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| **DEPARTMENT OF HEALTH SERVICES**  Division of Quality Assurance  F-03082D (08/2022) | **STATE OF WISCONSIN** |
| **SUBSTANCE USE TREATMENT PROVIDER**  **INITIAL CERTIFICATION (or) CHANGE OF OWNERSHIP APPLICATION**  **DHS 75.60 – Office-Based Opioid Treatment** | |
| Questions regarding this form may be directed to the Division of Quality Assurance (DQA), Behavioral Health Certification Section (BHCS) at [DHS DQA Mental Health AODA](mailto: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 CHECK (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 BCHS 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](mailto:dhsdqamentalhealthandsubstanceusecertification@dhs.wisconsin.gov) 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. | |
| **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. | |

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| 1. **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 Telephone Number | | | Facility Fax Number | | | | | | | | | Facility Web Address | | | | | |
| 1. **FACILITY CONTACT INFORMATION** | | | | | | | | | | | | | | | | | |
| Name Contact Person | | | Will program 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 Code | |
| 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 | | | | | | | | | | | |
| Name – Owner / Board Member | | | | | | SSN\* - Owner or Board Member | | | | | | | | | | | |
| Address – Street | | City | | | | State | | | | | | | | Zip Code | | | |
| Phone – 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 |
| Phone – 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. § 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 ever 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** | |
| **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. |
|  | 1. A diagram reflecting the ownership structure and names of any affiliate organization associated with the entity owner (parent corporations, other LLC, partnership, etc.). |
|  | 1. If there are no additional owners, check here. |

Name of Business Organization *(if any)* that owns the Direct Owner of Certified Entity below

Note: Often referred to as the ‘grandparent’ level owner

Licensee Representative

Must be Individual Owner, both partners if Partnership, or Board Member Representative as specified and signed on Page 5 and as applicable on Pages 5 and 8

**Note: This representative(s) must submit an entity background check with ‘Licensee’ role selected as specified in Step 1 on Page 1**

List of Board Members, may refer to separate list supplied in #1 above

Note: Not applicable to Individual or Partnership Owners

If needed, list on separate document

Direct Owner of Facility listed on Page 2 as the Direct Owner, Legal Entity

Type of Entity: Individual, Partnership, LLP, LLC, Corporation, Nonprofit, etc. listed on Page 2

Name of Certified Entity which matches the Facility Name specified on Page 2, Facility General Information. Facility NPI number as supplied on Page 2.

*(This is the name of main location of program requesting certification and match signage used by clients and patients)*

List of other entities owned and licensed/certified by DHS Division of Quality Assurance as requested on Page 3

If known, supply license/certificate number

If needed, list on separate document

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| 1. **ENTITY OWNER ATTESTATION** | | |
| 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 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 |
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| 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 |
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| Name – Owner or Board Member | Title – Owner or Board Member | |

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| 1. **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 | Clinical Supervisor | | |
| **Signature** - Owner or Board Member *(Full signature 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 |

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| 1. **REQUIRED DHS 75 FACILITY POSITIONS** | | |
| Name | Phone Number | Email Address |
| Client Rights Specialist – required per DHS 94.40(3) |  |  |
| Record Custodian – required per DHS 92.03(1)(c) |  |  |

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| 1. **INITIAL SERVICES CERTIFICATION** | | | | |
| *Indicate which services will be offered; review and complete the section fully; and, submit the specified additional documentation.* | | | | |
| **DHS 75.60 – Office-Based Opioid Treatment Service** | | | | |
| 1. **REQUIRED POSITIONS** | | | | |
| **Service Director – See DHS 75.60(6)(a)** | | | | |
| Name | Telephone Number | | Email Address | |
| List Professional License # or Certification # if applicable: | | | | |
| List Qualifications including applicable professional licenses or certifications: | | | | |
| List Duties: | | | | |
| **Prescriber – See DHS 75.60(2)** | | | | |
| Name | Telephone Number | | Email Address | |
| List Professional License # or Certification # if applicable: | | | | |
| List Qualifications including applicable professional licenses or certifications: | | | | |
| List Duties: | | | | |
| 1. **REQUIRED SUPPORTING DOCUMENTATION**(Submit these required documents per Wis. Admin. Code ch DHS 75) | | | | |
| 1. All policies and procedures for DHS 75.60. 2. Is the location of the OBOT a stand-alone-office based opioid treatment clinic, a private office, or a public sector clinic setting and treatment is not occurring in any location listed under DHS 75.60(1)? Please provide details on the location of the OBOT service. 3. Submit information on types of medications prescribed – use of buprenorphine – with or without naloxone, oral, extended release, injectable, or implanted. 4. Submit information on the use of naltrexone – oral, extended release, or injectable. | | | | |
| 1. **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 75.60 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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| 1. **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, Recovery 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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| 1. **BIENNIAL FEES** |
| Submit check with application materials.   * Make checks payable to: **DHS / Division of Quality Assurance.** * All fees are non-refundable. * If adding a service to an already existing certificate, full application fee for one service is required if the certificate is in year 1 of the 2-year biennial fee period. Half of the one service application fee is required if the certificate is in year 2 of the 2-year biennial fee period.   Example – Biennial Fee period is currently 04/01/2022 to 03/31/2024. If a new service is being added between 04/01/2022 and 03/31/2023, the full biennial fee for a new service is due, $1,100.00. If a new service is added between 04/01/2023 and 03/31/2024, only one half of the biennial fee for a new service is required, $550.00. |

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| **Service Type** | **Fees**  *(See fee table below.)* |
| DHS 75.60 | $ |
| **TOTAL FEES DUE:** | $ |

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| **Biennial Fee Table**  **Initial DHS Services / Programs** | |
| For each service being added at initial certification of adding in year 1 of biennial fee cycle | $1,100.00 |
| For each service adding in year 2 of biennial fee cycle | $550.00 |