**Department of Health Services State of Wisconsin**

Division of Quality Assurance Wis. Admin Code ch. 75.53-75.58

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|  |  |
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| **Residential Substance Use Treatment Services** | **Internal Use Only** |
| **(DHS 75.53, DHS 75.54, DHS 75.55, DHS 75.56, DHS 75.57, DHS 75.58) Initial Certification (Or) Change of Ownership Application** | Date Received: |

**Instructions:** Questions regarding this form may be directed to the Division of Quality Assurance (DQA), Behavioral Health Certification Section (BHCS) at [DHSDQAMentalHealthandSubstanceUseCertification@dhs.wisconsin.gov](mailto:DHSDQAMentalHealthandSubstanceUseCertification@dhs.wisconsin.gov)**.**

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.

### Before submitting this application

Please answer the questions below to determine if a Physical Environment Review if required:

1. Is the building/address associated with this application, currently licensed as a DHS 83 Community Based Residential Facility (CBRF) or currently a residential service that is licensed as a DHS 124 Hospital?

Yes  No

If **“Yes”** provide license number(s):

1. Will the above license remain active/open through the DHS 75 certification process?

Yes  No  N/A

If **“No”** to either question 1 or 2, a [Plan Approval application](https://www.dhs.wisconsin.gov/forms1/f6/f62333.docx) must be submitted to the [Office of Plan Review and Inspection (OPRI](https://www.dhs.wisconsin.gov/regulations/plan-review/forms.htm)). OPRI will conduct a Physical Environment Review to determine compliance with Wis. Admin. Codes §§ DHS 75.42, 75.43, 75.45, and 75.46. Physical Environment Review can take up to 45 working days for completion.

1. Are there any proposed building alterations/remodel?

Yes  No

If **“Yes”** a [Plan Approval application](https://www.dhs.wisconsin.gov/forms1/f6/f62333.docx) must be submitted to the [Office of Plan Review and Inspection (OPRI)](https://www.dhs.wisconsin.gov/regulations/plan-review/forms.htm). OPRI will conduct a Physical Environment Review to determine compliance with Wis. Admin. Codes §§ DHS 75.42, 75.43, 75.45, and 75.46. Physical Environment Review can take up to 45 working days for completion.

1. If there is no current CBRF license, are you also planning to apply for a DHS 83 CBRF license for the address associated with this application?

Yes  No

If **“Yes”** a [Plan Approval application](https://www.dhs.wisconsin.gov/forms1/f6/f62333.docx) must be submitted to the [Office of Plan Review and Inspection (OPRI)](https://www.dhs.wisconsin.gov/regulations/plan-review/forms.htm).

1. If there is no current Hospital license, are you also planning to apply for a DHS 124 Hospital license for the address associated with this application?

Yes  No

If **“Yes”** a [Plan Approval application](https://www.dhs.wisconsin.gov/forms1/f6/f62333.docx) must be submitted to the [Office of Plan Review and Inspection (OPRI)](https://www.dhs.wisconsin.gov/regulations/plan-review/forms.htm).

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|  | **Fees:** | | | Initial Physical Environment Review fee: | | | |  |
|  | Initial Physical Environment Review\* | **Fees based on project dollar value**  (Fee from table) | |  | **Fee based on project dollar value** | |  |  |
|  | **Estimated cost of work submitted** | **Fee** |  |
| Est. Cost: | $ |  | Less than $2,000 | $100 |  |
|  | $2,000 – $24,999 | $300 |  |
|  | **Please note:** Any building that does **not** have a current/active CBRF license or current/active residential service that is licensed as a DHS 124 Hospital associated with this service application is required to comply with current building/construction requirements.  \* Separate fees apply for Physical Environment Review submission. | | |  | $25,000 - $99,999 | $500 |  |  |
|  | $100,000 - $499,999 | $750 |  |
|  |  | $500,000 - $999,999 | $1,500 |  |  |
|  | $1,000,000 - $4,999,999 | $2,500 |  |
|  |  | $5,000,000 and over | $,5,000 |  |  |

### Step 1 – Initial application to BHCS and physical environment review/conditional approval

* Complete this application document and submit to BHCS.
* Submit [Plan Approval application](https://www.dhs.wisconsin.gov/forms1/f6/f62333.docx) to OPRI (if applicable).
* Submit fees for the initial physical environment review to BHCS (if applicable).
* When you receive the “Conditional Approval” from OPRI (as applicable), submit the Conditional Approval letter and provider fees to BHCS.

