IDD SERVICES

PROVIDER MANUAL

FISCAL YEAR 2016/2017
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Introduction

Welcome to MHMRTarrant (MHMR). We are pleased to recognize you as a member of our Provider Network and look forward to enjoying a long and mutually satisfying contractual relationship with you.

The purpose of this Provider Manual is to educate you about the policies and procedures of MHMRTarrant. We ask that you read this material carefully and discuss any questions you may have with Provider Relations at (817) 569-4456. As a contractor you are responsible for knowing and abiding by the MHMRTarrant policies.

MHMRTarrant is staffed by a team of highly dedicated professionals experienced in the provision of services for persons who are diagnosed with Intellectual Developmental Disorders. MHMRTarrant is dedicated to providing high quality, innovative, and cost-effective management of IDD services.

Our philosophy is propelled by a strong commitment to service excellence supported by management flexibility and accountability. Our on-going objective is to continually refine our system so that we can excel in the delivery of quality services as we balance the best interests of our consumers, providers, and employees. We are also committed to contracting with providers to offer consumer provider choices and a wider array of options.

MHMRTarrant clearly understands that open communication must exist between our service providers and our organization in order for us to be able to provide individuals in our community with the best possible care. We, therefore, invite you to share your perceptions, needs, and suggestions with our Director of Contracts Management/Provider Relations, Kevin McClean, who will also, from time to time, ask you to respond to surveys to help us identify other opportunities to improve our services and to assess your satisfaction as a member of our provider network.

We will do all that we can to support your entry into our system and assure that your continued participation in our network will be beneficial for all concerned.

In this Provider Manual, references may be made to consumers and clients. Both of these terms are to be considered interchangeable. Other references that are used interchangeably are MHMRTarrant and Local Authority (LA), and Texas Department of Aging and Disability Services (DADS) and State Authority (SA).
Mission Statements & Values

Mission Statement of
MHMRTarrant:
To enhance the mental health and intellectual development of people in our community.

Mission Statement of
IDD Services:
IDD Services of Tarrant County expands opportunities for people to participate actively in the community.

Values

Respect for persons and families who are active in planning and evaluating their services

Recovery as a life-long process of better health and well-being

Success as positive outcomes for each person

Choice and participation of persons and their families in the planning process

Inclusion in the community through services that promote growth and independence

Safe, ethical and cost-effective services

Best practices in current research in medical, psychosocial and organizational fields

Collaboration with other organizations for better services and efficiencies
Organizational Structure

The organizational structure of MHMRTarrant includes the Behavioral Health and IDD Community Advisory Committees (CAC). These two committees are composed of individuals from the community, including consumers, who have a vested interest in assuring that quality services are readily available to our consumers. These committees are empowered to provide input into the planning process that will lead our organization into the future. Both of these committees report to our Board of Trustees.

Our Chief Executive Officer is accountable to our Board of Trustees and oversees the administrative duties of our organization. Chiefs who report directly to the Chief Executive Officer are the Chief of Early Childhood Intervention, Chief Financial Officer, Chief of Organizational Development, Chief of IDD Services, Chief of Behavioral Health Services and the Managing Director of Information Services.

Currently, MHMRTarrant has providers in the areas of Behavioral Health Services, IDD Services, and Early Childhood Intervention Services. We anticipate continued growth in expanding our service providers from the community.
Important Points to Remember

It is the provider’s responsibility to render services to MHMRTarrant consumers in accordance with the terms of the contract and according to Home and Community Based Services (HCS)/Intermediate Care Facilities for the Intellectual Disability (ICF – ID) rules as applicable. www.dads.state.tx.us (HCS - Title 40; Part 1 Chapter 9 Subchapter D. ICF/ID – Title 40; Part 1 Chapter 9; Subchapter E.) The provider is required to render these services to MHMRTarrant consumers in the same manner, adhering to the same standards, and within the same time availability as offered to all other consumers.

MHMRTarrant does not guarantee that a MHMRTarrant consumer or any number of MHMRTarrant consumers will utilize any particular provider. Each consumer is given information regarding all providers in the provider network and then makes the choice of provider(s).

MHMRTarrant is committed to providing our consumers with ethically sound, efficient and effective quality services. It is your duty to assist in the prevention, detection and correction of any instances of noncompliance with applicable federal, state and private health care plans. Call to report your compliance concerns to the

- **Compliance Action Line:**
  1-800-500-0333

Providers are required to inform consumers that they have the right to report any complaints about the services they are receiving to the

- **Consumer Complaint Reporting Line:**
  (817) 569-4367
  or
  1-888-636-6344 (toll free)

All provider complaints and/or suggestions are to be communicated to

- **Provider Relations:**
  (817) 569-4456.

**Within one hour** of witnessing or becoming aware of possible abuse/neglect/exploitation each staff person is responsible for reporting the incident to the

- **Texas Department of Family and Protective Services**
  1-800-647-7418 or www.txabusehotline.org

**Credentialing of Provider Employees and Agents**

Local Authority will review and credential all of the Provider staff, employees and agents at the professional level (i.e. licensed staff). Providers holding professional licenses and/or certifications must maintain those
licenses and/or certifications in good standing with their respective licensing/certifying bodies. Provider will submit completed credentialing application forms to the Local Authority for each licensed professional providing services to MHMRTarrant consumers. Local Authority will notify Provider of any individual not meeting the credentialing criteria. If Provider has its own credentialing process that meets or exceeds standards set forth by Local Authority’s Credentialing Committee, credentialing of staff may, upon prior approval by the Local Authority, be delegated to the Provider.

Non-licensed Provider Qualifications
All service providers must have a high school education (or GED), or equivalent, be 18 years of age, and not have been convicted of a crime relevant to a person’s duties including (1) criminal homicide, (2) kidnapping and unlawful restraint, (3) indecency with a child, (4) sexual assault, (5) aggravated assault, (6) injury to a child, elderly individual, or disabled individual, (7) abandoning or endangering a child, (8) aiding suicide, (9) agreement to abduct from custody, (10) sale or purchase of a child, (11) arson, (12) robbery, (13) aggravated robbery, (14) indecent exposure, (15) improper relationship between educator and student, (16) improper photography or visual recording, (17) deadly conduct, (18) aggravated sexual assault, (19) terroristic threat, (20) online solicitation of a minor, (21) money laundering, (22) Medicaid fraud, (23) cruelty to animals, and (24) a conviction which occurred within the previous five years for: (A) assault that is punishable as a Class A misdemeanor or as a felony; (B) burglary; (C) theft that is punishable as a felony; (D) misapplication of fiduciary property or property of a financial institution that is punishable as a Class A misdemeanor or felony; or (E) securing execution of a document by deception that is punishable as a Class A misdemeanor or a felony. (F) false identification as peace officer, and/or (G) disorderly conduct. Provider is required to provide external audit reports, if any, related to accreditation, licensure or certification. Programs must meet the requirements of those licenses, certifications or accreditations with regard to medication storage, handling, administration and documentation.

Provider is required to provide copies of each staff person’s high school diploma, GED, or an equivalent. Educational equivalency requires the submission of 3 letters of reference (required Personal Reference Questionnaire form attached), and a competency exam (form attached).

Provider is also required to provide copies of each staff person’s driver’s license, consent for Criminal History Background Checks and Employee Misconduct/Nurse’s Aide Registry Verifications. MHMRTarrant will prior to contracting and annually thereafter check the Client Abuse and Neglect Reporting System (CANRS) records from the state database on all direct contact staff. Staff persons with a record on the CANRS system may or may not be eligible for work with MHMRTarrant consumers depending upon program requirements and/or severity of offense.

Initial/annual updates of Criminal History Background Checks, Employee Misconduct, Nurse’s Aide Registry and CANRS checks will either be completed or verified by MHMRTarrant staff. MHMRTarrant will conduct the background checks for owners/managers for our Providers that do not have a designated person to conduct these checks. All background checks must be completed through The Texas Department of Public Safety. In the event a staff person has resided outside of the State of Texas within five years prior to employment/contracting with MHMRTarrant, a fingerprint criminal history background check will be performed at a cost to the provider.
Coordination with MHMRTarrant GR Service Coordinator

The primary contact person regarding any MHMRTarrant GR consumer will be the MHMRTarrant Service Coordinator. The MHMRTarrant Service Coordinator is responsible for assisting the consumer with accessing medical, social, educational, and other appropriate services and supports that will help a consumer achieve a quality of life and community participation acceptable to the consumer. The MHMRTarrant Service Coordinator is responsible for the overall coordination of services to the individual. All issues regarding an MHMRTarrant consumer must be brought to the attention of the MHMRTarrant Service Coordinator for assistance in resolution. MHMRTarrant recognizes that a team effort is needed to successfully provide services to consumers. For this reason, the Provider is seen as a valuable member of the team, having insight into successes or problems as they occur. Providers are encouraged to ask questions of the MHMRTarrant Service Coordinator as the Person Directed Plans are developed to ensure those specific areas most important to the consumer are included at that time. It is expected that regular communication will occur between the Provider, consumer, and MHMRTarrant Service Coordinator, and that roles and responsibilities are tailored to meet the Consumers needs. All questions/concerns regarding GR Service Coordination should be directed to the Director of Service Coordination at 817-569-5632 or the Managing Director as 817-569-5654.

