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| **Department of Health Services**  Division of Care and Treatment Services  F-03385 (06/2025) | **State of Wisconsin**  Wis.Admin Code. § DHS 31.04(4)(a-b) |

# Request for Approval Crisis Urgent Care and Observation Facilities (CUCOF)

# 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 a CUCOF 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 31.04 through the Division of Quality Assurance (DQA).

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| Name of organization (required)  Click or tap here to enter text. | |
| If any, list any certified behavioral health programs the CUCOF will be partnered with. | 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 CUCOF location and the region in which it intends to operate within, include the address if known.

Click or tap here to enter text.

* Describe the current crisis related resources within the geographical region, including any other certified CUCOFs and psychiatric inpatient units.

Click or tap here to enter text.

* How does the agency plan to coordinate and work in collaboration with the county in which it operates?

Click or tap here to enter text.

* Describe any other current or planned use of the CUCOF building if it is not a stand-alone facility.

Click or tap here to enter text.

1. **Program design**

* Describe the organization’s eligibility for admission and how that will be communicated to persons in need of care and partners referring persons for care.

Click or tap here to enter text.

* Describe the population(s) intended to be served, including the number of client rooms and beds available and how beds are allocated within the CUCOF in secured spaces, non-secured spaces, and observation units, as applicable.

Click or tap here to enter text.

* Describe how the program will safely serve involuntary clients, those with acute behavioral health needs, substance use needs, and those at high risk of harm to self or others.

Click or tap here to enter text.

* Describe how care will be provided to persons with minor physical health conditions and how care will be coordinated for those with medical needs that can’t be met at the CUCOF.

Click or tap here to enter text.

* Describe the interventions and evidenced-based practices that will be used to meet the needs of persons in crisis in a trauma informed manner.

Click or tap here to enter text.

* Describe the organizations policy on prescribing and administering medication and identify which licensed pharmacy or pharmacies the organization plans on using.

Click or tap here to enter text.

* Describe the organization’s policy to address medical emergencies and safety concerns specific to the population being served. Explain the criteria utilized and process if the CUCOF is not able to meet the needs of the person.

Click or tap here to enter text.

* Describe the organization’s policy on the use of seclusion and restraint, including how staff will be trained in seclusion and restraint consistent with s. 51.61(1)(i)(1) and industry best practices.

Click or tap here to enter text.

* What criteria will be utilized to determine appropriateness for discharge and how will the CUCOF work with external partners to establish a coordinated discharge?

Click or tap here to enter text.

* Describe the staffing plan for the CUCOF under WI Admin. Code § DHS 31.09(2). 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 CUCOF outlined in this document.

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| Organization 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: [dhscucof@dhs.wisconsin.gov](mailto:dhscucof@dhs.wisconsin.gov)

Mailing address: Department of Health Services

Division of Care and Treatment Services

PO Box 7851

Madison, WI 53707