STATE OF CONNECTICUT

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

A Healthcare Service Agency

DANNEL P. MALLOY
GOVERNOR

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COMMISSIONER

CONNECTICUT DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES (DMHAS)

Application for Certification of Intermediate Duration Acute Care Beds

Please complete this pre-application and, along with the original and three (3) copies, forward to DMHAS the following documents:

☐ Completed Certification Application signed by authorized official (original signature required)

☐ Copies of all applicable state licenses

☐ Copy of current medical malpractice, comprehensive professional, general and/or umbrella liability insurance certificates that identifies the limits of liability and policy period. Except as provided by state law, Hospital shall maintain professional liability insurance coverage of at least three million dollars ($3,000,000) per occurrence and ten million dollars ($10,000,000) in aggregate.

☐ Joint Commission (formerly known as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation letter

☐ Certification(s)
- ☐ Medicaid
- ☐ Medicare
- ☐ Other

This Application and other required documents should be mailed to:

Managed Services Division
CT Department of Mental Health and Addiction Services
410 Capitol Avenue - 4th Floor
Hartford, CT 06134

(AC 860) 418-7000
410 Capitol Avenue, P.O. Box 341431, Hartford, Connecticut 06134
www.dmhas.state.ct.us
An Equal Opportunity Employer

Section 1: GENERAL INFORMATION

Hospital Name: _____

DBA (if applicable) _____

Primary Mailing Address:

_____

City, State Zip

Phone Number ( )

Authorized Official and Signature

Chief Executive Officer:	Phone: ( ) Fax: ( ) E-Mail:
Signature:	Date:

Additional Points of Contact

Chief of Psychiatry:	Phone: ( ) Fax: ( ) E-Mail:
Certification Contact:	Phone: ( ) Fax: ( ) E-Mail:
Person Completing this Pre-Application and Title:	Phone: ( ) Fax: ( ) E-Mail:

INSURANCE INFORMATION

Malpractice/Professional Liability*

Name of Carrier_____

Occurrence _____

Aggregate _____

Effective Date _____

Expiration Date _____

* Provide documentation of proof of coverage.

General Liability**

Name of Carrier_____

Effective Date _____

Expiration Date _____

** Provide documentation of proof of coverage.

CLAIMS HISTORY

Please complete this section in its entirety. If a question does not apply to your facility, you may check Not Applicable (N/A).	Yes	No	N/A
Has the hospital's state license/certification ever been revoked, suspended, or limited?	❑	❑	❑
Is there action pending to revoke, suspend or limit the hospital's license/certification?	❑	❑	❑
Has the hospital ever had its Joint Commission accreditation revoked, suspended, or limited?	❑	❑	❑
Is there action pending to revoke, suspend, or limit the hospital's Joint Commission accreditation?	❑	❑	❑
Has the hospital ever had any OTHER certification/accreditation revoked, suspended or limited?	❑	❑	❑
Is there action pending to revoke, suspend, or limit the hospital's OTHER certification/accreditation?	❑	❑	❑
Has the hospital ever had any sanctions imposed by Medicare and/or Medicaid?	❑	❑	❑
Has the hospital ever been denied professional liability insurance or has its insurance ever been canceled or denied renewal?	❑	❑	❑
Has the hospital ever been a defendant in any lawsuit in regard to the practice of mental health or substance abuse treatment where there has been an award or payment of $50,000 or more?	❑	❑	❑
Has the hospital had any malpractice claims in regard to the practice of mental health or substance abuse treatment where there has been an award or payment of $50,000 or more?	❑	❑	❑

Note: *If you have answered yes to any of the above questions, please provide the current status and details on a separate sheet of paper. Please include the following: description of incident, including correspondence with state licensing boards, and/or a detailed description of any litigation, including settlements, court awards, etc. Please feel free to include a personal summary of the events; however, your pre-application cannot be processed without the necessary official documentation.*

Section 2: CERTIFICATION REQUIREMENTS

1. A description of the location of proposed intermediate duration acute care beds, including the exact number of beds (minimum of four (4) beds and not to exceed sixteen (16) beds) and an attached floor plan, demonstrating that the beds are located within a distinct unit;

2. Documentation of experience in providing intermediate duration acute psychiatric care;

3. Demonstrate ability to provide intermediate duration acute psychiatric care on a distinct unit that is designated for the provision of this specific level of care;

4. Demonstrate ability to employ or contract with the following specialized staff that hold the required license, certification, or registration issued by the State of Connecticut:
    a. A medical director
    b. A board-certified or board-eligible psychiatrist
    c. A neurologist
    d. A psychologist
    e. Social workers
    f. Rehabilitation workers and (Occupational Therapist Registered OTR)/Certified Occupational Therapy Assistant (COTA)
    g. A physician on site 24 hours per day, seven (7) days per week
    h. Registered nurses on site 24 hours per day, seven (7) days per week

    Include documentation of staff credentials, licenses, competencies, and languages spoken and qualifications to meet specialized needs of individuals needing Intermediate Psychiatric Care;

5. Describe proposed staff to client ratio;

6. Provide a detailed table of organization;

7. A description of the psychiatric rehabilitation services that will be provided, especially those that will enhance the independent living skills and illness management skills of the individuals receiving intermediate duration acute psychiatric care;

8. Demonstrate that there is a need for the proposed intermediate duration acute care beds and describe how they will enhance statewide access and complement distribution of existing services and resources;

9. Demonstrate ability to collaborate with multiple Local Mental Health Authorities (LMHAs) on a continued/on-going basis. Demonstrate a willingness to receive approval from the LMHA for each admission and to process the success and difficulties of community living prior to this admission;

10. Provide example of current policies specific to the care and management of individuals with persistent instability;

11. Provide examples of staff training topics addressing the care and management of individuals with persistent instability;

12. Provide an example of current specialized training procedure for clinical, support, and discharge planning staff that prepares them for the challenges presented by individuals who require intermediate duration acute psychiatric care and demonstrate ;

13. Provide a copy of current medical malpractice, comprehensive professional, general and/or umbrella liability insurance certificates that identify the limits of liability and policy period. Except as provided by state law, Hospital shall maintain professional liability insurance coverage of at least three million dollars ($3,000,000) per occurrence and ten million dollars ($10,000,000) in aggregate;

14. Demonstrate that Joint Commission-accreditation and Centers for Medicaid and Medicare Services approval is maintained;

15. Provide a copy of state-required facility license(s);

16. Demonstrate ability to provide intermediate duration acute psychiatric care;

17. Demonstrate ability to conduct an admission 24 hours per day, seven (7) days per week;

18. Demonstrate ability to perform a diagnostic evaluation, including a screening for a co-occurring substance use disorder, a bio-psychosocial assessment, a functional assessment and a risk assessment;

19. Demonstrate ability to obtain a medical history and physical examination upon each admission;

20. Demonstrate ability to perform a medication evaluation and monitoring, including the ability to do laboratory testing as needed;

21. Demonstrate ability to perform medical management and monitoring of coexisting medical problems, except that life support systems or a full array of medical services are not required;

22. Demonstrate ability to perform appropriate observation and precautions for individuals who may be suicidal;

23. Demonstrate ability to develop a recovery plan with each individual;

24. Demonstrate ability to provide individual and group therapy and, when indicated family therapy;

25. Demonstrate ability to provide rehabilitative social and recreational therapies, with emphasis on psychiatric rehabilitation techniques and training; and

26. Demonstrate ability to provide discharge planning that begins upon admission to an intermediate duration acute care bed and includes involvement of the LMHA to ensure the continuation of appropriate treatment and recovery support services or non-clinical services necessary to support stable functioning in the community.