Certification Manual
For
Rehabilitative Services for Persons with Mental Illness

Appendix

1088.0.0 **DHS PARTICIPANT EXCLUSION RULE**

1088.1.0 **Purpose**

1088.1.1 DHS shall conduct business only with responsible participants. Participants will be excluded from participation in DHS programs not as penalty, but rather to protect public funds, the integrity of publicly funded programs, and public confidence in those programs. It is also the intent of this policy to prevent excluded participants from substituting others, usually immediate family members, as surrogates to continue the practices that caused DHS to exclude the participant.

1088.1.2 Participant exclusion is a serious action that shall be used only in the State's best interests and for the protection of the public and DHS. DHS shall impose exclusion only in accordance with this rule.

1088.2.0 **Substantive Rules**

1088.2.1 **Definitions:**

A. Administrative Adjudication - an adjudication conforming to the Administrative Procedure Act, codified as Ark. Code Ann. §25-15-201 *et seq*. Administrative adjudications must be limited to the extent necessary to avoid compromising any ongoing criminal investigation.

B. Appropriation - the authority granted by the Arkansas General Assembly to expend public funds for specified purposes.

C. Automatic Exclusion - exclusion imposed following and based upon a final adjudication of one or more acts or omissions described in 1088.2.3. Participants automatically excluded cannot have an administrative adjudication of the facts or law determined by the final adjudication.

D. Civil Judgment - the disposition of a civil action by any court of competent jurisdiction, whether entered by verdict, decision, settlement, stipulation, or otherwise creating a civil liability for a wrongful act.

E. Collateral Exclusion - exclusion from one program based upon a previous final exclusion from another program as provided in 1088.2.5.A and B.

F. Common Ownership - when an entity, entities, an individual or individuals possess 5% or more ownership or equity in the participant.

G. Control - where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of a participant.

H. DHS - the Arkansas Department of Human Services, including all divisions, offices, and units thereof.

I. Director - the DHS Director or the Director's designee.

J. Due Process - a full and fair opportunity to be heard, including the right to call and cross examine witnesses, as part of a civil, criminal, or administrative adjudication.

K. Final Determination – Unless provided otherwise in federal law or regulation, a final determination exists when, with respect to a determination upon which the exclusion is based, the deadline to appeal that determination has passed or all appeals have been exhausted.

L. Immediate Family Member - spouse; natural or adoptive parent, child, or sibling; step-parent, child, or sibling; father, mother, brother, sister, son or daughter-in-law; grandparent or grandchild.

M. Nonconforming Commodities or Services - goods or services not in accordance with the obligations under the contract.

N. Participant - a person or entity that is a party or is seeking to become a party to a contract, grant or agreement with DHS to furnish commodities or services to, on behalf of, or as a grantee or sub-grantee or recipient of DHS.

O. Preponderance of the Evidence - proof of any nature that, when compared with that opposing it, leads to the conclusion that the fact in issue is more probably true than not.

P. Related Party - a person or an entity associated or affiliated with, or which shares common ownership, control, or common board members, or which has control of or is controlled by the participant.

Q. Temporary Exclusion - exclusion pending an investigation and adjudication (if the participant timely requests adjudication) imposed upon a finding that there is a reasonable basis to believe that one or more grounds for exclusion as specified in this rule exist.

1088.2.2 **Application**

This rule applies to all contracts, grants, and agreements between DHS and participants involving the expenditure of appropriated funds. The rights, obligations, and remedies created and imposed by this rule are in addition to any other laws and rules pertaining to contracts and grants.

1088.2.3 **Causes for Exclusion**

DHS shall automatically exclude a participant if the participant is the subject of final determination that the participant has wrongfully acted or failed to act with respect to, or has been found guilty, or pled guilty or *nolo contendere*, to any crime related to:

A. Obtaining, attempting to obtain, or performing a public or private contract or subcontract

B. Embezzlement, theft, forgery, bribery, falsification or destruction of records, any form of fraud, receipt of stolen property, or any other offense indicating moral turpitude or a lack of business integrity or honesty

C. Dangerous drugs, controlled substances, or other drug-related offenses when the offense is a felony

D. Federal antitrust statutes

E. The submission of bids or proposals

F. Any physical or sexual abuse or neglect when the offense is a felony

1088.2.4 DHS shall exclude participants for any of the following acts or omissions that are of a character regarded by the Director to be so serious as to justify exclusion:

A. Refusal or knowing failure, without good cause, to comply with applicable requirements (including requirements contained or incorporated in statutes, rules, contracts, or purchase orders) or within the time provided in the contract or grant

B. Failure to perform or unsatisfactory performance, provided that the failure to perform or unsatisfactory performance beyond the control of the contractor or grantee shall not be considered to be a basis for exclusion

C. Failure to post any surety bond, or to provide similar guarantees acceptable to DHS required under any contract or grant

D. Substitution of commodities or services without prior written approval of DHS

E. Failure to cure nonconforming commodities or services within the lesser of a reasonable time, or the time specified in the contract or in a corrective action plan

F. Refusal to accept a contract or grant awarded in accordance with the request for proposal or invitation for bid

G. Making material misrepresentations or failing to make representations when required or when a reasonable person would naturally have been expected to affirm or deny the existence of a material fact

H. Collusion or collaboration with any bidder, proposer, or applicant in the submission of any proposal, bid, or grant application for the purpose of lessening or reducing competition

I. Failure to submit to or to supply an audit as required by federal or state law or rule

J. Failure or refusal, after request by DHS, to supply records related to the contract, proposal, bid, or application

K. Any act or omission that causes or materially contributes to placement of a lien upon the assets of the State

L. Conviction related to the use of illegal drugs, controlled substances, or other drug-related offenses when the offense is a misdemeanor

M. Any physical or sexual abuse or neglect when the offense is a misdemeanor

N. Submitting, without good cause, a bill or claim for payment exceeding the amount to which the participant is entitled

O. Failure to make repayment arrangements acceptable to the Department to repay any funds owed the Department, or failure to strictly adhere to the terms of any agreed-to repayment arrangements.

