MHMR of Tarrant County
as the Local Mental Health and Intellectual and Developmental Disabilities (IDD) Authority

Intellectual and Developmental Disabilities (IDD) Services
OPEN ENROLLMENT APPLICATION

The Texas Department of Aging and Disability Services (DADS) has authorized MHMR of Tarrant County (MHMRTC), as the Local Authority, to assemble a network of service providers to provide intellectual and developmental disabilities (IDD) services to the Priority Population of persons with intellectual and developmental disabilities (IDD) in Tarrant County.

The goals of this network are:

1. To provide a comprehensive community system of services and supports.
2. To identify, implement, and evaluate successful programs based on client outcomes so that these efforts can be replicated.
3. To create meaningful cooperative relationships between the Local Authority and providers in the community.
4. To increase client access and allow client choice in the selection of qualified providers.
5. To provide quality services and achieve the desired outcomes at the most efficient cost possible.

This document requests participation from applicants for the purpose of providing intellectual and developmental disabilities (IDD) services as described in Attachment A to persons with intellectual and developmental disabilities (IDD), persons with pervasive developmental disorders, including autism, and persons with related conditions. The individuals to be served under this arrangement will meet the definition for the Priority Population for intellectual and developmental disabilities (IDD), which is included as Attachment A, and reside in Tarrant County.

There is no guarantee of referral volume to any provider. It is expected that contracted programs/services will address issues of consumer choice, quality, access, price, and ultimate cost-benefit while assuring adherence to standards of care and service requirements.

Target Population

The target population recipients are individuals with intellectual and developmental disabilities (IDD), autism and related conditions who have been identified by the Local Authority as **Priority Population,** in accordance with the definitions established by DADS. (See Attachment A -- Intellectual and developmental disabilities (IDD) Priority Population.) Designation of an individual as a member of the Priority Population must be made by the Local Authority and documented in each individual's record maintained by the Local Authority. Levels of disability range from mild impairments to profound retardation and physical disabilities.

Eligible Applicants

Applicants must be registered with the Secretary of State in Texas and have a Tax Identification Number. Individuals providing professional services must hold valid Texas licenses and/or certifications as required by state law. In any situation where a consortium of providers is applying, a single entity responsible for services delivered must be identified and the financial agent must be an organization with a demonstrated ability to manage funds. Applicants may not subcontract responsibilities for these services. All service providers must be eighteen (18) years of age or older. Applicants may not have been convicted of a crime relevant to a person's duties including any sexual offense, drug-related offense, homicide, theft, assault, battery, or any other crime involving personal injury or threat to another person.

Local Authority Responsibilities

The Local Authority will be responsible for making referrals, authorizing services, reviewing claims, and paying for appropriate, authorized services rendered by the Applicant. The Local Authority is also responsible for utilization management and quality assurance. The length and type of service will be determined in collaboration with the individual, his/her family (when appropriate), the provider, and the Local Authority. All services contracted by Local Authority are reviewed for effectiveness and continued value to the individual (and when appropriate, the family) every ninety (90) days. The Local Authority ensures that contracted services addressing the needs of the Priority Population are provided as required by the Texas Department of Aging and Disability Services and comply with the rules and standards adopted under Section 534.052 of the Texas Health and Safety Code. The Local Authority does not guarantee any referral volume to any Network Provider.

Provider Responsibilities

The Provider will be responsible for providing services as specified in the individual's plan of care. Provider must maintain all records regarding treatment and/or services rendered to individuals referred by the Local Authority for a period of five (5) years, and must allow the Local Authority immediate access during regular business hours to such records upon request. The Provider is required to comply with all state and federal laws regarding the confidentiality of consumers' records and nondiscrimination. The Provider must perform criminal history checks on employees to ensure that individuals convicted of crimes against persons are not allowed to work with Local Authority consumers. The Provider will actively assist in the disbursement of consumer and advocate satisfaction surveys. The Provider will obtain prior authorization, provide acceptable levels of care, and maintain acceptable levels of liability insurance and appropriate licenses and accreditations. The 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 providers. The 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.

Application Instructions

Applicants must follow the attached outline for submissions (see below) to facilitate objective review. 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 its clients.

