**Child Specific Congregate Care**

**Use of form:** Use of this form is mandatory for DMCPS Contracted Case Management Agencies who are requesting to place a DMCPS child in a Child Specific Congregate Care Facility. Child Specific Congregate Care refers to any facility in Wisconsin that does not have a contract with DMCPS, OR any out-of-state facility that provides treatment for children.

**Instructions**: Please complete this form entirely and as accurately as possible to ensure a setting is appropriate for the child and a Child Specific contract can be completed. Incomplete forms will be returned, causing a delay in approval. Allow a minimum of 30-days for a response as to the appropriateness of the Congregate Care site.

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| **SECTION A – CONTRACTED CASE MANAGEMENT AGENCY INFORMATION** | | | | | | |
| Contracted Case Management Agency | | | | | | |
| Name of Individual Completing Form | | | | | | |
| Role of Individual Completing Form | | | | | | |
| Email of Individual Completing Form | | | Phone Number of Individual Completing Form | | | |
| **SECTION B – CHILD SPECIFIC FACILITY TYPE** | | | | | | |
| Expect 30 days for an approval of the facility for placement. If the facility will not accept a letter of intent to pay (see Section F) prior to the contract being signed, an additional 30-day approval time can be expected (for a total of up to 60-days). The form must be completed in its entirety. | | | | | | |
| Facility Type  Group Home  Residential Care Center  Treatment Foster Care Agency  Group Home – QRTP  Residential Care Center – QRTP  Psychiatric Residential Treatment Facility (PRTF)  Other – Specify: | | | | | | |
| **SECTION C – CHILD’S CASE INFORMATION** | | | | | | |
| Child’s Name | | | | | | eWiSACWIS ID |
| Child Current Placement Type | | | | Anticipated Placement Start Date | | |
| If the child has any physical health, medical diagnoses, or other concerns, explain the child’s needs in detail. If there are none, answer “none.” | | | | | | |
| **SECTION D – ASSESSMENT OF THE CHILD SPECIFIC CONGREGATE CARE FACILITY** | | | | | | |
| Yes  No Is the facility associated with a corporate agency (e.g., Rite of Passage, Universal Health Services, etc.)? If “Yes”, provide the name, address, and phone number of the agency. If “No”, skip to Facility Name below. | | | | | | |
| Corporate/Organization Name | | | | | | |
| Corporate/Organization Address | | | | | | |
| Corporate/Organization Phone Number | | | | | | |
| Facility Name (if different from Corporate name) | | | | | | |
| Facility Owner/Operator | | | | | | |
| Facility Address (if different from Corporate address) | | | | | | |
| Facility Phone Number (if different from Corporate number) | | | | | | |
| Name of Person Responsible for Signing a Contract with DMCPS | | | | | | |
| Title of Person Responsible for Signing a Contract with DMCPS | | | | | | |
| Address of Person Responsible for Signing a Contract with DMCPS | | | | | | |
| Person’s Phone Number | Person’s Email | | | | | |
| Child Specific Facility Research: Information on the Child Specific Facility should be well researched. Please include websites, media alerts, dates of concerns, State licensing portals, etc. Information can be entered in this section or submitted as an attachment. | | | | | | |
| Yes  No Does the facility report any licensing violations in the last five (5) years? If “Yes,” list the date of the violations, any corrective action plans/holds, and how the facility modified or made changes to reflect the violations. Note: This can be submitted as an attachment. | | | | | | |
| Yes  No Does this facility use conversion therapy? If “Yes”, youth cannot be placed per [Executive Order #122:](https://evers.wi.gov/Documents/EO/EO122-Conversion%20Therapy.pdf) and the placement will not be approved. | | | | | | |
| Yes  No Does this facility use chemical restraints?  Yes  No If “Yes”, does the facility agree to adhere to [Wis. Stat. Ch. 48](https://docs.legis.wisconsin.gov/statutes/statutes/48/vi/345) or [Wis. Admin. Code Ch. DCF 52](https://docs.legis.wisconsin.gov/code/admin_code/dcf/021_099/52) and refrain from using chemical restraints for any child placed by DMCPS? | | | | | | |
| Yes  No Is the facility considered a “secured” facility? If “Yes”, explain the facility and the State’s definition of secure versus unsecure. | | | | | | |
