**Application for Adult 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 Adult Crisis Residential Program for purposes of Medicaid reimbursement. All information is to be submitted to:**

**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**

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

**Program name and address:**

**PIHP:**

**Population to be served:**

**Crisis residential bed capacity (please attach a copy of the license):**

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

**Psychiatric Supervision-**

**Therapeutic support services-**

**Medication management/stabilization and education-**

**Behavioral Services-**

**Milieu therapy-**

**Nursing Services-**

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

**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):**

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| --- | --- | --- |
| NAME, DEGREE, LICENSE | POSITION – Title and % FTE | QMHP, QIDP, etc. as applicable to population |
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**Describe the admission criteria:**

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

**Describe the duration of services:**

**Describe the discharge criteria and transition out of the crisis residential:**

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**PIHP CEO or Designee Signature Date**