Kansas Department for Aging and Disability Services

Rev: Jan 2022

Kansas Certified Community Behavioral Health Clinic (CCBHC) Application

Section A: Administrative Information

Name of Organization:	Main Street Address:	City:	State:	Zip Code:

NPI Number:	Tax ID Number:

****Please include address for additional site(s) as an attachment to this document****

Organization Type:

☐ Local Mental Health Authority/Local Behavioral Health Authority (LMHA/LBHA)
☐ 501 (c)(3) Non-Profit
☐ Other: _____

Indicate your organization's fiscal period: _____ i.e. calendar (Jan-Dec) or fiscal (July-June)

How long has your organization been operating? _____years

What is your catchment area? _____ What is your

anticipated certification date? _____

Select the population and service types your organization provides. (Select all that apply)

Core Services	Adults (18+)	Adolescents (13-18)	Children (0-13)
Crisis Services	☐Yes ☐No ☐ In Progress	☐Yes ☐No ☐ In Progress	☐Yes ☐No ☐ In Progress
Treatment Planning	☐Yes ☐No ☐ In Progress	☐Yes ☐No ☐ In Progress	☐Yes ☐No ☐ In Progress
Outpatient Mental Health & Substance Use Services	☐Yes ☐No ☐ In Progress	☐Yes ☐No ☐ In Progress	☐Yes ☐No ☐ In Progress
Screening, Assessment, Diagnosis & Risk Assessment	☐Yes ☐No ☐ In Progress	☐Yes ☐No ☐ In Progress	☐Yes ☐No ☐ In Progress

Other service types provided:

Core Services	Adults (18+)	Adolescents (13-18)	Children (0-13)
Targeted Case Management Services	☐Yes ☐No ☐ In Progress	☐Yes ☐No ☐ In Progress	☐Yes ☐No ☐ In Progress
Psychiatric Rehabilitation Services	☐Yes ☐No ☐ In Progress	☐Yes ☐No ☐ In Progress	☐Yes ☐No ☐ In Progress
Outpatient Primary Care Screening & Monitoring	☐Yes ☐No ☐ In Progress	☐Yes ☐No ☐ In Progress	☐Yes ☐No ☐ In Progress
Peer Support & Counseling Services	☐Yes ☐No ☐ In Progress		
Mental Health Services for Armed Forces/Veterans	☐Yes ☐No ☐ In Progress		

What forms of payment does your organization receive?

☐ Medicaid/Medicare
☐ State Funding
☐ Private Insurance
☐ Foundation funding
☐ Self-Pay/Other _____

Have you implemented an Electronic Health Record (EHR) at the CMHC?

☐ Yes ☐ No ☐ In Progress

If yes, please provide the name of the system _____

Is your system capable of reporting client level data? _____

Executive Director/CEO:	Area Code with Phone No.:	Email:
Main Point of Contact for CCBHC Certification:	Area Code with Phone No.:	Email:

Note: *This person will be responsible for all correspondence between KDADS and the Organization identified on this form.*

Section B: Service Provision

Does your organization have a client or community needs assessment process? ☐ Yes ☐ No
How often is this conducted? _____ ☐N/A

Are you currently licensed to provide SUD services? ☐ Yes ☐ No

Does your organization have a psychiatrist as a medical director? ☐ Yes ☐ No
If no, does your organization have a psychiatrist as a behavioral health medical director? ☐Yes ☐No ☐N/A

Does your organization provide services outside of the usual Monday-Friday business hours (8 a.m. – 5 p.m.)? ☐Yes ☐No
If so, what are your hours of operation? _____ ☐N/A

Does your organization include the following provider types? (Select all that apply)

☐Certified Community Psychiatric Support Treatment (CPST)
☐Certified Peer Support Specialist
☐Certified Psychological Rehabilitation Specialist (PSR)
☐Community Support Specialist
☐ Licensed Addictions Counselor
☐ Licensed Mental Health Professional
☐ Physician
☐ Physician Assistant
☐ Qualified Mental Health Professional (QMHP)
☐ Registered Nurses (RNs)
☐Licensed Professional Counselors
☐Licensed Social Workers (LCSWs)
☐Non-licensed Personnel
☐Case management professionals
☐Certified peers and family support specialists
☐Advanced Practice registered nurses (APRNs)

Please indicate which core EBPs are being practiced and provide policy documents for each practiced EBP (if not established, please provide a detailed plan for implementation) (Select all that apply)

