Chapter 503

Licensed Behavioral Health Center (LBHC) Services

Appendix 503D

Comprehensive Community Support Services Program Certification Form

COMPREHENSIVE COMMUNITY SUPPORT SERVICES PROGRAM
REQUIRED DOCUMENTATION

A. Please indicate that copies of the following documents are attached to this application by placing a check or "X" in each of the blanks below:

_____ Behavioral Health License that is current and lists the site(s) where the Community Focused Treatment Program will be implemented;
_____ Consumer complaint or grievance policy/procedure related to Community Focused Treatment Program.
_____ Emergency (psychiatric/medical) procedures;
_____ Procedure for responding to inappropriate behaviors/aggressive behavior;
_____ Medication management/monitoring as it relates to Community Focused Treatment Program

B. List each staff member used by your center for Comprehensive Community Support Services. (If additional space needed, make copies of this form (HS = High School - GED) (BA= Bachelors) (MA = Masters +)

Name_____

Job_____

Title_____

Highest Degree Obtained_____

Major Field of Study_____

Professional License and/or Certifications _____

_____

Hours per week in program_____

MANAGEMENT AND PERSONNEL

1. Comprehensive Community Support Services Program Director/Supervisor

Name: _____

Education: _____

_____

2. ATTACH QUALIFYING WORK EXPERIENCE (Resume may be used if it indicates dates of experience for each position held by month/year):

3. As qualifying work experience, this agency assures that the individual named above meets the minimum qualifications for Comprehensive Community Support Services supervisor in terms of education, type(s) of position(s) held previously, length of work experience, and experience with the disability type served by this program, and written reference checks.

Date of Review: _____

PROGRAM SUMMARY

Please provide a summary description of the program at this site which includes the following points:

Hours of Operation: _____AM to _____PM

Days of Operation: (CIRCLE ALL THAT APPLY)

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

PROGRAM CAPACITY_____

Maximum Number of Members who can be served on any day? _____

PROGRAM SUMMARY

- **Program Name**
- **Target Population**
- **Program Description**
- **Programmatic Approaches**
- **Differences in programmatic approaches to individuals with lower-versus-higher functional impairment**
- **Address how activities are fashioned to be age appropriate**
- **Any specialty programmatic emphasis or focus**
- **Admission Criteria**
- **Continuing stay criteria**
- **Discharge Criteria**

Application for Comprehensive Community Support Services Treatment
Program Certification

Please complete the following identifying information for your agency:

PROVIDER IDENTIFYING INFORMATION

Name of Provider/Agency Operating Comprehensive Community Support Services Treatment Program site listed below:

Provider/Agency Address:_____

Provider/Agency Telephone Number:_____

Provider/Agency Executive Director/CEO:_____

Current Medicaid Provider Number: _____

Effective Dates of Behavioral Health License: _____

Date of Approved Certificate of Need: _____

Name & Title of Individual Completing Application: _____

Telephone Number: _____

Extension: _____

Fax Number: _____

E-Mail: _____

Send Application to:

West Virginia Department of Health and Human Resources
Bureau for Medical Services
350 Capitol Street Room 251
Charleston, West Virginia 25301