The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Mental Health

Application for _____Initial or ____Renewal or ____Revised License to Operate a Psychiatric Unit within a General, Municipal or Other Hospital, or to Operate a Psychiatric Hospital

Note that during the state of emergency, we request an initial completion of pages 2 and 3 of the application (questions 1 through 12), along with the closing signature page. The most recent Joint Commission (or other acceptable accrediting agency) report, as well as any CMS surveys conducted in the prior three years should be submitted. An attestation statement from the person in charge that the hospital/unit is meeting all of the DMH regulations covered in questions 13 through 39 (as applicable) should be attached, along with an attestation statement from the Director of Human Resources regarding tracking of professional licensure.

Applications should be addressed to:

Janet E. Ross, MS, RN
Assistant Commissioner for CPS/Director of Licensing
Department of Mental Health
25 Staniford Street
Boston, MA 02114
Email submissions should be sent via Teresa.J.Reynolds@massmail.state.ma.us

Once a date is set for the Licensing Survey, the remainder of the application should be completed and submitted by the date identified in the email notice. The fee will be required at that time. ***All attachments should be labeled and identified by the corresponding question number.*** A description of the survey process is included in the email sent to the facility with the date of the survey and available on our website. For any questions regarding the application, payment, or survey process please contact Teresa Reynolds, Office Manager at 617-626-8117 or Teresa.J.Reynolds@state.ma.us

Application Fee Schedule (due with the fully completed application, submitted after a date for the survey has been set):
Please enclose a check made payable to "*The Commonwealth of Massachusetts.*" The amount of fee will be as follows:

For hospitals with 40 or fewer DMH licensed beds, the Application fee will be $500.00.
For hospitals with 41 to 60 DMH licensed beds, the Application fee will be $750.00.
For hospitals with 61 or more DMH licensed beds, the Application fee will be $1000.00.

Requests for a change in license (e.g., adding a Class, increased capacity, etc.); the fee will be $100.00.

1. Name of Hospital:_____

2. Address:_____
   (# & Street) (City) (Zip Code)
   Telephone #:_____

3. Legal Entity: _____

   Address of Legal Entity: _____

   Identify ownership of the facility: (Check all that apply)
   Individual _____ Partnership _____ Corporation _____
   Society _____ Association _____ Other _____
   (Specify)_____

4. Total Number of Licensed Psychiatric Beds:_____

5. Indicate Number of Operational Beds (if Different from Licensed Capacity):_____

6. Name of President or Chief Executive Officer:
   _____
   Name Title

7. Please list name, title and telephone number of person to contact regarding scheduling of DMH visits and related matters.

_____
Name Title Phone #

_____
Email Address

8. Classes of License Requested (see 104 CMR 27): (Check all that apply. If shared license please indicate for each facility)
   Class II _____ Class III _____ Class V _____
   Limited Class VI ____ Class VI _____ Class VIII (ECT) ____

9. Please complete the following for each unit covered by this Application:

Unit Name	Licensed Capacity	Operational Capacity	ADC	ALOS	Age Range	Specialty Services Offered

10. Does the facility wish to apply for licensure under the Deemed Status provisions of 104 CMR 27.03(12)? Yes _____ No _____
    If "Yes"- Submit most recent accreditation letter and agency's full survey report.
    If "No"- a full licensing survey will be scheduled.

    If the facility has received any accreditation visit of any kind, please submit the letter and report.
    Accrediting Agency:_____
    Effective Date: _____ Expiration Date: _____

11. Designated Physician Waiver Request
    Waiver Requested? Yes _____ No _____

    At the time of submitting a full application, if designated physician waiver is requested, attach any petitions for new or renewal waiver. Note that petitions must meet training and support description requirements expressed in 104 CMR 27.03 (22) and/or 104 CMR 33.02(1) (e). ***Please include a detailed description of the annual training provided, and an attestation statement from the Medical Director verifying that all training is completed and will continue for all new hires.***

12. Telemedicine Request
    Telemedicine Requested? Yes____ No ____

    If a new or renewal telemedicine request is made, attach the request at the time of submitting a full application,. Note that requests must meet requirements expressed in DMH Licensing Bulletin #16-01 – Use of Telemedicine to Comply with 24/ 7 Physician Coverage/ Designated Physician Requirements, Revised June 2018. ***Please include a detailed description of the annual training provided, and an attestation statement from the Medical Director verifying that all training is completed and will continue for all new hires.***

Questions 13 through 39 (as applicable) may be delayed in response, but attestation statements should be submitted as noted on page 1.

13. Please describe the provision of services that facilitate the admission of the following specialty populations within the class of license for which you are applying. The specialty populations are comprised of individuals with clinical needs in addition to their mental health needs that may require the provision of specialized services, staff competencies, or treatment structure in order to receive suitable treatment within a facility. These groups may include, but are not necessarily limited to:

    - individuals who present with assaultive or severely disruptive behavior;
    - individuals with co-occurring mental health and intellectual or developmental disabilities *(adults and children)*;
    - individuals with complex medical needs;
    - individuals with co-occurring substance use disorder; or
    - are children (particularly young children) or older adults.

