CT DMHAS
Interim Certification Application

Instructions
MHRS CORE PROVIDER

✓ **Please provide the entire application electronically, either in Microsoft Word or scanned formats.**

✓ **Please enclose the following items:**

- ❑ **Completed Application to be a Core Provider.**
- ❑ **Completed Application to deliver Community Support Team services.**
- ❑ **Appendix A: Staffing Roster**
- ❑ **All policies, procedures or documents listed in Appendix B.**

✓ **If applying to be certified as an Assertive Community Treatment Provider, attach:**

- ❑ **Completed Application to deliver ACT services.**

Please return all material to:
Dan Olshansky
DMHAS, 4th Floor
410 Capitol Avenue
Hartford, CT 06130

BY JANUARY 24, 2007

Please remember to make a copy of all documentation submitted.

If you have any questions, please contact:
Dan Olshansky
(860) 418-6908
Dan.Olshansky@po.state.ct.us

Section 1: GENERAL INFORMATION

Provider Name: _____

DBA (if applicable) _____

Primary Mailing Address:

_____

City, State Zip

Phone Number ( )

Check all that pertain to your business:

❑ Private ❑ Public ❑ Government

❑ For-Profit ❑ Not-for-Profit

Points of Contact

Chief Executive Officer: E-Mail:	Phone: ( ) Fax: ( )
Clinical Director: E-Mail:	Phone: ( ) Fax: ( )
Certification Contact: E-Mail:	Phone: ( ) Fax: ( )
Person Completing this Application: E-Mail:	Phone: ( ) Fax: ( )

LICENSURE

Does the provider hold any DPH Licenses? Yes ❑ No ❑ *If yes, please complete the following.*

Type	License #	Expiration Date
		/ /
		/ /
		/ /

ACCREDITATION/CERTIFICATION

Accreditation/Certification	Yes	No	N/A	Expiration Date
Has the agency been reviewed and accredited by JCAHO? *(Please attach a current copy of the accreditation letter)*	❑	❑	❑	/ / ❑ N/A
Has the agency been reviewed and accredited by CARF? *(Please attach a current copy)*	❑	❑	❑	/ / ❑ N/A
Has the agency been accredited by COA? *(Please attach a current copy)*	❑	❑	❑	/ / ❑ N/A
Has the agency been approved or certified for Medicaid?	❑	❑	❑	/ / ❑ N/A
Has the agency been approved or certified for Medicare?	❑	❑	❑	/ / ❑ N/A
Please indicate any other accreditations/certifications:	❑	❑	❑	/ / ❑ N/A

INSURANCE INFORMATION

Malpractice/Professional Liability

Name of Carrier_____

Occurrence _____

Aggregate _____

Effective Date _____

Expiration Date _____

General Liability

Name of Carrier_____

Effective Date _____

Expiration Date _____

Worker's Compensation

Name of Carrier_____

Effective Date _____

Expiration Date _____

Automobile (applicable if agency cars are used in delivering ACT or Community Support)

Name of Carrier_____

Effective Date _____

Expiration Date _____

CLAIMS HISTORY

Please complete this section in its entirety. If a questions does not apply to your facility, you may check Not Applicable (N/A).	Yes	No	N/A
Has the agency's state license/certification ever been revoked, suspended, or limited?	❑	❑	❑
Is there action pending to revoke, suspend or limit the agency's license/certification?	❑	❑	❑
Has the agency ever had its JCAHO accreditation revoked, suspended, or limited?	❑	❑	❑
Is there action pending to revoke, suspend, or limit the agency's JCAHO accreditation?	❑	❑	❑
Has the agency ever had its CARF accreditation revoked, suspended, or limited?	❑	❑	❑
Is there action pending to revoke, suspend, or limit the agency's CARF accreditation?	❑	❑	❑
Has the agency ever had its CHAMPUS certification revoked, suspended, or limited?	❑	❑	❑
Is there action pending to revoke, suspend, or limit the agency's CHAMPUS certification?	❑	❑	❑
Has the agency ever had any OTHER (i.e. COA, AOA, etc.) certification/accreditation revoked, suspended or limited?	❑	❑	❑
Is there action pending to revoke, suspend, or limit the agency's OTHER (i.e. COA, AOA, etc) certification/accreditation?	❑	❑	❑
Has the agency ever had any sanctions imposed by Medicare and/or Medicaid?	❑	❑	❑
Has the agency ever been denied professional liability insurance or has its insurance ever been canceled or denied renewal?	❑	❑	❑
Has the agency ever been a defendant in any lawsuit in regard to the practice of mental health or substance abuse treatment where there has been an award or payment of $50,000 or more?	❑	❑	❑
Has the agency had any malpractice claims in regard to the practice of mental health or substance abuse treatment where there has been an award or payment of $50,000 or more?	❑	❑	❑

