# DANE COUNTY CCS PROVIDER APPLICATION

Revised: 1.2024

|  |  |
| --- | --- |
| **ORGANIZATION LEGAL NAME** |  |
| **MAILING ADDRESS**If P.O. Box, include Street Address on second line | Street Address:       City/ State/Zip:       |
| **TELEPHONE** |       | **LEGAL STATUS** |
| **FAX NUMBER** |       | [ ]  Private, Non-Profit[ ]  Private, For ProfitFederal EIN:       DUNS Number:       |
| **NAME OF AGENCY DIRECTOR** |       |
| **DIRECTOR’S E-MAIL ADDRESS** |       |
| **INTERNET WEBSITE****(if applicable)** |       |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **CONTACT TYPE** | **NAME** | **TITLE** | **PHONE NUMBER** | **E-MAIL ADDRESS** |
| **Primary CCS** **Contact**  |       |       |       |       |
| **Fiscal Staff or Accountant** |       |       |       |       |
| **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 INFORMATION**

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 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** | **N/A** |
| --- | --- | --- | --- |
| 1. 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.)
 | [ ]  | [ ]  |  |
| 1. Agency maintains a uniform double entry accounting system which is compatible with cost accounting and generally accepted accounting principles.
 | [ ]  |  |  |
| **Name of accounting system:**       |  |  |  |
| 1. Agency maintains a cost allocation plan with costs allocated in a manner consistent with these plans.
 | [ ]  | [ ]  |  |
| 1. Agency audit is performed annually by an independent, outside party in accordance with generally accepted auditing standards.
 | [ ]  | [ ]  | [ ]  |
| Name of auditing agency:       |  |  |  |
| 1. Has the most recent audit revealed any significant or ongoing concerns?
 | [ ]  | [ ]  | [ ]  |

1. Please answer the following legal questions (*attach a detailed explanation for any YES responses*)

|  |  |  |
| --- | --- | --- |
| **Legal Statements** | **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? | [ ]  | [ ]  |

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 75.50 certified |
| [ ]  | No |

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

1. **SERVICES:** Check all of the service for which you request approval to offer in Dane County’s 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=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 Training |
|  |  |  |
| [ ]  | 10. | Individual and/or Family Psychoeducation |
|  |  |  |
| [ ]  | 11. | Wellness Management and Recovery/Recovery Support Services |
|  |  |  |
| [ ]  | 12. | Psychotherapy |
|  |  |  |
| [ ]  | 13. | Substance Abuse Treatment |
|  |  |  |

**SECTION 4: CCS SERVICE INFORMATION**

The following information will be used to set up the services in the web-based application. This will be used by Service Facilitators who may be searching for services for clients. This information will also be incorporated into a directory of CCS services that will appear in an on-line service directory made available to the general public.

1. **AGE GROUPS SERVED** (Check all that apply)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  | Prenatal |  | [ ]  | 60-64 |
| [ ]  | Birth – 3 |  | [ ]  | 65-69 |
| [ ]  | 4-12 |  | [ ]  | 70-74 |
| [ ]  | 13-17 |  | [ ]  | 75-79 |
| [ ]  | 18-21 |  | [ ]  | 80-84 |
| [ ]  | 22-49 |  | [ ]  | 85+ |
| [ ]  | 50-54 |  | [ ]  | Other: Specify |
| [ ]  | 55-59 |  |  |       |

1. **SPECIAL POPULATIONS SERVED** (Check all that apply)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  | Abuse/Neglect, Victim of |  | [ ]  | Homeless |
| [ ]  | ADD/ADHD |  | [ ]  | Immigrant or Undocumented |
| [ ]  | Alcoholic/Alcohol Impaired |  | [ ]  | Juvenile Delinquent(s) |
| [ ]  | Alzheimer’s Disease/Related Dementia |  | [ ]  | LBGT |
| [ ]  | Blind/Visually Impaired |  | [ ]  | Mentally Ill |
| [ ]  | Deaf/Hard of Hearing |  | [ ]  | Migrant |
| [ ]  | Developmental Disability – Autism |  | [ ]  | Physically Disabled/Mobility Impaired |
| [ ]  | Developmental Disability – Brain Trauma |  | [ ]  | Pregnant Teens |
| [ ]  | Developmental Disability – Cerebral Palsy |  | [ ]  | Rape/Incest/Sexual Assault, Victim of  |
| [ ]  | Developmental Disability – Cognitive Imp. |  | [ ]  | Refugee |
| [ ]  | Developmental Disability - Epilepsy |  | [ ]  | Severe Emotional Disturbance |
| [ ]  | Developmentally Disabled |  | [ ]  | Sexual Offender |
| [ ]  | Domestic Violence, Victim of |  | [ ]  | Trauma Informed |
| [ ]  | Drug Impaired |  | [ ]  | Unmarried Parents |
| [ ]  | Gambling Client |  | [ ]  | Other: Specify |
|  |  |  |  |       |