    See DMH Licensing Bulletin #2018-01 for details regarding services, clinical competencies, treatment structure, as well as physical space (e.g., single rooms, limited census, and/ or an area allowing increased ability for observation and intervention).

    No application for licensure or for renewal of a license shall be approved unless the facility demonstrates, and the Department determines, that the facility it seeks to license is:

    1. responsible and suitable to meet the needs of the Commonwealth's; and
    2. able to meet the clinical competencies and operational standards for providing care and treatment to the population(s) it will serve.

14. <u>Physical Adaptations</u>
    Describe the facility's plan for physical adaptations, such as by providing single occupancy bedrooms, when necessary to address behavioral acuity in its patient population, as needed.

15. Please briefly describe the following:
    a. The psychiatry, nursing, social work, psychology, occupational therapy, physical therapy, if any, rehabilitation, dietary, and pharmacy services along with the reporting and supervisory responsibilities for each group.
    b. The screening and referral processes for applicable services (i.e., Psychology, OT, Medical Specialties, Dietary, Physical Therapy, Laboratory, etc.) if these services are not provided by employees of the facility.

16. Does the facility offer a separate, identifiable inpatient substance use disorder treatment unit or program, or hold itself out as providing substance use disorder treatment or services as a primary or specialty service? If yes, and the unit or program is within a general hospital licensed by the Department of Public Health under M.G.L. c. 111, § 51, it must meet the requirements of 105 CMR 164.012(D)(2). If yes, and the unit or program is not within a general hospital licensed by the Department of Public Health under M.G.L. c. 111, § 51, it must apply for and obtain a BSAS license for a Department of Mental Health licensed facility as provided in 105 CMR 164.012(D)(3). Identify the unit or service and attach a copy of the current Department of Public Health/ Bureau of Substance Abuse Services (DPH/ BSAS) license(s) for the unit(s)

    Yes No

    _____ _____

    _____ _____

17. If there is no separate, identifiable inpatient substance use disorder treatment unit or program as described above, are substance use disorder treatment or services provided which are incidental to the evaluation, diagnostic and treatment services for which the facility is licensed under 104 CMR 27.00? If yes, identify the location(s) where incidental/occasional medically monitored detoxification and/or opiate maintenance are provided.

    Yes No

    _____ _____

    _____ _____

18. For each unit identified as providing incidental/occasional medically monitored detoxification and/or opiate detox/maintenance, by unit, please attach a list of medically monitored detoxification and/or opiate maintenance provided and include an approximate number of patients served each year in each category.

19. Please submit copies of all program/hospital detoxification protocols and any substance use assessment tools utilized. Please also include policies/procedures regarding the management of medications used for assisted treatment (e.g. methadone, suboxone, etc.) ***** Please note: Protocols will be forwarded to the DPH/ BSAS for review.**

20. Please submit the *most recent* certifications/licenses or explanation for the following:

Certificate/License	**Expiration Date**	**No- with explanation**
local fire inspection		
local building inspection		
Dept. of Public Safety inspection		
Board of Health food service inspection		
DEA license if applicable		
Dept. of Public Health License(s)		
Medicare Certification		
Medicaid Certification		

21. Please describe the facility's payer mix.

22. Organizational Charts:
    a. Please include an organizational chart for the governing body of the hospital.
    b. Please include an organizational chart, with names, of the psychiatric unit(s) (If not included in above.)

23. Clinical Programming
    Please attach current copies of program schedule(s) and description of the groups offered including the disciplines/staff responsible for the running the groups. Describe the hospital/units approach to person centered treatment, as well as a description of all recreational activities and equipment, alternatives provided for patients who decline to attend groups or whose condition precludes their participation in groups. In addition, for facilities licensed as Class VI, Limited VI and VII, the plan shall include educational programs, and youth guided and family driven treatment.

24. Curriculum Vitae
    Please provide ***current*** CVs/ ***resumes*** for the following positions as applicable. Please include an attestation statement from the Human Resources Department that verifies current licensures/certifications held and expiration dates for the following key clinical/leadership positions:

- Facility/Program Director (Person in Charge)
- Medical Director
- Primary Attending Physicians
- Nurse Leader
- Nurse Educator
- Social Work Director
- Psychologist
- Human Rights Officer
- Occupational Therapist
- Dietician
- Rehabilitation Therapist
- Clinical Director

25. Staffing

Licensed facilities must have sufficient staff who have training and demonstrate competencies in functions consistent with their job responsibilities and, if required, have certification, and who demonstrate competencies, in such specialty services as the facility may provide. If the facility is operating below its licensed capacity, specify the reasons for operating below its licensed capacity and the plan to meet the staffing requirements for its full licensed capacity.

26. Direct Care Staff

Describe core staffing in terms of numbers of RNs, LPNs, and mental health associates expected to be on duty, by each shift, at various levels of census.

a. Please describe the system in use for ensuring adequate direct care staff coverage (including accessing additional staff to fill vacancies and/ or when acuity, special needs, or census dictates), and minimum nursing care hours per patient day across all three shifts for each inpatient unit. (Adult 6.00, Adolescent and Geriatric 7.00, Child 8.00, ID/ASD 8.00). A registered nurse must be on duty at all times, with sufficient additional staff to provide care and treatment as well as emergency response.

