early childhood services
MHMR TARRANT | WE CHANGE LIVES

ECI Provider Application
for an
Individual

A red arrow ➔ indicates documents you are required to attach when submitting this application.

I. Demographics

Provider Name:_____
Last First Middle Initial

Address:_____
Street Address City State Zip Code

Phone#: _____ Date of Birth:_____ SS#:_____

Employed by:_____ Business Phone: _____ Fax:_____

Business Address:_____
Street Address City State Zip Code

II. Conflicts of Interest

Identify any relationships you have with any MHMRTC employee or Board of Trustees - Current MHMRTC Board Members are: William R. Brown, Lea Ann Capel, Carey Cockerell, Roy Griffin, Linda Harmon, Chief Henry Reyes, Carolyn Sims, Jim Teague, Theodis "T" Ware, and Lyn Willis. ◯ None ◯ If yes, indicate who below:

_____
Person's Name *Relationship to you*

➔ *If any relationships, complete the Conflict of Interest Questionnaire (CIQ) form located on MHMRTC's https://www.mhmrtarrant.org/Business-Opportunities webpage, under the Conflict of Interest section, and submit it along with this application.*

III. Licenses /Certification for Service Delivery

License type: ☐ LPT ☐ OTR ☐ SLP ☐ Other:_____
Texas Certification: ☐ EIS ☐ Other:_____

➔ *Attach a copy of your discipline license or certification*

A valid Texas driver's license is required.

➔ *Attach a copy of your Texas driver's license*

IV. Professional Experience & Skills

A. Tell us about your professional experience, emphasizing work with children under 3 years.

➔ *Attach a current resume.*

B. Are you currently certified in Cardiopulmonary Resuscitation (CPR) for children and infants that included live demonstration, and covered first aid, and emergency care of seizures?

➔ ☐ Yes *Attach a copy.* ☐ No *Register with MHMRTC's Training Dept. (no charge) or with another approved CPR training facility.*

C. Do you speak other languages besides English?

☐ Spanish ☐ Vietnamese ☐ Other:_____

☐ Functional or ☐ Fluent

V. Health Status

A. A provider who routinely performs any job duty in proximity to any ECI child must provide evidence of negative TB testing.

➔ *Attach current TB test results.*

B. Please disclose if you have any medical, physical and/or psychiatric issues (such as: substance abuse, medical marijuana, or needing special accommodations) that might affect your ability to perform the essential functions of your profession.

➔ *Document issues on a separate page.*

VI. Provider Manual & Training

The ECI Provider Manual is a reference guide, designed as instruction to ensure quality services are delivered to ECI children and their families.

Read the ECI Provider Manual located on MHMR's https://www.mhmrtarrant.org/Business-Opportunities webpage, under the Provider Relations section and attest that you understand its contents and that you have completed the required HHS/ECI training requirements, as described in the Provider Manual.

➔ *Sign the Attestation (page 6 of this application).*

VII. Criminal History

Criminal background checks are conducted annually; details are available in the Provider Manual.

➔ *Complete the DPS Verification form (page 3 of this application).*

VIII. HHS/ECI TKIDS

All professionals providing ECI services must be registered in the HHS/ECI TKIDS system to accurately document service delivery.

➔ *Complete the TKIDS form (page 4 of this application).*

DPS Computerized Criminal History (CCH) Verification

(AGENCY COPY)

I,_____, have been notified that a computerized criminal
APPLICANT or EMPLOYEE NAME (Please print)
history (CCH) verification check will be performed by accessing the Texas Department of Public Safety Secure Website and will be based on name and DOB information I supply.

Because the name based information is not an exact search and only fingerprint record searches represent true identification to criminal history, the organization (as listed below) conducting the criminal history check is not allowed to discuss any information obtained using this method, therefore the agency may offer the opportunity to have a fingerprint search performed to clear any misidentification based on the name search, if the search provides a criminal report I know could not be mine.

For the fingerprinting process I will be required to submit a full and complete set of my fingerprints for analysis through the Texas Department of Public Safety AFIS (automated fingerprint identification system). I have been made aware that in order to complete this process I must have the correct fingerprinting (FAST) form from this agency, make an online appointment, submit a full and complete set of my fingerprints, and pay a fee of $9.95 to the fingerprinting services company, L1Enrollment Services.

Once this process is completed and the agency receives the data from DPS, the information on my fingerprint criminal history record may be discussed with me.