### Step 2 – Entity Owner Background Checks (ECBC) – Not applicable if adding a service to an existing certificate

* Complete an Entity Owner Background Check for the current year. For information on how to complete the EBC, visit [Regulated Entity Background Check Process.](https://www.dhs.wisconsin.gov/misconduct/entity.htm) EBC can take up to 10 business days after submission. If assistance is needed with EBC, contact the Office of Caregiver Quality (OCQ) at 608-261-8319.

\*The applicant submits background information documents and fee directly to OCQ. Background materials should not be submitted with this certification application.

### Step 3 – Finalizing application and fee requirements

Submit the OPRI Conditional Approval letter and provider fees to BHCS. Submit all supporting documents listed in Section F (below), including the Fit and Qualified application and requested documents in that application. BHCS staff will review the submitted documents to ensure completion and 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. Approved Background Check information
3. All supporting documentation as specified in the application including fit and qualified documents

Email application and supporting documents to: [DHS DQA Mental Health and Substance Use Certification](mailto:DHSDQAMentalHealthandSubstanceUseCertification@dhs.wisconsin.gov)

Mail the required physical environment fees and provider fees with “Initial App [Provider name, service type]” in the memo line to:

**DHS / DQA / BAL / Behavioral Health Certification Section**

**PO Box 2969**

**Madison, WI 53701-2969**

**Please Note:** All fees are non-refundable.

### Step 4 – 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](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 5 – 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 email a formal certificate to the provider for posting at the primary clinic location.

### General information – Entity/entity owner requesting certification

Initial certification  Change of ownership - Provide current certification number:

Adding service to existing certificate – Provide current certification number:

### Service(s) applying for:

DHS 75.53 – Transitional Residential Treatment Service

DHS 75.54 – Medically Monitored Residential Treatment Service

DHS 75.55 – Medically Managed Inpatient Treatment Service – *if already a residential service approved as a hospital under DHS 124, submit information under Section A only.*

DHS 75.56 – Adult Residential Integrated Behavioral Health Stabilization Service

DHS 75.57 – Residential Withdrawal Management Service

DHS 75.58 – Residential Intoxication Monitoring Service

### Facility general information

Facility name (Should match signage and Medicaid enrollment, if applicable):

Facility address – Street:

City:       State:       County:       ZIP code:

Facility phone number:       Facility fax number:

Facility web address:

Number of beds/capacity:

Identify genders served – (select one)

Male  Female  Both Male and Female

Choose ambulatory status of clients – (select one)

Ambulatory  Semi-ambulatory  Non-ambulatory

Are services provided to minors (per DHS 75.35)?

Yes  No

Are minors allowed to reside with the parent/guardian while the parent/guardian receives treatment services per DHS 75.36?

Yes  No

### A. Facility contact information

Name – Contact person:       Facility NPI number (if known)

Contact phone number:       Contact email address:

Will program obtain Medicaid certification?

Yes  No

Physical address – Street:

City:       State:       County:       ZIP code:

### B. 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:       County:       ZIP code:

### C. Entity owner information

Type of entity (check only one)

Church  Government - State  Proprietorship (Individual)

Corporation – Business  Government - Other  Partnership

Corporation – Non-Profit  Tribal  Other – Specify below:

Government - County  Limited Liability Corp (LLC)

Name – Owner (Individual/Partnership names) or Corporation (Legal Entity):

FEIN\* - Legal entity:

Name – Owner/Board member:

SSN\* – Owner/Board member:

Address – Street:

City:       State:       County:       ZIP code:

Phone number – Owner/Board member:       Fax – Owner/Board member:

Email address – Owner/Board member:

**Signature:** Title:

***If partnership, complete for second owner.***

Name – Direct owner, legal entity:

FEIN\* - Legal entity:

Name – Owner/Board member:

SSN\* – Owner/Board member:

Address – Street:

City:       State:       County:       ZIP code:

Phone number – 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.

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

### D. 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 where they need to identify the name, role, email, and/or phone number.

Check applicable role:

Program Contact  Service Director  Proprietorship (Individual)  Clinical Supervisor

**Signature** — Owner or Board Member (Full signature required)**:**

Name – Owner or board member:       Title:

Date signed:

**Signature** — Partner if applicable (Full signature required. If Partnership, both owners must sign)**:**

Name – Owner or board member:       Title:

Date signed:

### E. Required DHS 75 facility positions

|  |  |  |
| --- | --- | --- |
| Name | Phone number | Email address |
| Program Contact |  |  |
| Service Director |  |  |
| Medical Director |  |  |
| Clinical Supervisor |  |  |
| Client Rights Specialist |  |  |
| Record Custodian |  |  |

