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 <u>moving</u> a program from one location to another, changing name or capacity

## Application for new service(s)



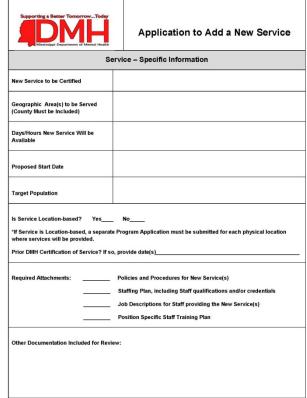
#### Division of Certification

#### **New Service Application Cover Sheet**

INSTRUCTIONS: This application is utilized by DMHI certified providers to add services as part of the public mental health system to individuals with serious mental liness (SMI), serious emotional disturbance (SEID), 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 byte 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.

Α.	DMH Certified Provider:				
	Date of Application:				
	DMH Certification Designation	n(s) Currently I	leld:		
	DMH/D DMH/H	DMH/C	DMH/O	DMH/G	DMH/P
В.	Provider Contact Information: F primary place of business, prin included. It is the responsibilit communication during the appl contact person or the provider's	nary and second y of the application process.	lary telephone nu ant to provide va All corresponder	mbers, and val	id email address must be ormation to ensure timely
	Contact Person:		Positi	on	
	Street Address:				
	City:	_ State:		Zip C	ode:
	Mailing Address (if not same)	:			
	City:	State:		Zip C	ode:
	Telephone Number (primary)			(secondary)	
	Email Address		Fax Number _		
c.	Assurances and Signatures: As evidenced by my signature below, I understand that submission of and/o 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 an 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, legial and professional manner and that this agency meets the DMH Operational Standards for provision of services				
	Executive Director Signature_			Dat	e



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.

- The following must be submitted with the application:
  - Policies and procedures for the service
  - Staffing plans
  - Job descriptions
  - Staff Training Plans
- All <u>completed attachments</u> must be submitted <u>with</u> 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

۹.	DMH Certified Provider:					
	Date of Application:					
	DMH Certification Designation(s) Currently H	Held:				
	DMH/D DMH/H DMH/C	DMH/O DMH/G DMH/P				
3.	primary place of business, primary and secon included. It is the responsibility of the applic	a single contact person responsible for this application. dary telephone numbers, and valid email address must be ant to provide valid contact information to ensure timel . All correspondence will be conducted with the indicate or.				
	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				
С.	<u>Assurances and Signatures</u> : 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**

Supporting a Batter TornorrowToday	Application to Add a New Program *Provider must already be certified for the Service
Prog	gram – 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?  Was the Location Previously Certified by DMI	Yes If yes, Provide Certificate Number No H? If so, provide date(s)

Page 2 of 3

at this physical location?	□ Yes □ No	
signated usable space with se ffing Plan, including Staff qual Descriptions for Staff providi	ervice areas clearly identified ilifications and/or credentials ing the New Services	)
	or Plan for New Program (inc signated usable space with s fing Plan, including Staff qua Descriptions for Staff provid	at this physical location?

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 was be submitted.

- 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 <u>only</u> a proposed date. The certification start date is the date that programs can begin operation.
- All <u>completed attachments</u> must be submitted <u>with</u> 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.

- 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



A. DMH Certified Provider:

#### **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 Illiess (SMI), serious emotional distabilities (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.

Date of Applic	cation:					
DMH Certifica	ition Designatio	n(s) Currently H	Held:			
DMH/D	DMH/H	DMH/C	DMH/O	DMH/G	DMH/P	
place of busine responsibility	ess, primary and of the applicant occess. All corresponding	secondary teleph to provide valid	none numbers, and contact information	I valid email ac on to ensure t	le for this application idress must be includ imely communication contact person or the	ed. It is the during the
Contact Perso	on:		Position	on		_
Street Addres	ss:					_
City:		State:	-	Zip C	ode:	
Mailing Addre	ess (if not same)	:				
City:		State:		Zip C	ode:	_
Telephone Nu	ımber (primary)			(secondary)		_
Email Addres	s		Fax Number _			
approval of this this application of Mississippi DMH fiscal ma external fundin that all program	s application is no n is true and corre (documentation a nagement standa ng sources. I furt	t a guarantee of ct to the best of ttached). I certif rds and practice her certify that the erate in an ethica	funding from any s my knowledge. I c fy that the agency es and is compliar he agency I repres II, moral, legal and	ource. I certify ertify that the a I represent is nt with and in ent has sufficie	stand that submissio that the information of gency is incorporated fiscally compliant with good standing with a ent safeguards in plac anner and that this ag	contained in in the state applicable all non-DMH e to assure
Executive Dir	ector Signature			Da	te	_

Supporting a Bester TomorrowTode	th	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.

