**Application for Crisis Residential Service Program Enrollment**

**Michigan Department of Health and Human Services**

**This information must accompany the attached Service Agency Profile for any request to enroll Child Crisis Residential Program for purposes of Medicaid reimbursement. All information is to be submitted to:**

**MDHHS-BH-Special-Program-Enrollment@michigan.gov**

**If you have any questions please contact Jackie Wood, Program Specialist at**

**(517) 373 – 4316 and** **MDHHS-BH-Special-Program-Enrollment@michigan.gov**

**Contact information for this application:**

**Name:** Click here to enter text.

**E-Mail Address:** Click here to enter text.

**Phone:** Click here to enter text.

**Program name and address:**

 **Program Name:** Click here to enter text.

 **Program Address:**

Click here to enter text.

**PIHP:** Click here to enter text.

**Describe the population to be served (for example-females, ages 7-17 SED; males, ages 12-17 SED and SED with I/DD, etc. Specify if children/youth with autism will be included in the population to be served):**

Click here to enter text.

**Type of MDHHS license (please submit a copy of the license with the application):**

Click here to enter text.

**Note, per Section 6 Crisis Residential Services, 6.2.A, Medicaid Provider Manual**: “Child Crisis Residential Services may not be provided to children with serious emotional disturbances in a Child Caring Institution (CCI) unless it is licensed as a "children's therapeutic group home" as defined in Section 722.111 Sec. 1(f) under Act No. 116 of the Public Acts of 1973, as amended...”

**Crisis residential bed capacity:** Click here to enter text.

**Describe how the following required services will be provided in the crisis residential program for the population served:**

**Psychiatric Supervision:**

Click here to enter text.

**Therapeutic Support Services:**

Click here to enter text.

**Medication Management/Stabilization and Education:**

Click here to enter text.

**Behavioral Services:**

Click here to enter text.

**Milieu therapy:**

Click here to enter text.

**Nursing Services:**

Click here to enter text.

**If other services are to be provided, please provide a description of the services:**

Click here to enter text.

**Complete the chart below for all crisis residential qualified staff. Also, indicate those who are designated as program supervisor(s) (refer to the Medicaid Provider Manual for a description of required qualifications):**

|  |  |  |
| --- | --- | --- |
| **NAME, DEGREE, LICENSE** | **POSITION –****Title and % FTE** | **CMHP, QIDP\*, etc. as applicable to population** |
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**Describe the admission criteria and explain how parents/caregivers will be involved in this process:**

Click here to enter text.

**Describe how the Individual Plan of Service will be developed and how services will be delivered for the population served:**

Click here to enter text.

**Describe the duration of services:**

**They will be up to 2 weeks or as appropriate**

**Describe how the child/youth’s needs will be addressed in context with the family needs and explain how parents/caregivers will be involved in this process:**

Click here to enter text.

**Describe how the educational services will be included and how the plan will be developed in consultation with the child/youth’s school district staff:**

Click here to enter text.

**Describe the discharge criteria and transition out of the crisis residential, please explain how parents/caregivers will be involved in this process:**

All parents involved

\*Child Mental Health Professional (CMHP)

 Qualified Intellectual Disability Professional (QIDP)

Please refer to the MDHHS website for the Medicaid Provider Qualifications Chart for a complete description of provider qualifications at:

<http://www.michigan.gov/documents/mdch/PIHP-MHSP_Provider_Qualifications_219874_7.pdf>

Click here to enter text. Click here to enter text.

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**PIHP CEO or Designee Signature Date**