P. Failure to comply with professional standards of care or conduct applicable to the service provided.

Q. Failure to comply with standards or requirements relating to any license, permit, certification, other publicly granted authority, or accreditation needed to provide any service funded in whole or in part with public funds.

R. Failure to fully and accurately make any disclosures required by contract, federal or state law or rule.

S. Transaction of business in knowing contravention of an exclusion imposed under this rule.

1088.2.5 **Mandatory Exclusion:**

A. DHS shall exclude a participant that is presently subject to debarment, suspension, or other exclusion by any unit of the federal government or any unit of a state government, if the debarment, suspension, or exclusion was imposed after an opportunity for due process, and if federal law does not expressly prohibit collateral exclusion under the circumstances. Exclusion shall be concurrent with the period of debarment, suspension, or exclusion imposed by the federal or state government.

B. DHS shall exclude a participant upon learning that within the past year the participant was terminated for cause by any unit of the federal government or any unit of a state government, provided that the debarment or exclusion was imposed after an opportunity for due process, and provided that federal law does not expressly prohibit collateral exclusion under the circumstances. The term of exclusion shall be determined under section 1088.2.9.

1088.2.6 **Persons and Entities Excluded:** In addition to excluded participants, exclusion applies to:

A. All the participant's related parties, and the heirs and assigns of the participants and related parties.

B. The participant's immediate family members in order to prevent continued wrongdoing via a surrogate. Generally, immediate family members will be excluded from participation in any entity to which the excluded participant was a related party, any successor entity, or a start-up entity in the same or a similar program.

1088.2.7 Effect of Exclusion: Excluded participants may not receive appropriated funds except to the extent such funds are for proper charges approved before the date of exclusion. Payments are limited to the amount by which the proper charges exceed the amount of any indebtedness to DHS.

1088.2.8 DHS shall maintain a list of excluded participants. Upon being listed as an excluded participant, the participant cannot continue as a party to any DHS contract or grant, and is ineligible to submit proposals, bids, or applications to DHS for the term of the exclusion.

1088.2.9 **Term of Exclusion:** The term of the exclusion shall be set after consideration of the nature and seriousness of the wrongful act or omission warranting exclusion, the length of time since any wrongful act or omission warranting exclusion, and the goals and purposes underlying this rule. The term of exclusion must be stated in the exclusion determination. Exclusion shall be for not less than one year and at least until all appropriated funds, costs, and penalties owed to DHS by the participant are paid in full and the participant meets all contract or grant requirements as well as all applicable requirements in federal rules and laws. Exclusion of immediate family members and related parties shall run concurrently not to exceed five years.

1088.3.0 **Procedural Rules**

1088.3.1 DHS must prove the act or omission upon which the exclusion is based by a preponderance of the evidence. The participant must prove the elements of any defense by a preponderance of the evidence.

1088.3.2 Administrative due process shall be accomplished via existing DHS processes for appeals by participants.

1088.3.3 If a participant is entitled to an administrative hearing, the hearing must be held within a reasonable time after temporary exclusion, and before any exclusion other than a temporary exclusion.

DEPARTMENT CONTACT

Office of Finance and Administration
Policy and Administrative Program Management
P.O. Box 1437 – Slot W403
Little Rock, Arkansas 72203-1437
Telephone: (501) 682-6476

Ownership and Conviction Disclosure

DHS Division of Medical Services, Title XIX (Medicaid)

[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]

IMPORTANT

Read ALL instructions and definitions contained on this form and use the information as a reference while completing the Ownership and Conviction Disclosure Form.

Completion and submission of this form is a condition of participation in the Medicaid Program and is a condition of approval or renewal of a provider agreement between the disclosing entity and the Division of Medical Services.

Full and accurate disclosure of ownership and financial interests is required. Failure to submit full and accurate requested information may result in a refusal to enter into a provider agreement or contract, or in termination of existing provider agreements.

INSTRUCTIONS FOR COMPLETING DISCLOSURE FORM

Answer all questions as of the current date. If additional space is needed, attach the information at the end of the provider application before returning to the Medicaid Provider Enrollment Unit.

DEFINITIONS

Provider: a named person or entity that furnishes, or arranges for furnishing health related services for which it claims payment under the Medicaid Program

Disclosing entity: a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Indirect ownership: an ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership interest in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. (Example: If A owns 10% of the stock in a corporation which owns 80% of the stock of the disclosing entity, A's interest equates to an 8% indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80% of the stock of a corporation which owns 5% of the stock of the disclosing entity, B's interest equates to a 4% indirect ownership interest in the disclosing entity and need not be reported).

Ownership or control interest: a person or corporation that: (1) has an ownership interest totaling 5 percent or more in a disclosing entity; (2) has an indirect ownership interest equal to 5 percent or more in a disclosing entity; (3) has a combination of direct and indirect ownership interest equal to 5 percent or more in a disclosing entity; (4) owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity; (5) is an officer or director of a disclosing entity that is organized as a corporation; or (6) is a partner in a disclosing entity that is organized as a partnership.

Ownership Interest: equity in the capital, stock, or profits of the disclosing entity. To determine the percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. (Example: If A owns 10% of a note secured by 60% of the provider's assets, A's interest in the provider's assets equates to 6% and must be reported. If B owns 40% of a note secured by 10% of the provider's assets, B's interest in the provider's assets equates to 4% and need not be reported).

Managing employee: a general manager, business manager, administrator, director, or other individuals who exercise operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization, or agency

Subcontractor: (1) an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of furnishing health related services; or (2) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease to obtain space, supplies, equipment, or services provided under the Medicaid agreement. Additionally, if the accrediting agency prohibits subcontracting, sub-leasing or lending its accreditation to another organization, Arkansas Medicaid will follow the restrictions set forth by the accrediting agency.

Supplier: an individual, agency, or organization from which a provider purchases goods or services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Wholly owned supplier: a supplier whose total ownership interest is held by a provider or by a person/ persons or other entity with an ownership or control interest in a provider.