Please be sure to answer every question. If the question does not apply to you or your organization, simply and clearly document "N/A." All supporting documentation should be attached, including "Form A - Credentialing Application and Attestation for Licensed Individuals". Form A must be completed for each licensed individual providing services to Covered Individuals. Non-licensed providers of direct care services must complete "Form B (Attached) – Credentialing and Attestation for Non-Licensed Providers".

The Local Authority reserves the right to not evaluate incomplete enrollment Applications. False statements by any Applicant may disqualify the Application. Interviews or site visits may be conducted to further evaluate applications.

Applications must be sent to:

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

Applications may be sent by regular mail or special carrier.
--Applications may not be faxed.
--Return original and keep one (1) copy of the application.

The contents of all applications may be made available upon written request. Therefore, any information contained in the Application that is deemed to be proprietary or confidential in nature must clearly be so designated in the Application. Such information may still be subject to disclosure under the Public Information Act depending on opinions from the Attorney General's office.

Questions regarding this Application should be directed to Kevin McClean at (817) 569-4456.

☐ Contracts Mgmt. Dept.

APPLICATION –

Please indicate service(s) you are applying for by checking in the box(es) below.
Refer to Attachment B for descriptions of services and rates.

☐ Audiology*
☐ Behavioral Supports*
☐ Community Supports
☐ Counseling*
☐ Day Habilitation
☐ Dietary*

☐ Employment Assistance
☐ Nursing*
☐ Respite
☐ Supported Employment

☐Specialized Therapies*
Occupational Therapy*
Physical Therapy*
Speech Therapy*

NOTE: All services above that have been marked with an asterisk (*) require completion of the *Texas Standardized Credentialing Application* for each licensed individual providing the service. The form and instructions can be found at: www.mhmrtarrant.org/Business-Opportunities/Credentialing.

All other services require completion of the attached Form B "Credentialing and Attestation for Non-Licensed Providers"–for each individual providing direct care services.

I. BUSINESS DEMOGRAPHICS

Legal Name: ________________________________ Social Security # and/or Tax ID #:________________

DBA: ____

Address: ________________________________City: ________________

Zip Code:____________ Business Phone: ________________Fax #: ________________

Contact Person: ________________ Title: ____________Phone: ________________

Email: ________________________________

Billing Address (if different from above): ________________________________

City: ________________________ State: ____________Zip: ________________

Business locations in this market area:

	Street	City	County	Zip Code
1.				
2.				
3.				
4.				

Indicate if you provide any of the following:

1. TTY/TTD (Hearing Impaired Services/Capabilities _______Yes _______No
2. American Sign Language _______Yes _______No
3. Handicap Accessible _______Yes _______No
4. Public Transportation Access _______Yes _______No
5. Bilingual Services (please list below) _______Yes _______No

____

Is the business owner a current or former MHMRTC board member or employee? ☐Yes ☐No

Is the business owner related to a current MHMRTC board member or employee? ☐Yes ☐No If yes, who: ______________________

Owners/Partners:

	Name	% Ownership	If corporate, list organization
1.			
2.			
3.			
4			

Certification Number if a Historically Underutilized Business: ________Years in Operation: ________

No employee of the Local Authority or DADS, 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:

____

____

____

II. QUALITY MANAGEMENT/UTILIZATION MANAGEMENT

A. Provide copies of all licenses, credentials, certifications, and/or accreditations the organization or provider currently holds relative to this Application. ***Label as II.A.***

B. Provide a summary of the most recent consumer satisfaction surveys or other on-going efforts to obtain and evaluate consumer satisfaction. Describe how this information was obtained and how it is used to improve quality:

____

____

____

____

____

C. Describe or attach your process to track, monitor and investigate critical incidents (e.g. serious injuries, serious medication errors):

____

III. SERVICES

A. Identify the services that the organization/provider will provide: (Attach additional sheets for each service type if applying to provide more than one service. Examples of service types are speech therapy, physical therapy, occupational therapy, community supports, etc.): ______________________________
____
____

B. Will the organization/provider have qualified staff available to administer medications or to supervise individuals in the self-administration of medication? ____

