Green County Human Services
Green/Lafayette Comprehensive Community Services (CCS)
Psychosocial Rehabilitation Services

Request for Proposals Application

<table>
<tr><td>ORGANIZATION LEGAL NAME</td><td colspan="2"></td></tr>
<tr><td>MAILING ADDRESS

If P.O. Box, include Street Address on second line</td><td colspan="2"></td></tr>
<tr><td>TELEPHONE</td><td></td><td>LEGAL STATUS</td></tr>
<tr><td>FAX NUMBER</td><td></td><td rowspan="5">☐ Private, Non-Profit
☐ Private, For Profit

Federal EIN: Click or tap here to enter text.

DUNS Number: Click or tap here to enter text.</td></tr>
<tr><td>WEBSITE (IF APPLICABLE)</td><td></td></tr>
<tr><td>NAME CHIEF ADMIN/CONTACT</td><td></td></tr>
<tr><td>EMAIL ADDRESS</td><td></td></tr>
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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 (CCS) for persons with mental disorders and substance-use disorders. I have reviewed the RFP and Chapter DHS 36.

Signature of Legal Representative/Organization Head	Title
Printed Name	Date

SECTION 1: AGENCY BACKGROUND INFORMATION

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?

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

5. Total number of current employees (CCS + Non-CCS):

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 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: Click or tap here to enter text.		
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? If yes, please attach an explanation.	☐	☐

8. Is your agency currently DHS 35 (Outpatient Mental Health Clinic) or DHS 75 (Community Substance Abuse Service Standards) certified?

☐	Yes, DHS 35 Certified
☐	Yes, DHS 75 Certified
☐	Yes DHS 35 & DHS 75 Certified
☐	No

SECTION 2: 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 an proceedings pending?	☐	☐
Are any owners, Directors, or staff included on the Office of Inspector General Exclusion List?	☐	☐

Please attach a detailed explanation for any YES responses.

SECTION 3: CLIENT SERVICE INFORMATION:

A. AGE GROUPS SERVED (Check all that apply)

- ☐ Kids
- ☐ Teens
- ☐ Young Adults
- ☐ Older Adults

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 Impairment
- ☐ 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
- ☐ Sever 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 population you intend to serve.

E. SERVICE LOCATIONS (Please record the locations of any facilities where serves may be provided, if different from mailing address.)

Building Name	Street Address	City

Do you provide community-based services? ☐ Yes ☐ No

Do you provide home-based services? ☐ Yes ☐ No

F. SERVICE DAYS AND HOURS

Check if Open	Day of the Week	Opening Time	Closing Time
☐	Sunday		
☐	Monday		
☐	Tuesday		
☐	Wednesday		
☐	Thursday		
☐	Friday		
☐	Saturday		

Do you offer services outside of the above service hours? ☐ Yes ☐ No

SECTION 4: EVIDENCE-BASED PRACTICE

Please list any Evidenced Based Practices utilized by Staff:

Evidenced-Based Practice	Familiar With	Utilize Concepts	Practiced to Fidelity
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

SECTION 5: OTHER CCS CERTIFICATION

Please list any other CCS Programs in Wisconsin (Outside of Green/Lafayette County) for which you or your organization provides CCS services.

County/Region/Tribe	Services Provided	Dates Services Provided

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)(6) 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 prescriber 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.

☐	Our Agency can provide the required supervision or collaboration.	Please Provide the Name and Credentials of the Person who would provide the Supervision and/or Clinical Collaboration. Name: Credentials:
☐	Our agency does not have any providers who qualify under DHS 36.10(2)(6) 1. To 8.	

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 assistances, 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 the CCS hours of operation. Please indicate below by checking the appropriate box(es), how this supervision will be provided for these staff in your agency.

☐	Our agency can provide the required supervision: 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.	Please Provide the Name and Credentials of the Person who would provide the Supervision and/or Clinical Collaboration. Name: Credentials:

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
☐	A Master Log
☐	Supervisory Records
☐	Staff record of each staff member who attends the session or review.
☐	Consumer records

SECTION 7: CCS PSYCHOSOCIAL REHABILITATION SERVICE ARRAY

A. SERVICES: Check all of the services for which you are requesting to offer in Green/Lafayette's CCS Program. Definitions for each service may be found in the on-line Forward Health 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

Service	Individual	Group
Diagnostic Evaluations	☐	

Type of Evaluations that can be provided:

Name, credentials, and relevant experience of individual(s) who would provide this service *(Please indicate if you would be hiring staff to provide this service):*

Medication Management	☐	

Name, credentials, and relevant experience of individual(s) who would provide this service *(Please indicate if you would be hiring staff to provide this service):*

Physical Health Monitoring	☐	

Name, credentials, and relevant experience of individual(s) who would provide this service *(Please indicate if you would be hiring staff to provide this service):*

Peer Support ☐ ☐

Name, credentials, and relevant experience of individual(s) who would provide this service *(Please indicate if you would be hiring staff to provide this service):*

Individual Skill Development and Enhancement ☐ ☐

Name, credentials, and relevant experience of individual(s) who would provide this service *(Please indicate if you would be hiring staff to provide this service):*

Employee Related Skill Development ☐ ☐

Name, credentials, and relevant experience of individual(s) who would provide this service *(Please indicate if you would be hiring staff to provide this service):*

Individual and/or Family Psychoeducation ☐ ☐

Name, credentials, and relevant experience of individual(s) who would provide this service *(Please indicate if you would be hiring staff to provide this service):*

Wellness Management and Recovery/Recovery Support Services	☐	☐

Name, credentials, and relevant experience of individual(s) who would provide this service *(Please indicate if you would be hiring staff to provide this service):*

Psychotherapy	☐	☐

Name, credentials, and relevant experience of individual(s) who would provide this service *(Please indicate if you would be hiring staff to provide this service):*

Substance Abuse Treatment	☐	☐

Name, credentials, and relevant experience of individual(s) who would provide this service *(Please indicate if you would be hiring staff to provide this service):*

SECTION 8: RATE SETTING INFORMATION

Please complete a Rate Worksheet for each Service identified under Section #7.

CCS Rate Worksheet

Name of Service:

Please enter the rates that your agency will be requesting for the 2021-2022 contracting period.

	Individual	**Group**
Professional Type	**Rate Per Unit***	**Rate Per Unit***
MD		
APNP Advanced Practice Nurse Prescriber		
PH.D.		
Masters		
Registered Nurse		
Bachelors		
Certified Peer Specialist		
Associates with qualifying DSPS Credential (Includes SAC-IT, SAC, CSAC, LPN, COTA)		
Rehabilitation Worker		

* One Unit = One Quarter Hour of Service.

Please attached a detailed explanation of how your agency established the above rates.

Please Note: Rates above the Comprehensive Community Services (CCS) Interim Medical Assistance rates, will be considered based on the extent to which the provider is filling an identified gap in the Green/Lafayette CCS Provider Network.

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