Chapter 503

Behavioral Health Rehabilitation Services

Appendix 503C

Application for Day Treatment Certification

APPLICATION FOR
MEDICAID DAY TREATMENT CERTIFICATION

Please complete the following identifying information for your agency.

Name of Provider/Agency operating Day-Treatment at site listed below: ________________________________

____

Provider/Agency Address: ____

____

Current Medicaid Provider Number: ____

Name of Day-Treatment Program: ____

Day-Treatment Program Address: ____

____

Effective Dates of B. H. License: ______________________ Date of Approved CON: _____________________

Name & Title of Individual Completing Application: ____

____

Telephone Number: _______________________________ Extension: __________________________________

Fax Number: ____________________________________

PROGRAM DESCRIPTION

A. THIS AGENCY IS APPLYING FOR CERTIFICATION (PLEASE CHECK ALL BOXES THAT APPLY):

☐ Initial or New Certification
☐ Clinic Services Day-Treatment Program
☐ Recertification
☐ Rehabilitation Services Day-Treatment Program

B. TYPES OF POPULATION(S) TO BE SERVED:

An application must be submitted for each day-treatment licensed program site operated by your agency. If your agency is serving more than one population at one site, a separate program activity time grid must be completed for each of the populations checked below.

1. ADULTS WITH:

☐ Alcohol/Substance Abuse ☐ Mental Illness ☐ Intellectually/Developmentally Disabled

2. CHILDREN WITH:

☐ Developmental Delay ☐ Serious Emotional Disturbances

C. SITE OF OPERATIONS

Day-Treatment Program Site:

____

Address:

____

D. HOURS OF OPERATIONS

Hours of Operation: ___a.m. ___a.m.
___p.m. ___p.m.

Days of Operations: M T W T F S S
(CIRCLE ALL THAT APPLY)

E. PROGRAM CAPACITY

In the last month, what was:

1. Average number of clients served in program per day? ________________
2. Maximum number of clients who can be served on any day? ________________

PROGRAM SUMMARY

Please provide a summary description of the program at this site which includes the following points:

- ❈ Difference in programmatic approaches or emphasis on each population served at this site

- ❈ Program admission and discharge criteria

- ❈ Differences in programmatic approaches to individuals with lower-versus-higher functional impairment

- ❈ Any specific programmatic emphasis or focus

MANAGEMENT AND PERSONNEL

1. DAY-TREATMENT PROGRAM DIRECTOR:

   NAME: ____

   QUALIFICATIONS: ____

   EDUCATION: ____

   ____

   ____

2. ATTACH QUALIFYING WORK EXPERIENCE (Resume may be used if it indicates dates of experience for each position held by month/year.)

   Date of Experience:

3. As qualifying work experience, this agency assures that the individual named above meets the minimum qualifications for day-treatment program director in terms of education, type(s) of position(s) held previously, length of work experience, and experience with the disability type served by this program, and written reference checks.

   _____ Yes   Date of Review: _______________________________

4. PROGRAM DIRECTOR TIME SCHEDULE:

   A. Please indicate the number of hours per week the program director spends in program management activities, such as staff scheduling, activities planning, service plan review, treatment planning, etc.

      _________________ Program management hours per week

   B. Please indicate the number of hours per week the program director spends carrying out or participating directly with clients in activities listed on weekly grid.

      __________________ Day-treatment activities hours per week.

   C. List each type of staff member by job title used by your agency for day-treatment services.

JOB TITLE	NUMBER OF STAFF IN DAY-TREATMENT WITH THIS TITLE
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

5. Attach a job description for each job title listed in #1 above.

6. Attach a weekly schedule for all staff reflected in #1 above.

CLINIC DAY-TREATMENT

A. Program Activities: Population MR/DD

Please indicate which of the following activities are carried out in your agency's day-treatment program by checking the appropriate boxes and filling in the staff-to-client ratio for each activity:

Activity	Yes	No	**Staff-to-Client Ratios**
Self-Care Skills	☐ Yes	☐ No	_____ to ______
Emergency Skill	☐ Yes	☐ No	_____ to ______
Mobility Skills	☐ Yes	☐ No	_____ to ______
Nutrition Skills	☐ Yes	☐ No	_____ to ______
Social Skills	☐ Yes	☐ No	_____ to ______
Communications/Speech	☐ Yes	☐ No	_____ to ______
Physical/Occupational Therapy Reinforcement	☐ Yes	☐ No	_____ exercise to ______
Interpersonal Skills	☐ Yes	☐ No	_____ to ______
Functional Community Skills	☐ Yes	☐ No	_____ to ______
Volunteering in Community Skills	☐ Yes	☐ No	_____ to ______
Citizenship, Rights, and Responsibilities	☐ Yes	☐ No	_____ to ______
Self-Advocacy	☐ Yes	☐ No	_____ to ______
Other Services	☐ Yes	☐ No	_____ to ______
(Specify)_________________________	☐ Yes	☐ No	_____ to ______
_________________________________	☐ Yes	☐ No	_____ to ______
_________________________________	☐ Yes	☐ No	_____ to ______