Significant business transaction: any business transaction or series of related transactions that, during any one fiscal year, exceeds either $25,000 or 5 percent of a provider's total operating expenses.

Ownership and Conviction Disclosure

DHS Division of Medical Services, Title XIX (Medicaid)

[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]

Print the name, address and percentage of interest of each person, Corporation, Limited Liability Company, Partnership, Limited Liability Partnership, or other organization with a direct or indirect ownership or control interest of 5% or more in the named entity or in any subcontractor in which the named entity has direct or indirect ownership of 5% or more. [This applies to all Medicaid providers.]

Individuals – for each individual listed, provide date of birth and social security number

Name	Address	% of interest	DOB	SS#

Corporations/Limited Liability Companies/Partnerships/Other legal Entities or Organizations – for each legal entity or organization listed, provide the tax identification number and submit a copy of the legal entity or organization's IRS form SS4 and the approval letter with this application.

Name	Address	% of interest	Tax ID #

Are any of the above mentioned persons related to each other as a spouse, parent, child, or sibling? Yes_____ No_____ If yes, print name and provide relationship.

Name	Relationship

Do any of the persons, legal entities or organizations with an ownership or control interest have any ownership or control interest of 5% or more in any other entity doing business with the Arkansas Medicaid Program? Yes_____ No_____ If yes, print name and give other provider name and percentage of interest.

Name	Other Provider	% of Interest

Ownership and Conviction Disclosure

DHS Division of Medical Services, Title XIX (Medicaid)

[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]

Print the name, address, date of birth, and social security number for any person who is a managing employee of the named entity:

Name	Address	DOB	SS#

List any person who has a direct or indirect ownership or control interest in the named entity, or is an agent, or managing employee of the named entity who has been convicted of a criminal offense related to that person's involvement in any program under Medicaid, Medicare, or Title XX programs in any state:

Name	Offense

List names of persons or entities with direct/indirect ownership or control interest in the named entity, or is an agent or managing employee of the named entity who, as listed in DHS Policy 1088 (Participant Exclusion Rule), has been found guilty, or pled guilty or nolo contendere, to any crime related to: (1) obtaining, attempting to obtain, or performing a public or private contract or subcontract, (2) embezzlement, theft, forgery, bribery, falsification or destruction of records, any form of fraud, receipt of stolen property, or any other offense indicating moral turpitude or a lack of business integrity or honesty, (3) dangerous drugs, controlled substances, or other drug-related offenses when the offense is a felony, (4) federal antitrust statutes, (5) the submission of bids or proposals, (6) any physical or sexual abuse or neglect when the offense is a felony.

Name	Offense

Ownership and Conviction Disclosure

DHS Division of Medical Services, Title XIX (Medicaid)

[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]

Provider Statement:

"By signing this form, I certify that the information provided on this form is true and correct. I will notify the Division of Medical Services Medicaid Provider Enrollment Unit if any information changes. I will comply with all aspects of this disclosure form. By completing and signing this form, I give consent for the information contained herein to be disclosed to the Department of Health and Human Services or any other appropriate governmental agencies, including the Office of Homeland Security."

Name: (Print or Type) _____

Title: (Print or Type) _____

Signature: _____ Date: _____

Disclosure of Significant Business Transactions

DHS Division of Medical Services, Title XIX (Medicaid)

[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]

IMPORTANT

Read ALL instructions and definitions contained on this form and use the information as a reference while completing the Significant Business Transactions Disclosure Form.

Completion and submission of this form is a condition of participation in the Medicaid Program and is a condition of approval or renewal of a provider agreement between the disclosing entity and the Division of Medical Services.

Full, complete and accurate disclosure of ownership and financial interests is required. Failure to submit requested information may result in a refusal to enter into a provider agreement or contract, or in termination of existing provider agreements.

INSTRUCTIONS FOR COMPLETING DISCLOSURE FORM

Answer all questions as of the current date. If additional space is needed, please attach the information at the end of the application for new enrollments, or attached to the form for updated information from existing providers, before returning to the Medicaid Provider Enrollment Unit.

DEFINITIONS

Provider: a named person or entity that furnishes, or arranges for furnishing health related services for which it claims payment under the Medicaid Program.

Disclosing entity: a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Subcontractor: (1) an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of furnishing health related services; or (2) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease to obtain space, supplies, equipment, or services provided under the Medicaid agreement. Additionally, if the accrediting agency prohibits subcontracting, sub-leasing or lending its accreditation to another organization, Arkansas Medicaid will follow the restrictions set forth by the accrediting agency.

Supplier: an individual, agency, or organization from which a provider purchases goods or services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Wholly owned supplier: a supplier whose total ownership interest is held by a provider or by a person/persons or other entity with an ownership or control interest in a provider.

Significant business transaction: any business transaction or series of related transactions that, during any one fiscal year, exceeds either $25,000 or 5 percent of a provider's total operating expenses.

Disclosure of Significant Business Transactions

DHS Division of Medical Services, Title XIX (Medicaid)

[As required by 42 C.F.R. §455, Subpart B: Disclosure of Information by Providers and Fiscal Agents]

Submit full, accurate and complete disclosure concerning the following information:
Ownership of any subcontractor with whom the named entity has had business transactions totaling more than $25,000 during the last 12 months (12 month period ending as of the date on this application).

_____
_____
_____

Any significant business transaction between the named entity and any wholly owned supplier in the last 5 years (5 year period ending as of the date of this application).

_____
_____
_____

Any significant business transaction between the named entity and any subcontractor in the last 5 years (5 year period ending as of the date of this application).

_____
_____
_____

Beginning on the effective date of enrollment in the Arkansas Medicaid Program, full, accurate and complete disclosure shall be submitted concerning any significant business transaction that occurs between the named entity and any subcontractor or wholly owned supplier. This information shall be submitted within 35 days of the date the transaction takes place.

Provider Statement:

"By signing this form, I certify that the information provided on this form is true and correct. I will notify the Division of Medical Services Medicaid Provider Enrollment Unit if any information changes. I will comply with all aspects of this disclosure form. By completing and signing this form, I give consent for the information contained herein to be disclosed to the Department of Health and Human Services or any other appropriate governmental agencies, including the Office of Homeland Security."

