

*Supporting a Better
Tomorrow...Today*

DMH Provider Meeting

January 21, 2015



Purpose of Today's Meeting

- Provide information regarding changes implemented by the Division of Certification that will affect the following:
 - Submission of applications for new services, programs and changes to programs
 - Submission of plans of compliance
 - Requests for waivers of DMH Operational Standards

Submission of Applications

- Separate applications based on action
 - **Application for new service(s)** – submitted when an agency is not currently certified to provide a service
 - **Application for new program** – submitted when an agency is adding a physical location for a certified service
 - **Application to change a service** – submitted when an agency is modifying a service (i.e. target population or geographic location to be served)
 - **Application to change a program** – submitted when an agency is moving a program from one location to another, changing name or capacity

Application for new service(s)



Division of Certification New Service Application Cover Sheet

INSTRUCTIONS: This application is utilized by DMH certified providers to add services as part of the public mental health system to individuals with serious mental illness (SMI), serious emotional disturbance (SED), intellectual/developmental disabilities (IDD), and substance abuse disorders (SA). Please read carefully and complete this form. All attachments must be submitted with the completed application. Please type or print legibly. If additional space is needed, please provide the information as attachments and reference the application section.

Please note, incomplete applications or applications that do not include required attachments will not be processed by DMH. The Division of Certification will not keep incomplete applications on file. If an application is voided a new application must be submitted.

A. DMH Certified Provider: _____

Date of Application: _____

DMH Certification Designation(s) Currently Held:

DMH/D _____ DMH/H _____ DMH/C _____ DMH/O _____ DMH/G _____ DMH/P _____

B. **Provider Contact Information:** Please include a single contact person responsible for this application. A primary place of business, primary and secondary telephone numbers, and valid email address must be included. It is the responsibility of the applicant to provide valid contact information to ensure timely communication during the application process. All correspondence will be conducted with the indicated contact person or the provider's Executive Director.

Contact Person: _____ Position _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address (if not same): _____

City: _____ State: _____ Zip Code: _____

Telephone Number (primary) _____ (secondary) _____

Email Address _____ Fax Number _____

C. **Assurances and Signatures:** As evidenced by my signature below, I understand that submission of and/or approval of this application is not a guarantee of funding from any source. I certify that the information contained in this application is true and correct to the best of my knowledge. I certify that the agency is incorporated in the state of Mississippi (documentation attached). I certify that the agency I represent is fiscally compliant with applicable DMH fiscal management standards and practices and is compliant with and in good standing with all non-DMH external funding sources. I further certify that the agency I represent has sufficient safeguards in place to assure that all program components operate in an ethical, moral, legal and professional manner and that this agency meets the DMH Operational Standards for provision of services

Executive Director Signature _____ Date _____

		Application to Add a New Service
Service – Specific Information		
New Service to be Certified		
Geographic Area(s) to be Served (County Must be Included)		
Days/Hours New Service Will be Available		
Proposed Start Date		
Target Population		
Is Service Location-based? Yes _____ No _____ *If Service is Location-based, a separate Program Application must be submitted for each physical location where services will be provided. Prior DMH Certification of Service? If so, provide date(s) _____		
Required Attachments: _____ Policies and Procedures for New Service(s) _____ Staffing Plan, including Staff qualifications and/or credentials _____ Job Descriptions for Staff providing the New Service(s) _____ Position Specific Staff Training Plan		
Other Documentation Included for Review: _____		

Please note, incomplete applications or applications that do not include required attachments will not be processed by DMH. The Division of Certification will not keep incomplete applications on file. If an application is voided a new application must be submitted.

Important to Remember

- The following must be submitted with the application:
 - Policies and procedures for the service
 - Staffing plans
 - Job descriptions
 - Staff Training Plans
- All **completed attachments** must be submitted **with** the application in order for it to be processed.
 - Includes pest control, fire inspection, health inspection (if applicable), etc.
- Separate Applications must be submitted if the provider is applying for more than one service.

Application for a New Program



Division of Certification New Program Application Cover Sheet

INSTRUCTIONS: This application is utilized by DMH certified providers to add programs within the public mental health system to individuals with serious mental illness (SMI), serious emotional disturbance (SED), intellectual/developmental disabilities (IDD), and substance abuse disorders (SA). Please read carefully and complete this form. All attachments must be submitted with the completed application. Please type or print legibly. If additional space is needed, please provide the information as attachments and reference the application section.

Please note, incomplete applications or applications that do not include required attachments will not be processed by DMH. The Division of Certification will not keep incomplete applications on file. If an application is voided a new application must be submitted.

