

MHMR SERVICES OF TEXOMA
OPEN ENROLLMENT REQUEST FOR APPLICATIONS

MHMR Services of Texoma (MHMRST) is the Department of State Health Services designated Mental Health Authority established to plan, coordinate, develop policy, develop and allocate resources, supervise, and ensure the provision of community based mental health and mental retardation services for the residents of Cooke, Fannin and Grayson counties.

Pursuant to Texas Administrative Code §412.60, **MHMR Services of Texoma**, as a Department of State Health Services (DSHS) designated Local Authority, has the authority to assemble a network of service providers to provide the following services to the DSHS Target Population of persons with mental illness and co-occurring substance use disorder(s) who reside in Cooke, Fannin and Grayson counties:

- **Psychosocial Rehabilitative Services**
 - **Skills Training and Development Services**
-

The goals of this network are:

1. To develop a comprehensive network of providers for consumers receiving certain designated mental health services
2. To increase consumer access and allow consumer choice in the selection of service providers
3. To identify, implement and evaluate successful programs so that these efforts can be replicated
4. To create meaningful, cooperative relationships between the Local Authority and the private service providers in the local community
5. To provide a comprehensive community treatment system

I. SERVICES SOUGHT

This Request for Applications seeks participation from applicants for the purpose of offering Psychosocial Rehabilitative Services and Skills Training and Development Services for adults with mental illness and a co-occurring substance use disorder, who meet the target population in Cooke, Fannin or Grayson counties. Any qualified applicant may submit an application to provide these services.

- **Psychosocial Rehabilitative Services (Adult Service Package 3)**
- **Skills Training and Development Services (Adult Service Packages 1 and 2)**

Psychosocial Rehabilitative Services include social, educational, vocational, behavioral, and cognitive interventions provided by members of an individual's therapeutic team that address deficits in the individual's ability to develop and maintain social relationships, occupational or educational achievement, and independent living skills that are the result of a severe and persistent mental illness in adults. Psychosocial rehabilitative services will address the impact of co-occurring disorders upon the individual's ability to reduce symptomology and increase daily functioning. Therapeutic modalities include: independent living services, coordination services, employment related services, housing related services, medication management/education services and crisis related services.

Skills Training and Development Services include training that (A) addresses severe and persistent mental illness or serious emotional disturbance and symptom-related problems that interfere with the individual's functioning and living, working, and learning environment; (B) provides opportunities for the individual to acquire and improve skills needed to function as appropriately and independently as possible in the community; and (C) facilitates the individual's community integration and increases his or her community tenure. The training consists of teaching an individual the following: daily

responsibilities, communication skills, pro-social skills, problem-solving skills, assertiveness skills, social skills, stress reduction techniques, anger management skills, symptom management skills, utilization of community resources, leisure time skills and independent living skills.

To view the Resiliency and Disease Management Guidelines including the service package definitions and service descriptions for the entire service package(s), go to: <http://www.dshs.state.tx.us/mhprograms/RDMClinGuide.shtm> (navigate to “Adult Utilization Management Guidelines.”)

The following grid indicates which services are being sought as well as the percent of service capacity the Local Authority intends to procure:

ROUTINE SERVICES	Current # of LMHA individuals receiving services**	Estimated % of individuals in each service package with co-occurring substance use disorders (i.e. potential amount to contract to private providers)**
Adult Service Package 1 (Skills Training & Development)	641	10%
Adult Service Package 2 (Skills Training & Development)	16	10%
Adult Service Package 3 (Psychosocial Rehab Services)	108	10%

**Capacity is based on current information and is subject to change as a result of fluctuating consumer enrollment, as well as the consumers’ choices of services and/or providers.

The Local Authority does not guarantee a specific number of referrals to any provider.

Population to be served under contract

All persons for which services will be contracted must be over age 18, have a substance abuse diagnosis and be part of the state’s “target population.” Persons included in the “target population” must have a diagnosis of schizophrenia, bipolar disorder, and major depression.

Acceptance of Applications

All qualified applications will be accepted barring any recognized performance concerns. Referrals to each provider will be dependent on the MHMR Services of Texoma population needing contracted services and the choice of provider by each consumer. No total amount of payment to a provider is guaranteed or implied.

II. MINIMUM REQUIREMENTS

At a minimum, Applicants must be qualified providers. Thus they must:

1. Meet the minimum qualifications of the DSHS performance contract
2. Assure services are provided by Licensed Chemical Dependency Counselors
3. Demonstrate one’s ability to provide services in compliance with DSHS contract requirements
4. Comply with Resiliency and Disease Management (RDM)
5. Be able to provide services in the language as needed by the person receiving services
6. Engage and involve consumers, legally authorized representatives, and families in the policy and practice levels within the applicant’s organization or individual practice
7. Provide services in Cooke, Fannin and/or Grayson counties during hours that are consistent with the needs of the individuals receiving services

Notwithstanding the above, Applicants must be eligible or registered to do business in Texas. In any situation where a consortium of providers is applying, a single entity responsible for services must be identified and the financial agent must be an organization with a demonstrated ability to manage funds. See other applicant credentialing requirements in Attachment A.

