# Table of Contents

- Introduction .................................................................................................................. 1
- Tools and Tips ................................................................................................................ 1
- Section A. School Information ....................................................................................... 2
- Section B. Array of Services Certified to Provide .......................................................... 2
- Section C. Practice Site Information ............................................................................. 2
- Section D. In-Home Services ......................................................................................... 2
- Section E. Mental Health Staff ....................................................................................... 3
- Section F. Current Agency Status ................................................................................... 3
- Section G. Quality Assurance ......................................................................................... 4
- Section H. Assurances .................................................................................................... 5
- Completing the Application ............................................................................................ 5
- For Further Information ................................................................................................. 6
- Submission ...................................................................................................................... 6
A review by the Department of Human Services (DHS) Children’s Mental Health Division for certification is required of providers applying to receive initial certification to file claims with Minnesota Health Care Programs MA for CTSS. Re-certification is required at least every three years. DHS assumes responsibility for the certification review. **This re-certification application is for a school seeking re-certification for an additional three years.** Schools needing information regarding initial certification should review DHS-4982B – CTSS School Primary Certification Overview, DHS-4982A – CTSS School Primary Certification Guide and DHS-4982 – CTSS School Primary Certification Application.

To allow adequate time for re-certification, the completed application to continue certification should be received by the DHS Children’s Mental Health Division 60 days before the current certification expires – but not more than 120 days or it may be returned as “Not Timely”. Re-certification review typically involves review of the submitted application and potentially a site visit to evaluate implementation of statutory requirements for administrative and clinical infrastructure components. Upon completing the re-certification review, DHS will notify the applicant of its decision. If the applicant has not received written notification two weeks before existing certification expires, contact the DHS Children’s Mental Health Division.

The applicant (a.k.a. “school/school district”) must incorporate all individuals, agencies and organizations that are a partner, vendor, or subcontractor providing supervisory functions or services to students when completing the application.

Note: This application only applies to CTSS services. DO NOT include information on services, plans, personnel, activities, et cetera unless directly related to providing CTSS. There is a different re-certification process for community providers. See DHS-4976.

Applicant must submit an electronic version of the re-certification application. If completing the application constitutes a hardship for the applicant, contact the DHS Children’s Mental Health Division for an alternative means of submitting the application.

**Introduction**

**Tools and Tips**

**General Information**

These instructions include additional information about some CTSS Application questions to assist the school through the certification process. Every question in the application does not include a corresponding instruction reference. The application contains data fields that must be completed in order for the school to continue advancing through the application. Pop up boxes will contain instructions on how to complete the fields.

**Hyperlinks**

For your convenience there are hyperlinks throughout the application that will connect you to the relevant section of these instructions or to other external relevant sections. Simply click on the underlined text to view the information.

**Filling out fields**

A **radio button** is a type of graphical user interface element that allows the user to choose only one of a predefined set of options. These will appear as circles to the left of the text. ☐ **YES**

A **check box** is a graphical user interface element that permits the user to make multiple selections from a number of options. These will appear as square boxes to the left of the text. ☐ **CRISIS ASSISTANCE**

For sections that have the option to **add and remove rows**, the button to add a row is + and the button to remove a row is −.
Remember to save
The department highly recommends saving the PDF application form under a new name until it is completed and ready to submit. Remember to follow instructions on front of the application form regarding naming and saving the application prior to submission.

Attachments
Some sections may require you to include attachments. Follow the instructions presented on the cover of the application.

Section A. School Information

Name of School
Provide the legal name and address information of school that will submit claims to Minnesota Health Care Programs (MHCP) for CTSS mental health services.

Contact Person Information
While many people will likely contribute to this application, list here the person primarily responsible for submitting the application and his/her contact information. This is the contact information for the person that can facilitate questions that the department may have about the application.

Section B. Array of Services Certified to Provide

Click the check box for each service that is provided through at least one practice site, in student homes or in other community locations. Also indicate the date your current certification expires.

Do not check additional services that you have not been certified to provide but would like to start providing after re-certification. Providing services that were not approved as part of your existing certification requires submitting an Addendum Application.

Section C. Practice Site Information

A practice site is a specific location or physical plant, where the school provides CTSS services. The main practice site should function as the school’s record and documentation storage area and house most of the administrative functions for the school.

Services delivered at secondary practice sites or in the community should meet the same administrative and clinical standards as those in the main site.

Do not list student homes as a practice location. A student’s home is a place of service in the community but is not a practice location because other students should not be receiving services in another student’s home.

A therapist’s vehicle is not a practice location or place of service.
Click the check boxes for the services provided at each practice site.

Section D. In-Home Services

If services are provided in student’s homes, identify each potential county where in-home services may be delivered.
Section E. Mental Health Staff

Mental Health Professionals (MHP)

Mental Health Professional’s Name
Enter the full name of each MHP who is employed by or under contract with the school.

Licensure
Indicate the MHP’s current licensure.

Counties/Sites
Refer to Practice Sites for the list of sites. Indicate the site(s) name from that list, where the MHP provides services. For example, if a person works at three sites, find those locations on the table in Practice Sites and list each of those site(s). Also list the counties the professional will deliver services in.

Clinical Supervision
Is the MHP identified responsible to provide clinical supervision for any mental health practitioners and/or mental health behavioral aides? If yes, total the number of mental health practitioners and MHBAs separately (if applicable) that person supervises from all sites combined. This should include both part and full time staff.

Mental Health Practitioners

Mental Health Practitioner’s Name
Enter the full name of each practitioner who is employed by or under contract with the agency.

Degree/Licensure
Indicate the practitioner’s current degree/licensure if applicable.