| Yes  No Does the facility violate any codes under [Wis. Stat. Ch. 48](https://docs.legis.wisconsin.gov/statutes/statutes/48/vi/345), or [Wis. Admin. Code Ch. DCF 52](https://docs.legis.wisconsin.gov/code/admin_code/dcf/021_099/52)? If Yes, please explain. Note: This can be submitted as an attachment. | | | | | | |
| Yes  No Under the facility’s state licensing code, is the child specific facility QRTP certified? If “No,” skip to the “Provide a detailed explanation of how this facility is experienced” question below.  Yes  No Does the QRTP-certified facility have a state-required assessment protocol before acceptance/placement? If “Yes”, explain the protocol including how often the child will be re-evaluated, is payment through service dollars by the Contracted Case Management Agency (a copy of the payment agreement to DMCPS is required for the contract). | | | | | | |
| Provide a detailed explanation of how this facility is experienced and appropriate in meeting the youth’s treatment needs, including those listed in Section C. You may provide this in an attachment. | | | | | | |
| Yes  No  Not applicable If the child has any physical health, medical diagnoses, or other concerns as stated in Section C, is the facility aware of the needs and are able to safely tend to those needs? | | | | | | |
| Discharge Plan. Please summarize the Contracted Case Management Agency’s plan for the youth after placement in the Child Specific Congregate Care Facility. Note: Information should also be documented in eWiSACWIS. | | | | | | |
| ICPC Status | | | | | | |
| IV-E Determination | | | | | | |
| Yes  No Does this state accept Wisconsin Medicaid? If “No”, what is the Contracted Case Management Agency’s plan to ensure the child’s medical needs (emergency and non-emergency) are met while out of state? | | | | | | |
| **SECTION E – CHILD SPECIFIC FACILITY INFORMATION FOR CONTRACT** | | | | | | |
| Child Specific Daily Rate. Detail what the daily rate includes. An attachment from the facility on the breakdown of the daily rate is acceptable. | | | | | | |
| Yes  No The Child Specific Facility has their own Scope of Services. If “Yes”, please request a copy and attach it to this form. If “No”, please attach a draft version of DMCPS’s *Out-of-State Child Specific Scope of Service* that is a summary of the contract obligations, and add the date sent below. | | | | | | |
| Child Specific Facility License Status (current, expired, on hold, etc.). Attach a copy of the license. | | | | | | |
| Name of the Child Specific Facility’s Licensor or Licensing Agency | | | | | Licensing Phone Number | |
| Child Specific Licensing Email Address | | Child Specific Licensing Website | | | | |
| **SECTION F – LETTER OF INTENT** | | | | | | |
| Yes  No Is the Child Specific Facility willing to accept a Letter of Intent to Pay while the contract is in process? If “No,” what is the Facility’s preference? | | | | | | |
| **SECTION G – CHILD SPECIFIC FACILITY PERSON RESPONSIBLE FOR RECEIVING LETTER OF INTENT** | | | | | | |
| Yes  No The person responsible for signing the contract (Section D) is also responsible for signing the letter of intent. If “No,” provide the information below: | | | | | | |
| Name | | | | | | |
| Title | | | | | | |
| Address | | | | | | |
| Phone Number | Email | | | | | |

When this form is appropriately completed, send it along with the child’s approved DMCPS *Higher Level of Care Request* form to: [DCFDMCPSHLOCRequest@wisconsin.gov](mailto:DCFDMCPSHLOCRequest@wisconsin.gov).

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| **TO BE COMPLETED BY DMCPS ONGOING SERVICES SECTION** | | | |
| Name of OSS Reviewer | | | Date Form Received |
| Yes  No Approved to continue (after review of information). If “Yes,” provide date of approval: | | | |
| Yes  No Denied. If “Yes,” provide the reason for the denial: | | | |
| Yes  No Staffing needed. If “Yes,” provide date staff needed by: | | | |
| **Task** | **Date of Contact** | **Date Completed** | |
| Site Visit |  |  | |
| New Vendor Contract Paperwork |  |  | |
| Letter of Intent |  |  | |
| **Final Placement Determination** | | | |
| Approved (Date       Note: Approval expiration is 90 days after final approval date)  Not approved (Reason for denial      )  Follow up needed (Date needed      . Explanation for what is needed      ). | | | |