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| **DIRECTIONS:** *During* the Office of Licensing application process new providers must email this completed form AND your Complaint Resolution Policy ONLY to [OHRpolicy@dbhds.virginia.gov](mailto:OHRpolicy@dbhds.virginia.gov)  By initialing beside each requirement below, you are attesting that you have a policies and procedures that are in compliance with the [Human Rights Regulations](https://law.lis.virginia.gov/admincode/title12/agency35/chapter115/) | |
| **Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| (as it will appear on the license) | |
| **Provider Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
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| **Program Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| (if different from Provider name)  **Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
| (if different from program address) | |
| **Provider Director’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |
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| **Provider Director’s Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Provider Director’s Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Select All Applicable Service Types below:** | |

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| **MH Group Home** |
| **REACH Group Home Adult** |
| **ICF-IID** |
| **BI Residential Treatment Serv** |
| **DD Supervised Living** |
| **MH Supervised Living** |
| **MH Crisis Stabilization** |
| **MH Crisis Stabilization C/A** |
| **DD Residential Respite Adult** |
| **DD Residential Respite C/A** |
| **REACH Group Home C/A** |
| **ASAM Level 3.5 Adult** |
| **ASAM Level 3.3 Adult** |
| **ASAM Level 3.1 Adult** |
| **DD Center-Based Respite** |
| **Center-Based Day Sup Adult** |
| **Center-Based Day Sup C/A** |
| **Non Center-Based Day Sup Adult** |
| **Non Center-Based Day Sup C/A** |
| **Psychosocial Rehabilitation** |
| **MH Partial Hospitalization** |
| **TDT School Based** |
| **MH Partial Hospitalization C/A** |
| **ASAM Level 2.5 Adult** |
| **ASAM Level 2.5 C/A** |
| **ASAM Level 2.1 Adult** |
| **ASAM Level 2.1 C/A** |
| **MH Intensive Outpatient Adult** |
| **MH Intensive Outpatient C/A** |
| **Mental Health Skill Building** |
| **DD Supportive In-Home** |
| **Inpatient Psychiatric Adult** |
| **Inpatient Psychiatric C/A** |
| **ASAM Level 4.0 Adult** |
| **ASAM Level 4.0 C/A** |
| **ASAM Level 3.7 Adult** |
| **ASAM Level 3.7 C/A** |
| **Intensive In-Home** |
| **MAT/Opioid Treatment** |
| **MH Outpatient** |
| **Crisis Stabilization** |
| **DD Crisis Stabilization-REACH** |
| **ASAM Level 1.0 Adult** |
| **ASAM Level 1.0 C/A** |
| **DD Sponsored Residential Adult** |
| **DD Sponsored Residential C/A** |
| **MH Sponsored Residential** |
| **DD In-Home Respite** |
| **MH Correctional Facility RTC** |
| **Psychiatric RTF for C/A** |
| **MH Therapeutic GH for C/A** |
| **DD Group Home for C/A** |
| **ASAM Level 3.5 C/A** |
| **ASAM Level 3.1 C/A** |
| **ICF-IID for C/A** |
| **DD RESIDENTIAL RESPITE C/A** |
| **MH RESIDENTIAL RESPITE C/A** |
| **SA Case Management** |
| **MH Case Management Adult** |
| **MH Case Management C/A** |
| **ACT Small** |
| **ACT Medium** |
| **ACT Large** |
| **MH Center-Based CRC/23-hour Child & Adolescent** |
| **MH Center-Based CRC/23-hour**  **Adults**  **OTHER - (Name service type): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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|  | I attest that I have a written mission/value statement and other documents that promote the policy 12VAC35-115-20 of the Human Rights Regulations |
|  | I attest that I have written policies and procedures that are in full compliance with each of the following sections of the Human Rights Regulations: |
|  | 12 VAC35-115-40 Assurances |
|  | 12 VAC 35-115-50 Dignity |
|  | 12 VAC 35-115-60 Services |
|  | 12 VAC 35-115-70 Participation in Decision Making |
|  | 12 VAC 35-115-80 Confidentiality |
|  | 12 VAC 35-115-90 Access to and amendment of services record |
|  | I attest that I have a written policy for the use of behavioral treatment plans developed in accordance with 12 VAC 35-115-105. |
|  | 12 VAC 35-115-100 Freedoms of everyday life |
|  | I understand that I must submit Program Rules to the DBHDS Human Rights Advocate for review prior to implementation. And any changes to these Rules in the future, must also be reviewed by the Advocate. |
|  | I will use seclusion. If you initial here, you must also submit a Policy that describes compliance with 12 VAC 35-115-110 to [OHRPolicy@dbhds.virginia.gov](mailto:OHRPolicy@dbhds.virginia.gov) A license to provide services via CRC/23 hour stabilization and/or residential Crisis Stabilization Units (CSU) will not be issued until this Policy has been reviewed and approved. |
|  | I will use restraint and/or time out and I have a behavioral management policy written in accordance with 12 VAC 35-115-110 for the use of such interventions. |
|  | I will NOT use seclusion. |
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|  | I will NOT use restraint and/or timeout; however, I do have a policy for behavioral management written in accordance with 12 VAC 35-115-110.  I attest that I have a written policy that addresses decision making, consent and authorization as well as substitute decision making in accordance with 12 VAC 23-115-145 and 12 VAC 35-115-146 |
| \_\_\_\_\_\_\_ I attest that I have or will have immediately upon receiving a license, a trained  investigator to conduct a thorough investigation in accordance with 12 VAC 35-115-175.    **\_\_\_\_\_\_\_Waiver Service Providers only:** I attest that I have written policies and procedures in  accordance with the Home and Community Based Services settings requirements per  42 CFR 441.301 | |
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| Signature of Provider Director | Date Form Completed |

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| **\*\*\*\*\* OHR USE ONLY \*\*\*\*\*** |

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| Name of OHR Advocate Assigned to review Policies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date Waiver Validation Visit Completed (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Did Provider complete OHR New Provider Orientation:  Yes  No |

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| Verification of Trained Investigator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date:\_\_\_\_\_\_\_\_\_\_\_ |
| Verification of Human Rights Competency Training: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date:\_\_\_\_\_\_\_\_\_\_\_ |

rev. July 18, 2024