Each Provider will receive a copy of the PDP for each consumer served; this includes the initial/annual PDP as well as any revisions that are relevant to that Provider.
General Revenue (GR)
Referral and Authorization Process

Referral Process
There is no guarantee that a Provider will be used by an MHMRTarrant consumer or any number of MHMRTarrant consumers. The MHMRTarrant Service Coordinator will offer the consumer a choice of providers from the list of contracted Providers. Consumer’s choice will be documented. Once the consumer has decided upon a provider the service coordinator will make the referral to the appropriate provider. No services should be provided for any MHMRTarrant consumer without possession of a written Letter of Authorization (LOA). In the case of an emergency where a service is needed to be provided without a LOA, the Provider should only respond to a verbal request made by their designated program contact.

The LOA will be sent to the Provider chosen following the development and approval of a Person Directed Plan (PDP). The PDP will specify the services to be provided for the consumer. The PDP will be consumer specific; however, the Provider should not solely rely on the PDP for all pertinent information regarding the consumer. The Provider is encouraged to contact the Service Coordinator if assistance is needed to obtain guardianship information, doctor’s orders, current medications, etc.

The consumer may change Providers at any time. Whenever a change of providers is requested within the service plan year a notice will be sent to the Provider in the form of a lapsed LOA which will specify the date services are to end. After the LOA is lapsed the Provider is no longer expected to provide services and will not continue to be paid for services rendered.

Authorization of Services
The MHMRTarrant Service Coordinator will anticipate the type and amount of service needed to meet the consumer’s needs. The PDP will outline the outcome for each service authorized. An Authorization Letter will be sent to the chosen Provider which includes the consumer’s name, the date services are authorized to begin, the quantity of services authorized, the lapse date for the Authorization (by when the services must be provided or will no longer be authorized), and the Authorization Number.
GR Contracted /Services

- Behavioral Supports
- Community Support
- Counseling
- Day Habilitation
- Employment Assistance
- Nursing
- Respite
- Supported Employment

PASRR Contracted Services

- Day Habilitation
- Behavioral Support
- Employment Assistance
- Independent Living Skills Training (Community Support)
- Supported Employment
Home and Community Based Services (HCS)
Referral and Authorization Process

Referral Process
There is no guarantee that a sub-contractor will be used by an MHMRTarrant consumer or any number of MHMRTarrant consumers. The MHMRTarrant HCS Program Provider will offer the consumer a choice of service providers from the list of sub-contracted Providers. Consumer’s choice will be documented. Once the consumer has decided upon a service provider the HCS Program Provider will develop and approve an Implementation Plan (IP) and make the referral to the appropriate sub-contractor. The IP will specify the services to be provided for the consumer. The IP will be consumer specific; however, the service provider should not solely rely on the IP for all pertinent information regarding the consumer. No services should be provided for any MHMRTarrant consumer without possession of a written Letter of Authorization (LOA). In the case of an emergency where a service is needed to be provided without a LOA, the Provider should only respond to a verbal request made by their designated program contact.

The LOA will be sent to the service provider following the development and approval of an IP. The service provider is encouraged to contact the Provider Representative if assistance is needed to obtain guardianship information, doctor’s orders, current medications, etc.

The consumer may change service providers at any time. Whenever a change of providers is requested within the service plan year a notice will be sent to the Provider in the form of a lapsed LOA which will specify the date services are to end. After the LOA is lapsed the Provider is no longer expected to provide services and will not continue to be paid for services rendered.

Authorization of Services
The HCS Provider Representative will anticipate the type and amount of service needed to meet the consumer’s needs. The IP will outline the outcome for each service authorized. An Authorization Letter will be sent to the chosen sub-contractor which includes the consumer’s name, the date services are authorized to begin, the quantity of services authorized, the lapse date for the Authorization (by when the services must be provided or will no longer be authorized), and the Authorization Number.
HCS Services

- Audiology
- Behavior Supports
- Day Habilitation
- Dental
- Dietary
- Employment Assistance
- Nursing
- Occupational Therapy
- Physical Therapy
- Residential Assistance
  - Community First Choice (PAS/HAB)
  - Host Home/companion care;
- Respite
- Speech and Language Pathology
- Supported Employment
Coordination with MHMRTarrant ICF-ID QIDP

The primary contact person regarding any ICF-ID consumer will be the ICF-ID QIDP. The ICF-ID QIDP is responsible for the overall coordination and monitoring of services provided to a consumer enrolled in the ICF-ID Program. All issues regarding an ICF-ID consumer must be brought to the attention of the ICF-ID QIDP for assistance in resolution. MHMRTarrant recognizes that a team effort is needed to successfully provide services to ICF-ID consumers. For this reason, the Provider is seen as a valuable member of the team, having insight into successes or problems as they occur. Providers are encouraged to ask questions of the ICF-ID QIDP as the Annual Staffings are developed to ensure those specific areas most important to the consumer are included at that time. It is expected that regular communication will occur between the Provider, consumer, and QIDP, and that roles and responsibilities are tailored to meet the consumer’s needs. All questions/concerns regarding ICF-ID should be directed to the Director of ICF Residential Services at 817-569-4029.

Each Provider will, upon request, assist the QIDP determine progress and/or barriers to meeting outcomes on at least an annual basis.
ICF-ID
Referral and Authorization Process

Referral Process
There is no guarantee that a Provider will be used by an MHMRTarrant consumer or any number of MHMRTarrant consumers. The MHMRTarrant ICF-ID QIDP will offer the consumer a choice of providers from the list of contracted Providers. Consumer’s choice will be documented. Once the consumer has decided upon a provider the QIDP will make the referral to the appropriate provider. No services should be provided for any MHMRTarrant consumer without possession of a written Letter of Authorization (LOA). In the case of an emergency where a service is needed to be provided without a LOA, the Provider should only respond to a verbal request made by their designated program contact.

The LOA will be sent to the Provider chosen following the development and approval of an Annual Staffing. The Annual Staffing will specify the services to be provided for the consumer. The Annual Staffing will be consumer specific; however, the Provider should not solely rely on the Annual Staffing for all pertinent information regarding the consumer. The Provider is encouraged to contact the QIDP if assistance is needed to obtain guardianship information, doctor’s orders, current medications, etc.

The consumer may change Providers at any time. Whenever a change of providers is requested within the service plan year a notice will be sent to the Provider in the form of a lapsed LOA which will specify the date services are to end. After the LOA is lapsed the Provider is no longer expected to provide services and will not continue to be paid for services rendered.

If the consumer requests a change of Providers at the end of their service plan year the QIDP will place a courtesy call to the Provider to inform them of the change.

Authorization of Services
The QIDP will anticipate the type and amount of service needed to meet the consumer’s needs. The Annual Staffing will outline the outcome for each service authorized. An Authorization Letter will be sent to the chosen Provider which includes the consumer’s name, the date services are authorized to begin, the quantity of services authorized, the lapse date for the Authorization (by when the services must be provided or will no longer be authorized), and the Authorization Number.
ICF-ID Services

- Audiology
- Counseling/Therapy
- Day Habilitation
- Dental
- Occupational Therapy
- Physical Therapy and Evaluations
- Speech and Language Pathology
Documentation

Provider must maintain records necessary to verify services delivered and billed to MHMRTarrant. Contact Notes must be completed for all services rendered. A correct contact note will have the following elements:

1. Documented on the correct/approved MHMRTarrant contact note;
2. Date, time and case number matches the claim form;
3. The data is complete;
4. Original signature(s) of the consumer/family member for each contact;
5. White out is never used;
6. Progress and/or lack of progress is noted and defined;
7. The contact is documented with adequate and sufficient detail as it relates to each outcome; and
8. The person providing the service is properly credentialed prior to service delivery (credentials include but is not limited to current insurance, training, background checks).

It is the expectation of MHMRTarrant that each Contracted Provider will initiate contact with each new referred person within 10 days of receiving the Letter of Authorization. Consistent and regular service provision shall be maintained for all authorized MHMRTarrant consumers. Provider staff will be fully responsible for the supervision of all MHMRTarrant consumers when they are providing services. No person shall be left unsupervised during service provision.