1. **GENDER SERVED** (For gender specific services only. Check that which applies.)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  | Females |  | [ ]  | Males |
| [ ]  | Gender, non-conforming |  | [ ]  | Transgender |

1. **SPECIAL RESTRICTIONS**

In the following space, please provide a description of any restrictions on the type of the population you intend to serve.

|  |
| --- |
|       |

1. **SERVICE LOCATIONS** (Please record the locations of any key facilities where services may be provided)

|  |  |  |
| --- | --- | --- |
| Street Address | City/ State/ Zip | Wheelchair Accessible |
|       |       | [ ]  Yes [ ]  No |
|       |       | [ ]  Yes [ ]  No |
|       |       | [ ]  Yes [ ]  No |
|       |       | [ ]  Yes [ ]  No |
|       |       | [ ]  Yes [ ]  No |

Do you provide community-based services? (“community-based” refers to services provided in the consumer’s home or community setting outside of your office location)

[ ]  Yes [ ]  No

1. **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 |       |       |       |       |

1. **SERVICE DESCRIPTION**

In the following space, please provide a description of the services (beyond that in the ForwardHealth service array) that will be provided. Attach additional sheets as necessary. This description may be used for marketing purposes. It will be included in the resource directory that will be made available to clients and service facilitators who will be identifying the resources that will be part of the clients’ recovery plans.

|  |
| --- |
|       |

**SECTION 5: EVIDENCE-BASED PRACTICE**

1. **EVIDENCE-BASED PRACTICE (EBP)**

Please indicate below with an “X” which (if any) of the listed Evidence-Based Practices (EBPs) will be offered to CCS clients through your agency, 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) | NotOffered(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:       |       |       |       |

1. **EBP FIDELITY**

Please answer the following questions for each EBP indicated as being implemented (fully or partially) within your organization in Part A.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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:       |   |
|  8. |       |            |             |            |            |
|   |   | Fidelity Measure Used:       |   |
|  9. |       |            |             |            |            |
|   |   | Fidelity Measure Used:       |   |
| 10. |       |            |             |            |            |
|   |   | Fidelity Measure Used:       |   |

**SECTION 6: CCS STAFF SUPERVISION**

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.

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.

|  |  |
| --- | --- |
| Types of Supervision Allowed | Name of Person(s) Providing the Supervision  |
| * 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.
 |       |

.

CCS supervision records shall be dated and documented on the Dane County CCS Supervision/ Clinical Collaboration Log with the signature of the person providing supervision or clinical collaboration. Documentation of supervision/clinical collaboration needs to be submitted to the Provider Network Coordinator on a monthly basis**,** unless another timeline has been approved by the CCS Provider Network Coordinator, for any personnel actively providing face-to-face psychosocial rehabilitation services. Please refer to the *CCS Provider Handbook* for further details regarding CCS supervision and clinical collaboration requirements.

**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.

Minimum Requirements for all agencies

1. Each agency’s CCS supervisor, defined by minimum qualifications in DHS 36.10(2)(g)1-8. must be directly employed by the agency, **OR**

Staff on the agency’s CCS staff listing must have a mean experience of at least 2 years providing psychosocial rehabilitation within any of the service array categories to individuals with mental health and/or substance use disorders.

1. At all times during the contract period, staff cannot be on more than two (2) different agency staff listings concurrently. Exceptions can be requested in writing to the CCS Administrator. Exceptions will only be granted if the integrity of the CCS program can be assured.

Additional Minimum Requirements for Service Facilitation Agencies

1. Within one year of contracting with Dane County’s CCS Program, agencies that are contracted to provide service facilitation are required to directly employ at least 3.0 FTE (Full-Time Equivalent) Service Facilitators and provide service facilitation to a minimum of 30 CCS participants across the agency.
2. Within one year of contracting with Dane County’s CCS Program, agencies that are contracted to provide service facilitation are required to directly employ their Mental Health Professional role, and must maintain Mental Health Professional staff at a ratio of at least 1.0 FTE Mental Health Professionals for every 100 CCS program participants. Mental Health Professionals cannot serve as the MHP on more than 100 CCS participant teams at the same time. Short term exceptions to this requirement can be granted during times of unexpected staff absence.
3. Service Directors, or their county-approved designee, are required to attend Service Director meetings at DCDHS as well as on-site Technical Assistance meetings. Attendance rates <75% are considered out of compliance.
4. Personnel filling the role of service facilitator must have a minimum of six (6) months experience providing psychosocial rehabilitation to individuals with mental health and/or substance use diagnoses **or** have an Associate’s degree or higher in an approved human services related field.

