# DANE COUNTY RECERTIFICATION APPLICATION

# FOR CCS SERVICE PROVIDERS

Revised: 6.14.18

**APPLICATION SUMMARY**

|  |  |
| --- | --- |
| **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 ProfitFederal EIN:       DUNS Number:       |
| **NAME CHIEF ADMIN/ CONTACT** |       |
| **INTERNET WEBSITE****(if applicable)** |       |
| **E-MAIL ADDRESS** |       |

|  |  |  |  |
| --- | --- | --- | --- |
| **CCS CONTACT PERSON** | **CCS CONTACT TITLE** | **PHONE NUMBER** | **E-MAIL** |
|       |       |       |       |

|  |  |  |  |
| --- | --- | --- | --- |
| **FISCAL OR ACCOUNTING FIRM CONTACT PERSON** | **FISCAL CONTACT TITLE** | **PHONE NUMBER** | **E-MAIL** |
|       |       |       |       |

**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:

|  |
| --- |
|       |
|       |

1. 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 the employees in your organization who will have CCS fiscal responsibilities, such as billing and claiming, payroll, etc.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name**  | **Job Title** | **Percent of Time Spent Per Week on Fiscal Duties** | **If Less than 100% of Time is Spent on Fiscal Duties, Describe the Other Duties** |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |

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

| **Statement** | **Yes** | **No** |
| --- | --- | --- |
| 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. 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: 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 Development |
|  |  |  |
| [ ]  | 10. | Individual and/or Family Psychoeducation |
|  |  |  |
| [ ]  | 11. | Wellness Management and Recovery/Recovery Support Services |
|  |  |  |
| [ ]  | 12. | Psychotherapy |
|  |  |  |
| [ ]  | 13. | Substance Abuse Treatment |
|  |  |  |

1. Do you provide community-based services?

|  |  |
| --- | --- |
| [ ]  | Yes |
| [ ]  | No |

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

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

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 – (Complete only if making changes from the last application. Not sure what is out there, check the Provider Directory on the DCDHS CCS web site.)**

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.

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|       |

**SECTION 3: EVIDENCE-BASED PRACTICE**

1. **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) | 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 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? (Yes/No) | Did you use the EBP’s toolkit to guide your implementation?(Yes/No) | Do you monitor fidelity for this EBP?(Yes/No) | Do you use an outside monitor to review fidelity for this ECP?(Yes/No) |
|       |       |       |       |       |
|  | Fidelity Measure Used: |       |
|       |       |       |       |       |
|  | Fidelity Measure Used: |       |
|       |       |       |       |       |
|  | Fidelity Measure Used: |       |

**PLEASE BE SURE TO ATTACH AN UPDATED CCS STAFF LISTING IF NEEDED.**

**THIS MUST BE CURRENT AT ALL TIMES.**

**SECTION 4: APPLICATION ATTACHMENTS**

A completed application is to include the agency materials cited below:

Agency Materials

|  |  |
| --- | --- |
| [ ]  | Signed, completed application; |
| [ ]  | Copy of personnel policies delineating the non-discrimination, background checks, and misconduct reporting if there have been any changes to these policies since the last application submission; |
| [ ]  | CCS Staff Listing Chart; |
| [ ]  | Fair Labor Practices Certification form, signed and dated; |
| [ ]  | Usual and customary rate schedule; |
| [ ]  | Rate Proposal Template (if Usual and Customary Rates are higher than county interim rates) (must be submitted electronically); |
| [ ]  | Certificates of Insurance |
|  |  |
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| **FAIR LABOR PRACTICES CERTIFICATION****Dane County Ordinance 25.11(28)** |

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. 28.11 (28) is as follows:**

**(28)** BIDDER RESPONSIBILITY. **(a)** 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 Committee (WERC) to have violated any statute or regulation regarding labor standards or relations within the last seven years. The purchasing manager 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.

|  |
| --- |
| **Certificate of 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 | [ ]  | [ ]  |
| Professional Liability | Required | [ ]  | [ ]  |
| Worker’s Compensation | Required | [ ]  | [ ]  |