**Qualified Residential Treatment Program Continuation Application**

**Use of form:** Completion of this form is mandatory to seek certification continuation as a qualified residential treatment program (QRTP). The information requested on this form is required under DCF 61.05. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

**Instructions:** Complete each section of the application and submit this form and any additional documentation to the department by uploading each form to the Provider Information Exchange (PIE) website.

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| **A. FACILITY & LICENSEE INFORMATION** | |
| Facility Name: | Facility Type:  Group Home  Shelter Care  Residential Care Center |
| Facility Address: | Mailing Address: |
| Licensee Name: | Licensee Email Address: |
| Are you seeking continuation of all programs currently certified as a QRTP?  YES  NO  If ‘NO,’ please list all programs seeking certification as a QRTP: | |
| **B. POLICY/PROGRAM REQUIREMENTS & DOCUMENTATION INSTRUCTIONS** | |
| Policy and program requirements are outlined below. Each area must be supported with documentation provided by the facility. Documentation should be uploaded to the facility’s folder in the Provider Information Exchange (PIE) website. In the facility’s folder, locate the folder named ‘QRTP Certification’ and upload all applicable documents labeled according to its corresponding section and number. For example, label the facility’s proof of accreditation as B.6, etc. | |
| 1. Trauma-Informed Treatment Model  Provide a copy of the trauma-informed treatment model to be used by the facility with a description of how the facility’s treatment model meets the conditions in DCF 61.03(1). | |
| 2. Nursing Staff  Will the facility be utilizing the 24/7 nursing hotline contracted by DCF?  YES  NO  Are there any changes or updates to the facility’s plan to meet the requirements of DCF 61.03(2) since the previous certification period?  YES  NO  If ‘YES,’ provide documentation of the facility’s plan to meet the requirements of DCF 61.03(2). Documentation should include job descriptions and resumes or contract information for each staff member. | |
| 3. Licensed Clinical Staff  Are there any changes or updates to the facility’s plan to meet the requirements of DCF 61.03(2) since the previous certification period?  YES  NO  If ‘YES,’ provide documentation of the facility’s plan to meet the requirements of DCF 61.03(2). Documentation should include job descriptions and resumes or contract information for each staff member. | |
| 4. Family Participation Policies  Are there any changes or updates to the family participation policies and procedures as required in DCF 61.03(3)(c) since the previous certification period?  YES  NO  If ‘YES,’ provide a copy of the policies and procedures as required in DCF 61.03(c). | |
| 5. Discharge Planning and Family Based After-Care Support    Are there any changes or updates to discharge planning and family-based aftercare support policies and procedures as required in DCF 61.03(4) since the previous certification period?  YES  NO  If ‘YES,’ provide documentation of the policies and procedures pursuant to DCF 61.03(4). | |
| 6. Accreditation  Provide documentation of accreditation by one of the following agencies, as required by DCF 61.03(5):  The Commission on Accreditation of Rehabilitation Facilities (CARF)  The Joint Commission on Accreditation of Healthcare Organizations (JCAHO)  The Council on Accreditation (COA)  Teaching Family Association (TFA)  Educational Assessment Guidelines Leading toward Excellence (EAGLE) | |
| **C. SIGNATURE AND ACKNOWLEDGMENT** | |

I acknowledge having received the rules for certification of a QRTP (DCF 61) and accept legal responsibility for complying with all administrative rules as promulgated by the department under the authority of s. 48.675, Wis. Stats. By signature, I signify a willingness to provide the department with information to verify whether or not the requirements for a QRTP certification are met and further authorize the department to make such investigation as is necessary for verification of these factors, including access to premises any time during hours of operation.

I affirm that all statements made in this application and any attachments are true and correct to the best of my knowledge. I understand that failure to submit correct or truthful information or omitting information is grounds for denial, suspension, restriction, refusal to renew, revocation, withholding of a QRTP certification, or other sanction under the authority of applicable statutes or administrative codes. Credible statements made to the department that contradict information I provide under my written attestation also may be grounds for denial, revocation or other sanction of my license or certification. I will comply with all laws, rules, and regulations in Wisconsin.

     

Name – Licensee (printed) Title of Licensee

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Signature – Licensee Date of Signature