(This copy must remain on file by your agency. Required for future DPS Audits)

_____
Signature of Applicant or Employee

_____
Date

MHMR of Tarrant County / ECS
Agency Name (Please print)

_____
Agency Representative Name (Please print)

_____
Signature of Agency Representative

_____
Date

Please:
Check and Initial each Applicable Space

CCH Report Printed:

YES ☐ NO ☐ _____initial

Purpose of CCH: _____

Hire ☐Not Hired ☐ _____initial

Date Printed:_____ _____initial

Destroyed Date:_____ _____initial

Retain in your files

CONTRACTOR INFORMATION AND UPDATE FORM
For TKIDS

Name:

(Last) (First) (Middle Initial)

Race/Ethnicity: *(Circle Appropriate):*

◯American Indian/Alaska Native ◯Asian/Pacific Islander ◯Black/African American ◯Hispanic/Latino ◯White

SS#: *(last 4 digts only)*	Start Date:	College Graduated From / Location:
____ ____ ____ ____		Degree(s):
		+ year(s) graduated:

TKIDS CREDENTIALS

Please re-submit this section if your credentials change during your contract with ECI.

- ☐ BCBA
- ☐ OT - Occupational Therapist
- ☐ OTA - Occupational Therapy Assistant
- ☐ PT - Physical Therapist
- ☐ PTA - Physical Therapy Assistant
- ☐ RN ◯Associates ◯Bachelors ◯Masters
- ☐ SLP - Speech Language Pathologist
- ☐ SLP - CFY
- ☐ SLPA - Assistant in Speech Pathology
- ☐ Other:

State License # / Effective Date / Expiration Date:

For SPLA, PTA, COTA
Supervisor's Name & Credentials:

PHONE #:	Have you worked at another ECI Program? ☐Yes ☐No If yes, which program?

HULEN STAFF COMPLETE THE FOLLOWING FOR CONTRACT STAFF

Credentialing Application	Returned	To Credentialing	Approved	Contract Coversheet	Contract Log

HULEN STAFF COMPLETE THE FOLLOWING AND ROUTE TO NEXT PERSON

Enter into TKIDS	Entered in CMHC	Contractor ID #

Staff Licensure Code Entered:

07 - LCSW	**08** - LBSW	**13** - LPC	**16** - LMSW	**17** - RD/LD	**19** - OTR/LOT
21 - LPT	**23** - SLP	**29** - RN	**34** - LPC-I	**39** - Psych Assoc.	**44** - Para Professional
51 - Other	**52** - EIS-EL	**53** - EIS-FQ	**60** - LPTA	**63** - COTA	**65** - SLPA

REVISED 1/9/15 KD

IX. Checklist of Attachments

Indicate with a ✓ check mark to indicate items that you have attached.

Attached	N/A	
☐	☐	Conflict of Interest Questionnaire, if applicable (Section II)
☐	☐	Discipline License (Section III)
☐	☐	Texas Driver's License (Section III)
☐	☐	Resume (Section IV)
☐	☐	CPR Card (Section IV)
☐	☐	TB Test Results (Section V)
☐	☐	Health Status, if applicable (Section V)
☐	☐	Training: "Making It Work" certificates & self-assessment (Section VI & XI)
☐	☐	Training: "Just Being Kids" videos - 6 observations & 6 progress notes (Section VI & XI)

X. Submission Instructions

Submit this application by U.S. mail, hand delivery, courier, fax, or email electronically to:

Laura Kender, Chief of ECS
ECI of North Central Texas RU3100
3840 Hulen Street, Suite #602
Fort Worth, TX 76107
817-569-5348-fax
Laura.Kender@mhmrtc.org

False statements on this proposal by prospective providers may disqualify enrollment.

ECI reserves the right to reject any and all applications, to waive technicalities, and to accept any advantages deemed beneficial to the ECI program and its clients.

XI. Attestation

I do hereby attest that:

Indicate with a ✓ check mark.

Yes	No	
☐	☐	1. The information provided by me in and attached to this application is true and correct.
☐	☐	2. I have read and understand all elements of the **ECI Provider Manual** and agree to abide by its requirements, terms, and conditions, including instruction concerning: *(✓ each completed)*

- ☐ **Parent Handbook**
- ☐ **Service Guidelines / Delivery**
- ☐ **Communicable Diseases / Notifiable Conditions**
- ☐ **Incident Reporting**
- ☐ **Home Visit Safety**
- ☐ **Dress Code**
- ☐ **Child Eligibility**
- ☐ **Service Descriptions**
- ☐ **Documentation & Timelines**

☐	☐	3. I have completed a Pediatric Cardiopulmonary Resuscitation (**CPR**) that includes live demonstration, and covers **First Aid,** emergency care of **Seizures**, and a live demonstration.
☐	☐	4. I have read and understand the required **Training** section included and linked in the ECI Provider Manual: *(✓ each completed)*