### F. Required supporting documentation (Submit with Step 3 above)

(Submit these required documents specific to Wis. Admin. Code ch. DHS 75.53 to DHS 75.58 – Subchapters 4-5-6)

|  |  |
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| * Submit all policies and procedures that are applicable to DHS 75 service choice(s) indicated above. To expedite the program/policy review process, please submit only the policies and procedures associated with regulatory requirements. * Physical Environment Review *Conditional Approval* Letter from OPRI (if applicable) * Staff Rosters completed | |
| The following items must be submitted during Step 3. | |
|  | A floor plan specifying dimensions of the facility, exits, and planned room usage – required per DHS 75.29(1)(a) |
|  | An explanation of the 24−hour staffing pattern for the service – required per DHS 75.29(1)(b) |
|  | A statement indicating whether the service will provide treatment services for patients that are non−ambulatory or semi−ambulatory. If a service provides treatment services for patients that are non−ambulatory or semi−ambulatory, the floor plan shall include ramped exits to grade – required per DHS 75.29(1)(c) |
|  | Municipal zoning approval or occupancy permit – required per DHS 75.29(1)(d) |
|  | The results of an approved fire inspection completed within the last 12 months – required per DHS 75.29(1)(e) |
|  | Fireplace and chimney inspections completed within the last 12 months, if applicable – required per DHS 75.29(1)(f) |
|  | The results of furnace inspection completed within the last 12 months – required per DHS 75.29(1)(g) |
|  | The results of smoke and heat detector inspection completed within the last 12 months – required per DHS 75.29(1)(h) |
|  | The results of sprinkler inspection completed within the last 12 months – required per DHS 75.29(1)(i) |
|  | Well water test results completed within the last 12 months, if applicable – required per DHS 75.29(1)(j) |
|  | Building emergency evacuation plan – required per DHS 75.29(1)(k) |
|  | A disaster recovery plan in the case of flood, gas leak, electrical outage, or other emergency – required per DHS 75.29(1)(l) |
|  | Service policies and procedures – required per DHS 75.29(1)(m) |
|  | Policy for service approach to assessment and treatment for concurrent tobacco use disorders – required per DHS 75.24(7) |
|  | Policy regarding a smoke-free environment – required per DHS 75.24(7) |
|  | Fit and Qualified Application, [Form F-03089,](https://www.dhs.wisconsin.gov/library/F-03089.htm) with required supporting documentation requested on form – required per DHS 75.29(1)(o) and DHS 75.30 |
|  | Policies and procedures - written plans for the provision of medical care for residents and written plan for providing emergency transportation for patients needing emergency medical services – required per DHS 75.37 |
|  | Policies and procedure regarding infection control program – required per DHS 75.40, refer to DHS 83.39 |
|  | Policies and procedures regarding guests and visitors – required per DHS 75.44 |
| **Per DHS 75.32 – General Facility Requirements** | |
|  | DHS 75.32(4)- Is the facility physically separated from other entities, programs, and services?  Yes  No Submit information accordingly. |
|  | Is the residential service facility’s living areas separate and secure to prevent non-resident entry?  Yes  No Submit information accordingly. |
| **Per DHS 75.35 – Residential Service for Minors** | |
| Will you be providing residential/inpatient treatment service to minors?  Yes  No | |
|  | If “yes”, submit information that the service maintains physically separate and secure living areas for minors and adults. |
|  | If “yes”, submit policy and procedure for addressing the educational needs of each participating minor. |
| **Per DHS 75.36 – Services for Parents with Residing Minors** | |
| Are minors allowed to reside at the facility while a parent or guardian receives treatment?  Yes  No | |
|  | If “yes”, submit policies and procedures that address the safety of minors, family services and supports, and behavioral expectations and interventions for residing minors and addressing the educational needs of each residing minor. |
| **Per DHS 75.37 – Emergency Medical Center** | |
|  | Submit policies and procedures and written plan for the provision of medical care for residents. |

### G. 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.
2. 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.
3. 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 required)**:**

Name – Owner or board member:       Title:

Date signed:

**Signature** — Partner if applicable (Full signature required. If Partnership, both owners must sign)**:**

Name – Owner or board member:       Title:

Date signed:

### H. Attestation – (Entity owner representative, or authorized representative specified above)

I hereby attest that all statements made in this application any submitted documents and facility policies 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**:**

Name – Owner or board member:       Title:

Date signed:

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| 1. **Staff roster** |

**Program Staff Roster**

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| --- | --- | --- | --- | --- |
| **Name**  (Last, First) | **Position** **title**  (Example: Service Director, Clinical Supervisor, Receptionist) | **Professional** **credential** (Example: LCSW, CSAC, SAC-IT) | **DSPS** **license** **number**  (as applicable) | **Hire date** |
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**Main Office – 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.

**BHCS Program Staff Roster**

**Main Office – 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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