Name: (Print or Type) _____

Title: (Print or Type) _____

Signature: _____ Date: _____

TECHNICAL TRAINING FOR PROVIDER APPLICANTS
Beginning the RSPMI Application Process

1. Training sessions will be held at set times (at least quarterly) and all interested applicants may register to attend
2. Training sessions will be co-hosted by DBHS and DMS
3. Training topics and materials:
    i. Accreditation Requirements
    ii. Certification Process & Program Requirements
    iii. Expectations for Standards of Care
    iv. Licensing Requirements i.e. Child Care Licensing Standards, RCF Licensing Standards, Health Department Standards, Professional Licenses, Paraprofessional Certification
    v. Corporate Compliance Issues & Ethics
    vi. Overview of Medicaid Enrollment process and claims processing (referral information for connecting with EDS)
    vii. Overview of Utilization Management process (referral information for connecting with appropriate UM contractors)
    viii. Introduction to Policy (how to use the Medicaid manual and other source documents)

RSPMI OPERATION TECHNICAL ASSISTANCE TRAINING AGENDA
Beginning the RSPMI Process

I. Completion of the Disclosure Form

II. Medicaid Enrollment Process & Claims Processing (Referral Information for Connecting with EDS)

III. Utilization Management Process (Referral Information for Connecting Maintenance of DBHS Certification)

IV. Policy (how to use the Medicaid manual and other source documents)

V. Licensing requirements and referrals for Child Care Licensing Standards, RCF Licensing Standards, Health Department Standards, Professional Licenses, Paraprofessional Certification, etc.

VI. Expectations for standards of care (Best Practices and System of Care information)

VII. Corporate Compliance & Ethics

VIII. Maintenance of DBHS Certification

IX. OADAP License and Certification Information

** Training agendas may be adjusted according to program and regulation needs within DHS or for community/audience needs.

Created:

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES
QUALIFICATION FORM FOR RSPMI PROVIDER CERTIFICATION BY THE DIVISION OF BEHAVIORAL HEALTH SERVICES

To be completed upon initial application for DBHS RSPMI Certification.

Name of Agency: _____

Chief Executive Officer (or equivalent): _____

Corporate Compliance Officer (or equivalent):_____

Administrative Address: _____

County: _____

Telephone: _____ Fax: _____

E-mail: _____

Website: _____

1. The provider named above is fully accredited and in good standing with one of the following accreditation organizations. (Please check your accreditation organization)

   ____ Joint Commission on Accreditation of Healthcare Organizations (J-CO)
   ____ Commission on Accreditation for Rehabilitation Facilities (CARF)
   ____ Council on Accreditation (COA)

2. Date(s) of most recent survey: _____

3. Accreditation Period: _____ through _____

4. The accredited provider is located within the State of Arkansas.

   _____ Yes _____ No

As the Chief Executive Officer (or equivalent) of the agency named above, I verify that all information contained in this form and in all attachments is correct and complete.

_____ _____
Signature of Chief Executive Officer (or equivalent) Date

_____
Name of Chief Executive Officer (or equivalent) typed or printed

Created:

Qualification Form for RSPMI Provider Certification

All of the following information must be attached to the Qualification Form for RSPMI Certification (DBHS Form 1). Applications must be submitted in full.

1. Latest accreditation survey results. (The entire survey report covering outpatient mental health services must be included.)

2. Copies of all correspondence and e mails (e mails may be copied to the DBHS office) between the agency and the accrediting organization that pertains to the accreditation of the provider's outpatient mental health services.

3. A signed agreement that DBHS may receive information directly from the accrediting organization regarding the agency's accreditation and any information pertaining to service delivery. (See DBHS Form 1 Attachment #1)

4. All Evidence of Compliance, Measures of Success, Performance Improvement Plans, and any Corrective Action Plans submitted to the accreditation organization pertaining to outpatient mental health services.

5. Annual RSPMI Services and Resource Summary Report with all attachments as designated in the RSPMI Services and Resource Summary Form (DBHS Form 2).

DBHS WILL SCHEDULE AN ONSITE SURVEY WITHIN TWENTY (20) CALENDAR DAYS OF APPROVING ALL REQUIRED CERTIFICATION DOCUMENTATION.

If you have any questions, please contact the Division of Behavioral Health Services at (501) 686-9164

Please send a cover letter and all application materials to be certified by DBHS as an RSPMI Provider to the following address:

Division of Behavioral Health Services
Policy & Certification Office
305 South Palm Street
Little Rock, AR 72205

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES
OFFICE OF POLICY AND CERTIFICATION

Accreditation Organization Release of Information Consent

I, _____, hereby consent to the exchange of information between
CEO (or equivalent)

_____ and
Accrediting Agency

The Division of Behavioral Health Services, Policy and Certification Office, for the specific purpose of obtaining or sharing information relevant to RSPMI Provider Certification.

I consent to information regarding my agency's national accreditation or state certifications being released by facsimile (FAX) _____ Yes _____ No.

I understand that the information I authorize for release may include sensitive information. I understand that a facsimile of this consent is considered as valid as if it were the original.

_____ _____
Signature of CEO (or equivalent) Date

_____ _____
Signature of Witness Date

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES
RSPMI SERVICES AND RESOURCE SUMMARY

State Fiscal Year XXXX: 7/01/20XX Through 6/30/20XX

Name of Agency: _____

Chief Executive Officer (or equivalent): _____

Corporate Compliance Officer (or equivalent): _____

Administrative Address: _____

Telephone: _____ Fax: _____

E-mail: _____

Provider Type: _____ Private Non-Profit _____ Private For Profit _____ Public Entity

Other (Specify): _____

Chief Executive Officer (or equivalent) **Certification:** By my signature I certify that I have reviewed this report and attachments and to the best of my knowledge it represents an accurate report of agency services and resources.

