DANE COUNTY APPLICATION FOR CCS SERVICE PROVIDERS

Revised: 3.19.18

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 Profit Federal 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.

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

4. Please list any other names under which this business may have operated:

   _____
   _____
   _____

5. Total number of current employees (CCS + non-CCS):
   _____ Full-time
   _____ Part-time
   _____ Independent Contractors

6. 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

7. 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

8. 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?	☐	☐

9. 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 CCS Programs in Wisconsin for which you or your organization provides service facilitation or other services to CCS clients.

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 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

SECTION 4: CCS SERVICE DESCRIPTION

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.

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

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

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

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

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

- ☐ Females
- ☐ Gender, non-conforming
- ☐ Males
- ☐ Transgender

D. SPECIAL RESTRICTIONS

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

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

Building Name	Street Address	City

Do you provide community-based services?

- ☐ Yes
- ☐ No

F. 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				

G. 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

A. 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:			

B. 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:	

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.
☐	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. Be sure to attach to the application, the completed Background Information Disclosure (BID) form, the response from the Department of Justice (DOJ) Wisconsin Criminal History Record Request, and the response letter or print out from the web site for the Department of Health Services report on the person's status.

If service facilitation services will be provided, please identify in the space below how Mental Health Professional services will be provided:

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: 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;
- ☐ CCS Staff Listing Chart.
- ☐ Fair Labor Practices Certification form, signed and dated.
- ☐ Usual and customary rate schedule

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

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
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						☐ E ☐ C				☐ Y ☐ N
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						☐ E ☐ C				☐ Y ☐ N
						☐ E ☐ C				☐ Y ☐ N
						☐ E ☐ C				☐ Y ☐ N

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 **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 be listed as an 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	☐	☐

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____

Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here | **Signature of U.S. person** ▶ | **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

COMPREHENSIVE COMMUNITY SERVICES
Usual & Customary Rate Schedule

Provider Agency Name: _____

CCS Service Delivery Time, Documentation, and Travel Time

Modifier Description	Cost Per Quarter Hour
(APNP) Advanced Practice Nurse Prescriber with Psychiatric Specialty	
(MD) Psychiatrist Level	
(PhD) Doctoral Level	
Masters Degree Level (includes Qualified Treatment Trainee Types 1 & 2)	
Registered Nurse	
Bachelors Degree Level	
Associate Degree Level (includes Certified Peer Specialist and Rehabilitation Worker)	

Provider Agency Signature: _____ **Date:** _____

Print Name and Title: _____

County Signature: _____ **Date:** _____

Print Name and Title: _____

DANE COUNTY
DEPARTMENT OF HUMAN SERVICES

JOE PARISI
DANE COUNTY EXECUTIVE

Dane County Department of Human Services
Division of Adult Community Services

Director – Lynn Green
Division Administrator – Todd Campbell

To: CCS Service Providers
From: Todd Campbell
Re: Usual & Customary Rates That Exceed CCS Interim Rates
Date: August 7, 2017

Dane County Department of Human Services (DCDHS) has a fiduciary responsibility to taxpayers and the Wisconsin Medicaid Program. This means that what DCDHS bills for CCS services must be reasonable and justifiable.

DCDHS typically limits rates to levels that are at or below the Wisconsin Department of Health Services' CCS Interim Rates. Your agency has submitted usual and customary rates for staff that exceed the CCS Interim Rates. In order for DCDHS to consider approving rates above this threshold, your agency must provide additional documentation, such as a budget or other detail that supports the requested rate.

If you have questions about this requirement or the documentation that must be provided, please contact Senior Accountant Laura Yundt at 608 242-6452 or yundt@countyofdane.com

Thank you.

Credential	Interim Rate (1/4 hour)
Masters Degree	$32.14
Bachelors Degree, RN	$21.43
APNP, MD	$53.57
PhD	$40.00
Associate Degree	$13.97

DANE COUNTY DEPARTMENT OF HUMAN SERVICES
COMPREHENSIVE COMMUNITY SERVICES

APPLICATION and CONTRACTING FAQ

12.7.2017

General Questions

1. I am just starting my business, what do I need to know?

   A lot. Thankfully, there are a number of resources to which you can turn, such as:
   - State of Wisconsin Business pages website at: http://www.wisconsin.gov/Pages/business.aspx . This is a treasure trove of information from registering your business to accessing tax information and forms.
   - Wisconsin Women's Business Initiative Corporation (WWBIC). Don't be fooled by the name, this statewide organization works with men and women by offering classes in business planning, financing, personal financial management, and more. Their website is at: https://www.wwbic.com/ .
   - Service Core of Retired Executives (SCORE) is a network of volunteer, expert business mentors who lend their time and expertise through mentoring, workshops, and educational resources. More information is on their website at: https://www.score.org/ .
   - University of Wisconsin School of Business offers a number of Startup Business Courses. More information may be found on their web site at: https://bus.wisc.edu/cped/sbdc/program-topics/start-up-business-solutions .
   - National Council of Non-Profits has an entire section to starting a non-profit organization on their web site at: https://www.councilofnonprofits.org/tools-resources/how-start-nonprofit .

