

# CT DMHAS Interim Certification Application

## Instructions MHRS SPECIALTY PROVIDER

---

- ✓ Please provide the entire application electronically, either in Microsoft Word or scanned formats.
- ✓ Please enclose the following items:
  - Completed Application to be a Specialty Provider.
  - Completed Application to deliver Community Support Team Services.
  - Appendix A: Staffing Roster
  - All policies, procedures or documents listed in Appendix B.
  - If not accredited, agency must attach documents listed in Appendix C.

Please return all material to:  
Dan Olshansky  
DMHAS, 4<sup>th</sup> 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:	Phone: (      )
E-Mail:	Fax: (      )
Clinical Director:	Phone: (      )
E-Mail:	Fax: (      )
Certification Contact:	Phone: (      )
E-Mail:	Fax: (      )
Person Completing this Application:	Phone: (      )
E-Mail:	Fax: (      )

## LICENSURE

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

Type	License #	Expiration Date
		/ /
		/ /

## ACCREDITATION/CERTIFICATION

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

<i>Please complete this section in its entirety. If a questions does not apply to your facility, you may check Not Applicable (N/A).</i>	Yes	N o	N/ A
Has the agency's state license/certification ever been revoked, suspended, or limited?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there action pending to revoke, suspend or limit the agency's license/certification?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the agency ever had its JCAHO accreditation revoked, suspended, or limited?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there action pending to revoke, suspend, or limit the agency's JCAHO accreditation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the agency ever had its CARF accreditation revoked, suspended, or limited?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there action pending to revoke, suspend, or limit the agency's CARF accreditation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the agency ever had its CHAMPUS certification revoked, suspended, or limited?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there action pending to revoke, suspend, or limit the agency's CHAMPUS certification?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the agency ever had any OTHER (i.e. COA, AOA, etc.) certification/accreditation revoked, suspended or limited?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there action pending to revoke, suspend, or limit the agency's OTHER (i.e. COA, AOA, etc) certification/accreditation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the agency ever had any sanctions imposed by Medicare and/or Medicaid?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the agency ever been denied professional liability insurance or has its insurance ever been canceled or denied renewal?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p><b>Note:</b> <i>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.</i></p>			

## Special Populations

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

<input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> Visually Impaired	<input type="checkbox"/> Speech Impaired
<input type="checkbox"/> Other Disabled ( <i>Please Specify</i> ):		

## Section 2: SPECIALTY PROVIDER QUALIFICATIONS

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. Each specialty provider shall establish and adhere to policies and procedures governing its relationship with a Core Provider which address access to records, clinical responsibilities, legal liability, dispute resolution, and all other MHRS certification standards and which are outlined in an Affiliation Agreement with that Core Provider.
  - **Evidence: Attach copies of all executed Affiliation Agreements in place with Core providers.**
2. Specialty Providers must either be accredited by a national accrediting body (JCAHO, CARF or COA) OR meet the additional certification requirements listed in Appendix C of Application Packet..
  - **Evidence: Attach proof of accreditation OR**
  - **Attach all information requested in Appendix C of Application Packet.**
3. Specialty providers must have the ability to contribute to and/or coordinate treatment planning with the Core Provider, the ability to develop specialty service-specific objectives with client that assist in achieving goals on the Master Treatment Plan, and the ability to use functional assessment and other appropriate tools with clients to expand comprehensive assessments performed by Core Provider and to assist in building client-centered specialty-service objectives and interventions.

Each specialty provider shall establish policies and procedures governing its collaboration with a referring Core Provider in the development, implementation, evaluation, and revision of each client's Master Treatment Plan and Rehabilitation Plans, as appropriate that comply with DMHAS rules (Collaboration Policy). The Collaboration Policy shall:

- (a) Be part of specialty provider's Treatment Planning Policy;
- (b) Require specialty providers to incorporate Core Provider-developed Diagnostic Assessment material and Master Treatment Plans into specialty provider's treatment planning process; and
- (c) Require specialty providers to coordinate the client's treatment with the client's primary contact at the Core Provider.
  - **Evidence: Attach an organizational plan, including policies and procedures, outlining how the agency will meet the treatment planning standards. Include a timeline and interim steps to achieve the standard.**
4. Required Staffing.
  - **Evidence: Attach completed Specialty Provider Staffing Grid from Appendix A.**
5. 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.**
6. 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.**

7. 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.**
8. 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.**
9. 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.**
10. 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 does *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 Specialty 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.*

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

**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
			Community Support Staff

## Appendix A: Staffing Grid for MHR Specialty Providers

Complete the following staffing chart for the proposed MRO program 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.