 All <u>completed attachments</u> must be submitted <u>with</u> 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

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

app	dication must be submitted.	
Α.	DMH Certified Provider:	
	Date of Application:	
	DMH Certification Designation(s) Currently Held:	
	DMH/D DMH/H DMH/C DMH/O	DMH/G DMH/P
В.	<u>Provider Contact Information</u> ; Please include a single contact p place of business, primary and secondary telephone numbers, a responsibility of the applicant to provide valid contact informa application process. All correspondence will be conducted wit Executive Director.	and valid email address must be included. It is the ation to ensure timely communication during the
	Contact Person:Po	sition
	Street Address:	
	City: State:	Zip Code:
	Mailing Address (if not same):	
	City: State:	Zip Code:
	Telephone Number (primary)	(secondary)
	Email Address Fax Number	er
C.	Assurances and Signatures: As evidenced by my signature approval of this application is not a guarantee of funding from a in this application is true and correct to the best of my knowled state of Mississippi (documentation attached). I certify that applicable DMH fiscal management standards and practices an non-DMH external funding sources. I further certify that the age to assure that all program components operate in an ethical, m agency meets the DMH Operational Standards for provision of se	ny source. I certify that the information contained ge. I certify that the agency is incorporated in the he agency I represent is fiscally compliant with d is compliant with and in good standing with all ncy I represent has sufficient safeguards in place oral, legal and professional manner and that this
	Executive Director Signature	Date

### Application to Change a Program

Supporting a Better TomorrowToday	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 provide	ded at this physical location?		
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:			

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:		

Change the Name of Program

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.

- 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 <u>complete attachments</u> must be submitted <u>with</u> 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**

#### Application received by Division of Certification

Application is **complete** – forward for programmatic review **within 3 days of receipt.** 

Programmatic Review and Review Committee approval/denial is completed within 30 days of submission. Application is **not complete** – provider is notified **within 3 days** of Division of Certification's receipt that application is void – must resubmit – reasons given

- Does not go for programmatic review
- Approval letter for initial 90 day certification will be issued. Certificates will not be generated at this point.
- Date of Review Committee approval (not the date of the submission of the application) is the start date of the 90 day certification.

On-site visit to occur within 30 days of approval.

Deficiencies are found during onsite visit.

- WRF from Division of Certification to provider within 14 days
- POC due to Certification within 7 days
- Approval of POC within 14 days. This includes any request for additional information.
- Any POC must be resolved and approved prior to end of 90 day certification to continue through cert. cycle
- POC approved = certificate issued through end of cert. cycle within 7 days
- POC isn't approved = certification ends at 90 day mark.

No deficiencies found during on-site visit.

- Certification to start day after end date of 90 day certification through end of certification cycle.
- · Certificate is issued.

- 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.

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## 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.

 Kris Jones, Director, Bureau of Quality Management, Operations & Standards

kris.jones@dmh.state.ms.us

- Shannon Rushton, Director, Division of Certification <u>shannon.rushton@dmh.state.ms.us</u>
- Brandy Andrews, Certification Liaison for IDD Services <u>brandy.andrews@dmh.state.ms.us</u>
- Shuana Fletcher, Certification Liaison for Substance Abuse Services

shauna.fletcher@dmh.state.ms.us

- Natasha Griffin, Certification Liaison for Adult MH Services <u>natasha.griffin@dmh.state.ms.us</u>
- Kimberly Wheaton, Certification Liaison for C/Y MH Services

kimberly.wheaton@dmh.state.ms.us

Kala Booth, Administrative Assistant

kala.booth@dmh.state.ms.us

### Supporting a Better Tomorrow...Today

# Mississippi Department of Mental Health