C. What times of day and what days of the week are services available? (Complete for each service being applied for.):

Service Type: ____________________________________

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
hrs:______	Hrs:______	hrs:______	hrs:______	hrs:______	hrs:______	hrs:______

Service Type: ____________________________________

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
hrs:______	Hrs:______	hrs:______	hrs:______	hrs:______	hrs:______	hrs:______

Service Type: ____________________________________

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
hrs:______	Hrs:______	hrs:______	hrs:______	hrs:______	hrs:______	hrs:______

Service Type: ____________________________________

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
hrs:______	Hrs:______	hrs:______	hrs:______	hrs:______	hrs:______	hrs:______

Service Type: ____________________________________

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
hrs:______	hrs:______	hrs:______	hrs:______	hrs:______	hrs:______	hrs:______

D. How many individuals can the organization/provider serve?:________________________________

E. How long do people currently wait to get into the organization's/provider's services?: ___________

F. Detail the specific population the organization/provider would serve. Include ages and level of severity and concurrent diagnoses: ____
____

G. Are there any restrictions on who the organization/provider will serve? ______________________
If yes, please explain: ____

H. Describe the organization's/provider's experience in working with persons with intellectual and developmental disabilities (IDD), autism, and related conditions over the last five (5) years: __________

I. 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:

J. Describe the organization's/provider's experience in working with persons with physical impairments and adaptive equipment: ____

K. Describe any specialized services you provide (ability to assist with eating, supervision, or self-medication, positioning, etc.): ____

L. Describe any "after hours" system for responding to client needs: ___________________________

M. Can Local Authority clients access services outside usual business hours? ____________________

N. Describe or attach ***(Label as III.N.)*** the organization's/provider's in-service training requirements for employees: ____

IV. FINANCIAL

A. Is the organization/provider incorporated as "Profit," "Not-for-profit," or "Other?"______________
If "Other," please explain: ____

B. Does the organization/provider have sufficient reserves or line of credit to operate during the time period between billing and receiving reimbursement from third party payors? ____________________
If not, please explain: ____
____
____
____

C. Has the organization/provider declared any type of bankruptcy in the prior seven (7) years? ______
If yes, please explain: ____
____
____

D. Has the organization/provider received a "qualified" opinion on a financial statement in the past three (3) years? _________ If yes, please explain: ____
____
____

Does the most recent audit report have any material instance of non-compliance with standard accounting practices? _______ If yes, please explain: ____
____
____
____

E. Describe any arrangements to subcontract part or all of these services. Name all subcontractors and attach ***(Label as IV.E.)*** information on their staff credentials, licenses and certifications: ___________
____
____
____

F. Is the organization/provider currently under investigation, or had a license or accreditation revoked by any state/federal/local authority or licensure agency, within the last five (5) years? ________________
If yes, please explain: ____
____
____
____

G. Has the organization/provider had any judgments or settlements against it within the last ten (10) years? _________ If yes, please explain: ____

____

____

____

H. Has the organization/provider been placed on "vendor hold" by any agency or government entity in the past three (3) years? _______ If yes, please explain: ____
____
____
____

I. Does the organization/provider have a "Letter of Good Standing" which 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 the letter or exception form. ***Label as IV.I.***

J. Is the organization/provider delinquent in the payment of any court-ordered Child Support Payments? _________ If yes, explain: ____
____
____

K. Is the organization/provider currently held in abeyance or barred from the award of a federal or state contract? _______________ If yes, has this occurred in the last five (5) years? ______________
If yes, explain: ____
____
____

L. Describe any contracts, Memoranda of Understanding, or employment relationship the organization or provider has with other state, city or county agencies in the Tarrant County community. ____________
____
____

V. RISK ASSESSMENT

A. Does anyone working for the organization/provider providing direct care or in management have any felony convictions? __________ If yes, explain. ____
____
____

Describe the process, if any, the organization/provider uses to check on previous convictions of employees. Describe or attach ***(Label as V.A.)*** any policies and procedures regarding the hiring and retention of persons with criminal histories: ____
____
____
____

