Chapter 503

Licensed Behavioral Health Center (LBHC) 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
☐ Recertification
☐ Clinic Services Day-Treatment Program
☐ 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 Sun
(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:

			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 _____