Core EBP Services	Are EBPs Being Practiced?
Assertive Community Treatment (ACT) or Flexible Community Treatment (F/ACT)	☐Yes ☐No ☐ In Progress
Supported Employment	☐Yes ☐No ☐ In Progress
Medication-Assisted Treatment (MAT)	☐Yes ☐No ☐ In Progress
Cognitive Behavioral Therapy (CBT)	☐Yes ☐No ☐ In Progress

Please attach a list of all other EBP's practiced at your CMHC

☐ **List is attached**

What are the "core" services that your agency currently provides? (if not established, please provide a detailed plan for implementation) (Select all that apply)

Core Services	Are Services Currently Being Provided?
24-hour Mobile Crisis Team	☐Yes ☐No ☐ In Progress
Emergency Crisis Intervention Services	☐Yes ☐No ☐ In Progress
Crisis Stabilization	☐Yes ☐No ☐ In Progress
Screening, Assessment, and Diagnosis, including Risk Assessment	☐Yes ☐No ☐ In Progress
Patient-Centered Treatment Planning (or similar process)	☐Yes ☐No ☐ In Progress
Risk Assessments	☐Yes ☐No ☐ In Progress
Crisis Planning	☐Yes ☐No ☐ In Progress
Outpatient Mental Health Services	☐Yes ☐No ☐ In Progress
Outpatient Substance Use Services	☐Yes ☐No ☐ In Progress
Outpatient Clinic Primary Care Screening & Monitoring	☐Yes ☐No ☐ In Progress
Targeted Case Management	☐Yes ☐No ☐ In Progress
Psychiatric Rehabilitation Services	☐Yes ☐No ☐ In Progress
Peer Supports & Counselor Services	☐Yes ☐No ☐ In Progress
Family Supports	☐Yes ☐No ☐ In Progress
Armed Forces/Veterans Mental Healthcare	☐Yes ☐No ☐ In Progress

Please attach a list of all other services provided by your CMHC.

☐ **List is attached**

What types of services does your organization provide through a partnership (i.e. DCO, formal contract)? (Select all that apply)

- ☐ Targeted Case Management
- ☐ Outpatient Primary Care Screening & Monitoring
- ☐ Community-Based Mental Health Care for Veterans
- ☐ Peer, Family Support & Counselor Services
- ☐ Psychiatric Rehab Services
- ☐ Crisis Mental Health Services (including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization
- ☐ Screening, assessment and diagnosis, including risk assessment.
- ☐ Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.
- ☐ Outpatient mental health and substance use services.
- ☐ Outpatient clinic primary care screening and monitoring of key health indicators and health risk.
- ☐ Intensive, community-based mental health care for members of the armed forces and veterans.

For services provided through a partnership (i.e. DCO, formal contract), please describe the following for each service/partner/partnership:

Name of Organization	Agreement Type	Date of Partnership	Services Provided
	☐ DCO ☐ MOU ☐ Formal Contract ☐ Other _____		
	☐ DCO ☐ MOU ☐ Formal Contract ☐ Other _____		
	☐ DCO ☐ MOU ☐ Formal Contract ☐ Other _____		
	☐ DCO ☐ MOU ☐ Formal Contract ☐ Other _____		
	☐ DCO ☐ MOU ☐ Formal Contract ☐ Other _____		
	☐ DCO ☐ MOU ☐ Formal Contract ☐ Other _____		

Please attach additional pages if needed

Section C: Organizational Authority, Governance and Accreditation

Does your organization meet one of the following? Please make sure to attach supporting documents. (Select all that apply)

☐ Is a non-profit organization, exempt for tax under Section 501(c)(3) of the United States Internal Revenue Code; Is part of a local government mental or behavioral health authority.

☐ Is operated under the authority of the Indian Health Service, and Indian tribe, or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act (25 U.S.C. 450 et seq.).

☐ Is an urban Indian organization pursuant to a grant or contract with the Indian Health Service under Title V of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

Does your organization have a governing or advisory board with > 50% consumer participation?

☐ Yes, a governing board
☐ Yes, an advisory board.
Please describe: _____
☐ No

Does your organization have another accreditation (i.e. CARF)?