In the event that the Provider is unable to make contact with a person who is authorized for services, the Provider should utilize the “Monthly Summary of non-billable contact with Consumer” form (see forms). The completion of this form will be utilized by the Contract Monitors to communicate the number of failed attempts to contact the consumer so that if necessary, changes can be made to the PDP of the consumer.

Provider must provide copies of the following documentation to the Contract Monitor annually and/or as changes occur:

1. Names of all Staff employed by the Provider
2. Evidence of licensure, certification or accreditation, as required
3. Evidence of Life Safety Code or ADA inspection and compliance, if applicable
4. Evidence of insurance coverage
5. Evidence of annual criminal history checks of staff if performed by Provider
6. Evidence of required staff training
7. If MHMRTarrant consumers are paid by Provider, evidence of compliance with Department of Labor (DOL) regulations regarding salaries and pay
8. Fire Marshall inspection and results of fire drills
EMERGENCY PLAN

Provider will be responsible for completing an emergency plan for each program site that addresses relevant emergencies appropriate to the program site’s services, consumers, and geographic location.

The Emergency Plan will:

1. clearly identify the roles and responsibilities of specific staff during each type of emergency addressed in the plan;
2. include a process for a program site staff to contact the Quality Management Coordinator in a timely manner with details of an emergency, actions taken, and any future plans; and
3. include an evacuation plan for each type of emergency addressed by the plan,
   - which ensures reliable and available transportation,
   - an appropriate destination,
   - that staff are knowledgeable about consumers’ needs, and
   - allows for consumers to have access to their assistive devices.

If a provider is accredited/certified/licensed through a certifying body they will be exempt from this requirement and will only need to submit evidence that the program site has an emergency plan that has been reviewed and approved by the certifying body such as HCS DADS.

PROVIDER REQUESTS

Provider will be responsible for submitting the “MHMR Tarrant IDD Services Provider Requests” form (see forms) any time a change is requested regarding the consumer served. Changes may include increase in authorization units; lapsing services; and/or change/clarification of a training objective.

CAPACITY

Provider will determine and report their eligibility criteria and capacity for providing each service. If the Provider maintains a wait list for services, documentation will be submitted by the Provider regarding how that list is monitored. If the Provider fails to provide consistent service provision to all MHMRTarrant authorized consumers, a cap may be imposed on that Provider for that specific service until 100% of the consumers are served without interruption.

SUPPORTS FOR GR PDP PERSONAL OUTCOMES

The Service Coordinator is responsible for the Person Directed Planning process for GR consumers that empower the person/LAR to direct the development of a plan of supports and services that meet the person’s personal outcomes. The PDP will identify existing supports and services necessary to achieve the person’s outcomes as well as identify natural supports available to the person and negotiate needed services system supports.

Each Program Provider will be responsible for the development and implementation of the specific supports that will be put in place to assist the consumer with achieving their personal outcomes. Each Program Provider will receive a request for the specific supports once the PDP has been approved. This request will be sent electronically to each Program Provider and the Program Provider will be required to develop the specific supports. Each Program Provider will be required to return the specific supports for each outcome to the Contract Monitor for tracking and approval within 10 working days of the date of receipt. Failure to
return the specific supports by the specified due date may result in sanctions to the Program Provider’s contract.

CONFIDENTIALITY

Provider will retain protected health information and all records, reports, and source documentation related to service event data sufficient to support an audit concerning contracted expense and services, including work papers used to calculate individual costs for a minimum of six (6) years. Provider will receive, store, process, or otherwise deal with client information, if any, accessed or generated during services.

OPERATING PROCEDURES

Provider will share any operating procedures that may affect the consumers served with the designated Contract Monitor upon request. No operating procedures that are in violation with this contract, the definition of the service or training received will be acceptable.

MANAGEMENT OF VERBAL AND PHYSICAL AGGRESSIVE CONSUMERS

MHMRTarrant is committed to the safety of each consumer served as well as each staff member. If a staff person is in a situation with a consumer who begins to display agitation, the staff person will use communication first SAMA Assisting Process (or other similar DADS approved training) in attempts to de-escalate the situation. If the situation becomes too difficult for the staff to manage and there is threat of harm to anyone, the staff may use the SAMA Protection techniques (or other similar DADS approved training) to protect themselves and others.

Restraining/Containing a consumer is only to be used when there is a formal Behavior Supports program which includes containment or in an emergency situation. Restraint/Containment is only to be used by Provider employees who have completed training in SAMA Containment and Restraint (or similar DADS approved training).

If a consumer has been restrained, the Provider must immediately notify the consumer’s primary Case Coordinator/Service Coordinator/QIDP and the QM Coordinator. The incident report must be completed and faxed to the QM Coordinator at 817-569-5474 by no later than the end of the same business day that the restraint/containment occurred.
Claims and Billing

MHMRTarrant is monitored continuously by DADS for programmatic and financial compliance with the State Performance Contract. The programmatic responsibilities are shared with our Network of Providers; therefore when the Provider is in compliance, MHMRTarrant is in compliance. If MHMRTarrant is sanctioned financially by DADS due to an error by the Provider, MHMRTarrant may share those financial sanctions with the Provider. It is imperative that we work closely in order to maintain compliance with DADS requirements. MHMRTarrant follows the billing guidelines as outlined by DADS as well as documentation guidelines outlined by the Service Definition Manual. One essential element of the MHMRTarrant Performance Contract with DADS is the accurate and timely submission of data. The data for documentation of service provision is one area of focus. All data for service provision must be in compliance and submitted to the state within specified timeframes in order to avoid sanctions from DADS.

In order for MHMRTarrant to meet the requirements of the Performance Contract with DADS, each Provider must submit

1. A claim for services along with corresponding contact notes to MHMRTarrant no later than the 3rd business day following the month of service delivery.
2. Providers must ensure that all documentation submitted is in compliance with the Service Exhibits attached to the contract.
3. Claim forms must be completed accurately and completely.
4. Claims may be submitted either on a paper claim or electronically (also billing electronically).
5. All paper claims must have corresponding contact notes submitted with the claim form in order to ensure payment.
6. Electronic claims that are submitted must have corresponding contact notes submitted to the designated contact person no later than the 3rd business day following the electronic submission.

If the claim submitted by the Provider is not a clean claim the Provider must make the necessary corrections and return a clean claim by the 3rd business day of the following month in order to ensure payment. Questions regarding billing, claim format should be directed to the Business Office; questions regarding contact note documentation should be directed to the Contract Monitor.

Specific information is required on each MHMRTarrant consumer to process payment of the Claim:

1. The provider ID
2. The service date
3. The time the service started
4. The time the service ended
5. The service code of the covered service
6. The staff ID of the staff providing the service
7. The type of staff providing the service
8. The location where the service was provided
9. The client ID
10. The appointment type
11. The recipient code
12. The # of units provided
13. The total billed for each covered service
14. Original supporting documentation required to support billing for specific services with original signature of the person providing the service (as referenced in appropriate service exhibits)
15. Signature of provider and date
16. Completed and current supports for each personal outcome specified per Provider
Claims should be sent to:

**MHMRTarrant**  
**IDD Services Billing Department**  
1300 Circle Drive  
Fort Worth, Texas 76119

If the MHMRTarrant consumer has another payor for the service, the other payor (i.e. DARS, ISD, etc.) must be billed and benefits exhausted prior to billing MHMRTarrant for the services.

Payments will typically be made to Provider for Authorized Covered Services within thirty (30) days of receipt of the approved/completed claim for services. If required supporting documentation is not submitted, payments to the Provider will be denied. If required supporting documentation is not received by the specified timeframes as noted above payment will not be guaranteed. Included with the check for payment, Provider will receive an Explanation of Benefits (EOB) report showing which claims have been paid. Denied claims are included on the EOB showing paid claims.

If the Provider is not satisfied with the billing and payment services they receive they are encouraged to find resolution by following the MHMRTarrant informal processes:

1. **Claim Denial Letter Appeal**
   - To appeal the denial of claims listed on the Claim Denial Letter, the Provider should complete a Local Appeal Request (LAR) which should be submitted to the Claims Department for review and research within 10 calendar days of date on the Claim Denial Letter.
     - Claims Department contact information
     - Address:
     - FAX:
   - The Claims Department will review each LAR and will send a Letter of Determination or payment to the Provider within 10 calendar days of receipt of the LAR.
   - If the Provider continues to be dissatisfied with the resolution from the informal process; the Provider should submit a Formal appeal within 30 days from the date of the Letter of Determination as described below.