III. RESPONSIBILITIES

Local Authority Responsibilities

The Local Authority will:

- A. be responsible for service coordination/case management and facilitating an individual's selection of service providers, authorizing services, reviewing and processing claims, and paying for authorized services rendered by the service providers in its Network;
- B. be responsible for utilization management and quality assurance;
- C. ensure that contracted services address the needs of the Priority Population;
- D. ensure contracted services are provided as required by DSHS;
- E. ensure contracted services comply with the rules and standards adopted under Section 534.052 of the Texas Health and Safety Code, and Chapter 412, Subchapter G of the Texas Administrative Code; and
- F. **not** guarantee any referral volume to any service provider within its Network of Providers.

Service Provider Responsibilities

The service provider will:

- A. be responsible for submitting all original documentation reflecting service provision and will maintain additional secondary records, regarding treatment and/or services rendered to the Local Authority's individuals with mental illness, and allow the Local Authority access to such records upon request;
- B. comply with all state and federal laws, regarding the confidentiality of consumers' records and nondiscrimination;
- C. actively assist in the disbursement of consumer and advocate satisfaction surveys;
- D. obtain prior authorization, provide acceptable levels of care, and maintain acceptable levels of liability insurance and appropriate licenses and accreditations;
- E. agrees that its name may be used along with a description of its facilities, care, and services in any information distributed by the Local Authority listing its service providers;
- F. comply with the rules and standards adopted under Section 534.052 of the Texas Health and Safety Code and applicable local, state, and federal laws, rules and regulations;
- G. comply with all required minimum training requirements. **See Attachment A-1**; and
- H. work with the Local Authority to transition consumers.

IV. INSTRUCTIONS FOR SUBMISSION OF APPLICATIONS

To facilitate and ensure an objective review, applicants must follow the Required Application Information (see section V) for submissions.

Applicants must submit three (3) copies of the application and with a signed "Assurances" signature page (Attachment E, Form E-1) to:

(for US Postal Service)

MHMR Services of Texoma

Attn: Jill Livingston

P.O. Box 1087

Sherman, Texas 75091-1087

(for drop off @ Center)

MHMR Services of Texoma

ATTN: Jill Livingston

315 W. McLain Dr.

Sherman, TX 75092

All applications sent by regular mail must be postmarked no later than October 15, 2009.

All applications dropped off at the Center must be delivered by close of business (5:00 PM) on October 15, 2009 (insure that application is hand-delivered to an employee who can "date-stamp" as received or otherwise record time/date of

delivery.) The open enrollment period will close when the earliest of the following occurs: 1) the date and time by which proposals must be received is reached, i.e. 10/15/09 or 2) enough applications to meet the percentage of service capacity described and which qualify for award have been received.

False statements or information provided by an applicant may result in disqualification of enrollment into the Network. The Local Authority reserves the right to reject any and all applications, to waive technicalities, and to accept any advantages deemed beneficial to the Local Authority and the individuals served.

Each prospective service provider is responsible for ensuring that documents for potential enrollment are submitted completely and on time. The Local Authority expressly reserves the right not to evaluate any enrollment documents that are incomplete or late.

The entire response to this Request for Application shall be subject to disclosure under the Texas Public Information Act, Chapter 552 of the Texas Government Code. If the applicant believes information contained therein is legally exempted from disclosure under the Texas Public Information Act, the applicant should conspicuously (via bolding, highlighting and/or enlarged font) mark those portions of its response as confidential and submit such information under seal. Such information may still be subject to disclosure under the Public Information Act depending on opinions from the Attorney General's office.

V. REQUIRED APPLICATION INFORMATION:

Please be sure to answer every question included in sections A-F on separate sheet(s) of paper. Label each section of information submitted with the applicable letter and heading (i.e. "A. Business Demographics", "B. Quality Management/Utilization Management," etc.) If the question/necessary information does not apply, simply and clearly document "N/A". Interviews or site visits may be conducted to further evaluate applications. All applicants must submit the required forms from Attachments D and E. Individual applicants must submit Attachment B and "organization or company" applicants must submit Attachment C.