B. Has the organization/provider or its employees had any <u>validated</u> client abuse, client neglect, or rights violations claims in the last three (3) years? _________ If yes, explain in detail: __________________

____

____

____

Describe or attach ***(Label as V.B.)*** any current policies and procedures regarding client abuse, client neglect, or rights violations and the training of staff on these issues: ____________________________

____

____

____

C. Provide a Certificate of Insurance showing liability insurance coverage (property and vehicles, including riders) and include directors' and officers' professional liability, errors and omissions, and general liability insurance. ***Label as V.C.***

D. Provide the name of Workers' Compensation carrier if the organization/provider has Workers' Compensation coverage, or self-funding documents if self-funded. ***Label as V.D.***

E. Does the organization/provider currently have any malpractice claims pending or closed during the past five (5) years? ___________ If yes, please supply the following information: ***Label as V.E***.

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

VI. INFORMATION SYSTEMS

Can the organization/provider report data by the following categories?:

1. Client name
2. Client's Local Authority identification number
3. Date, number, type, and duration of services rendered
4. Authorization number
5. Amount to be paid
6. If medications are administered or supervised, number, type, and severity of medication errors and adverse drug reactions for Local Authority clients
7. Elopements or unauthorized departures from the program site
8. Confirmed abuse, neglect, or exploitation of Local Authority clients.
9. Death or serious injury to Local Authority clients occurring at program site

VII. RATE SCHEDULE

Applicant agrees to accept the fees listed in Attachment B as payment in full for approved Covered Services. The Applicant will not submit a claim or bill or collect compensation from Local Authority for any non-covered service. Applicant agrees that compensation for providing non-covered services will be solely between the client and the Applicant. The Covered Individual must be informed in writing, before any non-covered services are provided, that Local Authority is not responsible for payment for such services. Clients

are responsible for payment for non-covered services only if the Covered Individual consents in writing to the provision of such non-covered services. Local Authority is the payor of last resort. If the services authorized for a Covered Individual are currently paid for by a third party payor, applicant may not bill both entities for the same service.

ASSURANCES DOCUMENT

Applicant assures the following:

1. That all addenda and attachments to the Application as distributed by the Local Mental Health and Intellectual and developmental disabilities (IDD) Authority have been received.
2. 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 response document.
3. The Applicant does not discriminate in its services or employment practices on the basis of race, color, religion, sex, national origin, ethnicity, disability, veteran status, or age.
4. That no employee of the Local Authority or DADS, 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.
5. All cost and pricing information is reflected in the Application response document or attachments.
6. Applicant accepts the terms, conditions, criteria, and requirements set forth in the Application.
7. Applicant accepts the Local Mental Health and Intellectual and Developmental Disabilities (IDD) Authority's right to cancel the Application at any time prior to contract award.
8. Applicant accepts the Local Mental Health and Developmental Disabilities (IDD) Authority's right to alter the timetables for procurement as set forth in the Application.
9. The application submitted by the Applicant has been arrived at independently without consultation, communication, or agreement for the purpose of restricting competition.
10. 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.
11. 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.
12. Local Authority has the right to complete background checks and verify information.
13. The individual signing this document and the contract is authorized to legally bind the Applicant.
14. 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 A

Intellectual and Developmental Disabilities (IDD) Priority Population

The Priority Population for intellectual and developmental disabilities (IDD) services includes those persons who *request* and *need* services and possess one or more of the following conditions:

- Intellectual and developmental disabilities (IDD), as defined by Section 591.003 (13), Title 7, Health and Safety Code
- Autism as defined in the current edition of the Diagnostic and Statistical Manual (DSM)
- Pervasive Developmental Disorder (PDD) as defined in the current edition of the DSM
- Eligibility for OBRA '87 mandated services for intellectual and developmental disabilities (IDD)/related condition

The presence of intellectual and developmental disabilities (IDD) must be determined through the State Authority's (DADS) eligibility determination process or through the use of assessments performed by qualified professionals as per Interagency Memoranda of Understanding. Diagnoses of autism or PDD must be reviewed and endorsed by the Local Intellectual and Developmental Disabilities (IDD) Authority admission team. For persons with intellectual and developmental disabilities (IDD), autism, or PDD, the priority population includes only those individuals whose needs for services can be most appropriately met through programs currently or potentially offered by the DADS system rather than some other service system. Services are to be offered in coordination with efforts of other agencies to ensure that all services are provided by agencies as required by laws, rules, and regulations. The priority population does not include anyone whose service needs may be most appropriately met through other means, as determined by DADS.