2. **EOB Appeal**
   
   An Explanation of Benefits (EOB) report is created when a specific claim has reached final status of denied or paid. All claims will be considered final unless Provider requests an adjustment in writing within thirty (30) days after receipt of payment from Local Authority. Formal appeals of claim denials must be made in writing within thirty (30) days of receipt of denial (date on the Explanation of Benefits (EOB) form) to:

   **Kevin McClean, Director of Contracts Management and Provider Relations**  
   **MHMRTarrant**  
   **P.O. Box 2603**  
   **Fort Worth, Texas 76113**
Billable Time Guidelines

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<td>2 hrs.</td>
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<td>6</td>
<td>=</td>
<td>¾ hr. = 40 min.</td>
<td>=</td>
<td>.75</td>
</tr>
</tbody>
</table>

Exceptions: The only exceptions for billing hourly services occur when Respite or Community Supports consumer transportation are provided. When hourly Respite is provided to more than one consumer, providers should not use the above formula and should bill the actual time each consumer received respite.

When Community Supports/Community First Choice (PAS/HAB) are provided to multiple consumers or when transportation involves multiple consumers the time billed for these events must be split. Providers will document the start time of the service event as the time the first consumer is picked up and the end time as the time the group of consumers reaches its destination. The duration of the total service time is multiplied by the number of staff transporting and then divided by the number of consumers transported. The formula for calculating billing is:

# of service providers X # minutes for transportation event ÷ # of consumers = billable time for each consumer

Billing Multiple Services Simultaneously

In some cases, two services covering the same time period may be billed if both services are actually delivered simultaneously. For example, an Occupational Therapist observes and assesses a consumer’s gross and fine motor skills while the consumer performs specific tasks at the Day Habilitation site. In this instance, the Occupational Therapist is assessing the consumer while the consumer is participating in the Day Habilitation program. The consumer is clearly the recipient of both Day Habilitation and Occupational Therapy services and both may be billed simultaneously. In another example, a nurse visits a Day Habilitation program and has a consumer accompany her to another office where she administers medication to the consumer. In this case, the consumer is not receiving two services simultaneously; at the time the consumer is receiving the medication, Day Habilitation services are not being provided. Consequently, the consumer should be signed out of the Day Habilitation activity while receiving the Nursing service and signed back in when he/she resumes participation in the Day Habilitation activity.
## CONTACT NOTIFICATION SHEET

<table>
<thead>
<tr>
<th>If this happens:</th>
<th>Then call:</th>
</tr>
</thead>
<tbody>
<tr>
<td>You believe that you or someone else is in immediate danger, get to a safe place and</td>
<td>• Call 911 immediately</td>
</tr>
</tbody>
</table>
| You believe that abuse, neglect, or exploitation of a consumer of any age has occurred in an MHMRTarrant facility or with a contracted provider | • Texas Department of Family and Protective Services (TDFPS) at 1-800-647-7418 within the hour  
• Secure the safety of the alleged victim     
• Obtain immediate and ongoing medical and/or other appropriate supports for the alleged victim  
• Restrict access by the alleged perpetrator to the alleged victim  
• Notify the alleged victim, the alleged victim’s Legally Authorized Representative (LAR) of the allegation report within 24 hours  
• Notify the QM Coordinator at 817-569-4044 of the allegation report within 24 hours  
• Cooperate with the TDFPS investigation                                                                                                 |
| You believe that abuse, neglect, or exploitation has occurred to a person with a disability of any age or a person who is 60 years or older at the hand of a person’s parent, husband, wife, boyfriend, girlfriend or roommate | • TDFPS (formerly known as APS) at 1-800-252-5400  
• TDFPS (formerly known as CPS) at 1-800-252-5400  
• Contact the Domestic Violence Hotline 1-800-799-7233  
• Complete a Contractors Incident Reporting Form (fax 817-569-5474)                                                                 |
| You become aware of any of the following in a non-crisis situation:               | • MHMRTarrant Service Coordinator/Case Manager/QIDP; and  
• The QM Coordinator at 817-569-44044 within 24 hours  
• Complete a Contractors Incident Reporting Form (fax 817-569-5474)  
• Follow all other identified steps according to any other contractual obligations                                                                 |
| • a consumer dies  
• news media coverage is likely  
• a consumer threatens Homicide with a plan  
• a consumer attempts Homicide  
• a missing person police report is filed  
• there is a Catastrophic Event such as a bomb threat, explosions, or major fire which involves MHMRTarrant consumers  
• there is a litigation threat from a MHMRTarrant consumer or staff, family/guardian involving an MHMRTarrant consumer (if someone is threatening to sue)  
• a consumer is restrained/contained  
• you are notified by TDFPS that an investigation will be occurring regarding MHMRTarrant consumer | If any of the incidents occur as a crisis situation, of course, follow your crisis plan.                                                                 |
| You restrain/contain a consumer in accordance with a written Behavior Support Plan | • Notify the person who wrote the Behavior Support Plan within one hour of implementing the restraint/containment.                                                                                           |
| If you become aware of any of the following:                                    | • MHMRTarrant Service Coordinator/Case Manager/QIDP; and  
• The QM Coordinator at 817-569-4044 within 3 working days                                                                                           |
| Consumer was injured and required treatment by a Nurse, Doctor, EMS or Emergency Room |
| Consumer was injured but did not require ER treatment |
| 911 Called regarding an MHMRTarrant consumer |
| Physical Aggression by an MHMRTarrant consumer (forceful or hostile actions with intent to harm self/others or property) |
| Work Related Injury |
| Psychiatric Admission |
| Illegal Substances that are being used/found/reported |
| Sexual Misconduct |
| Auto Accident Involving Consumers |
| Consumer’s financial loss |
| Criminal activity by or against a consumer |
| Medication error |
| Possible exposure to infectious diseases |
| Self-Abusive Behavior |

| A Provider is not in compliance with MHMRTarrant’s Compliance Plan related to billing, contracting, ethics and following federal, state or contract guidelines |
| Complete a **Contractors Incident Reporting Form** (fax 817-569-5474) |

| MHMRTarrant’s Compliance Line, answered 24/7 at 1-800-500-0333 |
Contractor Staff Training Agreement

Scheduling Training with Training & Development Department of MHMR Tarrant
Provider is responsible for ensuring all required training is received. Provider may meet training requirements by either using the provided MHMR Tarrant Training Packet or purchasing required training from the Training & Development Department. Upon request, the Training & Development Department will provide a calendar of monthly training opportunities to the Provider. Provider may register staff for classes by calling at (817) 569-4342 prior to the scheduled class or emailing training.requests@mhmrtc.org. “Registration for classes are on a first come first serve basis and class sizes are limited. If a class is full another date will be provided. Payment is due prior to the class via credit card in person or over the phone. Provider will be billed for any persons registered for classes who do not attend. If the Training & Development Department must receive a cancellation notice by phone call or email at least forty-eight (48) hours prior to the scheduled class no charges will be applied.

Required (Initial/Annual) Training Elements for Unlicensed Contractors/Staff:

- Competency in the safe management of verbally and physically aggressive behavior (verbal SAMA)
- American Heart Association CPR
- American Heart Association First Aide
- Recognition, Reporting, and preventing abuse, neglect, and exploitation
- Infectious and communicable diseases
- MHMR Tarrant Compliance Plan
- Client Rights
- Self-Administering of Medications
- Charting and Observation
- Privacy/HIPPA
- Risk Management and Incident Reporting
- Environmental Safety for Individuals with Developmental Difficulties
- Customer Relations
- Hazardous Chemicals
- Any other Program specific trainings

The Training & Development Department of MHMR Tarrant offers a variety of training opportunities for any Provider who desires to participate. The Training & Development Department has a learning management system with a library of online courses that provide CEU certificates for specific disciplines.

Attached you will find the training cost sheet that lists some trainings offered and costs (please note pricing may change without notification).