A. DMH Certified Provider: _____

Date of Application: _____

DMH Certification Designation(s) Currently Held:

DMH/D _____ DMH/H _____ DMH/C _____ DMH/O _____ DMH/G _____ DMH/P _____

B. Provider Contact Information: Please include a single contact person responsible for this application. A primary place of business, primary and secondary telephone numbers, and valid email address must be included. It is the responsibility of the applicant to provide valid contact information to ensure timely communication during the application process. All correspondence will be conducted with the indicated contact person or the provider's Executive Director.

Contact Person: _____ Position: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address (if not same): _____

City: _____ State: _____ Zip Code: _____


Telephone Number (primary) _____ (secondary) _____

Email Address _____ Fax Number _____

C. Assurances and Signatures: As evidenced by my signature below, I understand that submission of and/or approval of this application is not a guarantee of funding from any source. I certify that the information contained in this application is true and correct to the best of my knowledge. I certify that the agency is incorporated in the state of Mississippi (documentation attached). I certify that the agency I represent is fiscally compliant with applicable DMH fiscal management standards and practices and is compliant with and in good standing with all non-DMH external funding sources. I further certify that the agency I represent has sufficient safeguards in place to assure that all program components operate in an ethical, moral, legal and professional manner and that this agency meets the DMH Operational Standards for provision of services

Executive Director Signature _____ Date _____

Application for a New Program

		Application to Add a New Program *Provider must already be certified for the Service	
Program – Specific Information			
Name of Program to be Certified			
Physical Address of New Program			
Room Number (if applicable)			
Program Location (Name of school or building if applicable)			
Days/Hours New Program will be in Operation			
Proposed Start Date			
Requested Capacity based on usable physical space			
Target Population (For Day Treatment, specify ages/age-range of individuals to be served)			
List all DMH – certified services to be provided at the locations (attach additional pages if needed)			
Is This Location Currently Certified by DMH? Yes _____ If yes, Provide Certificate Number _____ No _____			
Was the Location Previously Certified by DMH? If so, provide date(s) _____			

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Are any non-DMH certified services provided at this physical location? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Nature/description of the non-DMH – certified services	
Geographic Area(s) to be Served (county, city, school districts) *If School District, Must Specify District Wide or Specific School)	
Required Attachments: _____ Floor Plan for New Program (including dimensions and designated usable space with service areas clearly identified) _____ Staffing Plan, including Staff qualifications and/or credentials _____ Job Descriptions for Staff providing the New Services _____ Site Specific Permits, Licenses, Inspection Reports or other	
Other Documentation Included for Review:	

Please note, incomplete applications or applications that do not include required attachments will not be processed by DMH. The Division of Certification will not keep incomplete applications on file. If an application is voided a new application must be submitted.

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Important to Remember

- **Separate Applications must be submitted if the provider is applying for more than one program location.**
- Floor plans must designate either classroom numbers (school-based programs) or assigned room numbers.
- The proposed start date is only a proposed date. The certification start date is the date that programs can begin operation.
- All **completed attachments** must be submitted **with** the application in order for it to be processed.
 - Includes pest control, fire inspection, health inspection (if applicable).
 - Proof of operable utilities
 - Evidence of furnishings (as required by Rule 34.1 for Supervised Living Services)
- Submit the application and attachments when the program location is ready for review.

Important to Remember

- Usable square footage does not include:
 - Hallways, restrooms, storage areas, etc.
- Usable square footage must include space for programmatic activities.

Application to Change a Service



Division of Certification Service Modification Application Cover Sheet

INSTRUCTIONS: This application is utilized by DMH certified providers to make changes to existing certified services within the public mental health system to individuals with serious mental illness (SMI), serious emotional disturbance (SED), intellectual/developmental disabilities (IDD), and substance abuse disorders (SA). Please read carefully and complete this form. All attachments must be submitted with the completed application. Please type or print legibly. If additional space is needed, please provide the information as attachments and reference the application section.

Please note, incomplete applications or applications that do not include required attachments will not be processed by DMH. The Division of Certification will not keep incomplete applications on file. If an application is voided a new application must be submitted.

A. DMH Certified Provider: _____

Date of Application: _____

DMH Certification Designation(s) Currently Held:

DMH/D _____ DMH/H _____ DMH/C _____ DMH/O _____ DMH/G _____ DMH/P _____

B. **Provider Contact Information:** Please include a single contact person responsible for this application. A primary place of business, primary and secondary telephone numbers, and valid email address must be included. It is the responsibility of the applicant to provide valid contact information to ensure timely communication during the application process. All correspondence will be conducted with the indicated contact person or the provider's Executive Director.