Persons who are members of the Priority Population are eligible to receive services from the DADS system. Since resources are insufficient to meet all the service needs of all the members of the Priority Population, services are provided to meet the most intense needs first.

ATTACHMENT B

SERVICE DEFINITIONS AND RATES

A

udiology* – provides assessment and treatment by licensed audiologists and includes training and consultation with an individual's family member or other support providers.

Behavioral Support Service*

$ 72.15 per hour for each authorized ICF, PASRR, HCS, and GR person.

Provider – provider for behavioral support services is currently:

1. Licensed as a psychologist by the Texas Board of Psychological Examiners;
2. Certified as a DADS-certified psychologist; or
3. Certified as a behavioral analyst by the Behavior Analyst Certification Board, Inc.

Behavioral Support Services provides specialized interventions that assist a participant to increase adaptive behaviors to replace or modify maladaptive or socially unacceptable behaviors that prevent or interfere with the participant's inclusion in home and family life or community life. Services, including, but not limited to, all of the following:

a. assessment and analysis of assessment findings of the behavior(s) to be targeted necessary to design an appropriate behavioral support plan;
b. development of an individualized behavioral support plan consistent with the outcomes identified in the individual's PDP;
c. training of and consultation with family members or other support providers and, as appropriate, with the individual in the purpose/objectives, methods and documentation of the implementation of the behavioral support plan or revisions of the plan;
d. monitoring and evaluation of the success of the behavioral support plan implementation; and;
e. modification, as necessary, of the behavioral support plan based on documented outcomes of the plan's implementation.

Provider may not subcontract responsibilities for this service.

Providers of services are expected to address issues that fall within the scope of their knowledge, experience, and license. The Covered Individual's MHMRTC Designated Staff Liaison must be notified if the individual needs to be referred to another therapist. Provider must have experience in working with persons with intellectual and developmental disabilities (IDD)/autism/related conditions.

Community Support

$17.73 per hour for each authorized person.

Provider – provider for community support services has a high school diploma or its equivalent and transportation is provided in accordance with applicable state laws. When documenting transportation provided to one or more persons by one or more service providers, a billing log may be substituted for a written narrative.

The community support service component provides services and supports in an individual's home and at other community locations that are necessary to achieve outcomes identified in an individual's person-directed plan (PDP). The community support service component provides assistance with medications and the performance of tasks delegated by a registered nurse in accordance with state law. This service

component may not be provided at the same time that the respite, day habilitation, or supported employment service component is provided. This service must occur away from a program site. The community support service component provides habilitative or support activities that:

(a) provide or foster improvement of or facilitate an individual's ability to perform functional living skills and other activities of daily living;
(b) assist an individual to develop competencies in maintaining his or her home life;
(c) foster improvement of or facilitate an individual's ability and opportunity to:
    (i) participate in typical community activities including activities that lead to successful employment;
    (ii) access and use services and resources available to all citizens in the individual's community;
    (iii) interact with members of the community;
    (iv) access and use available non-TxHmL Program services or supports for which the individual may be eligible; and
    (v) establish or maintain relationships with people, who are not paid service providers that expand or sustain the individual's natural support network.

Counseling Services

$65.08 per hour for each authorized person.

The counseling service component provides assessment and treatment by licensed or certified professional for counseling and includes training and consultation with an individual's family members or other support providers.