Provider will be sent an invoice monthly for all training provided with a copy of the training record attached. Payment is expected prior to the class being taken.
<table>
<thead>
<tr>
<th>Class</th>
<th>Course Name</th>
<th>Cost for MHMR Contractors</th>
<th>Cost to Participant if cancels less than 24 hours</th>
<th>Credit Hours</th>
<th>Frequency for Employees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse</td>
<td>AB</td>
<td>$20.00</td>
<td>$20.00</td>
<td>2</td>
<td>Annual refresher</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>On-line course self paced Prerequisite for CLRT 101</td>
</tr>
<tr>
<td>Client/Patient Rights</td>
<td>CLR101</td>
<td>$20.00</td>
<td>$20.00</td>
<td>2</td>
<td>Annual refresher</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>On-line course self paced Prerequisite for CLRT 101</td>
</tr>
<tr>
<td>Clients Rights</td>
<td>CLRT101</td>
<td>$30.00</td>
<td>$30.00</td>
<td>3</td>
<td>One time only class</td>
</tr>
<tr>
<td>Confidentiality/Privacy/HIPAA</td>
<td>CH101</td>
<td>$30.00</td>
<td>$30.00</td>
<td>3</td>
<td>Annual Refresher</td>
</tr>
<tr>
<td>CPR- Heart Saver First Aid/Seizures adult/child/AED</td>
<td>CPRN400</td>
<td>$50.00</td>
<td>$50.00</td>
<td>6</td>
<td>Class-Room</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Every 2 years</td>
</tr>
<tr>
<td>CPR- Healthcare provider for MD's and RN's</td>
<td>CPRN300</td>
<td>$40.00</td>
<td>$40.00</td>
<td>4</td>
<td>Class-Room</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Every 2 years</td>
</tr>
<tr>
<td>Case Management Basics</td>
<td>CASEMG101</td>
<td>$30.00</td>
<td>$30.00</td>
<td>3</td>
<td>One-time</td>
</tr>
<tr>
<td>Deficit Reduction ACT</td>
<td>DRA101</td>
<td>$10.00</td>
<td>$10.00</td>
<td>1</td>
<td>Annual Refresher</td>
</tr>
<tr>
<td>Hazardous Chemicals</td>
<td>HC101</td>
<td>$15.00</td>
<td>$15.00</td>
<td>1.5</td>
<td>One-time</td>
</tr>
<tr>
<td>Infection Control</td>
<td>ICP1</td>
<td>$20.00</td>
<td>$20.00</td>
<td>2</td>
<td>Annual Refresher</td>
</tr>
<tr>
<td>Lifting and Transferring</td>
<td>BSAF101</td>
<td>$20.00</td>
<td>$20.00</td>
<td>2</td>
<td>One time</td>
</tr>
<tr>
<td>Defensive Driving- TEA</td>
<td>DDING100</td>
<td>$30.00</td>
<td>$30.00</td>
<td>6</td>
<td>Class-Room</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Every 3 years (adjusted cost-avg)</td>
</tr>
<tr>
<td>Environmental Safety for Individuals with Disabilities</td>
<td>ESIDD1001</td>
<td>$30.00</td>
<td>$30.00</td>
<td>3</td>
<td>Annually</td>
</tr>
<tr>
<td>Infection control Part 1/2</td>
<td>ICP1/2</td>
<td>$20.00</td>
<td>$20.00</td>
<td>2</td>
<td>Annually</td>
</tr>
<tr>
<td>Observation and Documentation</td>
<td>OBD100</td>
<td>$20.00</td>
<td>$20.00</td>
<td>2</td>
<td>One -time</td>
</tr>
<tr>
<td>Pharmacology</td>
<td>PH100</td>
<td>$20.00</td>
<td>$20.00</td>
<td>2</td>
<td>Every 3 years</td>
</tr>
<tr>
<td>Self Administration of Meds</td>
<td>SAM100</td>
<td>$20.00</td>
<td>$20.00</td>
<td>2</td>
<td>Every 3 years</td>
</tr>
<tr>
<td>SAMA- Assisting</td>
<td>SAMA100</td>
<td>$30.00</td>
<td>$30.00</td>
<td>4</td>
<td>Annual</td>
</tr>
<tr>
<td>SAMA- Assisting and protection</td>
<td>SAMA100/200</td>
<td>$50.00</td>
<td>$50.00</td>
<td>7</td>
<td>Annual</td>
</tr>
<tr>
<td>SAMA-Assisting/ protection/ containment</td>
<td>SAMA100/300</td>
<td>$60.00</td>
<td>$60.00</td>
<td>8</td>
<td>Annual</td>
</tr>
</tbody>
</table>

Group Rates can be negotiated based on contract, MOU and number of participants.
Complaints

Complaints from Consumers
All consumers receiving services will be informed of their right to file a complaint. MHMRTarrant desires a Network of Providers who provide quality services. At any time a consumer is unhappy with the services provided they will be encouraged to voice their concern. The consumer, or Service Coordinator/Case Manager/QIDP on the consumer’s behalf, will report their dissatisfaction to the designated Contract Monitor for investigation. The Provider will be notified of all concerns for collaboration of a resolution to satisfy all involved.

Consumers should call to report compliance concerns to the

- **Compliance Action Line:**
  1-800-500-0333

Consumers should report all complaints about the services received and rights issues to the

- **Consumer Complaint Reporting Line:**
  (817) 569-4367
  or
  1-888-636-6344 (toll free)

Consumers should call to report abuse/neglect/exploitation to

- **Texas Department of Family and Protective Services**
  1-800-647-7418 or [www.txabusehotline.org](http://www.txabusehotline.org)

Complaints from Provider
MHMRTarrant desires a successful partnership with Providers to best serve the Consumers. To this end, MHMRTarrant encourages Providers to call with concerns, problems and complaints regarding MHMRTarrant operations and interactions with the Provider. Every effort will be made to address the issues involved.

All complaints and/or suggestions by the Provider should be directed to the

- **Provider Relations Department:**
  (817) 569-4456.
Medications

Each Consumers medications (both prescription and over the counter) must be stored separately from other Consumers’ medications. Medications for internal use must be stored separately from those intended for external use. A locked storage container must be available for medication storage and if a medication requires refrigeration, it must be separated from food in a clearly labeled, designated locked container. Avoid storing medication in locations with extreme heat, cold, or moisture. Prescription medications must be in the original container, labeled with the individual’s name, date, instructions, name of medication, dosage, and physician’s name.

Programs which are licensed must meet the requirements of those licenses with regard to medication storage, handling, administration and documentation.

For programs which are not licensed, medications may be administered only by persons licensed under state law to administer medication or in accordance with rules of the Board of Nurse Examiners that permit delegation of the administration of medication to unlicensed care givers.

Site-based programs which are not licensed, but which supervise Consumers who self-administer must minimally have staff trained in MHMRTarrass Supervising the Self-Administration of Medication classes and provide on site verification of staff competency, by RN, Physician or pharmacist. Provider retains liability for handling, storage, and documentation of medications in its possession. It is recommended that Provider have a Consulting RN who performs medication counts (to verify accurate self-administration), verifies physician orders and verifies staff competency with regard to self-administration and documentation.

In all Site-based programs in which medications are administered or in which self-administration is supervised, a copy of the physician’s orders for all current medications must be kept in the Consumers record on site.

Assessment of Consumers Ability to Self Administer Medications

Provider must administer medications according to their license requirements. If medications are not administered by a licensed nurse, regulations from the Texas State Board of Nurse Examiners regarding RN delegation of administration of medications to unlicensed personnel must be followed.
Quality Management

Provider will comply with the most current DADS Standards relating to the delivery of IDD services.

The IDD Quality Management staff will conduct focused record reviews to determine possible training opportunities as well as voids in our Network System to include services provided by Contracted Providers. The result of these reviews will be shared with the Contract Monitors if there are issues that need to be addressed. IDD Quality Management staff will conduct random quality of service satisfaction calls to consumer/families to determine the level of satisfaction with each Contracted Provider. The results of these interviews will be shared with each Provider if appropriate. All unsatisfactory results will be shared with the expectation of prompt resolution. Unsatisfactory results over the course of the contract which is below 80% may result in cancellation of the contract.

The Provider is responsible for recording and sending incident reporting data to the MHMRTarrant IDD Quality Management Coordinator. The IDD Quality Management staff will maintain, track and train on incident reporting data.

Contract Monitoring

It is MHMRTarrant desire to have a cohesive, competent Network of Providers. In order to facilitate the best Network of Providers possible MHMRTarrant has designated staff to serve as Contract Monitors. Each Provider will have an assigned Contract Monitor that will be available to provide training and technical assistance on an as needed basis. The following activities are some of the responsibilities of the Contract Monitor:

1. Receive/review progress notes for accurate, appropriate, and billable documentation.
2. Follow-up with each provider if there are problems with progress notes.
3. Ensure each provider maintains current insurance.
4. Ensure each provider maintains current staff training.
5. Ensure background and registry checks are completed for all provider staff.
6. Ensure each provider maintains current credentials if appropriate.
7. Conduct annual site visit reviews for each site based provider to include Infection Control, Safety and Environmental Reviews.

Each Provider will be responsible for ensuring the Contract Monitor has current contract requirement documentation prior to the expiration of such documentation. The contract requirements include insurance, staff training, and background checks. Contract sanctions may be imposed if such documentation is not provided.
Sanctions, Appeals and Contract Termination

MHMRTarrant will take action for events that pose a hazard to Consumers or potentially violate service guidelines.