A. BUSINESS DEMOGRAPHICS

1. The following items must be included in your response:
 - Name and title; Business Name
 - Type of legal entity (i.e., private practice, corporation, 501(c)(3))
 - Social Security Number; Tax ID Number
 - Street Address, City, & Zip
 - Business Phone Number
 - E-mail Address
 - Does the provider own or lease its current business properties?
 - Other Business location in this Service Area; include name and address
 - Number of years in operation as a business
 - Certification Number if a Historically Underutilized Business
 - Are you a Medicaid and/or Medicare Provider

2. No employee of the Local Authority or DSHS, and no member of the Local Authority's Board of Trustees can directly or indirectly receive any pecuniary interest from an award of the proposed contract. If such a situation exists, please explain in detail.

B. QUALITY MANAGEMENT/UTILIZATION MANAGEMENT

List all licenses, credentials, certifications, and/or accreditations the organization currently holds. Provide copies

of documents regarding the Texas Department of State Health Services (DSHS), Texas Department of Aging and Disability Services (DADS), Texas Department of Assistive and Rehabilitative Services (DARS), or the Texas Department of Labor (DOL), status if applicable.

C. SERVICES

1. Identify geographical areas (i.e. counties) to be covered, where services are offered (i.e. address) and the times of day and days of the week the services would be available. Include a description of the applicant's ability to serve individuals with multiple challenges. What is your capacity?
2. Describe any "after hours" system for responding to consumer needs. Can consumers access services outside usual business hours? Are services provided outside the M-F 8-5 periods? Are services offered on holidays?
3. Is the organization's staff current with inservice training as required by the credentialing/ licensing agency or the local authority (if currently under contract as a service provider)?
4. Describe the organization's/provider's experience in working with persons with mental illness and related conditions over the last five years. How have services been made accessible for those who are difficult to reach, either due to geography or dissatisfaction with service delivery?
5. Describe the organization's/provider's history of working with persons who are not compliant with treatment. Describe the organization's/provider's ability to treat persons with disabilities.
6. Describe the organization's/provider's ability to work with persons who are hearing impaired, persons who have limited language skills and persons who speak a language other than English. Describe the organization's ability to work with persons with physical impairments and adaptive equipment. Describe how the organization/provider ensures cultural competency on the part of staff with regard to ethnic, racial, religious and sexual orientation differences.
7. Describe how the organization/provider involves consumers, legally authorized representatives, and families at the policy and practice levels within the applicant's organization or individual practice.
8. Describe the organization/provider's ability to provide specialized services to individuals with a co-occurring psychiatric and substance use disorder.
9. Describe the facility(ies) proximity to public transportation.
10. Describe the organization's/provider's transition plan for consumers.

D. FINANCIAL

1. Is the organization/provider incorporated as "Profit", "Not-for-profit", or "Other"? If "other", please explain.
2. Describe any arrangements to subcontract part or all of these services. Name all subcontractors and provide information on their staff credentials, licenses and certifications.
3. Provide a copy of a Certified External Audit for the past three years. Label as **Exhibit 1**

4. Provide a copy of the most recent Tax Statement (IRS Form 1120, Form 990 as applicable). Label as **Exhibit 2**
5. Provide a current Financial Statement including Cash Flow. label as **Exhibit 3**
6. Submit the most current Annual Report available. label as **Exhibit 4**
7. Provide evidence of continued financial viability to ensure your capabilities to support this service, label as **Exhibit 5**

E. RISK ASSESSMENT

1. Has the organization/provider had any abuse, neglect, exploitation or other rights violations claims in the last seven (7) years? If so, explain in detail. Describe or attach any policies and procedures regarding consumer abuse, consumer neglect, or rights violations and the training of staff on these issues. If attaching policies and procedures, label as **Exhibit 6**.
2. Does the organization/provider have a Letter of Good Standing that verifies that it is not delinquent in State Franchise Tax? Corporations that are non-profit or exempt from Franchise Tax are not required to have this letter, but will have a 501C IRS Exemption form from the Comptroller's Office. Attach and label as **Exhibit 7**. Is the Provider delinquent in the payment of any Child Support Payments? If so, explain.
3. Provide a Certificate of Insurance showing liability insurance coverage (property and vehicles, including riders) and including directors' and officers' professional liability, errors and omissions, general liability, and medical malpractice insurance - Label as **Exhibit 8**.
4. Provide the name of Workers' Compensation carrier if the organization/provider has Workers' Compensation coverage, or self funding documents if self funded - Label as **Exhibit 9**.
5. Are employees or agents of the organization bonded? What is your policy regarding criminal history checks on employees?
6. Describe any contracts, Memoranda of Understanding, or employment relationship the organization/provider has with other state, city or county agencies in Cooke, Fannin or Grayson counties.

F. INFORMATION SYSTEMS

Will the organization/provider be able to submit data electronically, if this is determined to be necessary by the Authority at some point in the future?