Contact Person: _____ Position _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address (if not same): _____

City: _____ State: _____ Zip Code: _____

Telephone Number (primary) _____ (secondary) _____

Email Address _____ Fax Number _____

C. **Assurances and Signatures:** As evidenced by my signature below, I understand that submission of and/or approval of this application is not a guarantee of funding from any source. I certify that the information contained in this application is true and correct to the best of my knowledge. I certify that the agency is incorporated in the state of Mississippi (documentation attached). I certify that the agency I represent is fiscally compliant with applicable DMH fiscal management standards and practices and is compliant with and in good standing with all non-DMH external funding sources. I further certify that the agency I represent has sufficient safeguards in place to assure that all program components operate in an ethical, moral, legal and professional manner and that this agency meets the DMH Operational Standards for provision of services

Executive Director Signature _____ Date _____

		Application to Modify Existing Service Certification
Service Specific Information		
Certified Service to be Modified		
Changes to Certified Service		
Reason for Requested Change		
Proposed Start Date		
Required Attachments:	_____ Policies and Procedures for Certified Service(s) _____ Staffing Plan, including Staff qualifications and/or credentials _____ Job Descriptions for Staff providing the Certified Service(s) _____ Position Specific Staff Training Plan	

Please note, incomplete applications or applications that do not include required attachments will not be processed by DMH. The Division of Certification will not keep incomplete applications on file. If an application is voided a new application must be submitted.

Important to Remember

- All completed attachments must be submitted with the application in order for it to be processed.

Application to Change a Program



Division of Certification
Program Modification Application
Cover Sheet

INSTRUCTIONS: This application is utilized by DMH certified providers to make changes to existing certified programs within the public mental health system to individuals with serious mental illness (SMI), serious emotional disturbance (SED), intellectual/developmental disabilities (IDD), and substance abuse disorders (SA). Please read carefully and complete this form. All attachments must be submitted with the completed application. Please type or print legibly. If additional space is needed, please provide the information as attachments and reference the application section.

Please note, incomplete applications or applications that do not include required attachments will not be processed by DMH. The Division of Certification will not keep incomplete applications on file. If an application is voided a new application must be submitted.

A. DMH Certified Provider: _____

Date of Application: _____

DMH Certification Designation(s) Currently Held:

DMH/D _____ DMH/H _____ DMH/C _____ DMH/O _____ DMH/G _____ DMH/P _____

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Contact Person: _____ Position _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address (if not same): _____

City: _____ State: _____ Zip Code: _____


Telephone Number (primary) _____ (secondary) _____

Email Address _____ Fax Number _____

C. **Assurances and Signatures:** As evidenced by my signature below, I understand that submission of and/or approval of this application is not a guarantee of funding from any source. I certify that the information contained in this application is true and correct to the best of my knowledge. I certify that the agency is incorporated in the state of Mississippi (documentation attached). I certify that the agency I represent is fiscally compliant with applicable DMH fiscal management standards and practices and is compliant with and in good standing with all non-DMH external funding sources. I further certify that the agency I represent has sufficient safeguards in place to assure that all program components operate in an ethical, moral, legal and professional manner and that this agency meets the DMH Operational Standards for provision of services

Executive Director Signature _____ Date _____

Application to Change a Program

	Application to Modify Existing Program Certification
Change in Physical Location	
Current Certified Program to be Modified	
Current Program Certificate #	
Physical Address of New Location	
List all DMH – certified services to be provided at the locations (attach additional pages if needed)	
Is The New Location Currently Certified by DMH? Yes _____ If yes, Provide Certificate Number _____ No _____	
Was the New Location Previously Certified by DMH? If so, provide date(s) _____	
Are any non-DMH certified services provided at this physical location? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Nature/description of the non-DMH – certified services	
Requested Capacity	
Proposed Change Date	
Required Attachments: _____ Floor Plan for New Program (including dimensions and designated usable space with service areas clearly identified) _____ Site Specific Permits, Licenses, Inspection Reports or other	
Other Documentation Included for Review:	

Change the Name of Program	
Current Certified Program to be Modified	
Current Program Certificate #	
New Name of Program	
Change Capacity of Program	
Current Certified Program to be Modified	
Current Program Certificate #	
Current Capacity	
Requested Capacity	
Reason for Change	
Required Attachments: _____ Floor Plan for New Program (including dimensions and designated usable space with service areas clearly identified)	
Other Documentation Included for Review:	

Please note, incomplete applications or applications that do not include required attachments will not be processed by DMH. The Division of Certification will not keep incomplete applications on file. If an application is voided a new application must be submitted.