Counties/Sites
Refer to Practice Sites for the list of sites. Indicate the site(s) from that list, where the practitioner provides services. For example, if a person works at three sites, find those locations on the table in Practice Sites and list each of those site(s). Also list the counties the practitioner will deliver service in.

Direction
Is the practitioner identified responsible to provide direction to mental health behavioral aides? If yes, total the number of MHBAs separately (if applicable) that person supervises from all sites combined. This should include both part and full time staff.

Section F. Current Agency Status

Accreditation or Certification
Check appropriate radio button and insert dates of current accreditation or certification as a:

- Community Mental Health Center as defined by Minnesota Statutes, section 256B.0625 or
- Mental Health Clinic as defined by Minnesota Rules, parts 9520.0750 to 9520.0870 (Rule 29) or
- Joint Commission on the Accreditation of Health Organization (JCAHO).

Governmental Status
Check appropriate radio buttons.
**Adverse Legal History**

Provide information about legal actions. Check yes or no to identify whether or not the applicant or its employees have been or are involved in any adverse legal actions.

If yes is checked, the provider must report on each adverse action. The report should identify:

- Adverse legal action (e.g., disciplinary action taken by a licensing board, criminal court conviction, malpractice actions or judgments, Medicare or Medicaid fraud),
- When it occurred,
- Agency that initiated the action (e.g., county law enforcement authority, criminal court, licensing or administrative body) and
- Resolution. For any reported action the agency must attach a copy of the resolution.

**Significant Changes**

These include, but are not limited to, change in ownership, name, location, inability to provide full array of CTSS services, or addition or loss of mental health professionals.

Provide a brief but adequate description of any significant changes since the last certification/re-certification. Be sure to indicate the counties affected by the change(s).

---

**Section G. Quality Assurance**

**Quality Assurance**

The initial CTSS School Certification process required the applicant to submit a quality assurance plan in addition to policies and procedures for development, review and updating of the plan. The review for this section will be on changes already made because of information the applicant gathered through client satisfaction surveys and/or client outcomes data since the prior certification.

**Client Satisfaction**

The review of this section will be on changes already made through existing processes as well as on plans for further changes deemed appropriate on the basis of client satisfaction data obtained since the last certification. Changes and/or plans specific to certain counties should be distinguished from changes and/or plans affecting all counties served. Identify affected counties.

- Results include client satisfaction with
  - Treatment progress
  - Access to services
  - Participation in treatment plan development
- Steps taken

  Describe changes made to CTSS as a result of the past year’s client satisfaction data for each of the above three domains. If some changes have not been fully implemented, indicate what the change will be when completed and what steps, to date, have been implemented. Include changes not yet begun under next item.
- Plans not yet begun

  Describe plans for future changes that have been developed as a result of client satisfaction measurement for each of the domains in the first bullet. Limit this to plans prepared during the past 12 months but not yet begun (the plan exists, but implementing the plan has not started). Also include timelines for when implementation will occur.
**Client Outcomes**

A client’s outcomes are changes resulting from a treatment/service provided. Outcomes are not merely the goal(s) of a treatment or service. The goal(s) of a treatment or service is what the provider and client intended to accomplish, but the outcomes are what was actually attained. Review of this section is not for success of treatment or services. Instead, it is focused on the provider incorporating changes as a result of measuring client outcomes.

Identify the outcomes measured, methodology, results, steps taken, and plans made for future implementation. See below for a brief description of what to include in each.

- **Which client outcomes**
  Include the name of the treatment/service, its goal(s), description of the treatment/service, and outcome(s) being measured.

- **Methodology**
  Title/name of the instrument(s) used to measure change, timing of administering these, and the methodology for analysis should be included.

- **Results**
  A brief summary of results.

- **Steps taken**
  Describe changes already made as a result of measuring client outcomes and reviewing these. Do not include changes made to programs solely for reasons other than the result of measuring client outcomes.

- **Plans to improve**
  Describe plans to improve the treatment/services based upon the result(s) of having measured and reviewed client outcomes which have not been implemented. Do NOT include plans for changes based upon reasons other than the result of measuring outcomes for clients receiving the treatment or service.

---

**Section H. Assurances**

The applicant is asked to certify compliance with a number of requirements. This is done rather than requiring explanations, descriptions of practices, and other means of demonstrating compliance with each of these items.

Read each assurance statement and select the appropriate response. The response default is “No”; choose “Yes” for all assurance statements to which the agency agrees. Keep in mind that the policies and procedures required under the assurance statements must be immediately available upon request by DHS. If any assurance statements are not agreed to and they are not clearly explained and justified, CTSS certification will be denied.

**Completing the Application**

Indicate that the agency application is complete and accurate by checking the box. Fill in the name of the agency, the name of the Executive Director or Agency Administrator, the name of the Board Chairperson, and the date the application is submitted. Please complete the information regarding the contact information of the person who actually submits the application in case there are any reasons DHS needs to contact the agency about the accuracy or any problems in the actual submission of the application document and attachments.
For Further Information

Contact Jill Johnson by

Email: DHS.SchoolCTSS@state.mn.us
Phone: (651) 431-2333

Or writing: Department of Human Services
Children’s Mental Health Division
CTSS School Re-certification
PO Box 64985
St. Paul, MN 55164-0985

Submission

Applications should be received by DHS 60 days prior to expiration of the existing certification.

Save an electronic copy of this PDF document with your agency name included in the new file name.

Check the file size of the PDF and any attachments you plan to submit with it. (In Windows, right click on the folder with the PDF and attachments. Go to “Properties” to see the size of the folder.) If over 20 MB (20,000 KB) contact Jill Johnson for an alternative delivery method.

Click the Submit button on the last page. The PDF will appear in the e-mail. Then attach all supporting documents to the e-mail as you normally would. Once all information is attached to the e-mail, complete the process by clicking the “Send” button.