G. BILLING REQUIREMENTS

Billable Service Requirements (omission of any element could result in claim denial)

- Current diagnosis by a Physician
- Uniform Assessment – RDM (UA-RDM) completed by a QMHP-CS
- Symptom Rating Scales completed by a QMHP-CS
- UA – RDM data entry into DSHS WebCare
- Treatment Plan completed by a QMHP-CS
- Determination of Medical Necessity by a LMHA Licensed Practitioner of the Healing Arts (LPHA)
- Service provision by a QMHP-CS or LPHA
- Document service that meets RDM Fidelity requirements
- Document service that meets Medicaid documentation requirements:
 - Name of the individual to whom the service was provided
 - The type of service provided
 - A summary of the activities that occurred
 - State the specific skill(s) on which client was trained
 - State the specific methods used to provided training
 - Date, start & end time, and location
 - Correlate the specific treatment plan goal that was the focus of the service
 - State the progress or lack of progress in achieving treatment plan goals
 - Signature of the staff member providing the service & credentials
 - Submission of claim/event data elements as detailed above, in format that meets DSHS Event Data rule requirements, utilizing same business day/next business day reporting requirements.

H. RATE AND METHOD OF PAYMENT

Applicant agrees, for those services it is submitting an application, to accept the fees and stipulations listed below for approved consumer services. The Applicant will not submit a claim, bill, or collect compensation from Local Authority for any service which it has not been approved.

If the Applicant becomes a Service Provider in the Local Authority's network, said Service Provider shall:

- o Bill the Local Authority for services provided (Psychosocial Rehabilitative Services and Skills Training/Development Services)
- o Receive compensation for authorized and properly documented services according to the following schedule:

ROUTINE SERVICES	RATE
Psychosocial Rehabilitative Services (Individual)	\$14.50 per 15 minute unit
Psychosocial Rehabilitative Services (Group)	\$1.30 per person per 15 minute unit (8 person maximum per group)
Skills Training and Development Services (Individual)	\$14.80 per 15 minute unit
Skills Training and Development Services (Group)	\$2.80 per person per 15 minute unit (8 person maximum per group)
Local Authority does not pay for "no show" or cancelled appointments	
<i>These rates were established utilizing the Center's current cost of delivering services based on the 1st Quarter FFY 2009 Time and Financial Information (TAFI) System, minus a 10% administrative fee.</i>	

- o Repay the Local Authority for the amount compensated for a service if subsequent audit by the Local Authority determines that any of the required billing or Medicaid documentation is missing or unacceptable
- o Reimburse the Local Authority for the relevant compensated portion of the above rates if subsequent determination is made by DSHS that the rate paid was too high.

ATTACHMENT A

Credentialing Criteria

The following criteria, information and components are required for a service provider to be included in the Local Authority's network of providers.

1. Minimum qualifications of providers for all services being sought:

- Qualified Mental Health Professional – Community Services (QMHP-CS) **and** Licensed Chemical Dependency Counselor (LCDC)
- Experience and proficiency adequate to perform the job tasks
- Ability to pass written competency-based assessment of service delivery skills
- At least three professional references from persons not related by blood that indicate the ability to provide a safe, healthy environment for the individuals being served (see Attachment D, Form D-2.)
- Current drivers license for each person that will potentially provide transportation to Local Authority consumers.
- Current Insurance Verification including:
 - Professional and general liability
 - Vehicle (if transporting consumers is likely)
 - Workers Compensation
- Verification of criminal history checks for all staff potentially working with Local Authority consumers.
- Life Safety code review for site assessment if not certified by a state agency.
- If applicable, documentation from certifying agency:
 - Texas Department of State Health Services
 - Texas Department of Assistive and Rehabilitative Services (DARS)

1. Additional clarification of minimum qualifications:

- **Qualified Mental Health Professional (QMHP-CS):** An individual with demonstrated competency in the work to be performed and: (A) has a bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention; or (B) is a registered nurse (RN.)
- **Licensed Chemical Dependency Counselor (LCDC):** An individual who possesses a valid Texas license as a Licensed Chemical Dependency Counselor.

**ATTACHMENT A-1
Minimum Training Requirements**

Providers will be required to complete the following training prior to delivery of any contracted service:

