**Application for Adult (Ages 19-64) Co-Occurring Enhanced Crisis Residential Service Program Enrollment-Healthy Michigan**

**Michigan Department of Health and Human Services**

**This information must accompany the attached Service Agency Profile for any request to enroll Adult Co-Occurring Enhanced Crisis Residential Program for purposes of Medicaid reimbursement for beneficiaries who meet the ASAM Criteria for Level 3.7 Medically Monitored Inpatient Services, or risk of admission but who can be appropriately served in less intensive settings.**

**Co-occurring enhanced crisis residential is further described as where:**

* **the primary focus is to capably treat those who present with unstable mental health and substance use disorders simultaneously**
* **the policies and procedures in place describe an integrated approach in assessment, treatment modalities, therapies, discharge planning, and transition back into the community**
* **integration is reflected in agency personnel, staff training, and incorporated into services offered, individual and group treatment content, crisis strategies address both mental health and substance use disorders effectively**

**Program requirements are outlined in the Medicaid Provider Manual, Healthy Michigan Chapter, Section 5.6.B.4 Crisis Services, Crisis Residential Services.**

**The completed form is to be submitted to:**

[**MDHHS-BH-Special-Program-Enrollment@michigan.gov**](mailto:MDHHS-BH-Special-Program-Enrollment@michigan.gov)

**Community Practices and Innovations Section**

**Behavioral Health and Developmental Disabilities Administration**

**Michigan Department of Health and Human Services**

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

**(517) 335 – 2309 and** [**woodj10@michigan.gov**](mailto:woodj10@michigan.gov)

**Contact information for this application (include name, email address, and phone no.):**

**Program name and address where services will be delivered:**

**PIHP:**

**Population to be served (male, female, both):**

**Crisis residential bed capacity (please attach a copy of the Substance Use Disorder (SUD) program license):**

**Please provide comprehensive descriptions on how the following covered services will be provided and coordinated in the enhanced co-occurring crisis residential program for the population served:**

**Psychiatric Supervision (in addition to the description, please provide assurance that the psychiatrist is available by telephone 24/7 when not on-site)-**

**Therapeutic support services-**

**Medication management/stabilization and education-**

**Behavioral Services-**

**Milieu therapy-**

**Nursing/Medical Services (Onsite nursing services are required for those who are in the detoxification process and who require medications to manage the current crisis. In addition to the description, please provide assurance that for settings of 6 beds or fewer on-site nursing is provided at least one hour per day, per resident, 24-hour availability on-call; and for settings 7-16 beds on-site nursing is provided eight hours per day, seven days per week, with 24 hour availability on call)-**

**If other services are to be provided, for example, safety planning, family therapy, peer support and recovery coach services, please provide a description of how they will be provided:**

**If de-toxification, withdrawal services are to be provided in this setting, please describe. Indicate in the chart below the staff who will be providing these services-**

**Complete the chart below for all co-occurring enhanced crisis residential qualified staff. Indicate those who are designated as program supervisor(s) and those who are direct care staff (refer to the Medicaid Provider Manual for a description of required qualifications):**

|  |  |  |
| --- | --- | --- |
| NAME, DEGREE, LICENSE | POSITION –  Title and % FTE dedicated to this program | QMHP, QIDP, etc. as applicable to population |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Describe the admission criteria:**

**Describe the duration of services:**

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

**Describe the discharge criteria, transition out of the enhanced crisis residential and follow-up with on-going treatment providers and primary care:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PIHP CEO or Designee Signature Date**