☐ Yes.
Please list: _____
☐ No

Section D: Signature

[Agency Name]_____
Hereby applies for certification from the Kansas Department of Aging and Disability (KDADS), has read the foregoing application, and agrees that the statements contained therein are true and correct and gives assurance of the ability and intention to comply with the laws applicable to certified facilities and the regulations established thereunder. It is understood that this agency will be eligible for full certification only after it has complied with the requirements of the law and the applicable regulations and codes, and that such full certification is subject to revocation at any time this agency fails to comply with the law, regulations, or codes. This agency may be eligible for a provisional certification upon review of the application, and any provisional certification provided by the Kansas Department for Aging and Disability is subject to revocation at any time this agency fails to make significant progress (as determined by KDADS) towards certification. Furthermore, it is agreed that agents of the Kansas Department for Aging and Disability are authorized by law to make inspections of premises; review agency, personnel, and client records; observe program operations; interview employees and clients about the program(s); and audit the financial records of this agency in order to determine compliance with standards or to investigate any complaints. It is understood that this agency will comply with all regulations contained in the survey reports completed by authorities of the Kansas Department of Aging and Disability and submitted to the agency.

Date:	CMHC Provider Number:
Print Name:	Signature:

Section E: Readiness Checklist

☐ Policy and Procedures (See attached checklist)
☐ Governing Authority information (board of directors' bylaws)
☐ Fiscal information (annual budget)
☐ Agency Brochure – list all services provided with description of services
☐Organizational Chart – include each person filling each position, lines of supervision, include vacancies
☐ List of all personnel – full time, part time, volunteers, administrative, practicum/intern students, contracted staff, maintenance
☐ A list of current sites – program name, physical address, services offered, contact person, hours of operation, telephone, and fax number.
☐ Signed Acknowledgement Statement
☐ Licensing, Certifying or Accrediting Body reports and verification of current status – NARR accreditation letter and certificate
☐ Explanation of the components/programs in your agency that you are not requesting certification
☐ Policy documents for core EBPs
☐ Detailed plan for implementation on any core EBPs that are currently not being provided
☐ list of all other EBP's practiced at your CMHC
☐ Policies for all core services the agency provides
☐ Detailed plan for implementation on any core services that are currently not being provided
☐ Partnership/DCO/MOU agreements (formal and/or draft copy).
☐ Supporting documents from Section C
☐ CCBHC Certification Attestation (if applicable)

Appendix

Core Evidence Based Practices	Definitions
Supported Employment	Supported Employment helps people with mental health and substance use disorders find and keep meaningful jobs in the community of their choosing. The State's preferred model is Individual Placement and Support (IPS). KDADS will provide training, technical assistance and fidelity reviews to support CCBHC's that are engaged in IPS.
Medication Assisted Treatment (MAT)	The use of medications in combination with counseling and behavioral therapies to provide a "whole-patient" approach to the treatment of substance use disorders. MAT is more effective when counseling and other behavioral health therapies are included. MAT Medications are administered, dispensed, and prescribed in various settings such as a SAMHSA-accredited and certified opioid treatment program (OTP), or certified practitioners depending on the medication. MAT patients receiving treatment in OTPs must receive counseling, which may include different forms of behavioral therapy. These services are required along with medical, vocational, educational, and other assessment and treatment services.
Cognitive Behavioral Therapy (CBT)	Cognitive Behavioral Therapy (CBT) is a type of psychotherapy that helps the client become aware of inaccurate or negative thinking, so the client can view challenging situations more clearly, and respond to them in a more effective way. CBT is generally considered short-term therapy and may range from about 5 to 20 sessions, depending on the severity of the client's symptoms. CBT may be done one-on-one, or in groups with family members or with people who have similar issues. CBT may be beneficial for clients with mental health disorders such as depression, anxiety, substance use disorders (SUD), phobias, schizophrenia, and more.
Assertive Community Treatment (ACT)*	Assertive community treatment provides a single, fixed point of responsibility for treatment, rehabilitation, and support needs for clients with serious mental illness. ACT services are offered 24 hours per day, seven days per week, in a community-based setting. ACT's goal is to give consumers adequate community care, and to help them have a life that isn't dominated by their mental illnesses. With ACT, consumers get help taking care of their basic needs such as taking medications, grocery shopping, cooking, paying bills, etc. ACT teams also work closely with the client to see which medications work best for them, help find housing, apply for state benefits, go back to school, or get a job.
Flexible Assertive Community Treatment (F/ACT)*	Flexible assertive community treatment (FACT) is a multidisciplinary service model aimed at providing integrated care for people with severe mental illness (SMI). In this model, care coordinators manage individual caseloads, but also work together to provide shared care for people at times of increased need, allowing for seamless transition between high and low-intensity care. A FACT approach could be a more efficient model than ACT, because people only receive high-intensity team-based interventions at times of need, freeing up resources for those who most need them. KDADS will provide training, technical assistance and fidelity review to support CCBHC's that are engaged in F/ACT.

