North Central Health Care

CCS Provider Application

Revised:7.21.21

|  |  |  |
| --- | --- | --- |
| **ORGANIZATION LEGAL NAME** |  | |
| **MAILING ADDRESS**  If P.O. Box, include Street Address on second line |  | |
| **TELEPHONE** |  | **LEGAL STATUS** |
| **FAX NUMBER** |  | Private, Non-Profit Private, For Profit  Federal EIN: |
| **NAME CHIEF ADMIN/ CONTACT** |  |
| **INTERNET WEBSITE**  **(if applicable)** |  |
| **E-MAIL ADDRESS** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **CONTACT TYPE** | **NAME** | **TITLE** | **PHONE NUMBER** | **E-MAIL ADDRESS** |
| **Primary CCS Staff** |  |  |  |  |
| **Fiscal Staff or Accounting Firm** |  |  |  |  |
| **HIPAA Privacy Officer** |  |  |  |  |
| **HIPAA Security Officer** |  |  |  |  |

**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 Comprehensive Community Services for persons with mental disorders and substance-use disorders. I have reviewed** [**Chapter DHS 36.**](http://docs.legis.wisconsin.gov/code/admin_code/dhs/030/36.pdf)

|  |  |  |
| --- | --- | --- |
| Signature of Legal Representative/Organization Head |  | Title |
| Printed Name |  | Date |

## SECTION 1. AGENCY BACKGROUND

1. Date Business Originally Established
2. Number of Years Under Current Ownership
3. How many years have you been doing business under your present firm or trade name?

years

1. Please list any other names under which this business may have operated:
2. Total number of current employees (CCS + non-CCS):

Full-time

Part-time

Independent Contractors

1. If you are working with an accounting firm to handle fiscal operations, how long have you worked with this firm?

|  |
| --- |
| Less than 2 years |
| 2 years or more |
| Not working with an accounting firm |

1. Please provide information on any employees in your organization who will have CCS fiscal responsibilities, such as billing and claiming, who will need access to the CCS Billing Module.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Job Title** | **Phone Number** | **E-mail Address** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

1. Please provide information on the accounting/auditing practices of your organization.

|  |  |  |
| --- | --- | --- |
| **Statement** | **Yes** | **No** |
| a. Agency maintains accounting records in accordance with Generally Accepted Accounting Principles (GAAP). GAAP is the general guidelines and principles, standards and detailed rules, plus industry practices that exist for financial reporting. (If you are unsure or don’t know, please mark No.) |  |  |
| b. Agency maintains a uniform double entry accounting system which is compatible with cost accounting and generally accepted accounting principles. |  |  |
| Name of accounting system: |
| c. Agency maintains a cost allocation plan with costs allocated in a manner consistent with these plans. |  |  |
| d. Agency audit is performed annually by an independent, outside party in accordance with generally accepted auditing standards. |  |  |
| Name of auditing agency: |
| e. Has the most recent audit revealed any significant or ongoing concerns? |  |  |

1. Is your agency currently DHS 35 (Outpatient Mental Health Clinics) or 75 (Community Substance Abuse Service Standards) certified?

|  |
| --- |
| Yes, DHS 35 certified |
| Yes, DHS 75 certified |
| Yes, DHS 35 and 75 certified |
| No |

## SECTION 2: OTHER CCS CERTIFICATION

Please list the other CCS Programs in Wisconsin (outside of Marathon, Lincoln or Langlade County) for which you or your organization provides CCS services.

|  |  |  |
| --- | --- | --- |
| County/Region/Tribe | Services Provided | Dates Services Provided |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

## SECTION 3: CCS PSYCHOSOCIAL REHABILITATION (PSR) SERVICE ARRAY

A. **SERVICES:** Check all of the service for which you request approval to offer in North Central Health Care CCS program. Definitions for each service may be found in the on-line ForwardHealth Handbook for Comprehensive Community Services found at: [https://www.forwardhealth.wi.gov/WIPortal/Online%20Handbooks/Display/tabid/152/Default.aspx?ia](https://www.forwardhealth.wi.gov/WIPortal/Online%20Handbooks/Display/tabid/152/Default.aspx?ia=1&p=1&sa=12&s=2&c=61)

[=1&p=1&sa=12&s=2&c=61](https://www.forwardhealth.wi.gov/WIPortal/Online%20Handbooks/Display/tabid/152/Default.aspx?ia=1&p=1&sa=12&s=2&c=61) .

|  |  |
| --- | --- |
| 1. | Screening and Assessment. |
| 2. | Service Planning. |
| 3. | Service Facilitation. |
| 4. | Diagnostic Evaluations |
| 5. | Medication Management |
| 6. | Physical Health Monitoring |
| 7. | Peer Support |
| 8. | Individual Skill Development and Enhancement |
| 9. | Employment Related Skill Development |
| 10. | Individual and/or Family Psychoeducation |
| 11. | Wellness Management and Recovery/Recovery Support Services |
| 12. | Psychotherapy |
| 13. | Substance Abuse Treatment |

1. **SERVICE LOCATIONS** (Please record the locations of any key facilities where services may be provided, if different from mailing address.)