Sanctions

MHMRTarrant will impose sanctions if the Provider does not maintain quality services in compliance with this contract, as well as state and federal standards. Notice of Default or Notice of Termination will be sent by certified mail to the Provider. Sanctions may include, but are not limited to:

a. Immediate termination of contract
b. Withholding of new referrals
c. Withholding of outstanding payments, in whole or in part
d. Request for recoupments of funds paid to the Provider for services
e. Fines, charge backs or offsets against future payments
f. Suspension of contract and referral of existing Consumers elsewhere, pending appeal
g. Determination of specific training/retraining for Provider staff

Appeal Process
If the Provider wishes to appeal a decision by MHMRTarrant to impose a sanction, the Provider must notify The Director of Contracts Management/Provider Relations in writing within seven (7) days of receipt of a Notice of Default or Notice of Termination of the request for appeal. If the Provider has additional information, not taken into consideration at the time the Sanction was imposed, documentation must be submitted with the request for appeal. Correspondence must be sent to:

Kevin McClean, Director of Contracts Management/Provider Relations
MHMRTarrant
P.O. Box 2603
Fort Worth, Texas 76113

Contract Termination

If the Provider elects to terminate the relationship with MHMRTarrant and no longer provide services to MHMRTarrant Consumers the Provider may terminate the Contract with a thirty (30) day written notice.

If the contract is terminated, the Provider is expected to cooperate with MHMRTarrant in the transfer of Consumers to other providers.
Requisite Rules & Regulations

Provider is responsible for ensuring that it and its employees read, understand and abide by the information contained in this Provider Manual, the contract, the Training packet as well as the following materials:

IDD Priority Population Definition:
The DADS priority population for IDD services consists of individuals who meet one or more of the following descriptions:

- Persons with IDD, as defined by Texas Health and Safety Code §591.003;
- persons with pervasive developmental disorders, as defined in the current edition of the Diagnostic and Statistical Manual, including autism;
- persons with related conditions who are eligible for services in Medicaid programs operated by the department, including the ICF/ID, HCS, and PASSR programs;
- nursing facility residents who are eligible for specialized services for IDD or a related condition pursuant to Section 1919(e)(7) of the Social Security Act; or,
- children who are eligible for services from the Early Childhood Intervention Interagency Council.

The determination of IDD, pervasive developmental disorders and related conditions must be made through the use of assessments and evaluations performed by qualified professionals. A member of the priority population for IDD services may not be eligible to receive all IDD services funded by the department. (For example, a person with related conditions may not be programmatically eligible for certain services or a person with IDD may not be eligible for a service because it is not appropriate for the individual’s level of need.) Admission to IDD services is based on an individual’s need and eligibility for a particular service, in accordance with the rules and policy of the department.

Texas Administrative Code:
Rules of the Texas Department of Mental Health and IDD Title 40, Part I
(Note: Rules may be accessed at www.state.tx.us or you may request a printed copy from MHMRTarrant.)

Relevant Rules Grid

Chapter 4, Subchapter A ......................... Protected Health Information
Chapter 4, Subchapter C ......................... Rights of an Individual with ID
Chapter 2, Subchapter A ......................... Notification and Appeals Process
Chapter 2, Subchapter C ......................... Charges for Community Services
Chapter 4, Subchapter L ......................... Abuse, Neglect, and Exploitation in Local Authorities and Community Centers
Chapter 1, Subchapter G ........................ Community Centers
Chapter 2, Subchapter L ......................... Service Coordination for Individuals with an ID
Chapter 2, Subchapter F ......................... Continuity of Services - State Facilities
Chapter 2, Subchapter G ......................... Role and Responsibilities of a Local Authority
Chapter 5, Subchapter D ......................... Diagnostic Eligibility for Services and Supports - IDD Priority Population and Related Conditions
Chapter 4, Subchapter K ......................... Criminal History and Registry Clearances
Forms
**EMPLOYEE CREDENTIALING REQUIREMENTS**

**IDD PROVIDER SERVICES**

The following documentation must be current and on file with MHMRTarrant Contract Services prior to provider performing any service with MHMRTarrant consumers and prior to provider being reimbursed for services provided.

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Program Provider must have a minimum of three years’ work experience in planning and providing direct services to people with an intellectual disability as verified by written professional references.</td>
<td>No potential contractor will be considered if there has been any confirmed abuse, neglect, or exploitation within the past 5 years.</td>
</tr>
<tr>
<td>Participation in new Contractor orientation training (service definitions, billing, expectations of a provider as outlined in this Provider Manual, strategies, service provision expectations, etc.)</td>
<td>Submission of a comprehensive emergency plan for all site-based service sites.</td>
</tr>
</tbody>
</table>
| Submission of training of the Provider Manual for each staff person within 30 days of contract initiation. | Documentation of one of the following:  
  - Copy of high school or college diploma,  
  - GED, or  
  - Competency-based assessment of the ability to document service delivery and observations of the individual 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 individual being served |
| Documentation that provider is at least 18 years of age: |  
  - Copy of driver’s license  
  - Texas ID, or  
  - Birth Certificate |
| If provider transports consumers: |  
  - Copy of current driver’s license, AND  
  - Current Auto Liability Insurance  
  - Current license and insurance must be present prior to reimbursement of services where provider transported consumer. **If the provider did not have liability insurance at the time consumer was transported, the claim will not be paid** |
| Documentation of current home owner’s insurance (if provider provides respite in their home) |  
  - Current insurance must be present prior to reimbursement of services when respite occurs in the provider’s home  
  - Documentation of certification as a foster home by an authorized entity (CPS, HCS, etc). |
| Documentation of criminal background check using all known names and aliases |  
  - Must be conducted prior to contact with consumer and annually thereafter  
  - If the person has been convicted of an offense that bars employment under THSC 2503006, they cannot work with MHMRTarrant consumers and any service performed by them will not be reimbursed |
| Employee Misconduct Registry |  
  - Must be conducted prior to contact with consumer and annually thereafter  
  - A person who is designated in the registry as having abused, neglected, or mistreated a consumer of a facility or has misappropriated a consumer’s property may not work with MHMRTarrant consumers and any service provided by them will not be reimbursed |
| Nurses Aid Registry |  
  - Must be conducted prior to contact with consumer and annually thereafter  
  - A person who is designated in the registry as having abused, neglected, or mistreated a consumer
of a facility or has misappropriated a consumer’s property may not work with MHMRTarrant consumers and any service provided by them will not be reimbursed

**CANRS**
- Must be conducted prior to contact with consumer and annually thereafter
- A person who is designated in CARE may not work with MHMRTarrant consumers and any service provided by them will not be reimbursed

**Documentation of the following training**
- Consumer Rights Training (Annually)
- Prevention of Abuse and Neglect Training (Annually)
- Management of Aggressive Behaviors (Annually)
- Confidentiality/HIPPA (Annually)
- Compliance (Annually)
- Infection Control (Annually)
- CPR (As per the certificate)
- First Aid (As per the certificate)

---

**PROVIDER CREDENTIALING REQUIREMENTS**

**IDD SERVICES**

The following documentation must be current and on file with MHMRTarrant Contract Services prior to provider performing any service with MHMRTarrant consumers and prior to provider being reimbursed for services provided.

<table>
<thead>
<tr>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current liability insurance for no less than the value of the contract with MHMRTarrant as an additional insured</td>
</tr>
<tr>
<td>Current auto liability insurance (if the provider or employees provide transportation for consumers)</td>
</tr>
<tr>
<td>Annual Life Code safety inspection (if site based services are provided)</td>
</tr>
<tr>
<td>Annual Fire safety inspection (if site based services are provided)</td>
</tr>
<tr>
<td>Quarterly Fire and Safety Drills (if site based services are provided)</td>
</tr>
<tr>
<td>Current Department of Labor Certificate Authorizing Special Minimum Wage Rates (if site based services are provided and consumers are participating in contract work)</td>
</tr>
<tr>
<td>Certificate of Occupancy (if site based services are provided)</td>
</tr>
<tr>
<td>Any other applicable licenses or certificates as appropriate to comply with local, state, and federal codes (Pet licenses, ADA, etc)</td>
</tr>
</tbody>
</table>
MHMRTarrant

Consumer: _________________________
Case #: _________________________
Medicaid #: _________________________

MONTHLY SUMMARY of non-billable contact with Consumer

<table>
<thead>
<tr>
<th>Date</th>
<th>Contact/Activity Log</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

Provider Signature/Date
MHMRTarrant  
IDD Contractor Services  

Texas Health and Safety Code, Chapter 250 Compliance  
Provider Employee/Volunteer Background Checks  

Provider Name:  

Employee Name: Last:                                  First:                                        Middle:  
Date of Birth:  
SS#: or SS# is on file with contractor □ Yes □ No  
Driver’s License or TDPS ID#:  
Employment Status □ Full-Time □ Part-Time □ Volunteer □ Student/Intern  

Criminal History Background Check:  
All employees and volunteers who have direct contact with MHMRTarrant consumers must have a  
criminal history record check obtained from the Texas Department of Public Safety (TDPS) within one  
year prior to contact with consumers and annually thereafter. Anyone who has been convicted of any of  
the offenses referred to in Chapter 250.006-Convictions Barring Employment and Chapter 31-Penal  
Code, or the Provider Agreement may not have any contact with MHMRTarrant consumers.  