***CCBHCs can choose between providing ACT or FACT.**

Certified Community Behavioral Health Center Applicant Review of Policy and Procedures

Submit documents in a searchable PDF.

CCBHC CRITERIA REFERENCE NUMBER	DOCUMENT NAME	APPLICATION PAGE #	ADDITIONAL INFORMATION	DATE REVIEWED
Note: Listed below from PAMA 223	**Note: Center Name of supported documentation.**	**Note: Page number of the submitted application documents.**	**Note: Please include the criteria reference number for any other criteria the document covers.**	**Note: Surveyor Use ONLY**
Ex: Criteria 1.A: General Staffing	***Org. Chart***	***Page: 10***	***1.a.1; 1.a.2; 1.a.3***	
Criteria 1.A: General Staffing				
1.a.1 Needs Assessment and Staffing Plan				
1.a.2 Staff appropriate to meet needs of consumer population				
1.a.3 Administrative Staff / Management Structure / Medical Director				
Criteria 1.B: Licensure and Credentialing of Providers				
1.b.1 State required licenses, certifications, credentials, supervision				
Criteria 1.C: Cultural Competence and Other Training				

Submit documents in a searchable PDF.

1.c.1 Training plan for all employed staff, contract providers, interns having contact with consumers.				
1.c.2 Documentation of training provided and staff skill assessment				
1.c.3 Documentation of successful training completion				
1.c.4 Qualifications of trainers				
1.d.5 Confidentiality / HIPAA / 42 CFR Part 2				

2.a.8 Disaster plan and continuity of operation				
Criteria 2.B: Requirements for Timely Access to Services, Initial and Comprehensive Evaluations for New Consumers				
2.b.1 Preliminary Screening and Risk Assessment				
2.b.2 Comprehensive Person Centered / Family Centered Treatment Plan. Treatment plan updates (Consumer signatures)				

2.b.3 Outpatient Treatment Services timeline. Routine / Urgent / Emergent				

Submit documents in a searchable PDF.

Criteria 2.C: 24/7 Access to Crisis Management Services				
2.c.1 Availability / Accessibility				
2.c.2 Methods of Delivery				
2.c.3 Consumer Education regarding crisis management services				
2.c.4 Relationship with local hospital Emergency Departments				
2.c.5 Reducing delay of services following psychiatric crisis				
2.c.6 Crisis planning				
Criteria 2.D: No Denial of Services				

2.d.1 No denial based on inability to pay for services				
2.d.2 Sliding fee discount schedule				
2.d.3 Fee Schedules				
2.d.4 Eligibility and implementation of Sliding Fee Discount Schedule				
Criteria 2.E: Provision of Services Regardless of Residence				
2.e.1 No denial of service based on place of residence /				

Submit documents in a searchable PDF.

homelessness / lack of permanent address				
2.e.2 Providing service to remote consumers				
Criteria 3.A: General Requirements of Care Coordination				
3.a.1 Coordination of Care				
3.a.2 Documentation of shared information, consumer consent				
3.a.3 Referral to external provider				
3.a.4 Consumer preference				
3.a.5 Coordination of medications				
3.a.6 Consumer choice of provider				
Criteria 3.C: Care Coordination Agreements				
Criteria 5.B: Continuous Quality Improvement Plan				
5.b.1 Development, implementation and maintenance of CQI plan				
Criteria 6.A: General Requirement of Organizational Authority and 6.a.2 **6.a.3** Annual financial audit and correction plan as necessary **Finances**				
6.a.2 **6.a.3** Annual financial audit and correction plan as necessary				

Criteria 6.B: Governance				
6.b.1 Board membership and participation				
6.b.2 Board transition plan and timelines				
6.b.3 Alternative advisory structure for consumer input				
6.b.4 Board membership requirement alternative				
6.b.5 Board member experience and expertise				
6.b.6 Verification of compliance with governance requirements				