27. Staff

Please submit a listing of all staff by name, degree/credentials, title, FTE, date of hire, license number and expiration date (as appropriate), annual de-escalation training expiration date (including all physicians), and CPR training expiration date for all staff as required. Use format below:

Name	Degree/ credentials	Job Position	FTE	Date of Hire	License Number	License Expiration Date	De-Escalation Training Expiration (1 yr.)	CPR Training Expiration
Mary Smith	M.D.	Medical Director	.75	10/1/12	#02456	10/4/18	1/1/18	12/31/18
John Doe	RN	Charge Nurse	1.0	2/14/16	#9521	11/25/18	4/5/18	1/20/19

28. Nursing

a. Please describe the nursing leadership structure (describe all roles and duties, including that of the nursing supervisor for each shift, as applicable).
b. Include the role and percentage of direct care time on unit(s) of nurse managers.

29. Nurse Leader/Nurse Educator

If the Nurse Leader ***or*** Nurse Educator does not hold an advanced degree in psychiatric nursing or an advanced degree in nursing and at least five years of experience in psychiatric nursing leadership, a consultant with that degree needs to provide supervision to the nurse leader and coordinate and oversee the training for nursing personnel. Please submit the resume of this individual and a description of the relationship with the consultant and the Nurse Leader and the frequency of contact. (Minimum of monthly, documented meetings is required.)

30. Program of Orientation and Continuing Education

Describe the program of orientation and, continuing education and demonstration of competencies for all personnel, who provide care and treatment to patients.

a. Describe the methods by which nursing and other clinical personnel are adequately prepared by education, training and experience to provide care and treatment for persons with mental illness. Please include length of Orientation by discipline.

31. Treatment Planning

Identify the frequency of treatment team meetings, expected participants, timeframes, and the patient and/or family participation in the treatment planning process.

32. Medical Coverage

Describe the medical services that are provided to the program. Describe the process for accessing routine, consultative, urgent and emergent care systems.

33. Restraint/ ***Seclusion Prevention*** Activities

Please submit a copy of the current (reviewed within the prior year) facility/unit strategic plan for preventing restraint/ seclusion (R/S) with this application.

This plan should address the ongoing commitment by the organization to prevent/minimize use of R/S. It is suggested that this plan is written in Performance Improvement (PI) format, identifying those responsible for the goals, and target dates. The plan should reference the Six Core Strategies: Leadership towards Organizational Change; Using Data to Inform Practice; Workforce Development; Use of R/S Reduction Tools; Consumer Roles in Inpatient Settings; Debriefing Techniques.

34. Please list all restraint devices/equipment used (e.g. restraints up to 5 points, restraint chair, restraint transport devices, mitts, etc.). Note that locking restraint devices may not be used.

_____ _____

_____ _____

35. Interpreter Law

Please describe how the program is implementing the Interpreter Law, the primary languages for which interpreters are utilized, the context and frequency in which they are utilized (e.g., team meeting, groups, discharge planning, etc.), and how services are tracked.

36. Patient Rights

Please include:

a. a copy of the program complaint policy and process;
b. a current Patient Handbook; and
c. provide documentation regarding compliance with Outdoor Access Regulations pursuant to 104 CMR 27.13(6)(f), please include plan.

37. Requirements for Class V Licensees
    a. Attach a copy of the formal designation issued by DMH and the CV of each physician and /or psychologist appointed pursuant to 104 CMR 33.03(2) or 104 CMR 33.03(3).
    b. Describe special security measures taken (both physical plant and staffing as applicable) to ensure the safe operation of this service
    c. Describe any restrictions in admission policy for forensic patients, if applicable.
    d. Identify the unit/s to which forensic patients are admitted

38. Requirements for Class VI and Limited Class VI Licensees:
    a. Description of age appropriate programming and services (e.g., description of educational services including daily time allotted for such services, assessment of immunization status)
    b. List of the Child Psychiatrist, Pediatrician and Pediatric Neurologist, Occupational Therapist, and CVs, if not previously included in Question 21 (include consultant arrangement if applicable)
    c. Number of minors admitted under the Limited VI license since last survey._____

39. Requirements for Class VIII Licensees
    a. Include written policies, procedures and staff training curriculum for the administration of electroconvulsive treatment for physicians and nursing staff that describe pre and post practices. This should include a description of the informed consent process and a copy of forms currently used by the service.
    b. Include current CV's of ECT privileged physicians, including the primary ECT service anesthesiologist(s).
    c. Number of ECT treatments per physician since last survey. _____
    d. Please describe the space being utilized for ECT.

As the duly authorized representative of

_____,

Legal entity applying for licensure

Pursuant to M.G.L. Ch.19, s.19. I hereby make application for licensure of

_____

Legal name of hospital

Name: _____

Signature: _____

Title: _____ Date: _____