

MENTAL HEALTH SERVICES OPEN ENROLLMENT REQUEST FOR APPLICATION

The Burke Center (Local Authority) is a contractor of the Texas Department of State Health Services (DSHS) 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 Angelina, Houston, Jasper, Nacogdoches, Newton, Polk, Sabine, San Jacinto, San Augustine, Shelby, Trinity and Tyler Counties, Texas.

Pursuant to Texas Administrative Code §412.60, Burke Center, as a DSHS designated Local Authority, has the authority to assemble a network of service providers to provide the following services to the Priority Population of persons with mental illness who reside in Angelina, Houston, Jasper, Nacogdoches, Newton, Polk, Sabine, San Jacinto, San Augustine, Shelby, Trinity and Tyler Counties. The specific services being sought are listed below.

- Pharmacological Management (CPT codes 90801, 90862, M0064)
 - Counseling (CPT codes 90804, 90806)
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The goals of this network are:

1. To develop a comprehensive network of providers for consumers receiving 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 Application seeks participation from applicants for the purpose of offering a comprehensive array of services and supports, within Angelina, Houston, Jasper, Nacogdoches, Newton, Polk, Sabine, San Jacinto, San Augustine, Shelby, Trinity and Tyler counties for individuals with mental illness who meet the target population. Any qualified applicant can submit an application to provide services. For a description of services, see Attachment A, “**SERVICE DEFINITIONS AND DESCRIPTION**”.

The grid below indicates the percent of services capacity the Local Authority intends to procure.

DESCRETE SERVICES	LMHA Capacity	% Capacity sought to procure
Pharmacological Management	1919	15%
Counseling	150	25%

Target Population

1. Adult Mental Health (MH) Target Population - Adults who have a diagnosis of schizophrenia, bipolar disorder, and severe major depression.
2. Child and Adolescent Mental Health Priority Population - children ages 3 through 17 with a diagnosis of mental illness (excluding a single diagnosis of substance abuse, mental retardation, autism or pervasive developmental disorder) who exhibit serious emotional, behavioral or mental disorders and who:
 - a. have a serious functional impairment; or
 - b. are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms; or
 - c. are enrolled in a school system’s special education program because of a serious emotional disturbance.

II. MINIMUM REQUIREMENTS

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

1. Meet the minimum qualifications of the DSHS performance contract and local plan.
2. Demonstrate their ability to provide services in compliance with DSHS contract requirements, submitting documentation within 48 hours of service provision and in a clean claim.
3. Comply with RDM (Resiliency and Disease Management).
4. Prescribers must comply with the Texas Implementation of Medication Algorithms (TIMA).
5. Counselors must comply with provision of Cognitive Behavior Therapy (CBT) as required by DSHS, and may not use any other form of therapy.
6. Be able to provide services in the language and English proficiency as dictated by the person receiving services.
7. Engage and involve consumers, legally authorized representatives, and families in the policy and practice levels within the applicant’s organization or individual practice.
8. Provide services in all counties during the hours of 8-5pm, and the days of Monday thru Friday.
9. Have the ability to transition at a minimum 10% of the individuals receiving procured service within first 45 days. Thereafter, transition consumers into services at a rate of 25% per month until applicant’s capacity is reached or utilization/referrals is not indicated.
10. Prescribers must provide documentation as needed to maintain client eligibility for Patient Assistance Program (PAP) medication.

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 B.

III. RESPONSIBILITIES

Local Authority Responsibilities

The Local Authority will be responsible for service coordination/case management and facilitating an individual's selection of service providers, authorizing services, reviewing claims and paying for appropriate, authorized services rendered by the service providers in its Network. The Local Authority will be responsible for billing Medicaid, Medicare, and other third party payers. The Local Authority is also responsible for utilization management and quality assurance. The Local Authority ensures that contracted services addressing the needs of the Priority Population are provided as required by DSHS, 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. The Local Authority does not guarantee any referral volume to any service provider within its Network of Providers. To review the Local Authorities FY07 Service Targets and Capacity go to

<http://www.dshs.state.tx.us/mhcommunity/LPND/LMHAs/burke-center.shtm>

The Local Authority will make space available in existing facilities for service providers, space permitting, to provide service in order to facilitate communication between the provider and Authority and for the convenience of individuals served.