Subject Area	Texas Administrative Code
Abuse, Neglect, Exploitation	4.12G.309(b) annually 419.L464 (a)(1)(D) 412 I.411 (a)(6)
Consumer Rights, Confidentiality	414.A.1 404E.165 annually 412G.309 © (e) &303 (36) 401G.464(c)
HIV/AIDS, Infection Control	405.L.285(b) 412G.308(d)
Safety & Emergency	412G.308(a)(1)&(b)
Cultural Competency	412G.303(15) 412G.306(6) 412G3.10(d) 412G3.10(e)(3)
Screening & Intervention	412G.303(40) 412.312(c)
Suicide & Homicide	412 G.303 (40) 412 G. 312 (c)
Psychoactive Medications/Pharmacology	412.G 312.(a) (1) (c) 412 G 303 (40) 4141.405 consent
CPR (or possession of valid/current Red Cross card)	412G.303 (14) 412 G.312 (a) (1) (b) 415F.257 (b)
First Aid (or possession of valid/current Red Cross card)	412 G 303(14) 412 G.312 (a) (1) (b) 415 F.257 (b)
Seizures	412 G.303 (14) 412 G. 312 (a) (1) (b) 415 F.257 (b)
Co-occurring Psychiatric and Substance Use Disorders (COPSD)	DSHS approved training curriculum
Medicaid Mental Health Rehabilitative Services	419.451 - 419.470
Medicaid MH Rehab Services Billing Guidelines, Updated 8/1/07	

Note: Local Authority does not pay providers for their time spent in required training

EDUCATION HISTORY

Undergraduate, graduate and postgraduate/professional training. You may submit a current resume or vita to meet this requirement.

School Name		Degree		Year Received	
City/State/Country		Major			
School Name		Degree		Year Received	
City/State/Country		Major			
School Name		Degree		Year Received	
City/State/Country		Major			
School Name		Degree		Year Received	
City/State/Country		Major			
School Name		Degree		Year Received	
City/State/Country		Major			

CURRENT PROFESSIONAL ASSOCIATION/SOCIETY MEMBERSHIPS:

PROFESSIONAL REFERENCES

Please provide the **Professional Reference Questionnaire** (Attachment D, Form D-2) to three (3) behavioral health care providers who have personal knowledge of your current clinical abilities, ethical character, health status, and other qualifications to practice. At least one individual must not be currently associated with you in a professional practice.

Please emphasize to these references the need for their prompt completion and return of the form directly to the Local Authority at the address on the bottom of the form.

WORK HISTORY - For the past 10 years or since completion of highest degree, graduate school or medical school. You may submit a current resume or vita to meet this requirement.

1.	Employer name	Address	City, State, Zip
	Position title/description	From	To
2.	Employer name	Address	City, State, Zip
	Position title/description	From	To
3.	Employer name	Address	City, State, Zip
	Position title/description	From	To
4.	Employer name	Address	City, State, Zip
	Position title/description	From	To
5.	Employer name	Address	City, State, Zip
	Position title/description	From	To
6.	Employer name	Address	City, State, Zip
	Position title/description	From	To

MALPRACTICE CLAIMS HISTORY

Have you had or do you currently have any claims pending or closed during the past 5 years?

Yes No If yes, please supply the following information:

1. Letter from your attorney explaining the facts of the case
2. Copies of the complaint and judgment
3. Name of malpractice carrier that handled the claim and firm representing the carrier
4. Completed Professional Liability Case Report form (Attachment D, Form D-1) for each claim

LIABILITY INSURANCE COVERAGE

Does each of your practice locations have **general liability** insurance coverage? Yes No

Professional Liability Insurance Coverage

Current Company _____

Address _____

City _____ State _____ Zip Code _____

Policy # _____ Effective Coverage Date ____/____/____

Expiration Date ____/____/____ Retroactive Coverage to ____/____/____

Amount of Coverage \$_____ per occurrence \$_____ aggregate

Type of policy: Claims made Occurrence

Do you participate in any state-funded liability pool? Yes No

If yes, please indicate which state(s) and provide the name of the fund and a brief summary of its coverage.

Have you ever been denied coverage (either initial or renewal) by any professional liability insurance carrier or had an individual policy canceled or individual surcharge placed on you based on your individual practice? Yes No

If yes, please explain:

ADVERSE/DISCIPLINARY ACTIONS

Have any of the following ever been or are currently in the process of being denied, revoked, suspended, reduced, limited, censured, placed on probation or not renewed? Have you relinquished, withdrawn, or failed to proceed with an application for one of the following to avoid an adverse action, to preclude an investigation, or while under investigation relating to professional conduct?

Please provide a full explanation on a separate sheet for any "yes" responses.

Description	Yes	No
License/registration to practice in any state	<input type="checkbox"/>	<input type="checkbox"/>
Participation in Medicare, Medicaid, CHAMPUS, or other government programs	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been assessed a penalty by the Medicaid, Medicare, or CHAMPUS programs?	<input type="checkbox"/>	<input type="checkbox"/>
Board certification	<input type="checkbox"/>	<input type="checkbox"/>
Health-related professional society membership or fellowship	<input type="checkbox"/>	<input type="checkbox"/>
Have you been convicted of or pleaded no contest to any criminal charges (other than motor vehicle violations) brought against you?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been convicted of or pleaded no contest to a drug- or alcohol-related offense?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been sanctioned by a peer review organization or similar federal, state, or military agency?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any felony convictions?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been found to be the perpetrator of a confirmed case of client abuse or neglect?	<input type="checkbox"/>	<input type="checkbox"/>

HEALTH STATUS

Do you currently have any medical and/or psychiatric problem, including substance abuse, that affects your ability to perform the essential functions of your profession, with or without accommodation?

