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| DEPARTMENT OF HEALTH SERVICES Division of Quality Assurance  F-62504 (11/2019) | | | | | **STATE OF WISCONSIN**  Page 1 of 2 | | | | | | | | | | |
| BEHAVIORAL HEALTH CERTIFICATION SECTIONINITIAL CERTIFICATION APPLICATION | | | | | | | | | | | | | | | |
| **INSTRUCTIONS**   * Questions regarding this form may be directed to **608-261-0656.** * Submission of this information is required by Wis. Stat. §§ 50.065 and 51.45 and Wis. Admin. Code chapters DHS 12, DHS 34 - 36, DHS 40, DHS 50, DHS 61 - 63, or DHS 75. Failure to provide complete and accurate information may result in denial of the application and /or delay in the process. * Collection of the applicant’s social security number (SSN) or federal employer identification number (FEIN) is required per Wis. Stat. § 73.0301. Failure to supply the number may result in denial of the application. This number will be disclosed only to the Department of Revenue for use in collection of tax delinquencies. * **Fees.** See Section III to determine fees. Make check payable to **“Division of Quality Assurance.”**   **ENTITY CAREGIVER BACKGROUND CHECKS (ECBC)**  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>. If you need assistance completing this form, call the Office of Caregiver Quality at 608-261-8319. | | | | | | | | | | | | | | | |
| I. GENERAL INFORMATION – Entity / Entity Owner Requesting Certification | | | | | | | | | | | | | | | |
| **Initial Certification**  **Change Of Ownership – Current Certification No.:** | | | | | | | | | | | | | | | |
| 1. **Entity Information** | | | | | | | | | | | | | | | |
| Name – Entity or Program | | | | | | | | | | | Will program obtain Medicaid certification?  Yes  No | | | | |
| Telephone No. | | Fax No. | | | | Web Address (if any) | | | | | | | | | |
| Physical Address – Street | | | City | | | | | | | County | | | State | Zip Code | |
| Mailing Address (if different from physical address) – Street or P.O. Box | | | | | | | | | 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 Corporation (LLC)  Proprietorship (Individual) | | | | | | | | Other *(Indicate below.)* | | |
|  | | |
| Name – Owner / Corporation (Legal Entity) | | | | | | | | | | | | FEIN – Legal Entity | | |
| Name – Owner / Board Member | | | | | | | | | | | | SSN – Owner / Board Member | | |
| Address – Street | | | | | | | | City | | | | | State | Zip Code |
| Telephone No. – Owner / Board Member | | | | | | | Fax No. – Owner / Board Member | | | | | | | |
| Email Address – Owner / Board Member | | | | | | | | | | | | | | |
| Name(s) – Any Affiliate Organization Associated with Owner (Parent Corporations, Other LLC, Partnership, Etc.) | | | | | | | | | | | | | | |
| *If more than one owner, attach a diagram of the ownership structure.* | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| II. SERVICES PROVIDED AND FEE SCHEDULE | | | | | | | | | | | | | | | |

A. Program(s) and Services(s) Requesting Certification *(Check all program(s) and/or service(s) requesting certification.)*

| **CSAS / AODA** | | |  | **Mental Health** | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | DHS 75.04 | Prevention Services |  |  | DHS 61.71 | | | | Inpatient Treatment |
|  | DHS 75.05 | Emergency Outpatient |  |  | DHS 61.75 | | | | Day Treatment |
|  | DHS 75.06 | Medically Managed Inpatient Detox |  |  | DHS 61.79 | | | | Adolescent Inpatient |
|  | DHS 75.07 | Med. Monitored Residential Detox |  |  | DHS 34 Subchapter II | | | | Emergency Service 2 |
|  | DHS 75.08 | Ambulatory Detoxification |  |  | DHS 34 Subchapter III | | | | Emergency Service 3 |
|  | DHS 75.09 | Residential Intoxication Monitoring |  |  | DHS 35 | | | | Mental Health Outpatient Clinic Srvcs |
|  | DHS 75.10 | Medically Managed Inpatient |  |  | DHS 36 | | | | Comprehensive Community Services |
|  | DHS 75.11 | Medically Monitored Treatment |  |  | DHS 40 Level 1 | | | | Day Treatment Children 1 |
|  | DHS 75.12 | Day Treatment |  |  | DHS 40 Level 2 | | | | Day Treatment Children 2 |
|  | DHS 75.13 | Outpatient Treatment |  |  | DHS 40 Level 3 | | | | Day Treatment Children 3 |
|  | DHS 75.14 | Transitional Residential Treatment |  |  | DHS 63 | | | Community Support Program | |
|  | DHS 75.15 | Narcotic Treatment |  |  | |  | | |  |
|  | DHS 75.16 | Intervention Services |  |  | | |  | |  |

1. **Fee Assessment**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Services / Programs** | **Amount** |  | **Branch Offices / Telehealth** | **Amount** |  |  | |
| 1 | $550.00 | Branch Office - Tier 1 | $200.00 |  | |
| 2 | $800.00 | Branch Office - Tier 2 | $500.00 |  | |
| 3 | $1,000.00 | Branch Office - Tier 3 | $200.00 |  | |
| 4 | $1,175.00 |  |  |  | |
| 5 | $1,350.00 |  |  |  | |
| Each Additional | $100.00 |  |  |  |  |

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| III. DISCLOSURE OF OWNERSHIP | | |
| On attached sheets, list all names, principal business addresses, 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 organizations or governmental organizations, list the names and principal business addresses of all officers and board members.  If there are no additional owners, check here. | | |
| IV. ATTESTATION | | |
| I attest, under penalty of law, that the information provided above 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. Stats. § 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 *(Print or type.)* | Title – Designee (Owner or Board Member) | |