin.gov/forms/f03082a.docx> |

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| **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 75.59 services, including Wis. Admin. Code chs. DHS 92, DHS 94, DHS 12, DHS 13, 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).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 | Date Signed      |
| Full Name      | Title      |

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| **III. Staff Roster** |

**Program Staff Roster**

**Main Clinic – Part 1 of 2**

Pursuant to Wis. Stat. s. 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, direct contact with clients of the entity.

Examples of caregivers include: Service Director, CSAC, LCSW, Receptionist, Volunteers, Peer Specialists, Recover Coaches, Security Guards, SAC-IT, etc.

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| **Name**(Last, First) | **Position** **Title**(Example: Service Director, Clinical Supervisor, Receptionist) | **Professional** **Credential** (Example: LCSW, CSAC, SAC-IT) | **DSPS** **Lic.** **No.**(as applicable) | Individual NPI No. |
|       |       |       |       |       |
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**BHCS Program Staff Roster**

**Main Clinic – Part 2 of 2**

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| **Name**(Last, First) | **List each service certified at this location in the column header. Example, DHS 75.49, DHS 75.51, DHS 75.15.****For each person, list the hours per week spent for each program service.****\*\* Align individual names with Part 1 of 2 on previous page. \*\*** |
| *List Service #1*      | *List Service #2*      | *List Service #3*      | *List Service #4*      | *List Service #5*      | *List Service #6*      | *List Service #7*      | *List Service #8*      | *List Service #9*      |
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| **IV. ANNUAL FEES** |
| * Submit check with application materials
* Make checks payable to: **DHS / Division of Quality Assurance**
* All fees are non-refundable
 |
| **Service Type** | **Fees** |
| DHS 75.59 | $550 |
| **Total Fees Due**  | $550 |