Yes No

If yes, please provide a full explanation on a separate sheet.

ATTESTATION

Are there any reasons you would be unable to perform the essential functions required with or without accommodation?

Yes No If yes, please provide explain fully on a separate sheet.

I hereby attest to the following:

- I do not currently use any illegal drug.
- I have reported accurately and completely any reasons for any inability to perform the essential functions of my profession with or without accommodation.
- I have reported accurately any history of loss of license and/or felony convictions.
- I have reported accurately any history of loss or limitation of privileges or disciplinary activity.
- I have reported accurately my chronological work history.
- I consent to the inspection of records and documents pertinent to this application, including the release by any person to the Local Authority of all information that may reasonably be relevant to an evaluation and verification of this application or evaluation of professional competence, including, but not limited to, consultation with any other health professionals or institutions with which I have been or am currently associated.
- The information submitted in and with this application is complete and correct to the best of my knowledge.

Print practitioner's name: _____

Practitioner's signature: _____ Date: _____

General Authorization for Release of Information

I, _____ (print name) hereby authorize _____ *MHMR Services of Texoma* to obtain any and all information required to complete a review and primary source verification of my/our credentials. Information and documents to be reviewed include, but are not limited to, licensure/certification, accreditations and claims made against licensure/certification, malpractice insurance and claims.

I hereby release from liability any and all individuals and organizations reviewing this application for their acts performed in good faith and without malice in connection with evaluating this application and the credentials and qualifications. I also release from any liability any and all individuals and organizations who provide information in good faith and without malice concerning the above release items.

A photostat, electronic or facsimile copy of this original statement constitutes my written authorization and request to release any and all documentation relevant to The Gulf Coast Center credentialing and/or network approval process. Such Photostat, electronic or facsimile copy shall have the same force and effect as the signed original.

Print practitioner's name: _____

Practitioner's signature: _____ Date: _____

References

I, the undersigned applicant, hereby release from liability and hold harmless for the consequences of any disclosure, to the fullest extent permitted by law, the below named reference and The Gulf Coast Center for their written and oral statements, decisions, and actions in connection with evaluating my application for network approval, my experience, competencies and qualifications, health status, emotional stability, professional ethics, and character.

Print practitioner's name: _____

Practitioner's signature: _____ Date: _____

	Name	Address	Phone Number
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

**ATTACHMENT C
PROVIDER PROGRAM APPLICATION**

Section A: GENERAL INFORMATION

1. Name of Program/Provider _____
2. Name of Chief Executive Officer _____
3. Contact Person _____ Title _____
4. Business Address _____
City _____ State _____ Zip Code _____
Phone _____ Fax _____
5. List location where services are provided ___Office ___Home ___MHMR Facility
6. Is your Service Address* different from Business address? ___Yes ___No
If Yes, list it below:
Address _____
City _____ State _____ Zip Code _____
7. Do you qualify as a Historically Underutilized Business (HUB)? ___Yes ___No
If yes, have you applied for certification? ___Yes ___No If yes, Certification# _____
8. Social Security # or Federal Tax ID # _____ Tax Code [Example: 501(c)(3)] _____
9. Please list any certifications or accreditations, if applicable: JCAHO ICF/MR CARF
 HCS HCSC CLASS ACDD TRC ECI TEA DOL Other, please specify: _____
10. Please list any licensure specifying the license #, licensing agency as well as level(s) of service as applicable:

11. Do you provide emergency or after hours services? ___Yes ___No
If yes, please explain including telephone. # _____

12. In what languages, including American Sign Language or Signed English, are staff able to provide services? _____
13. Are you a Medicaid provider? ___Yes ___No
If Yes, Group or Individual Provider # _____
14. Are you a Medicare provider? ___Yes ___No
If Yes, Group or Individual Provider # _____

15. Types of Services: Pharmacological management Rehab Services
 Adult Psychotherapy (CBT) Supported Housing
 Children Day Program for Skills Training (MH) Respite Services
 Adult & Child. Site-Based Habilitation. ACT Team Services
 Early Childhood Intervention Counseling
 In-Home & Family Support Consumer Peer Support
 Telemedicine Supported Employment
 Residential Services Other _____
 Other _____

Section B: Specialty Areas:

Please check each area in which your program is qualified.