Service Provider Responsibilities

The service provider will 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. The service provider is required to comply with all state and federal laws regarding the confidentiality of consumers' records and nondiscrimination. The service provider will actively assist in the disbursement of consumer and advocate satisfaction surveys. The service provider will obtain prior authorization, provide acceptable levels of care, and maintain acceptable levels of liability insurance, and appropriate licenses and accreditations. The service provider also 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. The service provider must 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.

Transition plan:

Develop a provider list	November 1, 2009
Verify provider information	November 1, 2009
Post Provider list to website and distribute to consumer and advocacy groups	December 1, 2009
Conduct provider forums to allow providers to share information with consumers, LARs, and other stakeholders.	December 1, 2009 – January 15, 2010

Develop internal procedures and forms for consumer selection of providers	December 1, 2010
Develop consumer information materials relating to selection of providers	December 1, 2010
Train internal staff on consumer selection procedures	December 1, 2010
Ensure external providers are trained on consumer selection requirements and procedures	December 1, 2010
Implement provider selection procedures for new intakes	February 1, 2010
Implement provider selection procedures for current clients (in conjunction with treatment plan reviews)	February 1, 2010
Develop and implement continuity of care plans for transitioning individual clients to new providers	February 1, 2010
Consumer transition complete	February 1, 2010

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. Submissions should be limited to ten (10) pages plus attachments and forms.

Applicants must send one (1) original and one (1) copy of the application and two (2) signed assurances signature pages to:

**Burke Center
Attn: Donna Moore
4101 S. Medford Drive
Lufkin, Texas 75901
936/558-6232**

Applications may be sent by regular mail or special carrier no later than August 15, 2009 at 5 pm CST.

Applications will be processed upon receipt. In the future, other open enrollment periods for services may be announced to ensure availability of adequate numbers of service providers to meet the volume of demand for services.

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. Any attached Form(s) must be completed by each applicant to be considered for possible enrollment in the Network.

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 excepted 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/or provide the necessary information. 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. In addition, the attached Form(s) must be completed by each applicant.

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
 - Whether you are 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 DSHS, DADS, DARS or DOL status if applicable.

C. SERVICES

1. List the services from Attachment C1 that the organization/provider would offer under this proposal. Identify geographical areas to be covered, where services are offered and the times of day and days of the week the services would be available. Describe any challenges you perceive in providing services in the service area. Detail the specific population to be served under this proposal. Include ages to be served as well as ability to serve individuals with multiple challenges. What is your capacity? How do you plan on transitioning consumers to your services?

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. Detail the specific population to be served under this proposal. Include ages and levels of severity.
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 the facility(ies) proximity to public transportation.
8. Describe how the organization/provider involves consumers, legally authorized representatives, and families at the policy and practice level.

D. FINANCIAL

1. Is the organization/provider incorporated as "Profit", "Not-for-profit", or "Other"? If "other", please explain.
2. Provide a copy of a Certified External Audit for the past three years. Label as **Exhibit VD3**
3. Provide a copy of the most recent Tax Statement (IRS Form 1120, Form 990 as applicable). Label as **Exhibit VD4**
4. Provide a current Financial Statement including Cash Flow. Label as **Exhibit VD5**
5. Submit the most current Annual Report available. Label as **Exhibit VD6**
6. Provide evidence of continued financial viability to ensure your capabilities to support this service. Label as **Exhibit VD7**

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 VE1**.
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 VE2**. 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 VE3**.

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 VE4**.

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 the Angelina, Houston, Jasper, Nacogdoches, Newton, Polk, Sabine, San Jacinto, San Augustine, Shelby, Trinity and Tyler counties.

F. INFORMATION SYSTEMS

Can the organization/provider information system report the following categories of data?