Provider – program provider must assure that a provider of counseling services is licensed by the appropriate State of Texas licensing authority**.**

The counseling service component provides support activities that are:

(a) specified in the individual's plan of services and supports;
(b) face to face or telephone contact or interacting by videoconference with an individual to conduct assessment or provide services within the scope of the service provider's practice;
(c) face to face or telephone contact with a family member or other service provider (excluding licensed/certified staff employed or contracted by the provider and service coordinators) necessary for the provision of a specific service to the individual
(d) training provided to direct service providers, except for providers of nursing and specialized therapies, or family members responsible for performing, monitoring, reporting and documenting a specific individual treatment plan for the individual;

Day Habilitation

$20.87 per day for each GR funded person
Rate based on Level of Need for each authorized HCS and ICF-IDD funded person

Provider – provider for day habilitation services must have a high school diploma or its equivalent and transportation is provided in accordance with applicable state laws.

Day Habilitation Services – The day habilitation service component assists an individual to acquire, retain, or improve self-help, socialization, and adaptive skills necessary to live successfully in the community and participate in home and community life and does not include services that are funded under the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act. The day habilitation component may not be provided at the same time

supported employment, hourly-reimbursed Respite, or Community Support is provided. The day habilitation service component provides:

(a) individualized activities consistent with achieving the outcomes identified in the individual's PDP;
(b) activities necessary to reinforce therapeutic outcomes targeted by other waiver service components, school, or other support providers;
(c) services in a group setting other than the individual's home up to five days a week, six hours per day;
(d) personal assistance for individuals that cannot manage their personal care needs during the day habilitation activity;
(e) assistance with medications and the performance of tasks delegated by a registered nurse in accordance with state law; and
(f) transportation necessary for the individual's participation in day habilitation activities.

Dietary Services*

$50.00 *per hour for each authorized person*

The dietary service component provides assessment and treatment by licensed dieticians and includes training and consultation with an individual's family members or other support providers.

Provider – program provider must assure that a provider of dietary services is licensed by the appropriate State of Texas licensing authority**.**

Employment Assistance

$23.52 per hour for each authorized person

Provider – provider for employment assistance services must have a high school diploma or its equivalent and transportation is provided in accordance with applicable state laws.

Employment Assistance Services – Consists of services and supports provided to assist individuals to locate paid employment in the community. The employment assistance component assists an individual to identify his or her employment preferences; job skills; requirements for the work setting and work conditions and prospective employers that may offer employment opportunities compatible with the individual's identified preferences, skills, and requirements. The employment assistance provider facilitates the individual's employment by contacting prospective employers and negotiating the individual's employment. This component must be re-authorized by the individual's service planning team every 180 calendar days after the initiation of the service component.

Nursing Services

$58.69 per hour per authorized person.

Services, including, but not limited to, all of the following:

a. administration of medication;
b. monitoring an individual's use of medications;
c. monitoring an individual's health data and information;
d. assisting an individual or LAR to secure emergency medical services for the individual;
e. making referrals for appropriate medical services;
f. performing health care procedures as ordered or prescribed by a physician or medical practitioner or as required by standards of professional practice or law to be performed by licensed nursing personnel; and

g. delegating and monitoring tasks assigned to other service providers by a registered nurse in accordance with state law

Physical Therapy Services

$77.43 per hour per authorized person

Provider – program provider must assure that a provider of specialized therapies is licensed by the appropriate State of Texas licensing authority for the specific therapeutic service provided by the provider**.**

Respite Services

$9.69 per hour per authorized person not to exceed $96.90 per day.

Provider – provider for respite services must have a high school diploma or its equivalent and transportation is provided in accordance with applicable state laws.

Respite Services – The respite service component is provided for the planned or emergency short-term relief for the unpaid caregiver of an individual or when the caregiver is temporarily unavailable to provide support due to non-routine circumstances. Respite may be provided in the individual's residence or, if certification principles stated in the TxHmL waiver are met, in other locations. The respite service component provides individuals:

(a) assistance with activities of daily living and functional living tasks;
(b) assistance with planning and preparing meals;
(c) transportation or assistance in securing transportation;
(d) assistance with ambulation and mobility; reinforcement of behavioral support of specialized therapies activities;
(e) reinforcement of behavioral support of specialized therapies activities;
(f) assistance with medications and performance of tasks delegated by a Registered nurse in accordance with state law; supervision of the participant's safety and security;
(g) supervision of the participants safety and security;
(h) habilitation and support that facilitates:
  (i) an individual's inclusion in community activities, use of natural supports and typical community services available to all people;
  (ii) an individual's social interaction and participation in leisure activities; and
  (iii) development of socially valued behaviors and daily living and functional living skills.