|  |  |  |
| --- | --- | --- |
| Building Name | Street Address | City |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Do you provide community-based services? Yes No

Is your service location wheelchair accessible? Yes No

### SERVICE DAYS AND HOURS

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Check if Open | Day of the Week | Opening Time | Please Indicate  A.M. or P.M. | Closing Time | Please Indicate  A.M. or P.M. |
|  | Sunday |  |  |  |  |
|  | Monday |  |  |  |  |
|  | Tuesday |  |  |  |  |
|  | Wednesday |  |  |  |  |
|  | Thursday |  |  |  |  |
|  | Friday |  |  |  |  |
|  | Saturday |  |  |  |  |

## SECTION 5: EVIDENCE-BASED PRACTICE

### EVIDENCE-BASED PRACTICE (EBP)

Please indicate below with an “X” which of the listed Evidence-Based Practices (EBPs) will be offered to CCS clients and whether this EBP is being fully or partially implemented in your organization.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Evidence-Based Practice (Adults) | | Yes, Implemented  – Fully (X) | Yes, Implemented Partially  (X) | Not Offered (X) |
| a. | Integrated Treatment for Co-Occurring Disorders (IDDT) |  |  |  |
| b. | Family Psychoeducation |  |  |  |
| c. | Illness Management and Recovery (IMR) |  |  |  |
| d. | MedTEAM |  |  |  |
| e. | Supported Employment |  |  |  |
| f. | Permanent Supportive Housing |  |  |  |
| g. | Tobacco Cessation Bucket Approach |  |  |  |
| h. | Motivational Interviewing |  |  |  |
| i. | Other, Specify: |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Evidence-Based Practice (Children) | | Yes, Implemented  – Fully (X) | Yes, Implemented Partially  (X) | Not Offered (X) |
| h. | Multisystemic Therapy (MST) |  |  |  |
| i. | Functional Family Therapy (FFT) |  |  |  |
| j. | Parent-Child Interactive Therapy (PCIT) |  |  |  |
| k. | Trauma-Focused Cognitive Behavior Therapy (TF- CBT) |  |  |  |
| l. | Trauma-Informed Child-Parent Psychotherapy (TI- CPP) |  |  |  |
| m. | Motivational Interviewing |  |  |  |
| n. | HeartMath |  |  |  |
| o. | Other, Specify: |  |  |  |

### EBP FIDELITY

Please complete the following items for each EBP listed above which will be offered to CCS clients.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Evidence-Based Practice (EBP) | Have CCS staff been specifically trained to implement this EBP? | Did you use the EBP’s toolkit to guide your implementation? | Do you monitor fidelity for this EBP? | Do you use an outside monitor to review fidelity for this ECP? |
| (Yes/No) | (Yes/No) | (Yes/No) | (Yes/No) |
| 1. |  |  |  |  |
| Fidelity Measure Used: | | | |
| 2. |  |  |  |  |
| Fidelity Measure Used: | | | |
| 3. |  |  |  |  |
| Fidelity Measure Used: | | | |
| 4. |  |  |  |  |
| Fidelity Measure Used: | | | |
| 5. |  |  |  |  |
| Fidelity Measure Used: | | | |
| 6. |  |  |  |  |
| Fidelity Measure Used: | | | |
| 7. |  |  |  |  |
| Fidelity Measure Used: | | | |

## SECTION 6: CCS STAFF SUPERVISION AND CLINICAL COLLABORATION

In accordance with DHS 36.11, all CCS staff are required to be supervised and provided with the consultation needed to perform assigned functions to ensure effective service delivery.

Staff qualified under DHS 36.10(2)(g) 1. to 8. which includes: psychiatrists, physicians, psychiatric residents, psychologists, licensed independent clinical social workers, professional counselors and marriage and family therapists, adult psychiatric and mental health nurse practitioners, and advanced nurse prescribers shall participate in at least one hour of either clinical supervision or clinical collaboration per month for every 120-clock hours of face-to-face psychosocial rehabilitation or service facilitation they provide. Please indicate below by checking the appropriate box(es), how this supervision will be provided for this staff in your agency.

|  |  |  |
| --- | --- | --- |
| Check if Providing | Supervision and/or Clinical Collaboration to be Provided | Name of Person(s) Providing the Supervision and/or Clinical Collaboration |
|  | Individual sessions with the staff member case review to assess performance and provide feedback |  |
|  | Individual side-by-side session in which the supervisor is present while the staff member provides assessments, service planning meetings, or psychosocial rehabilitation services and in which the supervisor assesses, teaches, and gives advice regarding the staff member’s  performance. |  |
|  | Group meetings to review and assess staff performance and provide the staff member advice or direction regarding specific situations  or strategies. |  |
|  | Another form of professionally recognized method of supervision designed to provide sufficient guidance to assure the delivery of  effective services to consumers by the staff member. |  |

