**Department of Health Services State of Wisconsin**

Division of Quality Assurance Wis. Admin Code ch. 31

F-03389 (06/2025) Page 1 of 4

|  |  |
| --- | --- |
| **Behavioral Health Certification Section**  **DHS 31 – Crisis Urgent Care and Observation Facilities Application** | **Internal Use Only** |
| Date received: |

**Instructions:** 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)**.**

Failure to provide complete and accurate information may result in denial of the application and/or delay in the process.

### 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 124 Hospital?

Yes  No

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

1. Will the above license remain active/open through the DHS 31 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. Code §§ DHS 31. 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 31. Physical Environment Review can take up to 45 working days for completion.

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).

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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 – Entity Owner Background Checks (ECBC) – Not applicable if adding to an existing certificate

* The applicant submits background information documents and fee directly to the Office of Caregiver Quality (OCQ). See below.
* **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 <http://dhs.wisconsin.gov/caregiver/entity.htm>.
* For assistance completing this form, call OCQ at 608-261-8319.

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

Initial certification

Adding service to existing certificate – Provide current certification number:

### 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:

### A. Facility contact information

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

Contact phone number:       Contact email address:

### B. Entity owner information (not applicable if adding to existing certification)

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.

**C. Population information**

Population to be served:

Adult  Minor

Number of beds:

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

(Submit these required documents specific to Wis. Admin. Code ch. 31)

|  |  |
| --- | --- |
| The following items must be submitted during Step 3. | |
|  | A floor plan of the proposed CUCOF which demonstrates all of the following: 1. Dimensions, exits, and planned room usage. 2. The proposed number of single-occupancy client rooms, double-occupancy client rooms, observation units, seclusion rooms, and private treatment spaces and the rationale for these numbers. 3. The floor plan, which shall demonstrate compliance with s. 51.61, Stats. and include all the following: a. An accessible and easily identified walk-in area for persons seeking immediate services to be triaged. b. A locked unit for service provision to accommodate clients under s. 51.15 Stats., which may also serve voluntary clients. c. Provides privacy for all clients. d. Provides safety for clients, visitors, and staff. |
|  | All inspection reports completed during the last 12 months, as required under s. DHS 31.26 (2). (f) Proof of building insurance, risk insurance, liability insurance, and agency-owned vehicle insurance if providing transportation. (g) Payment of any forfeitures, fees, or assessments related to any licenses or certifications issued by the department to the applicant, or a written statement signed by an authorized representative stating that no fees, forfeitures, or assessments are owed. |

### E. 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).
4. 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 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:

### F. Fees for the new provider: $       Biennial fee: $1,000.00

Mail the required fees with the “Initial App [Provider Name]” in the memo line to:

**USPS:**

Division of Quality Assurance

Behavioral Health Certification Section

PO Box 2969

Madison, WI 53701-2969

**Certified mail (recommended):**

Division of Quality Assurance

Behavioral Health Certification Section

1 West Wilson, Rm 450

Madison, WI 53703-3445