- Autism Elderly Services Mobility Impairment
 Criminal Justice Family Support Substance Abuse
 Developmental Disabilities Sign Language/Deaf culture Proficiency HIV/AIDS Issues
 Dual Diagnosis(MR/MI) Homeless Services Other _____

Describe additional services, specialties or areas of expertise:

Section C: Operations Information

1. Do you have a client appeals process? Yes No If Yes, Staff/Contact _____
 Phone# _____ Fax _____
2. Do you have an incident report process? Yes No If Yes, Staff/Contact _____
 Phone# _____ Fax _____
3. Do you have a confidentiality/client rights process? Yes No If Yes, Staff/Contact _____
 Phone# _____ Fax _____
4. Do you have an internal quality improvement process? Yes No If Yes, Staff/Contact _____
 Phone# _____ Fax _____
5. Do you have an internal utilization management process? Yes No If Yes, Staff/Contact _____
 Phone# _____ Fax _____
6. Do you have a customer/consumer satisfaction measure? Yes No If Yes, Staff/Contact _____
 Phone# _____ Fax _____
8. Please mark which of the following training you or all of your direct care staff receive:
 Client Rights/Confidentiality Pharmacology
 Abuse/Neglect/Exploitation reporting First Aid
 Verbal & Physical Mgmt of Aggressive behavior (PMAB) CPR
9. Does your program have a current operating plan and budget? Yes No
10. Do you maintain a file on each client? Yes No

11. Is your program in compliance with all local city, state and federal codes and local statues as applicable to your program including health codes, fire/safety codes, etc? If no, please submit reasons and plan of correction on a separate sheet of paper. ___Yes ___No

If you answer Yes to the following questions, please explain on a separate sheet of paper.

12. Have you or any of your current direct care staff ever had a confirmed allegation that you/they engaged in any class of client abuse/client neglect by the Department of Family and Protective Services or any equivalent state Agency? ___Yes ___No

13. Have you or any of your current staff been convicted of a felony against a person or property? ___Yes ___No

Section D: Insurance Information

Type of Liability Coverage: Professional General Auto Other

1. Type of Insurance: _____

Insurance Carrier _____ Expiration _____

Address: _____

City _____ State _____ Zip _____ Phone _____

Policy # _____ Coverage Limits: Per Occurrence \$ _____ Aggregate\$ _____

2. Type of Insurance: _____

Insurance Carrier _____ Expiration _____

Address: _____

City _____ State _____ Zip _____ Phone _____

Policy # _____ Coverage Limits: Per Occurrence \$ _____ Aggregate\$ _____

If more than one type of insurance, please indicate type and above information on a separate sheet of paper

3. Have you filed a claim under your general, professional auto or other liability insurance in the last three years? ___Yes ___No

4. Are there any claims pending against your program/organization? ___Yes ___No

5. Has your program/organization's liability/malpractice coverage ever been denied, cancelled, or non- renewed? ___Yes ___No

6. Have you ever had your program/organization's license(s), applicable certifications of accreditations, terminated, restricted, or voluntarily relinquished? ___Yes ___No

7. Has the program been sanctioned, placed on probation, placed on vender hold or lost accreditation, licensure or certification status during the last 3 years? ___Yes ___No

If you answered Yes to any of the above questions, please explain on a separate sheet of paper.

Section E: Program Application Required Documentation

- ___ Photocopies of certification and accreditation materials
 - ___ Photocopies of program license(s)
 - ___ Photocopies of general and professional, liability coverage
 - ___ Program brochures(s) if available
-

Section F: Program Application Required Certification Statement

I certify that the information provided in this application is correct to the best of my knowledge. I understand that any information contained in this application which subsequently is found to be false could result in denial of the application or termination from network participation.

On behalf of myself, I consent to allow MHMR Services of Texoma to inspect records and documents pertinent to this application.

Signature of Person or Program Representative

Date

Printed name of Person or Program Representative

Title of Representative
(if applicable)

Section G: General Authorization For Release Of Information

I, _____ (print name) hereby authorize MHMR Services of Texoma to obtain any and all information required to complete a review and primary source verification of my/our credentials. Information and documents to be reviewed include, but are not limited to, licensure/certification, accreditations and claims made against licensure/certification, malpractice insurance and claims.

I hereby release from liability any and all individuals and organizations reviewing this application for their acts performed in good faith and without malice in connection with evaluating this application and the credentials and qualifications. I also release from any liability any and all individuals and organizations who provide information in good faith and without malice concerning the above release items.

A photocopy, electronic or facsimile copy of this original statement constitutes my written authorization and request to release any and all documentation relevant to MHMR Services of Texoma credentialing and/or network approval process. Such photocopy, electronic or facsimile copy shall have the same force and effect as the signed original.