Staff qualified under DHS 36.10(2)(g) 9. to 22. which includes: certified social workers, certified advance practice social workers, certified independent social workers, psychology residents, physician assistants, registered nurses, occupational therapists, master’s level clinicians, alcohol and drug abuse counselors, certified occupational therapy assistants, licensed practical nurses, peer specialist, rehabilitation workers, clinical students, and other professionals are to receive, from a staff member qualified under DHS 36.10(2)(g) 1. to 8. day-to-day supervision and consultation and at least one hour of supervision per week or for every 30 clock hours of face-to-face psychosocial rehabilitation services or service facilitation they provide. Day–to-day consultation shall be available during CCS hours of operation. Please indicate below by checking the appropriate box(es), how this supervision will be provided for this staff in your agency.

|  |  |  |
| --- | --- | --- |
| Check if Providing | Supervision and/or Consultation to be Provided | Name of Person(s) Providing the Supervision and Consultation |
|  | Day-to-day supervision and consultation **AND** |  |
|  | At least one hour of supervision per week **OR** |  |
|  | At least one hour of supervision for every 30 clock hours of face-to-face psychosocial rehabilitation services or service facilitation provided. |  |

Clinical supervision and clinical collaboration records shall be dated and documented with the signature of the person providing supervision or clinical collaboration. Please indicate below by checking the appropriate box(es), how this will be documented for staff in your agency.

|  |  |
| --- | --- |
| Check if Means of Documentation | Documentation Type |
|  | The master log. (Needs to be unchecked) |
|  | Supervisory records. |
|  | Staff record of each staff member who attends the session or review. |
|  | Consumer records. |

## SECTION 7: CCS STAFF LISTING

Complete the attached CCS Staff Listing chart for all staff who will be providing services under the CCS Program. Include staff providing clinical supervision and collaboration.

## SECTION 8: LEGAL INFORMATION

|  |  |  |
| --- | --- | --- |
| **Statement** | **Yes** | **No** |
| Has the applicant or any owner been involved in any lawsuits or judgments in the last five (5) years or have any lawsuits pending? |  |  |
| Has the applicant or any owner been involved in any bankruptcy or insolvency proceedings or have any proceedings pending? |  |  |

Please attach a detailed explanation for any YES responses.

## SECTION 9: RATE SETTING INFORMATION

Complete the attached Rate Setting Spreadsheet.   
 <https://www.norcen.org/documents/contract%20staff/Budget-Request-Form-Final.xlsx>

## SECTION 10: APPLICATION ATTACHMENTS

A completed application is to include both the agency and staff materials cited below: Agency Materials

|  |
| --- |
| Signed, completed application; |
| IRS Form W-9 (Request for Taxpayer Identification Number and Certification); |
| Copy of personnel policies delineating the non-discrimination, background checks, and misconduct reporting;  Notice of Privacy Practices |
| CCS Staff Listing Chart. |
| Certificate of Insurance |
| Usual and customary rate schedule |
| Rate Setting Spreadsheet  Direct Deposit Form <https://www.norcen.org/documents/forms/ACH-VENDOR-DIRECT-DEPOSIT-AUTHORIZATION.docx> |
|  |

Staff Materials

For each person who will be providing CCS services, please provide:

|  |
| --- |
| Resume; |
| Degree, License, or Rehab Worker training verification; |
| Two (2) professional references in the form of a professional reference letter or reference check; |
| Background Information Disclosure Form (HFA-64A); |
| Department of Justice “No Record Found” or criminal record transcript; |
| Department of Health Services Response to Caregiver Background Check (IBIS) letter or on- line print out. |

Agency Name:

# CCS STAFF LISTING – Chapter DHS 36

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name**  (Last, First, MI) | **Position  Description** | **Credentials/  License Number** | **Functions and  Qualifications** | | **FTE %** | | **Caregiver Misconduct Background Checks –  Dates Conducted** | | | | |
|  |  |  | Functions  1 – MH Professional  2 – Administrator  3– Serv Director  4– Serv Facilitator  5 – Services Array | Minimum Qualifications  Per DHS  36.10 (c)  1-8  1-14  1-21  Any | **E** = Employed (full or part time)  **C** = Contracted | | **BID**  (Mon/ Yr) | **DOJ**  (Mon/ Yr) | **DHS  IBIS**  (Mon/ Yr) | **Review within last  4 yrs/** |
|  |  |  |  |  |  | ☐E  ☐C |  |  |  | ☐Y  ☐N |
|  |  |  |  |  |  | ☐E  ☐C |  |  |  | ☐Y  ☐N |
|  |  |  |  |  |  | ☐E  ☐C |  |  |  | ☐Y  ☐N |
|  |  |  |  |  |  | ☐E  ☐C |  |  |  | ☐Y  ☐N |
|  |  |  |  |  |  | ☐E  ☐C |  |  |  | ☐Y  ☐N |
|  |  |  |  |  |  | ☐E  ☐C |  |  |  | ☐Y  ☐N |
|  |  |  |  |  |  | ☐E  ☐C |  |  |  | ☐Y  ☐N |
|  |  |  |  |  |  | ☐E  ☐C |  |  |  | ☐Y  ☐N |
|  |  |  |  |  |  | ☐E  ☐C |  |  |  | ☐Y  ☐N |
|  |  |  |  |  |  | ☐E  ☐C |  |  |  | ☐Y  ☐N |