Note: *If you have answered yes to any of the above questions, please provide the current status and details on a separate sheet of paper. Please include the following: description of incident, including correspondence with state licensing boards, and/or a detailed description of any litigation, including settlements, court awards, etc. Please feel free to include a personal summary of the events, however, your application cannot be processed without the necessary official documentation.*

Special Populations

Please indicate if you have any expertise to treat the following. Check all that apply.

❑ Hearing Impaired ❑ Visually Impaired ❑ Speech Impaired

❑ Other Disabled (*Please Specify)*:

Section 2: CORE PROVIDER REQUIREMENTS

Part One: For each of the following requirements, provide evidence of meeting the standard in the manner indicated. If standard is only partially met, indicate that as well.

1. Have active accreditation by a national accrediting body, including JCAHO, CARF or COA.
    - **Evidence: Attach current proof of accreditation.**

2. On staff, have the direct capacity to provide the following clinical services to clients:
    - Diagnosis by a Licensed Practitioner of the Healing Arts (LPHA)
    - Comprehensive Assessment, including biopsychosocial, psychiatric, addictions, and functional abilities
    - Master treatment planning (Based on the diagnosis and comprehensive assessment, establishing – with the client – broad recovery goals and the services required to achieve those goals. For those services that are Medicaid funded, establishing medical necessity.)
    - Master treatment plan coordination, monitoring, review and updating in coordination with all providers delivering service and in accordance with the client's recovery goals.
    - Psychiatric medication assessment, prescription, and ongoing medication management.
    - Counseling and/or psychotherapy.
    - Community Support Team.
        - **Evidence:**
            - **Complete and Attach Staff listing Appendix A.**
            - **Attach policies and procedures indicating how agency intends to perform Master Treatment Planning and Master Treatment Plan coordination, monitoring, review and updating with all providers delivering services and in accordance with the client's recovery goals. Ensure that these policies are in compliance with the certification standards.**
            - **Attach an Organizational Plan for how agency will convert current operations to meet MHRS certification guidelines, specifically:**
                - **Diagnostic Assessment & Master Treatment Plan with a rehab focus**
                - **Affiliation & communication with specialty providers**
                - **Training for persons doing Diagnostic Assessment and Master Treatment Planning on new requirements and service definitions**
            - **Complete application for certification to provide Community Support Team.**

    - **Must offer, either directly or through contract, access to a clinician for review of any crisis on a 24 hour, 7-day a week, and 365-day a year basis to enrolled clients. For ACT clients, there must be an alert system developed to notify on call ACT staff that a client may require special services**.

3.
    - **Evidence: Attach an Organizational Plan outlining how agency will offer 24/7/365 crisis coverage for MHRS clients.**

4. Be a participating Medicaid provider in good standing in the State of Connecticut.
    - **Evidence: Attach Medicaid Provider Number for MH Outpatient Clinic Services.**

5. Meet timelines for treatment planning and review (and all other requirements, including clinical management/utilization management) of all enrolled clients, both for services provided internally and through specialty providers with which the Core Provider has an affiliation agreement.
    - **Evidence: Submit an approved set of agency policies and procedures and an agency plan documenting how the organization intends to meet all timelines and requirements, both internally and externally. Document how the organization will transition from current operations to meet the new requirements, including a timeline.**

6. Enter into affiliation agreements with specialty providers delivering MHRS services and ensure that coordination of care and ongoing clinical communication is maintained to meet the needs of those clients.
    - **Evidence: Attach copies of affiliation agreements.**

7. Ensure that all MHRS clients receiving treatment from the Core Provider shall have a primary contact person from the Core Provider's staff. In cases where the client is receiving Community Support Team or ACT services from the Core Provider, the primary contact person shall be the client's primary contact on the team. In cases where there are multiple services offered, the primary contact person shall be part of the client's treatment team at the Core Provider.
    - **Evidence: Submit an organizational plan, including approved policies and procedures, documenting how agency intends to meet this requirement.**