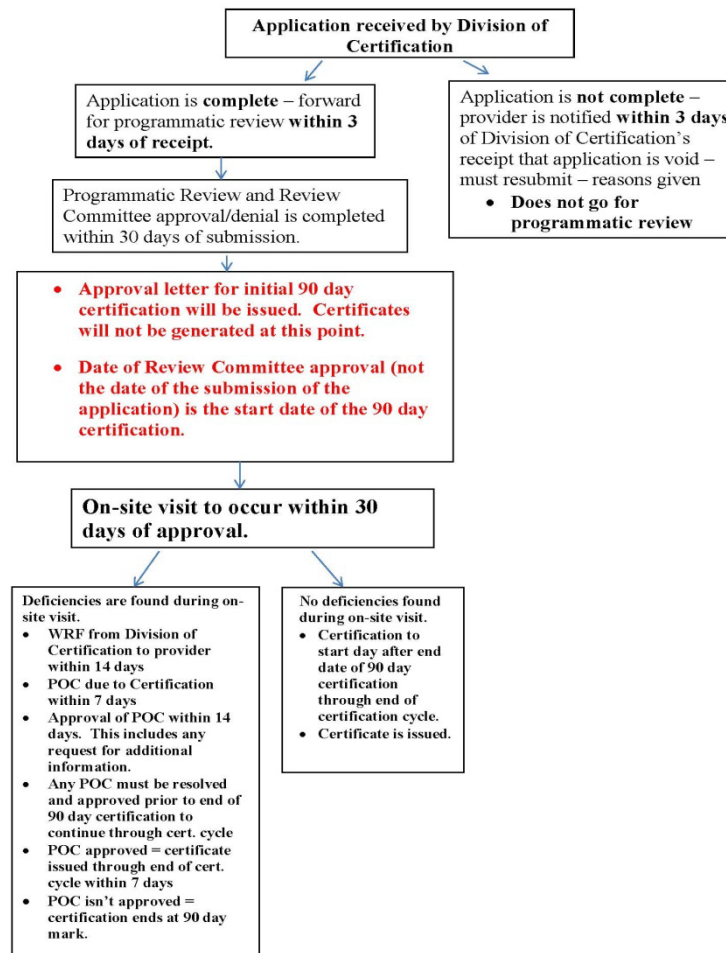
Important to Remember

- Changes in a Program can include a change in location, a change in program name, a change in capacity or any combination of the above.
 - Ex. a Day Tx program was initially in the provider's office and wants to relocate to a school setting. The location, program name and capacity will likely change.
- All **complete attachments** must be submitted **with** the application in order for it to be processed.

How Should You Submit The Information?

- **Preferred submission** is to submit a soft copy by scanning the application and attachments and email them to the Division of Certification.
 - If this is done, a hard copy via USPS is not needed by DMH. Provider should maintain the original documentation.
- Submit a hard copy of the application and attachments to the Division of Certification.
 - Provider should maintain a copy of the documentation.

Application Workflow



Important to Remember

- PLAN, PLAN, PLAN
 - Plan for a 30 day approval process for a complete application.
 - The purpose of the 30 day on-site visit is to observe the program in operation, verify staff qualifications and review documentation.
 - If programs are not ready for review and the visit cannot be conducted within the first 45 days, certification will lapse.

Plans of Compliance

Submission of a Plan of Compliance (POC) – Due Dates

- Applications for **new services and programs** – due within **7 calendar days**
 - POC must be approved in order to continue certification beyond 90 day initial certification.
- Written Reports of Findings from certification visits – due within **30 calendar days**
 - **All deficiencies related to Chapter 13,32, and 34 must be corrected within 30 days of WRF.**

Plans of Compliance

- Must be submitted on DMH required form.
DMH will no longer accept plans not submitted in this format.
- Must include evidence of corrective action.
 - Examples would include photographs of work completed, copies of invoices or work order for work completed, revised policies and procedures, revised staffing and continuing education plans, revised forms, etc.

Submission of Waiver Requests

- Waiver requests must be submitted with all required documentation.
 - Submitted by Ex. Director
 - Identifies Standard to be waived
 - How the intent of the standard will be met
 - Justification of how the waiver will not diminish the quality of service
 - The service/program location for which the waiver is requested
 - Length of time the waiver is requested

Submission of Waiver Requests

- Incomplete waiver requests will not be kept and will be returned to the provider.
- Incomplete waiver requests must be resubmitted.

Please Note

- New Processes go into effect **February 1, 2015.**
- For applications submitted between now and Feb. 1, the Division of Certification will provide technical assistance regarding the new processes.
- If applications and/or waiver requests are returned due to insufficient information to process, the agency must submit a new application and/or waiver request. DMH will not maintain the original submission.
- New applications will be available on DMH's website 1/22/2015 in the resource library.
- Copies of this information will be available on DMH's website.

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