Chief Executive Officer (or equivalent): _____ Date: _____

PERSONNEL RESOURCES (as of the date this report is submitted)	**SFY XXXX**
1. Psychiatrists	
2. M.D. Non-psychiatrists	
3. Psychologists	
4. Psychological Examiners	
5. Psychological Examiners, Independent	
6. Licensed Certified Social Workers	
7. Licensed Master Social Workers	
8. Registered Nurses	
9. Licensed Professional Counselors	
10. MHP in Related Profession (LAC, LMFT)	
11. Mental Health Professionals (sum of lines 1-10)	
12. Mental Health Paraprofessionals	
13. All other staff not included above	
14. Sum of lines 11, 12, and 13	
PROGRAM RESOURCES (round to nearest whole number)	
15. Number of counties in service area	
16. Number of counties in service area in which agency operates a service site	
17. Total number of service sites operated by Agency	
18. Number of sites at which a psychosocial rehabilitative day program is operated	
19. Total daily capacity of all psychosocial rehabilitative day programs combined	
20. Total projected daily average attendance at all psychosocial day sites combined	
21. Number of School Based Mental Health Programs run by agency	
22. Total projected daily average of clients in all school based sites combined	
23. Total projected number of clients served in the out patient clinic	

Created:

24. Please list other mental health services provided by the organization and provide capacity information, as appropriate (i.e. residential beds, crisis beds, inpatient beds, housing, therapeutic foster care, etc.)		
24.A.		
24.B.		
24.C		
24.D		
If more room is needed, please list on a separate page and attach to this report.		
FINANCIAL RESOURCES – PROJECTED MEDICAID/MEDICARE INCOME (Projected for current fiscal year – July 1 through June 30)	**SFY XXXX**	**SFY XXXX**
25. Total Medicaid revenues		
26. Total Medicare revenues		
CONTACT INFORMATION		
27. Contact person regarding this report		
28. Telephone number of contact person for this report		
29. E-mail address of contact person for this report		

PERSONNEL QUALIFICATIONS & RESOURCES

1. Attach organizational chart for agency making certification application. (Include names of staff for each position)
2. Describe the agency's governing body, to include the make up of the Board of Directors, and the rules/policies regarding oversight of the executive and administrative staff. Include the coordinated management plan for all operations.
3. Attach policy and procedures related to Code of Ethics and Client Grievance Procedures.
4. Identify one Clinical Director for the entire agency. Include name, credentials, resume and contact information.
5. Attach licenses or certifications and resumes of all administrators, medical director and consulting psychiatrist if medical director is not a psychiatrist.
6. Attach all contracts with consulting professionals.
7. Explain how psychological testing services are delivered. Include names, licenses and any contracts or signed agreements related to psychological services.
8. Attach all existing contracts the agency has with any other providers or agencies (including schools) to provide RSPMI services.
9. Attach one job description for Licensed Mental Health Professionals and one for Certified Mental Health Para Professional personnel.
10. Attach policy for supervision of all direct care staff and the plan for staff training and supervision of those staff whose licensure or certification require professional supervision.

PHYSICAL PLANT(S)

1. Attach a list of all service delivery sites including each site's address (street, city & county), telephone number, fax number, the name of the designated contact person for each site and that person's email address, the geographic area served by each site and the RSPMI services available at each site.
2. Submit website if available.
3. Attach a photograph of each service delivery site. Include outside entrance to building, staff offices and waiting area.
4. Describe any projected plan for expansion of the physical plant post RSPMI certification. Please include time frames for the expansions.

SERVICE DELIVERY PLAN CURRENTLY IN PLACE FOR EACH SITE

In a narrative report, describe the agency's plan for the provision of services including all requested information in compliance with the current RSPMI Certification Policy and RSPMI Medicaid Manual. Please utilize the following format:

I. Type of services available at each site, hours of operation and type of clients served (i.e. children, adults, Seriously Mentally Ill, Seriously Emotionally Disturbed, Juvenile Justice population, school based sites etc.)

II. The number of clients the agency is currently serving. Include the age ranges and total numbers of children (3y/o – 12y/o), adolescents (13 y/o – 17y/o) and adults (18y/o – 21y/o). Also, include the average length of treatment for clients served by the agency.

III. Identify the names and locations of schools where the agency provides services. Include the number of children/adolescents served in each school and specific services that are provided in each school (i.e. individual therapy, group therapy, day treatment case management). If the agency does not currently provide services in school, please identify any plans to do so in the future and the projected number of students anticipated to be treated.

IV. Description of agency's crisis services plan that is available at each site including policy and procedures for provision of crisis services 24 hours a day; 7 days a week.

V. Describe any plans for expansion or reduction in services, as described above, for the current fiscal year.

VI. Treatment Process:

A. Briefly describe the following:
(This item must include a description of the resources and procedures used to ensure the timely delivery of services and the policy addressing family involvement in treatment.)
1. How a client accesses treatment/services
2. Intake/diagnostic process (Include a sample of assessment instrument(s)
3. Treatment planning and review process (Include a sample of Treatment Plan and Treatment Plan Review)

B. Describe the agency's process for assessing, and criteria used to determine, which clients would benefit from case management services provided by mental health paraprofessionals. Briefly state the Center's definition of case management and how paraprofessionals will be utilized in service delivery including coordination/supervision with clinical staff.

C. Briefly explain how the agency utilizes and interfaces with other community resources to provide services for the recipient to reinforce the agency's efforts to support the System of Care.

VII. Substance Abuse Services: Describe in detail substance abuse services provided by the agency, including services for co-occurring disorders.

VIII. Submit plans and activities to overcome cultural and linguistic barriers to treatment.

IX. Quality Assurance & Improvement Efforts:

A. Submit the policy and procedures for the agency's quality assurance committee. Include committee make up, schedule for meetings and procedural activities.

B. Describe at least three significant quality improvement efforts the agency has initiated or plans to undertake during the coming fiscal year. Describe the outcomes expected and the methods by which these outcomes will be monitored.

This RSPMI Service Resource Summary and Plan of Services should cover the current fiscal year. If you have any questions, please contact the Division of Behavioral Health Services at (501) 686-9164.