8. Maintain listings, in a manner determined by DMHAS, of all current enrolled clients, along with each client's primary contact with the Core agency, and any specialty providers delivering mental health services to each client.
    - **Evidence:**
        - **Submit a sample report or listing demonstrating the capacity to maintain such a current listing.**
        - **Submit an organizational plan outlining the capacity and policies and procedures that will guide maintaining this listing.**
9. Required Staffing.
    - **Evidence: Complete and attach staffing MHRS Core Provider Staffing roster in Appendix X.**

10. Service Accessibility.
    - **Evidence: Attach an organizational plan, including policies and procedures, outlining how the agency will meet the service accessibility standards.**

11. All MHRS providers are responsible to ensure that coordination of care – including treatment planning, clinical management, and assessments – occurs efficiently and effectively with all affiliated providers. MHRS Core Providers have the affirmative responsibility to initiate and manage coordination of care with any specialty providers delivering MHRS services in conjunction with the Core Provider.
    - **Evidence: Attach an organizational plan, including policies and procedures, outlining how the agency will meet the service coordination standards.**

11. MHRS providers must establish a central communications and coordination contact link with affiliated core and/or specialty providers. For Core providers, this may be each client's designated primary contact person at the Core Provider, or a designated contact for multiple clients. For Specialty Providers, the designated link shall be the client's primary contact within the Mental Health Group Home, the Assertive Community Treatment Team, or the Community Support Team.
    - **Evidence: Attach an organizational plan, including policies and procedures, outlining how the agency will meet the central communications and coordination standards.**

12. Each Core provider shall establish policies and procedures governing its collaboration with affiliated specialty Providers in the development, implementation, evaluation, and revision of each client's Master Treatment Plan and Rehabilitation Plans, as appropriate. This Policy shall require Core Providers to actively engage with Specialty Providers to meet the treatment planning development, implementation, evaluation, and revision needs of each shared client; and require Core providers to coordinate the client's treatment with the client's primary contact at the Specialty Provider.
    - **Evidence: Attach an organizational plan, including policies and procedures, outlining how the agency will meet the treatment planning coordination standards.**

13. Each MHRS Provider shall have an annual audit for all program funds, whether state awarded or not, by a certified public accounting firm, and the resulting audit report shall be consistent with formats recommended by the American Institute of Public Accountants.
    - **Evidence: Attach most recent financial audit. Attach policies and procedures outlining how the agency will meet the audit standard.**

14. Each Core Provider shall establish formal, written agreements of clinical coordination and communication with specialty providers that outlines the responsibilities of the parties. The Affiliation Agreements shall address, at a minimum, access to records, clinical responsibility, treatment planning, clinical management, timelines, time frames, and dispute resolution.
    - **Evidence: Attach copies of all executed Affiliation Agreements in place with Specialty providers.**

15. Each Core and Specialty Provider shall be responsible for submitting all required information to DMHAS for client tracking and clinical management purposes within designated timeframes.
    - **Evidence: Attach description of how agency will comply with data submission requirements.**

16. Each MHRS provider must have and implement a Recovery Competence Plan that has been approved by the department.
    - **Evidence: Attach copy of Recovery Competence Plan.**

17. The MHRS provider shall develop and implement a Cultural Competence Plan in the form and manner designated by the department
    - **Evidence: Attach copy of Cultural Competence Plan.**

Part Two: If the organization d*oes **not yet** have the capacity* to fully meet any of the standards above, submit an organizational plan for each requirement that is currently unmet. This plan shall:

- Document concrete steps that the agency will take to become compliant by October 1, 2007
- Incorporate a timeline for achieving those steps.
- Outline any resources that the agency will need to become compliant, and document plans for acquiring those resources.
    - If agency will require specific financial or programmatic assistance from DMHAS to acquire these resources, include specific detailed requests.

Part Three: Capacity

For how many clients is the applicant currently able to serve as a Core Provider? _____

If the applicants plans to increase this capacity by October 1, 2007, indicate the number of clients that can be served at that time and outline how the agency will increase the capacity.

COMMUNITY SUPPORT TEAM REQUIREMENTS

1. For each of the certification standards for providing Community Support Team, outline the following:
    a. What components are currently in place within your organization?
    b. What components will need to be developed? For these, outline a specific agency plan for how these requirements will be in place prior to October 1, 2007. This plan shall:
        - Document concrete steps that the agency will take to become compliant by October 1, 2007
        - Incorporate a timeline for achieving those steps.
        - Outline any resources that the agency will need to become compliant, and document plans for acquiring those resources.
    c. If agency is requesting specific financial or programmatic assistance from DMHAS to acquire these resources, include specific detailed requests.