1. Consumer name
2. Admissions and Discharges to services
3. Date, Number, type, and duration of services (by Local Authority service codes)
4. Number, type and severity of medication errors/adverse drug reactions for Local Authority consumers
5. Deaths and suicide attempts of Local Authority consumers
6. Serious injury on premises of Local Authority consumers
7. Confirmed abuse, neglect, or exploitation of Local Authority consumers
8. Allegations of homicide/attempted homicide/threat with a plan by a Local Authority consumer

The provider must enter data directly into the Burke Center's Anasazi electronic medical records system (a fee may be charged by Anasazi Software, Inc, for access to the Center's software/license). Should the provider be unable to do so, a rate for data entry may be negotiated.

G. RATE AND METHOD OF PAYMENT

Applicant agrees, for those services it is submitting an application, to accept the fees listed below as payment in full for approved consumer services. The Applicant will not submit a claim or bill or collect compensation from Local Authority for any service which it has not submitted an application, or been approved, or contracted to provide. Applicant agrees that compensation for providing services not covered by its application will be solely between the consumer and the

Applicant. The consumer must be informed in writing before any services are provided, that the Local Authority is not responsible for payment for such services. Consumers are responsible for payment for those services only if the consumer consents in writing to the provision of such noncovered services.

If the Applicant becomes a Service Provider in the Local Authority’s network, said Service Provider shall be reimbursed for services described in the schedules below. Rates reflect 90% of current Medicaid reimbursement for selected CPT codes.

ROUTINE SERVICES	RATE
Pharmacological Management Initial Eval CPT 90801	\$118.13
Pharmacological Management CPT 90862	\$40.99
Pharmacological Management CPT M0064	\$32.73
CBT Counseling CPT 90804	\$25.45
CBT Counseling CPT 90806	\$50.90

VI. ASSURANCES (for signature copy see Attachment C2)

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.

ATTACHMENT A

SERVICE DEFINITIONS AND DESCRIPTIONS

RDM Service Descriptions for Adult Services

Psychiatric Diagnostic Interview Examination: A licensed professional practicing within the scope of their license must provide this service and document as described in the most current version of Title 25 Texas Administrative Code (TAC), Part I, Chapter 412, Subchapter G, Section 412.315(a)(5) *MH Community Services Standards*. Includes a face-to-face interview with the individual to evaluate the individual's psychiatric diagnoses and treatment needs.

Pharmacological Management Services: A service provided to a client by a physician or other prescribing professional, in accordance with TIMA when applicable to the client to determine symptom remission and the medication regimen needed. Includes supervision of administration of medication, monitoring of effects and side effects of medication, and assessment of symptoms.

Counseling (CBT) Individual and Group:

Individual, family and group therapy focused on the reduction or elimination of a client's symptoms of mental illness and increasing the individual's ability to perform activities of daily living. Cognitive-behavioral therapy is the selected treatment model for adult counseling services. Counseling must be provided by a Licensed Practitioner of the Healing Arts (LPHA), practicing within the scope of their own license. This service includes treatment planning to enhance recovery and resiliency.

For a complete description of RDM Service Package Definitions and Service Descriptions for Adult Service Packages, see:

http://www.dshs.state.tx.us/mhprograms/RDM/documents/Adult_UM_Guidelines_Revised20080527.pdf

RDM Service Descriptions for Children's Services

Psychiatric Diagnostic Interview Examination: A licensed professional practicing within the scope of their license must provide this service and document as described in the most current version of Title 25 Texas Administrative Code (TAC), Part I, Chapter 412, Subchapter G, Section 412.315(a)(5) *MH Community Services Standards*. Includes a face-to-face interview with the individual and family to evaluate the individual's psychiatric diagnoses and treatment needs.

Pharmacological Management: A service provided to a client by a physician or other prescribing professional, in accordance with the Texas Implementation of Medication Algorithms (TIMA) when applicable, to the consumer to determine symptom remission and the medication regimen needed.

Counseling: Individual, family, and group therapy focused on the reduction or elimination of a client's symptoms of emotional disturbance and increasing the individual's ability to perform activities of daily living. Counseling is intended to be brief, time-limited and focused, using

Cognitive Behavioral Therapy (CBT) for ages 9 & above and CBT or other therapy approaches for children ages 3 through 8. Counseling shall be provided by a Licensed Practitioner of the Healing Arts (LPHA), practicing within the scope of their own license.