Please send this form with your application to be certified by DBHS as an RSPMI Provider to the following address:

Division of Behavioral Health Services
Policy & Certification Office
305 South Palm Street
Little Rock, AR 72205

Created:

Appendix #7

PROVIDER SITE SURVEY FOR DBHS RSPMI CERTIFICATION REPORT

DHS/DBHS Reviewer(s): _____

#	Service Site Name/Location/Telephone/Fax/Site Coordinator	Date(s) of IOF
1		
2		

Chief Executive Officer (or equivalent): _____

Medical Director: _____

Clinical Supervisor: _____

Corporate Compliance Officer: _____

1: Clinical Record Management

1. Name of Medical Records Librarian: _____
2. Description of Medical Records Security
3. Review of Clinical Charts and Forms

2: Client Services

1. The services provided as well as the provider's service plans
2. Review of Client Rights
3. Activities to overcome cultural and linguistic barriers to treatment.
4. Review of Grievance Procedures Name of Grievance Officer: _____
5. Review of Emergency Services Policy Postings and Notification of Emergency Information

3: Physical Plant

1. Posting of Accreditation
2. General Appearance
3. Life Safety
4. Privacy and Confidentiality/ Name of Privacy Officer: _____
5. Medication Storage
6. Handicap Accessibility

4: Date of RSPMI Services Availability & Programs Overview

1. Outpatient Services—individual and family therapy at a minimum
2. Intervention services—on-site and off-site at a minimum
3. Medication Management
4. Crisis Services
5. Psychological Evaluation
6. Rehab Day

5: Staff Requirements (Personnel Record Documentation)

1. Policy for Staff Supervision
2. Documentation of Supervision Required by Licensure
3. Contract of Medical Director and Psychiatrist providing oversight
4. Policy for Quality Assurance Committee/Schedule of Activities and Quality Assurance Coordinator
5. Schedule and Process for Clinical Reviews

6. Process for justifying documentation with billing & compliance with Medicaid Regulations
7. Current Staff Composite
8. Documentation and Schedule for training of paraprofessionals
9. Procedure for utilizing paraprofessionals

CLIENT INTERVIEWS:

Summary

Recommendations:

Created:

Appendix #8
Example of Certification Certificate

Arkansas Department of Human Services
Division of Behavioral Health Services

Presents this certification for

Rehabilitative Services for Persons with Mental Illness

to

Behavioral Health Services Provider

123 Main Street in Anytown, Arkansas

This Certification extends through April XX, 20XX.

The mission of the Division of Behavioral Health Services is to improve the quality of life for Arkansans by providing recovery-based, consumer driven behavioral health care utilizing evidence-based practices.

Director
Policy and Certification

Director
Division of Behavioral Health Services

Created:

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES
NOTIFICATION FORM FOR CLOSING OR MOVING OF AN RSPMI PROVIDER SITE

Moving a site constitutes a closing of one site and a move of the program(s), move of existing staff and move of existing client base to another location. If a provider relocates a currently certified site within a fifty (50) mile radius the accrediting agency, DBHS and Medicaid must be notified thirty (30) days prior to that relocation. Neither an on-site survey nor a new Medicaid number is required in order to extend certification to the moved location.

Name of Agency:

_____

Chief Executive Officer (or equivalent):

_____

Corporate Compliance Officer (or equivalent):

_____

Administrative Address: _____

_____

Telephone: _____ Fax: _____

E-mail: _____

This is notification that the following site(s) have:

_____ moved _____closed

CLOSING **Date of Closing**: _____

ADDRESS:

_____

_____

_____

_____

MOVING **Date of Move**: _____

PREVIOUS ADDRESS (Include: street, city, county, telephone & fax)	NEW ADDRESS
_____	_____
_____	_____
_____	_____
_____	_____

Please attach all documentation to and from your accrediting organization regarding the above information. Certification will not be granted to the new site address until all information from the accrediting organization indicates that the new site address is accredited.

Chief Executive Officer (or equivalent) **Certification**: By my signature I verify that all information contained in this form and in all attachments is correct and complete.

_____ _____

Signature of Chief Executive Officer (or equivalent) Date

_____

Name of Chief Executive Officer (or equivalent) typed or printed

Created:

Page Two
Notification Form for Closing/Moving

1. In addition to this form, please provide any information that is specific to the site/s for which certification is being requested that is different from those agency sites already certified by DBHS.

2. Include a photograph of outside entrance to building, staff offices, and waiting area for all new site locations.

If you have any questions, please contact the Division of Behavioral Health Services at (501) 686-9164.

Please send this form with required documentation to the following address:

Division of Behavioral Health Services
Policy & Certification Office
305 South Palm Street
Little Rock, AR 72205

ARKANSAS DEPARTMENT OF HUMAN SERVICES

DIVISION OF BEHAVIORAL HEALTH SERVICES
RSPMI SERVICES AND RESOURCE SUMMARY

ADDITIONAL SITES SINCE LAST CERTIFICATION

State Fiscal Year 20XX: 7/01/20XX Through 6/30/20XX

Name of Agency:
_____

Chief Executive Officer (or equivalent):
_____

Corporate Compliance Officer (or equivalent):
_____

Administrative Address:

_____
_____
_____
_____

Telephone: _____ **Fax:** _____

E-mail: _____

NEW SITE PHYSICAL ADDRESS: **DATE SITE OPENED:**_____

_____
_____
_____
_____

Telephone:_____ **Fax Number:** _____

E-mail:_____

Chief Executive Officer (or equivalent) Certification: By my signature I certify that I have reviewed this report and attachments and to the best of my knowledge it represents an accurate report of agency services and resources.