<b>MHR Specialty Provider Staffing Roster</b>			
<b>Specify a "current staff" person, a "pending" employee, or one who "needs to be hired".</b>	<b>Degree/ Experience</b>	<b>License</b>	<b>Job Title</b>
			<b>Clinical Director who is a licensed clinician with overall responsibility for the MHR program</b>
<b>If the agency is NOT accredited, the following staff must also be listed:</b>			
			<b>Medical Records Administrator</b>

## Appendix B: Required Policies and Procedures

- Affiliation Policy
- Collaboration Policy
- Cultural Competence Plan
- Recovery Competence Plan

## Appendix C: Attachments for Non-Accredited Providers

Agencies applying for certification as MHRS Specialty Providers that do not have a national accreditation (JCAHO, CARF, COA) must attach the following information to their application:

1. Credentialing Policy & Procedure
2. Evidence that they are established as a legally recognized entity in the United States and qualified to conduct business in Connecticut.
3. Each MHRS provider shall attach proof of the following:
  - a) Have a governing authority, which shall have overall responsibility for the functioning of the MHRS provider;
  - b) Comply with all applicable federal and Connecticut laws and regulations;
  - c) Hire personnel with the qualifications necessary to provide MHRS and to meet the needs of its enrolled consumers;
  - d) Ensure that licensed clinicians are available to provide appropriate and adequate supervision of all clinical activities; and
  - e) Employ licensed clinicians that meet all professional requirements as defined by Connecticut's licensing laws and regulations relating to the profession of the licensed clinician.
4. Staff Selection Policy
5. Written job descriptions for all positions referenced within the Interim MHRS certification standards.
6. Performance Review Policy.
7. Staff Orientation Curriculum for MHRS staff members.
8. Annual Training Plan for MHRS staff.
9. Policies and procedures for handling routine, urgent, and emergency situations.
10. Clinical Records Policy
11. Interpreter Policy.
12. Natural Settings Policy
13. Quality Improvement Policy
14. Documentation that agency is in compliance with the following requirements for management of facilities where client-services are delivered:
  - a) Each MHRS provider's service site(s) shall be located and designed to provide adequate and appropriate facilities for private, confidential individual and group sessions.
  - b) Each MHRS provider's service site(s) shall have appropriate space for group activities and educational programs.
  - c) All areas of the MHRS provider's service site(s) shall be kept clean and safe, and shall be appropriately equipped and furnished for the services delivered.
  - d) Each MHRS provider shall comply with applicable provisions of the Americans with Disabilities Act in all business locations.
  - e) Each MHRS provider shall establish and adhere to a written evacuation plan to be used in fire, natural disaster, medical emergencies, bomb threats, terrorist attacks, violence in the work place, or other disaster for all service sites (Disaster Evacuation Plan).

- f)** The Disaster Evacuation Plan shall require the MHRS provider:
    - i)** To conduct periodic disaster evacuation drills;
    - ii)** Ensure that all evacuation routes are clearly marked by lighted exit signs; and
    - iii)** Ensure that all staff participate in annual training about the Disaster Evacuation Plan and disaster response procedures.
  - g)** Each MHRS provider shall obtain a written certificate of compliance indicating that all applicable fire and safety code requirements have been satisfied.
  - h)** Each MHRS provider shall provide physical facilities for all service site(s) which are structurally sound and which meet all applicable federal and Connecticut laws and regulations for adequacy of construction, safety, sanitation and health.
  - i)** Each MHRS provider shall establish and adhere to policies and procedures governing infection control (Infection Control Policy). The Infection Control Policy shall comply with applicable federal and Connecticut laws and regulations.
15. By-laws or other legal documentation regulating the conduct of its internal financial affairs.
16. Records Retention Policy
17. Policy on compliance and fraud and abuse prevention.
18. Disaster Recovery Plan