For a complete description of RDM Service Package Definitions and Service Descriptions for Children's Service Packages, see:

<http://www.dshs.state.tx.us/mhprograms/doc/ChildrensUMGuidelinesDec2007.doc>

ATTACHMENT B 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 requirements for all services being sought:

- Age of staff must be over 18, has a high school diploma or a General Education Development(GED) credential; or has documentation of a proficiency evaluation of experience and competence to perform the job tasks that includes:
 - written competency-based assessment of the ability to document service delivery and observations of the individuals to be served; and
 - at least three personal references from persons not related by blood that indicate the ability to provide a safe, healthy environment for the individuals being served.
- 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), **complete Attachment C3**
 - 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)

2. Additional required information:

- A. **Qualifications of Providers – SP-1 (Services must be delivered by staff with these MINIMUM qualifications)**
1. Pharmacological Management Services = MD (psychiatrist), RN, PA, Pharm.D., APN
 2. Routine Case Management = QMHP or CSSP
 3. Rehabilitative Services = QMHP, Licensed medical personnel, CSSP, or Peer Provider (consult Rule for specific credential requirements)
 4. Supported Employment = QMHP or CSSP
- B. **Qualifications of Providers SP-2 (Services must be delivered by staff with these**

MINIMUM qualifications)

1. Pharmacological management services = MD (psychiatrist), RN, PA, Pharm.D., APN
2. Routine Case Management = QMHP or CSSP
3. Psychotherapy-CBT = LPC, LCSW, LMFT, or Licensed Psychologist.
4. Rehabilitative Services = QMHP, Licensed medical personnel, CSSP, or Peer Provider (consult Rule for specific credential requirements for sub-component services)
5. Supported Employment = QMHP or CSSP
6. Supported Housing = QMHP or CSSP

C. SP-3 Qualifications of Providers (Services Must Be Provided by Staff With the Following Minimum Qualifications)

1. Pharmacological management = MD (psychiatrist), RN, PA, Pharm.D., APN
2. Rehabilitative Services = QMHP, Licensed medical personnel, CSSP, or Peer Provider (consult Program Rules for specific credential requirements),
3. Medical = Medical related services - Licensed medical personnel
4. For providers serving persons with co-occurring psychiatric and substance abuse disorder, competencies for serving this population must be demonstrated as defined by DSHS standards.
5. Supported Employment = Employment Specialist - QMHP or CSSP
6. Supported Housing = QMHP or CSSP

D. Qualifications of Providers – SP-4

Burke Center will not be procuring providers for clients receiving Assertive Community Treatment (ACT) services at this time.

Section D: Employment History

1. _____
Employer Name Address City,State,Zip From To

2. _____
Employer Name Address City,State,Zip From To

3. _____
Employer Name Address City,State,Zip From To

Section E: Operations Information

1. Do you have a client appeals process? **Yes or No**

2. Do you have an incident report process? **Yes or No**

3. Do you have a confidentiality/client rights process? **Yes or No**

4. Do you have an internal quality improvement process? **Yes or No**

5. Do you have an internal utilization management process? **Yes or No**

6. Do you have a customer/consumer satisfaction measure? **Yes or No**

7. Do you have a service outcome measure? **Yes or No**

8. Do you maintain a file on each person receiving services? **Yes or No**

9. Please mark which of the following training you have received:

<input type="checkbox"/> Client Rights/Confidentiality	<input type="checkbox"/> Pharmacology
<input type="checkbox"/> Abuse/Neglect/Exploitation reporting	<input type="checkbox"/> First Aid
<input type="checkbox"/> Verbal & Physical Mgmt of Aggressive behavior	<input type="checkbox"/> CPR

10. How many individuals are you able to serve? _____

11. Do you have a previous relationship with the Local Authority, or any of its staff or Board members? **Yes or No**
If yes, describe: _____

12. Have you ever provided services to individuals with disabilities before? **Yes or No**
If yes, explain _____

Section F: Adverse/Disciplinary Actions

Have you relinquished, withdrawn, or failed to proceed with an application for one of the following reasons described to avoid an adverse action, to preclude an investigation, or while under investigation relating to professional conduct or job performance.