_____ _____
Name of Chief Executive Officer (or equivalent) typed or printed Date

_____
Signature of Chief Executive Officer (or equivalent)

Created:

PERSONNEL RESOURCES FOR NEW SITE ONLY (as of the date this report is submitted)	**SFYXX**
1. Psychiatrists	
2. M.D. Non-psychiatrists	
3. Psychologists	
4. Psychological Examiners	
5. Psychological Examiners, Independent	
6. Licensed Certified Social Workers	
7. Licensed Master Social Workers	
8. Registered Nurses	
9. Licensed Professional Counselors	
10. MHP in Related Profession (LAC, LMFT)	
11. Mental Health Professionals (sum of lines 1-10)	
12. Mental Health Paraprofessionals	
13. All other staff not included above	
14. Sum of lines 11, 12, and 13	
PROGRAM RESOURCES FOR NEW SITE ONLY (round to nearest whole number)	
15. Number of counties in service area	
16. Number of counties in service area in which agency operates a service site	
17. Total number of service sites operated by agency	
18. Number of sites at which a psychosocial rehabilitative day program is operated	
19. Total daily capacity of all psychosocial rehabilitative day programs combined	
20. Total projected daily average attendance at all psychosocial day sites combined	
21. Number of school based sites that service site projects to operate	
22. Total projected daily average of clients in all school based sites combined	
23. Total projected number of clients served in the out patient clinic	
24. Please list other mental health services provided by the organization and provide capacity information, as appropriate (i.e. residential beds, crisis beds, inpatient beds, housing, therapeutic foster care, etc.)	
25. A	
26. B	
27. C	
28. D	
If more room is needed, please list on a separate page and attach to this report.	

FINANCIAL RESOURCES PROJECTED MEDICAID/MEDICARE INCOME FOR NEW SITE ONLY	**SFYXX**	**SFYXX**
29. Total Medicaid revenues		
30. Total Medicare revenues		

CONTACT INFORMATION	
33. Contact person regarding this report	
34. Telephone number of contact person for this report	
35. E-mail address of contact person for this report	

PERSONNEL QUALIFICATIONS & RESOURCES

1. Attach administrative structure for the new site/s for which extension of certification is being requested.

2. Attach licenses or certifications and resumes of all administrators of the new site. Include the medical director or consulting psychiatrist information if different from the main office site.

3. Attach any contracts with consulting professionals specific to the new site only if additional to the original certification.

PHSYICAL PLANT

1. Attach a list of all new service delivery sites including each site's address (street, city & county), telephone number, fax number, the name of the designated contact person, for each site and that person's email address, the geographic area served by each site and the RSPMI services available at each site.

Created:

2. Attach a photograph of each service delivery site for which you are requesting a certification extension. Include outside entrance to building, staff offices, and waiting area.

SERVICE DELIVERY PLAN THAT IS CURRENTLY IN PLACE FOR EACH NEW SITE

In a narrative report, describe the agency's plan for the provision of services including all requested information in compliance with the current RSPMI Certification Policy and RSPMI Medicaid Manual. Please utilize the format below:

1. Type of services available at additional site/s, hours of operation and type of clients served (i.e. children, adults, Seriously Mentally Ill, Seriously Emotionally Disturbed, Juvenile Justice population, etc.)

2. Provide any information that is specific to the site/s for which certification is being requested that is different from those agency sites already certified by DBHS.

3. Description of agency's crisis services plan that is available at the new site including the policy and procedures for provision of crisis services 24 hours a day 7 days a week.

4. Briefly explain how the new site will utilize and interface with other community resources to provide services for the recipient to reinforce the agency's efforts to support the System of Care.

5. Describe how the new site will be integrated into the Quality Improvement Program of the agency.

ACCREDITATION INFORMATION

I. Attach documentation notifying your accrediting organization of the site/s addition/s and the accrediting organization's acknowledgement of the accreditation extension. Certification extension **WILL NOT BE GRANTED** until you have the accrediting organization's documentation.

II. Include dates of current accreditation cycle.

This RSPMI Service Resource Summary and Plan of Services should cover the current fiscal year. If you have any questions, please contact the Division of Behavioral Health Services at (501) 686-9164.

Please send this form along with your application to be certified by DBHS as an RSPMI Provider to the following address:

Division of Behavioral Health Services
Policy & Certification Office
305 South Palm Street
Little Rock, AR 72205

Created:

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES
QUALIFICATION FORM FOR RSPMI PROVIDER RE-CERTIFICATION
BY THE DIVISION OF BEHAVIORAL HEALTH SERVICES

To be submitted to renew DBHS certification after receiving re-accreditation from the national accrediting agency at the time of the new accreditation cycle.

Name of Agency:
_____

Chief Executive Officer (or equivalent): _____

Corporate Compliance Officer (or equivalent): _____

Administrative Address: _____

Telephone: _____ Fax: _____

E-mail: _____

1. The provider named above is fully accredited and in good standing with one of the following accreditation organizations. (Please check your accreditation organization)

____ Joint Commission (J-CO)

____ Commission on Accreditation for Rehabilitation Facilities (CARF)

____ Council on Accreditation (COA)

2. Date of most recent survey: _____

3. National Accreditation Period: _____ through _____

4. The accredited provider is located within the state of Arkansas.

_____ Yes _____ No

Chief Executive Officer (or equivalent) Certification: By my signature I certify that all information contained in this form and in all attachments are correct and complete.

_____ _____
Signature of Chief Executive Officer (or equivalent) Date

_____
Name of Chief Executive Officer (or equivalent) typed or printed

Created:

Qualification Form for RSPMI Provider Re-Certification

All of the following information must be attached to the Qualification DBHS Form 3 for RSPMI Re-Certification. Applications must be submitted in full. Partial submissions will not be accepted.

1. Latest accreditation survey results. (The entire survey report with a listing of all provider service sites providing outpatient mental health services must be included.)

2. Copies of all correspondence and e-mails (e-mails may be copied to the DBHS office) between the agency and the accrediting organization that pertains to the accreditation of the provider's outpatient behavioral health services.

3. A signed agreement that DBHS may receive information directly from the accrediting organization regarding the agency's accreditation and any information pertaining to service delivery.

4. All Evidence of Compliance, Measures of Success, Quality Improvement Plans, and any Corrective Action Plans that were required and submitted to the accrediting organization pertaining to outpatient behavioral health services related to the latest accreditation survey.