2. Attach an organizational chart that shows
    a. How many community support teams will be functioning within agency
    b. Where the CST reports within the organization
    c. Required staffing.

3. Complete the following staffing chart for each proposed Community Support Team within the agency. You do not need to specify the names of the staff. Instead, use this grid to indicate if you already have the staff person employed, whether you are in the process of hiring them, or you will need to acquire them. In the last case, indicate a time line for hiring and orienting the staff. (If more than one team is proposed, attach a roster for each team.) *This roster should represent your agency's ability to staff a Community Support Team on October 1, 2007.*

COMMUNITY SUPPORT TEAM ROSTER **(Attach one roster for each distinct Community Support Team)**			
Specify a "current staff" person, a "pending" employee, or one who "needs to be hired".	**Degree/ Experience**	**License**	**Job Title**
			Licensed Professional Supervising Team Services
			Team Leader (may be same as above)
			Community Support Staff
			Community Support Staff
			Community Support Staff
			Community Support Staff
			Community Support Staff
			Community Support Staff
			Community Support Staff
			Community Support Staff

APPLICATION FOR INTERIM CERTIFICATION AS A PROVIDER OF ASSERTIVE COMMUNITY TREATMENT TEAM SERVICES.

(Complete and attach this section only if applying to offer ACT.)

1. ACT must be provided by an MHRS Certified Core Provider.

2. For each of the certification standards for providing Assertive Community Treatment, outline the following:
    a. What components are currently in place within your organization?
    b. What components will need to be developed? For these, outline a specific agency plan for how these requirements will be in place prior to October 1, 2007. This plan shall:
        - Document concrete steps that the agency will take to become compliant by October 1, 2007.
        - Indicate how the organization will transition from its current operations to delivering the MHRS ACT service.
        - Incorporate a timeline for achieving those steps.
        - Outline any resources that the agency will need to become compliant, and document plans for acquiring those resources.
    c. If agency is requesting specific financial or programmatic assistance from DMHAS to acquire these resources, include specific detailed requests.

3. Attach an organizational chart that shows:
        - How many assertive community treatment teams will be functioning within agency
        - Where the ACT reports within the organization
        - Required staffing.

4. Complete the following staffing chart for each proposed Assertive Community Treatment Team within the agency. You do not need to specify the names of the staff. Instead, use this grid to indicate if you already have the staff person employed, whether you are in the process of hiring them, or you will need to acquire them. In the last case, indicate a time line for hiring and orienting the staff. (If more than one team is proposed, attach a roster for each team.) *This roster should represent your agency's ability to staff an Assertive Community Treatment team on October 1, 2007.*

ACT Staff Roster (Attach one roster for each distinct ACT team.)				
Specify a "current staff" person, a "pending" employee, or one who "needs to be hired".	**Degree/ Experience**	**License**	**FTE**	**Job Title**
			1.0	Team Leader. Must be licensed clinician
				Psychiatrist
			1.0	Registered Nurse
				General Practitioner, either master's prepared or licensed clinician
			1.0	Program/Administrative Assistant
				Recovery Specialist
				Recovery Specialist

ACT Staff Roster (Attach one roster for each distinct ACT team.)				
Specify a "current staff" person, a "pending" employee, or one who "needs to be hired".	**Degree/ Experience**	**License**	**FTE**	**Job Title**

- In the above staffing grid, which staff member(s) have special training in rehabilitation counseling, especially vocational, work readiness, and educational support?

  _____

- In the above staffing grid, which staff member(s) have special training and/or certification in substance abuse treatment and/or treating persons with co-occurring disorders?

  _____

- In the above staffing grid, which staff member(s) are consumers in recovery who have been specially credentialed (or plan to be credentialed through the future CT Certification Process) based on their psychiatric and life experiences?

  _____

5. Attach a proposed schedule for the ACT Team, indicating staffing patterns and on-call schedules to meet the required program hours.

Appendix A: Staffing Grid for MHRS Core Providers

Identify all Staff who will be providing Diagnostic, Assessment, and Master Treatment Planning Services for MHRS Clients. You do not need to specify the names of the staff. Instead, use this grid to indicate if you already have the staff person employed, are in the process of hiring them, or you will need to acquire them. In the last case, indicate a time line for hiring and orienting the staff. *(Do not list staff members listed in Community Support Team or ACT.)*

MHRS Core Provider Staffing Roster			
Specify a "current staff" person, a "pending" employee, or one who "needs to be hired".	**Degree/ Experience**	**License**	**Job Title**
			Medical Director
			Clinical Director
			LPHA allocated to MHRS