Specialized Therapies: Occupational Therapy*, Speech / Language Therapy*

$72.95 per hour for each covered person for OT
$74.12 per hour for each covered person for Speech

The specialized therapies service component provides assessment and treatment by licensed occupational therapists, speech and language pathologists, and audiologists and includes training and consultation with an individual's family members or other support providers.

Provider – program provider must assure that a provider of specialized therapies is licensed by the appropriate State of Texas licensing authority for the specific therapeutic service provided by the provider**.**

Supported Employment

$23.52 per hour for each authorized person

Provider – provider for supported employment services has a high school diploma or its equivalent and transportation is provided in accordance with applicable state laws.

The supported employment service component provides ongoing individualized supports needed by an individual to sustain paid work in an integrated work setting. An individual receiving supported employment is compensated directly by the individual's employer in accordance with the Fair Labor Standards Act; and employed in an integrated work setting by an employer that has no more than one employee or 3.0% of its employees with disabilities unless the individual's PDP indicates otherwise or the employer subsequently hires an additional employee with disabilities who is receiving services from a provider other than the individual's program provider or who is not receiving services. Supported employment may only be provided when the service has been denied or is otherwise unavailable to an individual through a program operated by a state rehabilitation agency or the public school system, documentation of denial must be kept in record. Supported employment is provided away from the individual's place of residence. Supported employment does not include payment for the supervisory activities rendered as a normal part of the business setting. Supported employment does not include services provided to an individual who does not require such services to continue employment. An individual's program provider may not be the employer of an individual receiving supported employment.

FORM B
Credentialing and Attestation for Non-Licensed Providers
(Must be completed on each non-licensed provider of services, including subcontractors)

Provider Name ____
Last First MI

Date of Birth: ______________________ Social Security Number: __________________

Driver's license # ____________________ **Attach a copy of your driver's license.**

Have you ever been found to be the perpetrator of a confirmed case of client abuse? _____ Yes ______ No
If so, please explain.

Have you ever been convicted of a felony? _____ Yes ______ No If so, please explain.

Do you speak a language other than English? _____Yes _____ No If "yes", please list:_____________

Do you know sign language? _____ Yes ______ No

Education History - High School, Undergraduate, graduate and postgraduate education. **Attach a copy of diploma or GED**

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

Continuing Education - Please list the continuing education programs relevant to the services you intend to provide that you have attended in the past two years. **You may attach a current resume or other documentation of training.**

Date(s)		**Subject**	**# CE Hours**
From:	To:		
From:	To:		
From:	To:		
From:	To:		
From:	To:		
From:	To:		

WORK HISTORY - For the past ten (10) years or since completion of highest degree. Attach a separate sheet if additional space is needed. **You may submit a current resume or vita to meet this requirement.**

1. ____
Employer name Address City, State, Zip

____
Position title/description From To

2. ____
Employer name Address City, State, Zip

____
Position title/description From To

3. ____
Employer name Address City, State, Zip

____
Position title/description From To

4. ____
Employer name Address City, State, Zip

____
Position title/description From To

5. ____
Employer name Address City, State, Zip

____
Position title/description From To

Have you ever been terminated with cause from any human service agency?
☐ Yes ☐ No If yes, please explain fully on a separate sheet.

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

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

I hereby attest to the following:

- I do not currently use any illegal drug.
- I have reported accurately and completely any reason(s) for any inability to perform the essential functions required with, or without, accommodation.
- I have reported accurately any history of felony convictions or client abuse and neglect.
- 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 MHMR of Tarrant County of all information that may reasonably be relevant to an evaluation and verification of this application or evaluation of competence, including, but not limited to, consultation with any other professionals or institutions with which I have been or am currently associated.
- The information submitted in and with this application is complete and correct to the best of my knowledge.

____
Print applicant's name Applicant's signature Date

Please return completed form to:
Kevin McClean, Director of Contracts Management/Provider Relations
MHMR of Tarrant County
P. O. Box 2603
Fort Worth, TX 76113