**State Institutional Alternatives Application**

**Kansas Department for Aging and Disability Services**

503 S. Kansas Avenue

Topeka, KS 66603

**INTRODUCTION**

Kansas Department for Aging and Disability Services (KDADS) has worked in cooperation with the Mental Health Task Force, the Governor’s Behavioral Health Planning Council, Community Mental Health Centers (CMHCs), and other stakeholders to expand the number of regional psychiatric hospital beds (State Institutional Alternatives) to serve individuals with mental illness meeting the criteria for state hospital admission. Adding this capacity regionally will help serve patients closer to their home communities.

Funding from the State General Fund will be used to contract with providers to provide hospital bed space for adults and children. These “regional” beds would be financed using a combination of state dollars, Medicaid, or other private insurance when patients have insurance coverage available. These beds will supplement the Osawatomie State Hospital capacity to meet immediate needs with the same focus on short inpatient stays, initiating treatment, and smoothly transitioning patients into community-based treatment.

“State Institutional Alternatives (SIA)” are defined as facilities that provide inpatient psychiatric treatment and are authorized by the Kansas Department for Aging and Disability Services (KDADS) to serve as an alternative to placement in a state mental health institution.

*Source: Kansas Medicaid State Plan*

A facility or hospital seeking to receive authorization as an SIA shall submit this application to Adult Inpatient Coordinator Cynthia Edwards at [Cynthia.Edwards@ks.gov](mailto:Cynthia.Edwards@ks.gov)

**APPLICATION INSTRUCTIONS FOR SIA AUTHORIZATION**

1. **Application Instructions.** The Application Form for SIA Authorization must be completed in its entirety.

Section 1: Applicant information

1. Specify the full legal name of the applicant facility or hospital and any DBAs.
2. Specify the full official name of Director.
3. Specify the facility or hospital telephone number, fax number, and email address.

Section 2: Questions

1. Answer questions by checking yes or no.
2. If yes is checked, attaching supporting documentation.

Section 3: Declaration

* 1. Signature from the facility or hospital Executive Director, CEO, or President.

Applicants of Larger Organizations: If the applicant is part of a larger organization, it must fill out the optional section provided, in addition to Sections 1-3. The optional section provided should include:

* 1. Full legal name of larger organization and any DBAs.
  2. Full official name of Director of the larger organization.
  3. Contact information for the lager organization.
  4. Organizational chat demonstrating relationship between entities.

1. **Application Materials.**

The SIA Application for Authorization and the materials specified on the form must be completed and emailed to the KDADS Behavior Health Services Commission. An application will be considered complete once all required forms and supporting documents have been received and reviewed by KDADS. The following documents are required:

1. State Institutional Alternative Application Form for Authorization
2. Recognized national accrediting entity accreditation materials to include:
   1. The entire accrediting entity survey or inspection report of the applicant facility or hospital;
   2. Certificate of Accreditation; and
   3. Corrective action requirements and plans, if any, during the most recent accreditation process.
3. **Submission of Application Materials.** Submit the completed Application Form and all accreditation materials to KDADS:
4. By email send to Adult Inpatient Coordinator Cynthia Edwards at [Cynthia.Edwards@ks.gov](mailto:Cynthia.Edwards@ks.gov)
5. By mail to: Kansas Department for Aging and Disability Services

Attn: Behavioral Health Services Commission

503 S. Kansas Avenue

Topeka, KS 66603-3404

**Kansas Department for Aging and Disability Services**

**APPLICATION FORM FOR**

**STATE INSTITUTIONAL ALTERNATIVE AUTHORIZATION**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **SECTION 1: APPLICANT INFORMATION** | | | | | | | | | | |
| Facility Name: | | |  | | | | | | | |
| Facility Director’s Name: | | | |  | | | | | | |
| Address: | |  | | | | | | | | |
| City: | |  | | | State: | |  | | Zip: |  |
| Telephone: | |  | | | | Fax: | |  | | |
| Email: |  | | | | | | | | | |
| The facility is: ***New***  ***Currently Licensed*** | | | | | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **SECTION 2: QUESTIONS** | | | | | | | | | | | | | | | |
| * + 1. Has any state or other jurisdiction of the United States ever limited, restricted, warned, censured, placed on a corrective action plan, suspended, revoked, or otherwise disciplined a license or certification? | | | | | | | | | | | Yes | |  | No |  |
| * + 1. Have there been any legal judgments or settlements paid on behalf of the facility or hospital within the past 3 years | | | | | | | | | | | Yes | |  | No |  |
| If either answer above is **yes**, include date, reason, and resolution (please attach supporting documentation): | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| ***OPTIONAL SECTION: Applicants part of a larger organization only*** | | | | | | | | | | | | | | | |
| If different than Applicant, name of facility  for which SIA authorization is requested: | | | | |  | | | | | | | | | | |
| Organization Name: | | | |  | | | | | | | | | | | |
| Organization Director’s Name: | | | |  | | | | | | | | | | | |
| Address: | | |  | | | | | | | | | | | | |
| City: |  | | | | | State: | |  | | Zip: | |  | | | |
| Telephone: | |  | | | | | Fax: | |  | | | | | | |
| Email: | |  | | | | | | | | | | | | | |
| Organizational Chart demonstrating relationship between entities is **attached**. | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **SECTION 3: DECLARATION & SIGNATURE** | | | | | | | | | | | | | | | |
| ***By signing below, I hereby agree*** *that (1) the signature and title of the individual named below is authorized and empowered to represent and bind the governing body, corporation, partnership, joint venture, individual, or organization in the operation of this facility or hospital; and that all necessary and corporate approvals have been obtained (2) I have read and understood the KDADS SIA policy; and (3) the information provided in this form is true and correct to the best of my knowledge.* | | | | | | | | | | | | | | | |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | |  | |  | | ***Name of Signatory****:* | | ***Title*** | | ***Date*** | |  |  | |  | | | | | | | | | | | | | | | | | |