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

1. Have you ever had participation in Medicare, Medicaid, CHAMPUS, or other government programs restricted, sanctioned or limited? **Yes or No**

2. Have you ever been assessed a penalty by the Medicaid, Medicare, or CHAMPUS programs?
Yes or No
 3. Have you been convicted of or pleaded no contest to any criminal charges brought against you?
Yes or No
 4. Have you been convicted of or pleaded no contest to a drug or alcohol related offense?
Yes or No
 5. Has a peer review organization or similar federal, state, or military agency sanctioned you?
Yes or No
 6. Have you ever had any felony convictions?
Yes or No
 7. Have you ever been found to be the perpetrator of a confirmed case of abuse or neglect?
Yes or No
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Section G: 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 you ___ Yes ___ No

5. Has your liability/malpractice coverage ever been denied, cancelled, or non- renewed? ___ Yes ___ No

6. Have you ever had your license(s), applicable certifications of accreditations, terminated, restricted, or voluntarily relinquished? ___ Yes ___ No

7. Have you 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 H: 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 Burke 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.

Applicant's signature: _____ Date: _____

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

Section I: Attestation

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

Yes No If yes, please provide explanation 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 or 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 Burke Center of all information that may reasonable 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. I understand that any information contained in this application which subsequently is found to be false could result in a denial of the application or termination from network participation.

Applicant's signature: _____ Date: _____

Printed Name: _____

Section J: General Authorization for Release of Information

I, _____ (print name) hereby authorize Burke Center 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 Burke Center credentialing and/or network approval process. Such Photostat, electronic or facsimile copy shall have the same force and effect as the signed original.

Applicant's signature: _____ Date: _____

Printed Name: _____

If you are Board Certified by the American Board of Psychiatry and Neurology (ABPN), American Osteopathic Board of Neurology and Psychiatry (AOBNP), or the American Society of Addiction Medicine (ASAM), please complete the chart below, circling the appropriate certifying board:

Specialty	Certifying Board		Certification #	Year Certified	Expiration Date
Psychiatry	ABPN	AOBNP			
Addiction	ABPN				
Child	ABPN				
Child and Adolescent	ABPN				

CURRENT PROFESSIONAL ASSOCIATION/SOCIETY MEMBERSHIPS:

Physician Assistants and Advanced Nurse Practitioners:

- Are you authorized to prescribe medications: ____ Yes ____ No
- If yes, Prescription Authorization Number: _____ Exp. Date: _____

Section E: Government Program Participation

Medicare provider # _____
 Medicaid provider# _____

Section F: Education History

- | | | | | |
|---------------|---------|--------|------|----|
| Undergraduate | Address | Degree | From | To |
|---------------|---------|--------|------|----|
- | | | | | |
|----------|---------|--------|------|----|
| Graduate | Address | Degree | From | To |
|----------|---------|--------|------|----|
- | | | | | |
|----------------|---------|--------|------|----|
| Medical School | Address | Degree | From | To |
|----------------|---------|--------|------|----|
- | | | | | |
|------------|---------|--------|------|----|
| Internship | Address | Degree | From | To |
|------------|---------|--------|------|----|
- | | | | | |
|-----------|---------|--------|------|----|
| Residency | Address | Degree | From | To |
|-----------|---------|--------|------|----|
- | | | | | |
|-----------|---------|--------|------|----|
| Residency | Address | Degree | From | To |
|-----------|---------|--------|------|----|
- | | | | | |
|--|--|--|--|--|
| | | | | |
|--|--|--|--|--|

Fellowship	Address	Degree	From	To
------------	---------	--------	------	----

If you are a foreign medical school graduate, are you certified by the Education Council for Foreign Medical Graduates (ECFMG)? ___Yes___No

Section G: Employment History

(If a physician, since completion of medical school or post graduate school)

1. _____

Employer Name	Address	City,State,Zip	From	To
---------------	---------	----------------	------	----
2. _____