Applicant's signature: _____ Date: _____

Printed Name: _____

References

I, the undersigned applicant, hereby release from liability and hold harmless for the consequences of any disclosure, to the fullest extent permitted by law, the below named reference and The Gulf Coast Center for their written and oral statements, decisions, and actions in connection with evaluating my application for network approval, my experience, competencies and qualifications, health status, emotional stability, professional ethics, and character.

Print practitioner's name: _____

Practitioner's signature: _____ Date: _____

	Name	Address	Phone Number
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

**ATTACHMENT D
FORM D-1
PROFESSIONAL LIABILITY CASE REPORT**

Case Number _____ Carrier _____
Date of Incident ____/____/____ Date Claim Filed ____/____/____
Date Closed, if applicable ____/____/____

What is/was your role in the case? Primary defendant Co-defendant Other (please explain)
Other parties named in the case:

Current status of the case as it relates to YOU:

Dropped Dismissed, with prejudice
 Settled out of court Dismissed, without prejudice
 Judgment for Plaintiff: Settlement / Court award (judge or jury)
Amount paid: \$_____ Amount attributed to your involvement \$_____
 Judgment for Defendant
 Pending Date of last contact with plaintiff's attorney ____/____/____

CASE DETAILS:

What was your exact role in the client's care? Attending Consultant
 Other _____

What is the alleged harm to the client?

What were you alleged to have done incorrectly or to have failed to do? _____

Describe the client's condition and related effects of the alleged harm: _____

Describe any other details you believe are pertinent to the case:

**ATTACHMENT D
FORM D-2
PROFESSIONAL REFERENCE QUESTIONNAIRE**

Professional reference being provided for: _____

Referenced provided by:

Name _____ Title _____

Place of Employment _____

Street Address: _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

License(s) _____ Education _____

How long have you known this provider on a professional basis? _____

Briefly describe the circumstances through which you have current knowledge of the provider's clinical skills and competence: _____

Please rate the provider on each element below:

Element	Above Average/ Excellent	Average	Below Average	No Information
Clinical knowledge				
Clinical judgment				
Responsiveness to client needs				
Thoroughness in care				
Quality/appropriateness of client care outcomes				
Resource use				
Rapport with clients				
Professional ethics				

Do you have direct knowledge of any physical/emotional/mental health problems, including alcohol or drug dependencies, or other problems which impair the provider's ability to perform the essential functions of his/her profession, with or without accommodation? Yes No

If yes, please explain: _____

Signature

Date

PLEASE RETURN THIS FORM TO:

MHMR Services of Texoma
Attn: Jill Livingston
P.O. Box 1087
Sherman, TX 75091-1087

**ATTACHMENT E
FORM E-1
ASSURANCES**

Applicant must assure the following:

1. That all addenda, exhibits and/or attachments to the Application as distributed by the Local Authority have been received.
2. That the criteria for approval are met.
3. That the applicant is not currently held in abeyance or barred from the award of a federal or state contract.
4. That the applicant is not currently delinquent in its payments of any franchise tax or state tax owed to the state of Texas, pursuant to Texas Business Corporation Act, Texas Civil Statutes, Article 2.45.
5. No attempt will be made by the Applicant to induce any person or firm to submit or not to submit an application, unless so described in the application document.
6. The Applicant does not discriminate in its services or employment practices on the basis or race, color, religion, sex, national origin, disability, veteran status, or age.
7. That no employee of the Local Authority or DSHS, and no member of the Local Authority's Board of Trustees will directly or indirectly receive any pecuniary interest from an award of the proposed contract. If the applicant is unable to make the affirmation, then the applicant must disclose any knowledge of such interests.
8. Applicant accepts the terms, conditions, criteria, and requirements set forth in the Application.
9. Applicant accepts the Local Authority's right to cancel the Application at any time prior to contract award.
10. Applicant accepts the Local Authority's right to alter the timetables for procurement as set forth in the Application.
11. The application submitted by the Applicant has been arrived at independently without consultation, communication, or agreement for the purpose of restricting competition.
12. Unless otherwise required by law, the information in the application submitted by the Applicant has not been knowingly disclosed by the Applicant to any other Applicant prior to the notice of intent to award.
13. No claim will be made for payment to cover costs incurred in the preparation of the submission of the application or any other associated costs.
14. Local Authority has the right to complete background checks and verify information.
15. The individual signing this document and the contract is authorized to legally bind the Applicant.
16. The address submitted by the Applicant to be used for all notices sent by the Local Authority is current and correct.
17. All vehicles used to transport consumers will be properly maintained and have adequate comprehensive auto insurance that would cover liability and assume responsibility for any consumer injuries.
18. That the Applicant must include information in their actual application document demonstrating how the Applicant will meet the minimum requirements referenced in the Request for Application document on page 5, Section C - "Services," item numbers 1 through 10.

Signature Authority for the Applicant

Title of the Organization/Provider

Date _____