5. Identify any significant changes (since last certification period) in program resources (i.e. number of sites operated by agency, changes in administrative staff, and number of school-based Mental Health Programs). Please attach additional pages if needed.

6. Identify any significant changes (since last certification period) in personnel qualifications and resources (i.e. changes in code of ethics and client grievance policy, changes in how psychological testing services are delivered and changes in the plan for staff training and supervision). Please attach additional pages if needed.

7. Identify any significant changes (since last certification period) in the physical plant(s). (i.e. changes in address and phone numbers of service delivery sites, any structural/cosmetic changes). Please attach additional pages if needed.

Created:

8. Describe any significant changes (since last certification period) in the service delivery plan (i.e. types of services available at each site, changes in the crisis services plan and any plans for expansion or reduction in services). Please attach additional pages if needed.

If you have any questions, please contact the Division of Behavioral Health Services at (501) 686-9164.

Please send a cover letter and all application materials to be re-certified by DBHS as an RSPMI Provider to the following address:

Division of Behavioral Health Services
Policy & Certification Office
305 South Palm Street
Little Rock, AR 72205

ARKANSAS DEPARTMENT OF HUMAN SERVICES

DIVISION OF BEHAVIORAL HEALTH SERVICES
RSPMI ANNUAL REPORTING FORM

State Fiscal Year 20XX: 7/01/XX through 6/30/XX

Name of Agency:
_____

Chief Executive Officer (or equivalent):
_____

Corporate Compliance Officer (or equivalent):
_____

Address**:**

_____

_____

Phone Number **:**_____ Fax Number**:** _____

E-Mail**:**

Provider Type: Private Non-Profit _____ Private For Profit _____ Public Entity _____

Other (Specify): _____

Chief Executive Officer Certification (or equivalent)**:** By my signature I certify that I have reviewed this report and attachments and to the best of my knowledge it represents an accurate report of agency services and resources.

_____ _____
Signature of Chief Executive Officer (or equivalent) Date

_____
Name of Chief Executive Officer (or equivalent) typed or printed

THIS REPORT RELATES TO AGENCY WIDE INFORMATION

1. Please include all annual reporting requirements from the accrediting organization. This includes Annual Conformance to Quality Report, Maintenance of Accreditation or Periodic Performance Review. Please include all correspondence to and from the accrediting organization related to annual reporting requirements.

2. **RSPMI services provided at the agency (Please check all that apply):**

Individual Therapy
Family Therapy
Group Therapy
Rehabilitative Day Treatment
Adults U-21

Crisis Services
Acute Day Treatment
Adults U-21
Residential Programs
Adults U-21

Medication Management
Psychological Evaluation

MHPP Case Management
School Based

Created:

After School Programs School Linked

Other

(Please Explain):

3. Provider's plans and activities to overcome cultural and linguistic barriers to treatment. (Please include a brief statement regarding on-going efforts to serve clients from diverse backgrounds as well as those clients that may have physical disabilities.)

4. **Staff Composition (Please fill out the following chart)**

THIS INFORMATION RELATES TO AGENCY WIDE INFORMATION
PERSONNEL RESOURCES

(As of the date this report is submitted, report the number of employees. Also, indicate whether the employee is salary (W-9) or contract (10-99).)

See following page for example of filling out Staff Composition Chart.

	TOTAL	W-9 or 10-99
1. Psychiatrists		
2. M.D. Non-psychiatrists		
3. Psychologists		
4. Psychological Examiners		
5. Psychological Examiners, Independent		
6. Licensed Certified Social Workers		
7. Licensed Master Social Workers		
8. Registered Nurses		
9. Licensed Professional Counselors		
10. MHP in Related Profession (LAC, LMFT)		
11. Mental Health Professionals (sum of lines 1-10)		
12. Mental Health Paraprofessionals		
13. All other staff not included above		
14. Sum of lines 11, 12, and 13		

See following example as a guideline for filling out Staff Composition Chart. For a provider that has 3 psychiatrists, 6 licensed certified social workers, and 1 psychologist, the chart would look like:

	TOTAL	W-9 or 10-99
1. Psychiatrists	3	1 (W-9) 2(10-99)
2. M.D. Non-psychiatrists	2	2(10-99)
3. Psychologists	1	1(10-99)
4. Psychological Examiners	4	4(W-9)
5. Psychological Examiners, Independent	2	1(W-9) 1(10-99)
6. Licensed Certified Social Workers	6	6(W-9)
7. Licensed Master Social Workers	2	2(W-9)
8. Registered Nurses	2	1(W-9) 1(10-99)
9. Licensed Professional Counselors	6	4(W-9) 2(10-99)
10. MHP in Related Profession (LAC, LMFT)	2	1(W-9) 1(10-99)
11. Mental Health Professionals (sum of lines 1-10)	30	20(W-9) 10(10-99)
12. Mental Health Paraprofessionals	15	12(W-9) 3(10-99)
13. All other staff not included above	20	N/A
14. Sum of lines 11, 12, and 13	65	32(W-9) 13(10-99)

5. **Interagency involvement** (Please identify all existing formal or informal contracts the agency has with other providers or agencies to provide RSPMI services. Briefly explain how the agency utilizes and interfaces with other community resources to provide services for the recipient to reinforce the agency's efforts to support Recovery Model and System of Care philosophies.)

6. **Agency wide quality improvement and outcomes activities** (Please include agency organizational chart and the outcomes of identified quality improvement efforts to improve client care/outcomes.)

PLEASE SUBMIT THIS FORM AND INFORMATION TO:

Division of Behavioral Health
Policy & Certification Office
305 South Palm Street
Little Rock, AR 72205

Created:

FOR DBHS INTERNAL USE ONLY:

1) Services Provided — Yes ___ No ___
   Status: Complete

2) Cultural/Linguistic Barriers — Yes ___ No ___
   Status: Complete

3) Staff Composition — Yes ___ No ___
   Status: Complete

4) Interagency Involvement — Yes ___ No ___
   Status: Complete

5) Quality Improvement — Yes ___ No ___
   Status: Complete

6) ACQR MOA PPR — Yes___ No ___

Comments:

Created: