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|  | *The Commonwealth of Massachusetts*  *Executive Office of Health and Human Services*  *Department of Mental Health*  *25 Staniford Street*  *Boston, Massachusetts 02114-2575* |  |

Application Type:

* - Initial
* - Renewal
* - Revised License to Operate a Psychiatric Unit within a General,

Municipal or Other Hospital, or to Operate a Psychiatric Hospital

Please complete this application for Licensure. ***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 at 617-626-8117.

***Applications should be submitted via email* to** [**Teresa.J.Reynolds@mass.gov**](mailto:Teresa.J.Reynolds@mass.gov)

Please mail a check the same day the application is emailed. Check should be 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.**

**Mail check to:**

**Attn: Licensing Division**

**Department of Mental Health**

**25 Staniford Street, Room M045**

**Boston, MA 02114**

1. Name of Hospital:
2. Hospital Address/Phone Number:

Address:

Phone:

1. Legal Entity Name:

Legal Entity Address:

Identify ownership of the facility: (Check all that apply)

Individual:

Partnership:

Corporation:

Society:

Association:

Other:  (Specify)

1. Total number of licensed psychiatric beds requested:
2. Indicate number of operational beds (if different from licensed capacity):
3. Name of President or Chief Executive Officer:

**Name:** **Title:**

1. Please list name, title, telephone number and email address of key staff that can assist in matters related to the application. This should include person in charge, designee, .and best person to schedule visit.

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| **Name** | **Title** | **Phone** | **Email** | **PIC/Designee/Contact to Schedule** |
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1. 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  (Forensic)

Limited Class VI

Class VI

Class VIII (ECT)

1. Please complete the following for each unit covered by this Application **(please highlight if you are changing capacity, age range etc. from previous application)**:

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| --- | --- | --- | --- | --- | --- | --- |
| **Unit Name** | **Licensed**  **Capacity** | **Operational**  **Capacity** | **ADC** | **ALOS** | **Age Range** | **Specialty Services Offered** |
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1. 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: **Click or tap to enter a date.** Expiration Date: **Click or tap to enter a date.**

1. Designated Provider Waiver Request

Waiver Requested? Yes  No

Please 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 annually and for all new hires.* \*\*Any waiver renewal requests need to be submitted with the renewal application.**

1. Telepsychiatry Request

Telepsychiatry Requested? Yes  No

If a new or renewal telepsychiatry request is made, attach the request at the time of submitting a full application. Note that requests must meet requirements expressed in 104 CMR 27.00 and DMH Licensing Bulletin #16-01RR ([Bulletins | Mass.gov](https://www.mass.gov/service-details/bulletins)) ***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 annually and for all new hires. \*\**Any renewal requests for telepsychiatry need to be submitted with the renewal application.**

1. 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 104 CMR 27.00 and DMH Licensing Bulletin 18-01R ([Bulletins | Mass.gov](https://www.mass.gov/service-details/bulletins)) 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; and
2. able to meet the clinical competencies and operational standards for providing care and treatment to the population(s) it will serve.
3. Physical Adaptations

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.

1. Please briefly describe the following:
2. 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.
3. 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.
4. 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

     

     

1. 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

1. 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.
2. 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.**
3. Please submit the *most recent* certifications/licenses or explanation for the following:

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| **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 |  |  |

1. Please describe the facility’spayer mix.
2. Organizational Charts:
3. Please include an organizational chart for the governing body of the hospital.
4. Please include an organizational chart, with names, of the psychiatric unit(s) (If not included in above.)
5. Clinical Programming

Please attach current copies of program schedule(s) and description of the groups offered 7 days a week 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, the plan shall include educational programs, and youth guided and family driven treatment.

### 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 Providers
* Nurse Leader
* Nurse Educator
* Social Work Director
* Psychologist
* Human Rights Officer
* Occupational Therapist
* Dietician
* Clinical Director
* Activities/Expressive Arts Therapists

1. 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.

1. 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.

* 1. 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/Adolescent 7.50, 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.

1. 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 |

1. Nursing
2. Please describe the nursing leadership structure (describe all roles and duties, including that of the nursing supervisor for each shift, as applicable).
3. Include the role and percentage of direct care time on unit(s) of nurse managers.
4. 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.)

1. 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.

1. 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.
2. Treatment Planning

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

1. Medical Coverage

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

1. 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.

1. 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.

     

     

1. 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.

1. Patient Rights

Please include:

1. Visiting Hours – please list days/times for daily visitation;
2. a copy of the program complaint policy and process;
3. a current Patient Handbook; and
4. Outdoor Access Policy that is compliant with 104 CMR 27.13(6)(f), please include plan if secure outdoor space is not available yet.
5. Requirements for Class V Licensees
6. 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).
7. Describe special security measures taken (both physical plant and staffing as applicable) to ensure the safe operation of this service
8. Describe any restrictions in admission policy for forensic patients, if applicable.
9. Identify the unit/s to which forensic patients are admitted
10. Requirements for Class VI and Limited Class VI Licensees:
11. Description of age appropriate programming and services (e.g., description of educational services including daily time allotted for such services, assessment of immunization status)
12. 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)
13. Number of minors admitted under the Limited VI license since last survey:

1. Requirements for Class VIII Licensees
2. 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.
3. Include current CV’s of ECT privileged physicians and any other providers, including the primary ECT service provider of anesthesia.
4. Number of ECT treatments per provider since last survey:
5. 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:

Title:

Date: **Click or tap to enter a date.**

Signature: