Chapter 503

Behavioral Health Rehabilitation Services

Appendix 503E

Application for Assertive Community Treatment (ACT) Team Form & ACT Team Modification Form

ACT PROGRAM CERTIFICATION:

Provisional Certification will be granted by BMS, or its designee, when the provider's initial application for ACT certification meets all required elements with the exception of the hiring of staff. During the provisional period of 60 days the provider shall recruit and hire staff in order to achieve ACT compliance. Full certification is required prior to delivering ACT services.

Certification is granted when an ACT team is compliant with all service requirements , including fidelity factors. Once certified, the ACT team can provide services eligible for reimbursement under ACT to qualified members. Certification includes a site visit by BMS or their designee to ensure all required components are in place. Certification is granted for a period of one year.

Recertification *review* is *conducted* one year following the certification by BMS or their designee to ensure compliance with requirements. This review will consist of a site visit to score the ACT team on adherence to the fidelity scale, organizational and policy requirements. Following the recertification, the ACT team recertification date will then occur every two years. Failure to obtain a satisfactory fidelity rating during any recertification (initial or subsequent) will result in the following:

- Mandatory training for the ACT Team on service requirements and fidelity factors. This training will occur within 30 days from the recertification decision and be administered by BMS or its designee.
- A repeat recertification review will occur 6 months following the negative recertification attempt. If compliance is achieved, then recertification will be granted for a two year period.
- If compliance is not achieved within 6 months then the ACT program will be decertified and the behavioral health providers will transition members served to other appropriate programs or services
- A de-certified ACT program may reapply for certification upon receipt and approval of a remedial plan that addresses prior deficiencies.

If BMS or its designee receives information that an ACT team is not in full compliance with policy, use of licensed personnel, and all requirements then BMS or its designee will complete a recertification review prior to the two year expiration BMS reserves the right to review any program at any time for the purpose of certifying or de-certifying a program.

Please complete the following identifying information for your agency/company for each team.

Name of Provider/Agency Operating the Assertive Community Treatment Team	
Provider/Agency Telephone number	
Address of Provider/Agency	
Assertive Community Treatment Team Telephone Number/Extension	
Date of Approved Certificate of Need (if applicable)	
Name & Title of Individual Completing Application	
Telephone Number	
Fax Number	
E-Mail of Individual completing application	
Provider/Agency Executive Director/CEO	

Provider Agency Executive Director/CEO Telephone	
Provider Agency Executive Director/CEO Email	
Current Medicaid Provider Number for Rehabilitation Services	
Address from which the Assertive Community Treatment Team is operated from	
Number of ACT Teams Agency has Currently in Place	

ASSESSMENT - TREATMENT PLANNING - DOCUMENTATION

1. Procedure for conducting Assessments

2. Procedures for Treatment Planning - Treatment Place Reviews.

JOB DESCRIPTION/STAFF ROLES:

- Attach a job description for each job title associated with the Assertive Community Treatment Team.

PROGRAM ORGANIZATION AND OPERATION

1. Program Hours - Coverage (Address the following)
   - Description of weekday and weekend hours
   - Description of how after hours on-call will be addressed by the team to cover 24 hours/7 days week
   - Description of how Psychiatrist will be a after hours

2. Service, Intensity and Location (Address the following)

- Location of Site Assertive Community Treatment Team will base operations
- Capacity to provide assertive outreach (multiple contacts per week)
- Capacity to rapidly increase service intensity for an individual when his or her status requires
- Capacity to provide 75 % of contacts in a non-office or non-facility based setting
- Maintaining ongoing involvement with the client during days in environments such as inpatient care, convalescent care facilities, community care hospitals or rehabilitation centers.