Additional Information Regarding Service Facilitation Agencies

For agencies requesting to contract for Service Facilitation, please identify how the following roles will be met. Please note, if the person filling the Service Director role will not be attending the monthly Service Director meetings, please identify which staff will be designated to attend these meetings in lieu of the Service Director in the SD Designee field (see Minimum Standards above for who can qualify as a County Approved Designee).

|  |  |  |  |
| --- | --- | --- | --- |
| Role | Name(s) of Staff | Employed or Contracted | FTE % |
| Service Director (SD) |       |       |       |
| SD Designee(s) |       |       |       |
| Mental Health Professional(s)  |       |       |       |
| Substance Abuse Professional(s) |       |       |       |

|  |  |
| --- | --- |
| 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** |
|  |  |  | Functions1 – MH Professional2 – Administrator3 – Serv Director4 – Serv Facilitator5 – Services Array | Minimum Qualifications Per DHS 36.10 (c)1-81-141-21Any | **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 |

**SECTION 9: RATE SETTING INFORMATION**

Dane County’s interim rates for the 2024 contracting period are:

****

A standard rate sheet will be inserted into the contract with these rates for all new CCS contracts.

|  |
| --- |
| **FAIR LABOR PRACTICES CERTIFICATION****Dane County Ordinance 25.09** |

The undersigned, for and on behalf of the PROPOSER, BIDDER OR APPLICANT named herein, certifies as follows:

1. That he or she is an officer or duly authorized agent of the above-referenced PROPOSER, BIDDER OR APPLICANT, which has a submitted a proposal, bid or application for a contract with the county of Dane.

That PROPOSER, BIDDER OR APPLICANT has: (Check One)

\_\_     \_ not been found by the National Labor Relations Board (“NLRB”) or the Wisconsin Employment Relations Commission (“WERC”) to have violated any statute or regulation regarding labor standards or relations in the seven years prior to the date this Certification is signed.

\_\_     \_ been found by the National Labor Relations Board (“NLRB”) or the Wisconsin Employment Relations Commission (“WERC”) to have violated any statute or regulation regarding labor standards or relations in the seven years prior to the date this Certification is signed

Date Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Officer or Authorized Agent

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Business Name

**NOTE: You can find information regarding the violations described above at:** [www.nlrb.gov](http://www.nlrb.gov) **and** <http://werc.wi.gov>.

**For Reference Dane County Ord. 25.09 is as follows:**

(1)Any bid, application or proposal for any contract with the County, including public works contracts regulated under chapter 40, shall include a certification indicating whether the bidder has been found by the National Labor Relations Board (NLRB) or the Wisconsin Employment Relations Commission (WERC) to have violated any statute or regulation regarding labor standards or relations within the last seven years. The Controller shall investigate any such finding and make a recommendation to the committee, which shall determine whether the conduct resulting in the finding affects the bidder’s responsibility to perform the contract.

If you indicated that you have been found by the NLRB or WERC to have such a violation, you must include a copy of any relevant information regarding such violation with your proposal, bid or application.

**SECTION 10: INSURANCE**

Please attach all required Certificates of Insurance (COI) to this application and verify requirements of coverage below.

The following are required:

* The COI must list a minimum General Liability of $1,000,000, minimum Auto Liability of $1,000,000, and minimum Professional Liability of $1,000,000
* Dane County must listed as additional insured for Commercial General Liability
* The policy number must be listed for each type of insurance
* The policy dates must be current
* The name on the COI must match the agency name on the contract as it is listed with the Wisconsin Department of Financial Institutions (DFI).

|  |  |  |  |
| --- | --- | --- | --- |
| **Insurance Type** | **Requirements** | **Check if appropriate COI documentation is attached** | **Check if policy is active** |
| Commercial General Liability | Required | [ ]  | [ ]  |
| Dane County Must be listed as an additional insured | [ ]  |  |
| Automobile Liability | Required or Waiver Request | [ ]  | [ ]  |
| Professional Liability | Required | [ ]  | [ ]  |
| Worker’s Compensation | If required by state of WI | [ ]  | [ ]  |

**SECTION 11: APPLICATION ATTACHMENTS**

A completed application is to include 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;  |
| [ ]  | Fair Labor Practices Certification form, signed and dated; |
| [ ]  | Usual and customary rate schedule, if requesting a rate below the Dane County interim rate(s); |
| [ ]  | Letter of engagement from contracted accountant if no employed fiscal staff; |
| [ ]  | Certificates of Insurance, including an Automobile Liability waiver request, if no commercial policy is in place  |

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: (<https://www.dhs.wisconsin.gov/forms/f8/f82064.pdf>);  |
| [ ]  | Department of Justice “No Record Found” or criminal record transcript and Department of Health Services Response to Caregiver Background Check (<https://recordcheck.doj.wi.gov/>)  |