   A good approach is to work with or for another business and to learn as much as you can from them about the fiscal and administrative aspects of the business before venturing out on your own.

2. What are the minimum standards to become a CCS provider?

   A good place to start is to review the DCDHS Provider web page regarding the Comprehensive Community Services Program found at: https://danecountyhumanservices.org/ccs/prov/default.aspx . This has links to a number of resources including Wisconsin Administrative Code Ch. DHS 36 which outlines the program requirements and to the *Provider Handbook* that contains important information on the CCS service array, steps to becoming a provider, ongoing expectations of providers, and authorization and billing information.

   For all agencies, DCDHS requires that the agency has a designated fiscal staff person with the appropriate credentials who is not a program staff person OR that the agency contracts with an outside accounting firm.

   For agencies providing service facilitation services, DCDHS requires that the agency has at least a 25% full-time equivalent (FTE) CCS Mental Health Professional directly employed by the Agency who meets the minimum qualifications described in DHS 36.10(2)(g)1-8 with the ability to provide consultation during agency business hours throughout the work week AND has at least three (3) full-time equivalent (FTE) service facilitators directly employed by the agency. These

requirements must be met within one year of the initial contract, with the discretion to extend the timeline upon DCDHS approval.

For agencies providing service array services, DCDHS requires that the agency has a CCS Supervisor directly employed by the Agency who meets the minimum qualifications described in DHS 36.10(2)(g)1-8 OR CCS staff on the CCS Staff Listing have a mean experience of at least two (2) years providing psychosocial rehabilitation within any of the service array categories to individuals with mental health and/or substance use disorders. This means that while some staff may have less than two years of experience, across all CCS staff the average should be two years.

Fiscal Questions

3. I use Quickbooks, do I need an Accountant or Bookkeeper too?

   The short answer is yes. Quickbooks is a tool. It does not replace the knowledge or expertise of a fiscal professional or someone with an accounting background. Nor will it assure that your paperwork and documentation are ready to withstand an audit.

   In considering your organization's financial management system, you will want to reference the Department of Health Services *Financial Management Manual* https://www.dhs.wisconsin.gov/business/fmm-toc.htm . In particular Chapter 2, Accounting Records and Source Documentation, would be most helpful to small agencies.

4. Will I need an audit?

   If your organization receives $25,000 or more from the Department of Human Services in a year, then a financial audit will be needed.

5. How do I find an auditor?

   We can not recommend any specific auditing or accounting individual or firm. You may want to check with other businesses to see who they have used. The Wisconsin Institute of Certified Public Accountants has a web site that allows a search for Certified Public Accountants, including those who handle audits, at: http://www.wicpa.org/Content/PublicResources/findacpa.aspx . Accounting Firms and Certified Public Accountants in Wisconsin are credentialed by the Wisconsin Department of Safety and Professional Services.

   The State of Wisconsin, Department of Health Services on their web site: https://www.dhs.wisconsin.gov/business/fmm-d1.htm has additional resources on how to contract for audit services.

   Just like with any service, you will want to get more than one estimate on the cost of your audit. It is helpful to work with an auditor who has experience working with government/non-profit agencies; one with experience working with the Comprehensive Community Services program is a bonus.

6. What is the cost of an audit?

   There are a number of factors which impact the cost of an audit. Audits start in the neighborhood of $5,000 and go on up. The cost of an audit should be factored into the cost of doing business.

7. How do I set my rates for services?

   This is where a fiscal professional can help. See the resources listed under questions 1 and 5.

   An example prepared by our Accounting staff, which would need to be customized for your agency, is as follows:

Example Unit Rate Calculation:	
Direct Service (billable) Hours per Day:	6
Indirect (non-billable) Hours per Day:	2
Total Hours per Day	8
Total Hours per Year	2,080
Less Vacation, Sick, Holiday Hours	(184)
Net Annual Hours	1,896
Total Number of Staff	1
Net Allowable Operating Costs	$200,000
Divided by Net Annual Hours	1,896
Unit Rate per Hour	$105.49
Unit Rate per Quarter Hour	$26.37

8. How do I obtain the required insurance – professional liability insurance, commercial general liability insurance, etc.?

   Start by contacting your personal insurance company.

Application Specific Questions

Application Summary

9. What is a Federal EIN?

   An EIN is an Employer Identification Number. It is also known as a Federal Tax Identification Number (TIN) and is used to identify a business entity. To learn more, check out the IRS website at: https://www.irs.gov/businesses/small-businesses-self-employed/employer-id-numbers .

10. What is a DUNS number?

    D-U-N-S, which stands for data universal number system, is a unique nine-digit identifier for businesses. It is used to establish a business credit file. It is also required when doing business with the federal government and associated agencies. More information may be found on the Dun & Bradstreet web site at: http://www.dnb.com/duns-number/what-is-duns.html .

Agency Background

11. What is an independent contractor versus an employee?

    The Internal Revenue Service (IRS), has a web page dedicated to tackling this question at: https://www.irs.gov/businesses/small-businesses-self-employed/independent-contractor-self-employed-or-employee . Please be sure to check this site so that you do not inadvertently run afoul of the rules.