Employer Name	Address	City,State,Zip	From	To
---------------	---------	----------------	------	----
3. _____

Employer Name	Address	City,State,Zip	From	To
---------------	---------	----------------	------	----
4. _____

Employer Name	Address	City,State,Zip	From	To
---------------	---------	----------------	------	----
5. _____

Employer Name	Address	City,State,Zip	From	To
---------------	---------	----------------	------	----
6. _____

Employer Name	Address	City,State,Zip	From	To
---------------	---------	----------------	------	----

Section H: Hospital Affiliation

List your Current primary hospital affiliation first, then all others:

Name of Hospital	Type of Privileges
_____	Full___Courtesy___Restricted___Other___
_____	Full___Courtesy___Restricted___Other___
_____	Full___Courtesy___Restricted___Other___

Section I: Professional 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 Burke 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.

Applicant's signature: _____ Date: _____

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

Section J: 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.

- | | |
|---|--------------|
| 1. License/registration to practice in any state | Yes___ No___ |
| 2. DEA/controlled substance registration | Yes___ No___ |
| 3. Membership on any hospital staff | Yes___ No___ |
| 4. Clinical privileges at any hospital | Yes___ No___ |
| 5. Participation in Medicare, Medicaid, or other government programs | Yes___ No___ |
| 6. Have you ever been assessed a penalty by the Medicaid, Medicare or any other government program? | Yes___ No___ |
| 7. Non-hospital practice affiliation or authorization to provide services | Yes___ No___ |
| 8. Board certification | Yes___ No___ |
| 9. Military, state or federal agency | Yes___ No___ |
| 10. Health-related professional society membership or fellowship | Yes___ No___ |
| 11. Have you been convicted of or pleaded no contest to any criminal charges (other than motor vehicle violations) brought against you? | Yes___ No___ |
| 12. Have you been convicted of or pleaded no contest to a drug or alcohol related offense? | Yes___ No___ |
| 13. Have you been sanctioned by a peer review organization or similar federal, state, or military agency? | Yes___ No___ |
| 14. Have you ever had any felony convictions? | Yes___ No___ |
| 15. Have you ever been found to be the perpetrator of a confirmed case of client abuse or neglect? | Yes___ No___ |

Section K: 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 accommodations? Yes___ No___

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

Section L: Professional Liability Insurance Coverage

(Attach a copy of the declaration page of your current Professional Liability Insurance Coverage)

Company Name _____

Address _____

City _____ State _____ Zip Code _____

Policy Number _____ Coverage Limit _____ Expiration _____

Have you ever been denied coverage (either initial or renewal) by any professional liability insurance carrier or had an individual policy cancelled or individual surcharge placed on you based on your individual practice? Yes___ No___

If yes, please explain: _____

Section M: 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.

Section N: Attestation

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

Yes___ No___ If yes, please provide explanation 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 or 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 Burke Center of all information that may reasonable 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. I understand that any information contained in this application which subsequently is found to be false could result in a denial of the application or termination from network participation.

Applicant's signature: _____ Date: _____

Printed Name: _____

Section O: General Authorization for Release of Information

I, _____(print name) hereby authorize Burke Center 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 Burke Center credentialing and/or network approval process. Such Photostat, electronic or facsimile copy shall have the same force and effect as the signed original.

Applicant's signature: _____ Date: _____

Printed Name: _____

**ATTACHMENT B3
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 HCSO 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:
- | | | |
|---|---|--|
| <input type="checkbox"/> Adult | <input type="checkbox"/> Pharmacological management | <input type="checkbox"/> Rehab Services |
| <input type="checkbox"/> Children | <input type="checkbox"/> Psychotherapy (CBT) | <input type="checkbox"/> Supported Housing |
| <input type="checkbox"/> Adult & Child. | <input type="checkbox"/> Day Program for Skills Training (MH) | <input type="checkbox"/> Respite Services |
| | <input type="checkbox"/> Site-Based Habilitation. | <input type="checkbox"/> ACT Team Services |
| | <input type="checkbox"/> Early Childhood Intervention | <input type="checkbox"/> Counseling |
| | <input type="checkbox"/> In-Home & Family Support | <input type="checkbox"/> Consumer Peer Support |
| | <input type="checkbox"/> Telemedicine | <input type="checkbox"/> Supported Employment |
| | <input type="checkbox"/> Residential Services | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ |

Section B: Specialty Areas:

Please check each area in which your program is qualified.