Date Performed:                             Performed by:                                   Title:  
Results: □ Clear-No record on file □ N/A-Records found but are not above named individual  
□ Record on file-Does not bar employment □ Record on file-bars employment  
Comments: ________________________________________________________________  

Client Abuse and Neglect Reporting System (CANRS):  
All employees and volunteers who have direct contact with MHMRTarrant consumers must have a  
CANRS check obtained from the CARE system prior to working with MHMRTarrant consumers and  
annually thereafter effective during FY10. Anyone who has a record on this system may not be eligible  
to work with MHMRTarrant consumers.  

Date CANRS search done:_______________Performed by:_________________Title_______________  
Eligibility Determination:  : □ Eligible □ Not Eligible  
Comments: __________________________________________________________________________  

Employee Misconduct Registry and Nurse Aid Registry:  
All employees and volunteers who have direct contact with MHMRTarrant consumers must have a search  
of the Department of Aging and Disability Services (DADS) Employee Misconduct Registry and Nursing  
Aid Sanctions Database conducted prior to initial conduct and annually thereafter. Any individual listed  
in the database as unemployable due to a finding of abuse, neglect, exploitation, or misappropriation of a  
consumer’s property or misconduct, may not have any contact with MHMRTarrant consumers.  

Date EMR/NAR search done:       Performed by:       Title:  
□By website: (http://www.dads.state.tx.us/business/ltcr/credentialing/sanctions/index.cfm)  
□By Voice Information Processing System: (1-800-452-3934)  
Eligibility Determination: □ Eligible □ Not Eligible  
Comments: ________________________________________________________________
MHMRTarrant IDD Services
Provider Requests

Please complete and fax to your Contract Monitor (817) 569-5496

<table>
<thead>
<tr>
<th>Provider:</th>
<th>Provider Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer:</td>
<td>Consumer ID#</td>
</tr>
</tbody>
</table>

Program Type:  □ GR □ PASRR □ HCS □ ICF-MR

| Service Type | □ DH □ CS □ EA □ SE | Service Coordinator: |

**Request Type**

- [ ] Increase Service Units / #Units Requested _____________
- [ ] Decrease Units / #Units requested _____________

TOTAL # of units on plan: _____________

Justification for Increase/ Decrease:

- [ ] Request Lapse of Service:  Justification for Lapse of service:

- [ ] Change in Objective and Justification:
  Current Objective:

  Proposed Objective:

- [ ] Need updated contact information on consumer/ LAR

- [ ] Other:

**Contract Office:**

Date received in Contract Monitoring ________________

Forwarded to Program Manager on ________________

Forwarded to SC on ________________

revised: March 2015
Local Appeal Request

Name: ____________________________

Address: __________________________

Phone Number: _______________________

Best Time to reach me: ________________________  □ AM  □ PM

I wish to appeal the denial of the following service(s):

Check appropriate service(s):
□ Day Habilitation
□ Respite
□ Community Support
□ Other: ____________________________

Please write a detailed reason for the Appeal (If more space is needed, add additional sheet):

_______________________________________________________________________________________

Signature of Provider

Date

Return this form to: MHMRTarrant Claims Department.
1300 Circle Dr.
Fort Worth, Texas  76119

Comments/Findings:

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________
Date:

To:

Regarding Consumer (s):
Date of Event(s):
Type of Event:

The attached claim is being returned for the following reason:

Insufficient documentation

Explanation:

If the claim submitted by the Provider is not a clean claim the Provider must make the necessary corrections and return a clean claim by the 3rd business day of the following month in order to ensure payment. If the corrected claim is not received within this time frame it will not be considered for payment.

Please return corrections no later than____________________ .
Claim Denial Letter

Date:

To:

Regarding Consumer(s):
Date of Contact(s):
Type of Contact:

The attached claim is being **denied** for the following reason:

☐ Inaccurate documentation reflected on claim form and in notes

Explanation:


Or

☐ Claim form and notes were submitted after the 3rd business day of the month.

Claims Department
Original notes and claim forms are enclosed

IDD Business Services
1300 Circle Drive • Resource Connection • Fort Worth, Texas 76119 • 817-569-4141
MHMRTarrant
IDD Restraint Checklist
(To be attached to the Incident Report)

Consumer Name: _____________________________   ID# _____________   Medicaid: _______________

Program Name: ____________________  RU/Contract ID: _______________  Date: __________________

1. Reason for Restraint: Describe the behavior(s) by the consumer that led to the restraint:
   __________________________________________________________________________________________
   __________________________________________________________________________________________
   __________________________________________________________________________________________
   __________________________________________________________________________________________

2. Describe what happened just before the behavior:
   __________________________________________________________________________________________
   __________________________________________________________________________________________
   __________________________________________________________________________________________

3. Where did the restraint(s) happen? Please be specific:
   __________________________________________________________________________________________

4. How many times was the consumer restrained? (Each time the consumer is released and restrained again
counts as a separate restraint)
   __________________________________________________________________________________________

5. For each restraint provide the following: Use another page if more room is needed.

   Exact time the restraint was applied: _______ am/pm   Exact time restraint was removed
   _______am/pm
   Exact time the restraint was applied: _______ am/pm   Exact time restraint was removed
   _______am/pm

6. What type of restraint was applied? Be specific as to what parts of the body were held and how.
   __________________________________________________________________________________________

7. Was the restraint(s) part of a behavior therapy program? [ ] Yes [ ] No

8. Was the consumer injured as a result of the restraint? [ ] Yes [ ] No

9. Describe what less restrictive methods were attempted before restraint was used:
   __________________________________________________________________________________________

10. What was the consumer required to do before he/she was released?
    __________________________________________________________________________________________

11. Who told the consumer what was required for release? (Staff’s name)
    __________________________________________________________________________________________

12. What is the name or names of the staff who applied the restraint?
    __________________________________________________________________________________________
Signature/Title of Person Completing Checklist    Date

Signature-Nurse    Date

Signature Primary Case Coordinator    Date

Signature-Psychologist    Date

☐ Observation Notes Completed    ☐ Doctor’s Orders received for emergency restraint
☐ Behavior Management Data Sheet Completed (as necessary)
Incident Reporting Form

“Check all items on form that apply.”

- GR
- TxHmL
- HCS
- ICF/IDD
- Vocational

- Internal
- External
- Other:

**Persons residence:** (Street/City)  TX

**Date of completion:**
**Time completed:**  □ AM  □ PM

**Incident Place:**
**Staff Name/ID#:**
**Address:**
**Contact Phone#:**  Reporting unit#/Provider:

**Persons involved in incident:**

**Person reporting/Title:**
**Reporting Unit#/Provider:**

**Event Date:**  /  /  **Event Time:**  □ AM  □ PM  □ Occurred  □ Discovered

1. *Incident reports should be routed to the Program Director.*
2. *All reports that have a shaded area checked should be routed to Quality Management Coordinator.*
3. *Must be reported within 24 hours of witnessing or having knowledge of the incident.*

**Critical Event:**

- Client injury requiring ER
- Death
  - natural
  - unusual
- Suicide
- Homicide
- 911 Called by Staff
- Medical
- Behavioral/Psychiatric
- Both
- Arrest
- Restraint
  - physical
  - mechanical
  - chemical
- ER/Hospital Admission
  - medical
  - behavioral/psychiatric
  - both
- Missing person
  - (police report filed)

**Client Related Incident:**

- Abuse/Neglect/Exploitation
- Client injury not requiring ER
- Physical aggression
- Client property/financial loss
- Eloping
- Medication error
- Criminal activity
- Work related injury
- Illegal substances
- Sexual misconduct
- Self-abusive behavior
- Suicide attempt
- Suicide threat with plan
- News media coverage likely
- Homicide threat with a plan
- Homicide attempt (by client)
- Perpetrator of homicide (client)
- Catastrophic events — (Bomb threat, explosion, major fire)
- Litigation threat — (Client, staff, family/guardian, etc.)
- Other:

**Facility Related Incident:**

- Agency property damage/financial loss
- Auto Accident
- Fire at facility
- Complaints — (Client’s, family/guardian, etc.)
- Other:

**Staff Related Incident:**

- Staff death
- Staff injury (Must complete first report of injury [k:drive])
- Staff financial loss
- Staff infectious diseases
- Staff criminal activity
- Staff illegal substance abuse
- Staff auto accident in personal car while on duty
- Other:

**Medication Errors:**

- Person’s involved:
  - Consumer
  - Family
  - Pharmacist
  - Physician
  - Nurse
  - Staff

**Medication Error Type:**

- Wrong medication
- Wrong client
- Wrong dose
- Missed dose
- Wrong time

Total # errored
**Description of event/medication error:** (For medication errors list medication error, name of medication, intended dose, actual dose administered)  
Use addendum page if necessary.
<table>
<thead>
<tr>
<th>Person/Date/Time of those notified:</th>
<th>Last Name:</th>
<th>Medicaid #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Case Manager/QIDP/Habilitation Supervisor/Service Coordinator</td>
<td>Date:</td>
<td>Time:</td>
</tr>
<tr>
<td>□ Home Manager/Habilitation Trainer</td>
<td>Date:</td>
<td>Time:</td>
</tr>
<tr>
<td>□ Nurse Name:</td>
<td>Date:</td>
<td>Time:</td>
</tr>
<tr>
<td>□ Psychologist</td>
<td>Date:</td>
<td>Time:</td>
</tr>
<tr>
<td>□ Program Manager</td>
<td>Date:</td>
<td>Time:</td>
</tr>
<tr>
<td>□ Parent/Guardian</td>
<td>Date:</td>
<td>Time:</td>
</tr>
<tr>
<td>□ Physician</td>
<td>Date:</td>
<td>Time:</td>
</tr>
<tr>
<td>□ Program Director</td>
<td>Date:</td>
<td>Time:</td>
</tr>
<tr>
<td>□ Contract Services</td>
<td>Date:</td>
<td>Time:</td>
</tr>
<tr>
<td>□ Provider Name:</td>
<td>Date:</td>
<td>Time:</td>
</tr>
</tbody>
</table>

Follow-up Comments and Signatures:

Voc/Hab Supervisor/Home Manager Signature: Date: Comments:

Nurse Signature: Date: Comments:

Psychologist Signature: Date: Comments:

Case Manager or QIDP Signature: Date: Comments:

Program Manager Signature: Date: Comments:

Director Signature: Date:
PERSONAL REFERENCE QUESTIONNAIRE
Agency: ____________________________

Applicant: Please give this questionnaire to someone with whom you have had a personal or professional relationship within the past five (5) years and who is familiar with your work. Three references are required.

Personal reference being provided for: _________________________________________________

Reference provided by: ________________________________________________________________

Place of Employment (optional): _________________________________________________________

Street Address: _________________________________________________________________

City __________________ State __________ Zip Code __________
Phone __________________ Fax __________________

How long have you known this individual? ___________________________________________

Briefly describe the circumstances through which you have current knowledge of the individual’s skills and competence: _________________________________________________________________

Please rate the individual on each element below:

<table>
<thead>
<tr>
<th>Element</th>
<th>Above Average/Excellent</th>
<th>Average</th>
<th>Below Average</th>
<th>No Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsiveness to consumer needs</td>
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<tr>
<td>Thoroughness in care</td>
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<tr>
<td>Quality/appropriateness of consumer care outcomes</td>
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<tr>
<td>Resource use</td>
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<tr>
<td>Rapport with consumers</td>
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<td></td>
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<tr>
<td>Personal ethics</td>
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Do you have direct knowledge of any physical/emotional/mental health problems, including alcohol or drug dependencies, or other problems which impair the person’s ability to perform the essential functions of consumer care, with or without accommodation?

☐ Yes ☐ No

If yes, please explain:
____________________________________________________________________________________

____________________________________________________________________________________

I believe that this person can provide a safe and healthy environment for the individuals served by this agency.

☐ Yes ☐ No

__________________________________________  ________________________________
Signature                                      Date

Return this form to your Contract Monitor.
MHMRTarrant
1300 Circle Dr.
Fort Worth, TX  76119
Please read the following scenario and fully complete the attached Contact Note to document this scenario as if you provided the service yourself. The goal of this assignment is to assess your competency in documenting services provided. Please complete all 18 elements.

On May 13, 2015 you went to Sue’s house at 3:30 p.m. to provide community supports. Sue’s PDP directs you to assist Sue with learning how to clean her kitchen. Upon your arrival you notice that Sue has not cleaned her breakfast or lunch dishes and she has left food items out on her counter. You tell Sue that it is time to work on her community support objective and instruct her to clean her kitchen. Sue begins to talk about her desire to get a dog. You must redirect Sue several times by telling her specifically what needs to be cleaned in her kitchen. After 5 verbal prompts, Sue has cleaned the dishes and put the food items away in the refrigerator. You leave Sue’s home at 5:00 p.m.
GR Community Support Contact Note

Provider: ___________________________ Date of Service: ___________________________

Personal Outcome(s):

Support(s):

<table>
<thead>
<tr>
<th>Training 1</th>
<th>Training 2</th>
<th>Training 3</th>
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<tbody>
<tr>
<td># of trials</td>
<td># of trials</td>
<td># of trials</td>
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<table>
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<tr>
<th>Type of Prompts</th>
<th>Type of Prompts</th>
<th>Type of Prompts</th>
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</thead>
<tbody>
<tr>
<td># Prompts given</td>
<td># Prompts given</td>
<td># Prompts given</td>
</tr>
</tbody>
</table>

Progress toward Outcome:

☐ progress made       ☐ progress not made
☐ refused to participate ☐ objective not addressed

Time In: _____:______ ☐ AM ☐ PM  Time Out: _____:______ ☐ AM ☐ PM

(Provide information on what skills client has and what skills client does not have to reach this outcome. Indicate client choice in the process of community activities/outings. What is plan of action to help client in achieving his/her personal outcome?) Provide a detailed report of face-to-face contact for each service time/day. Hab must provide a detailed description of support services and/or training provided or lack of services for coverage day(s).

Narrative of factors/barriers in meeting outcome; training/support efforts to accomplish goal:

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Client Signature: ___________________________ Date: ___________________________

Must appear on all face to face documentation notes

_____________________________________________________________________________________

Habilitator’s Printed Name ___________________________ Date: ___________________________

Signature
Consent to Background Investigation
MHMRTarrant

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Name</th>
<th>Last Name</th>
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<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
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<tr>
<th>County</th>
<th>Area Code/Telephone No.</th>
<th>Date of Birth</th>
<th>Sex</th>
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<thead>
<tr>
<th>Social Security Number</th>
<th>Drivers License Number/State</th>
<th>State issued identification number/State ID Issued</th>
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List all states you have lived in the past five years:

- [ ] Contractor
- [ ] Volunteer
- [ ] Employee

Race: ______________________

MHMRTarrant can assume no liability nor responsibility should the results of this background check divulge the applicant as ineligible for consideration as a provider of services to this Professional Services Agreement.

With the below signature, I give MHMRTarrant my permission to run the above described background check, as well as declare my full understanding that the above test will be performed by MHMRTarrant and on an annual basis thereafter.

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</table>

If Provider, its officers, employees or agents have a conviction as described in this section of this Agreement, then this Agreement may be terminated without prior notice. For the purposes of this Agreement, convictions of criminal offenses which constitute an absolute bar to employment are (1) criminal homicide, (2) kidnapping and unlawful restraint, (3) indecency with a child, (4) sexual assault, (5) aggravated assault, (6) injury to a child, elderly individual, or disabled individual, (7) abandoning or endangering a child, (8) aiding suicide, (9) agreement to abduct from custody, (10) sale or purchase of a child, (11) arson, (12) robbery, (13) aggravated robbery, (14) indecent exposure, (15) improper relationship between educator and student, (16) improper photography or visual recording, (17) deadly conduct, (18) aggravated sexual assault, (19) terroristic threat, (20) online solicitation of a minor, (21) money laundering, (22) Medicaid fraud, (23) cruelty to animals, (24) a conviction under the laws of another state, federal law, or the Uniform Code of Military Justice for an offense containing elements that are substantially similar to the elements of an offense listed under paragraphs (1)-(13) of this subsection; and (25) a conviction which occurred within the previous five years for: (A) assault that is punishable as a Class A misdemeanor or as a felony; (B) burglary; (C) theft that is punishable as a felony; (D) misapplication of fiduciary property or property of a financial institution that is punishable as a Class A misdemeanor or felony; or (E) securing execution of a document by deception that is punishable as a Class A misdemeanor or a felony. (F) false identification as peace officer, and/or (G) disorderly conduct.