Behavioral Health Division

Youth Assertive Community Treatment (Y-ACT) Certification Application

Provider Information

AGENCY NAME			PROVIDER NPI
TEAM NAME			
PHYSICAL ADDRESS OF TEAM	CITY	STATE	ZIP CODE
MAIN PHONE NUMBER (number will be posted on the OHS website)			

Leadership Information

NAME OF CHIEF EXECUTIVE OFFICER (CEO)	CEO EMAIL
NAME OF CHIEF FINANCIAL OFFICER (CFO)	CFO EMAIL
NAME OF CLINICAL SUPERVISOR (IF APPLICABLE)	CLINICAL SUPERVISOR EMAIL
NAME OF TEAM LEADER	TEAM LEADER EMAIL
NAME OF PSYCHIATRIST	PSYCHIATRIST EMAIL
NAME OF OWNER (IF APPLICABLE)	OWNER EMAIL
NAMES OF MEMBERS OF THE BOARD OF DIRECTORS (IF APPLICABLE)	

Capacity of the Team

Refer to Minnesota Statutes 256B.0947, subdivision 5

MAXIMUM CAPACITY

DEPARTMENT OF HUMAN SERVICES

Service Area

Counties Served:

COUNTY NAME
COUNTY NAME
COUNTY NAME
COUNTY NAME
COUNTY NAME

Staffing Composition

Refer to Minnesota Statutes 256B.0947, subdivision 5

NAME OF STAFF PERSON	STAFF ROLE	HIGHEST CREDENTIAL	FTE	LICENSE NUMBER (IF APPLICABLE)

DEPARTMENT OF HUMAN SERVICES

Hours of Operation

HOURS OF OPERATION							
WEEKDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
START TIME							
END TIME							

Certification Requirements

1. Follow all statutory requirements identified in 256B.0947.

2. Policy/Procedures Guide including:

a. Admission- Follow statute requirements identified in 256B.0947, subdivision 3
b. Discharge
c. Crisis Services
    a. Hour of on-call
    b. Who provides on-call or on-call system
d. Documentation - Provide the policy and examples of the following:
    i. Diagnostic Assessment
    ii. Interpretive Summary
    iii. Functional Assessment
    iv. Treatment Plan
    v. Health Assessment (if applicable)
    vi. Co-Occurring Assessment
    vii. Vocational Assessment (if applicable)
    viii. Progress Notes
    ix. Continued Need of Care Assessment (LOCUS, CASII, SDQ)
e. Nursing (if applicable)
    i. Medication management
    ii. Medication storage
    iii. Medication disposal
    iv. Medication incident
    v. Other
f. Grievance
g. Individual served satisfaction evaluation
h. Incident
    i. Individual served related
        1. Suicide completion or attempt
        2. Homicide completion or attempt
        3. Assault on others
        4. Other
    ii. Staff related
        1. Inappropriate contact with individual served
        2. Fraudulent activity
        3. Other
i. Equity
    i. Non-Medical Assistance individuals served
    ii. Non-English speaking individuals serve—NOTE: DHS Interpreters Services

DEPARTMENT OF HUMAN SERVICES

By checking "I agree" and typing my name in the "Electronic Signature" field, I understand that l am electronically signing this form. In addition, I attest and certify that I have verified the profile change against an acceptable form of identification and that the information provided above is true and accurate. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (MN Stat. §325L.07)

☒ I agree	ELECTRONIC SIGNATURE OF EXECUTIVE DIRECTOR	DATE (M/D/YYYY)
☐ I agree	ELECTRONIC SIGNATURE OF EXECUTIVE DIRECTOR	DATE (M/D/YYYY)