- | | | |
|---|---|--|
| <input type="checkbox"/> Autism | <input type="checkbox"/> Elderly Services | <input type="checkbox"/> Mobility Impairment |
| <input type="checkbox"/> Criminal Justice | <input type="checkbox"/> Family Support | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Developmental Disabilities | <input type="checkbox"/> Sign Language/Deaf culture Proficiency | <input type="checkbox"/> HIV/AIDS Issues |
| <input type="checkbox"/> Dual Diagnosis(MR/MI) | <input type="checkbox"/> Homeless Services | <input type="checkbox"/> 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 _____

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 venter 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 Burke Center 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 Burke Center 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 Burke Center credentialing and/or network approval process. Such Photostat, electronic or facsimile copy shall have the same force and effect as the signed original.

Applicant's signature: _____ Date: _____

Printed Name: _____

ATTACHMENT C
Miscellaneous Required Forms

ALL OF THE FORMS IN ATTACHMENT C MUST BE INCLUDED IN YOUR SUBMISSION IN ORDER FOR THE OPEN ENROLLMENT APPLICATION TO BE CONSIDERED.

- C1. Designation of services sought**
- C2. Assurances page for signature**
- C3. Vehicle Safety Report**
- C4. Staff Roster**

**ATTACHMENT C1
DESIGNATION OF SERVICES**

Please indicate with a “√” which services you are submitting this request for application. The “X” indicates whether the service is being sought under this RFA. If there is no “X”, you can not submit an application for the service. Failure to “√” a service, may require you to submit another application or wait for the next open enrollment period (which has not been established).

ROUTINE SERVICES	Indicate (√) services you are submitting this application
Pharmacological Management	
Initial psychiatric evaluations	
Counseling	

The undersigned hereby certifies that he/she has the authority over all of the proposal documents and agrees to abide by the terms, certifications and conditions including the rate of reimbursement indicated within the RFA:

Authorized Signature: _____

Printed Name: _____

Title: _____

Date: _____

ATTACHMENT C2: 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.

Signature Authority for the Applicant

Title of the Organization/Provider

Date _____

**ATTACHMENT C3
VEHICLE SAFETY REPORT**

This form must be completed for each vehicle which may be used while transporting individuals receiving services.

Vehicle Custodian/owner: _____ Phone#: _____

License Plate Number: _____ Mileage: _____

Type and Model of Vehicle: _____

Name of Insurance Carrier: _____

Items To Be Checked:

Required for individuals safety and comfort

Inspection sticker expiration date: _____

Current insurance card in vehicle? Yes or No

A/C and Heating systems are operable? Yes or No

Jumper cables in vehicle? Yes or No or n/a

First aid kit in vehicle? Yes or No

Seat belts all lock Yes or No

Condition of tires, including spare: Ok or need replacing _____

Lights (head, tail, backup, turn) Ok or need replacing _____

Mileage of last oil change: _____ and does not exceed 3500 miles

Mileage of last transmission service: _____ and does not exceed 30,000 miles

Interior of vehicle, condition Ok or need cleaning _____

Fluid levels: Ok or need refilling or service

Additional recommended

Fire extinguisher in vehicle? Yes or No

Fire extinguisher secured? Yes or No or n/a

Flash light w/charged batteries? Yes or No or n/a

First aid kit secured? Yes or No or n/a

Biohazard kit in vehicle? Yes or No

Biohazard kit secured? Yes or No or n/a

Seat belt Saf-Cut installed Yes or No

I realize I am responsible for obtaining the necessary repairs or equipment to insure the vehicle is in a safe condition to transport individuals receiving services. I also realize the Local Authority at any time may inspect my vehicle at anytime to ensure validity of the information provided.

Vehicle custodian/Owner

Title

Date