3. Program Size (Address the following)

- Anticipated number of clients to be served by the Assertive Community Treatment Team.
- Description of Geographical Area to being served by the team
- Staff/Client Ratio for the following:
  - Psychiatrist (Certified Physician Assistant, Certified Nurse Practitioner, Clinical Nurse Specialist)
  - Nurse
  - Other Staff

4. Staff Communication (Address the following)

- Client Roster of Active Team Members
- Description of how the Daily Staff Assignment will be assigned
- Schedule of Treatment Plan meetings and Treatment Plan Reviews.
- Description of how the Daily Meeting will be conducted
- Procedure for ensuring an intensive review of each active client takes place on a weekly basis

5. Service Scope (Description of the following)

- Case Management
- Crisis Assessment and Intervention;
- Symptom Assessment, Management & Supportive Therapy;
- Provision of Substance Abuse Services
- Work Related Services
- Activities of Daily Living
- Assistance with securing basic necessities
- Social, Interpersonal Relationships and Leisure Time Skill Training
- Support Services
- Education, Support and Consultation to Clients= Families and Other Major Supports

6. Description of how medication will be handled by the team

- Medication Prescription
- Administration
- Monitoring
- Documentation

7. Staff Supervision

ADMISSION - CONTINUING STAY- DISCHARGE CRITERIA

1. ELIGIBILITY CRITERIA:
2. ADMISSION CRITERIA:
3. CONTINUING STAY CRITERIA:
4. DISCHARGE CRITERIA:
5. STAFF CREDENTIALS:

ACT TEAM STAFF COMPOSITION

- Name of Psychiatrist(s):

Attach Educational Background, Licenses/Certifications, and Qualifying Work Experience
(Resume may be used if it indicates dates of experience for each position held by month/year)

- Name of Certified Physician Assistant, Certified Nurse Practitioner, Clinical Nurse Specialist (if utilizing):

Attach Educational Background, Licenses/Certifications, and Qualifying Work Experience
(Resume may be used if it indicates dates of experience for each position held by month/year)

- Name of Registered Nurse(s)

Attach Educational Background, Licenses/Certifications, and Qualifying Work Experience
(Resume may be used if it indicates dates of experience for each position held by month/year)

- Name of Team Leader/Coordinator:

Attach Educational Background, Licenses/Certifications, and Qualifying Work Experience
(Resume may be used if it indicates dates of experience for each position held by month/year)

- Name of Substance Abuse Specialist:

Attach Educational Background, Licenses/Certifications, and Qualifying Work Experience
(Resume may be used if it indicates dates of experience for each position held by month/year)

- Name of Other Staff

Attach Educational Background, Licenses/Certifications, and Qualifying Work Experience
(Resume may be used if it indicates dates of experience for each position held by month/year)

OTHER DOCUMENTS

Please indicate that copies of the following documents are attached to this application by placing an X in the box in each of the blanks below:

	A Behavioral Health License that is current and list the site where the Assertive Community Treatment Team will be implemented:
	Emergency (psychiatric/medical) procedures
	Medication management/monitoring as it relates to the Assertive Community Treatment Team
	Consumer complaint or grievance policy/procedure related to Assertive Community Treatment Team.
	Procedure for responding to inappropriate behavior/aggressive behavior as it relates to the Assertive Community Treatment Team.
	Attached Plan of Patient Care in case of Decertification of ACT Team

For BMS Staff Only

BMS Received Date	
BMS Review Meeting Date	
BMS Certification Approval Date	
BMS ACT Team Non-Approval Decision Letter Sent Date	

Please mail the application and all required attachment to:

BUREAU FOR MEDICAL SERVICES, ACT CERTIFICATION
350 CAPITOL STREET, ROOM 251
CHARLESTON, WEST VIRGINIA 25301

ACT TEAM EMPLOYEE MODIFICATION FORM

Completion of this form is required when a change in the ACT Team personnel occurs. The change must be reported to BMS within 30 calendar days of the modification. It is the providers' responsibility
to ensure all team member requirements are met and the staff to member ratio is maintained. The ACT provider will be notified by BMS or its designee if any concerns are noted related to the team modification.

Name of ACT Provider: _____

ACT Team Leader Completing Form: _____

Date of Form Completion: _____

Name of new ACT Team Staff: _____

Designated Role on ACT Team: _____

Initial date performing ACT Team functions: _____

Name of previous ACT Team Staff: _____

Designated Role on ACT Team: _____

Last date of performing ACT Team functions: _____

The completed form may be submitted to BMS via fax, mail or email per the addresses below:

WV DHHR—BMS ACT
350 Capital St. Room 251
Charleston, WV 25301
Fax # (304) 558-4739

Attn: Program Manager BH Services

Email: Cynthia.A.Parsons@wv.gov

BMS Portion:
Date of Review: _____

BMS Staff Reviewing Form: _____

Notes:

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