- ☐ **Infection Prevention**
- ☐ **Procedural Safeguards** (FERPA & HIPAA)
- ☐ **Client Rights, Abuse, and Neglect**
- ☐ **Making It Work (Sections 1 through 8)** - submit certificates
- ☐ **Self-Assessment** - submit assessment
- ☐ **"Just Being Kids" Videos** - complete an Observation form (available on the next 2 pages), as well as a Progress Note (on the last page) for ***each*** of the 6 videos and submit along with this application. This section will be a total of 18 pages.
- ☐ **Coaching**

By: Applicant:_____
Print Name

By Applicant:_____ Date:_____
Signature

➔ *Complete this Observation form for each "Just Being Kids" video*

OBSERVATION – Service Delivery Visit

Child's first name and age: _____ Date of observation: _____

Name of staff doing observation: _____

Name and discipline of ECI provider observed: _____

1. How did the provider relate the activities during the visit back to the outcomes on the IFSP?

2. How did the provider explain to the parent/caregiver(s) what skills the child was developing or learning through the activities, and how the activities relate to the IFSP outcomes?

3. How did the provider involve the parent/caregiver(s) in the activities?

4. How did the provider use routines identified by the parent/caregiver(s) and materials from the child's natural environment?

5. How did the provider explain to the parent/caregiver(s) how to carry out the skill development or learning in other settings or routines?

6. How was the parent/caregiver's understanding of the intervention strategies demonstrated during the visit (return demonstration)?

7. How did the provider respect the parent/caregivers' cultural and socioeconomic backgrounds?

8. How did the provider support development across domains?

9. Describe the interaction between the family and the provider; how did the provider:

   - Support positive interactions between the child and caregiver?

   - Encourage the family to model activities/strategies for the provider?

   - Encourage the family to share updates about the family and about the child's progress?

   - Help the family determine which strategies worked (or didn't) in the context of the family's routines?

Document this visit on the Intervention Progress Note (on the following page).

Remember to include:

- ☐ how the intervention addresses the identified need and outcome
- ☐ the parent/caregiver's report of progress since the last visit
- ☐ information that clearly shows the adult is the learner and the service delivery triad (describes coaching, instruction, and the opportunity for return demonstration)
- ☐ the use of materials or toys found in the home or child care setting
- ☐ the child's progress toward the identified outcome
- ☐ information that demonstrates the application of the ECI provider's professional knowledge

➔ *Document each "**Just Being Kids**" video on this Intervention Progress Note form*

ECI #: _____
Child's Name: _____
Medicaid #: _____
DOB: _____

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INTERVENTION PROGRESS NOTE

Initial IFSP/Annual Review Date:			Orders Expire:		
Date:	Time Start:		Time Stop:		Code:
Service:	☐ SST	☐ OT	☐ PT	☐ ST	☐ Nursing	☐ Family Ed. & Training
Location:	☐ HM	☐ DC	☐ Other	☐ Interpretation/Translation		☐ Joint Visit

☐ Yes ☐ No **28-day** time line met for this service. **If no**, document reason on General Progress Note.

Present at Visit:

IFSP Outcomes Addressed	Addressed today:
1.	Yes ☐ No ☐
2.	Yes ☐ No ☐
3.	Yes ☐ No ☐

Developmental Goals supporting IFSP	
1.	Goal: Met ☐ Cont ☐ New Goal ☐ Discont ☐
2.	Goal: Met ☐ Cont ☐ New Goal ☐ Discont. ☐
3.	Goal: Met ☐ Cont ☐ New Goal ☐ Discont. ☐
4.	Goal: Met ☐ Cont ☐ New Goal ☐ Discont. ☐
5.	Goal: Met ☐ Cont ☐ New Goal ☐ Discont. ☐

What has the family been practicing since last visit?

What happened during the visit, who was involved, and how did the parent/caregiver participate?

Measurement of progress towards goals during visit?

Goal 1:	◯ Occurs Rarely	◯ Occurs Sometimes	◯ Occurs Often	◯ N/A
Goal 2:	◯ Occurs Rarely	◯ Occurs Sometimes	◯ Occurs Often	◯ N/A
Goal 3:	◯ Occurs Rarely	◯ Occurs Sometimes	◯ Occurs Often	◯ N/A
Goal 4:	◯ Occurs Rarely	◯ Occurs Sometimes	◯ Occurs Often	◯ N/A
Goal 5:	◯ Occurs Rarely	◯ Occurs Sometimes	◯ Occurs Often	◯ N/A

What strategies does the family want to work on to achieve the goal(s)?

Date / Time of next visit: _____ at _____ a.m. ☐ / p.m. ☐

Parent Signature: **Printed Name:**

Staff Signature: **Discipline:** **Printed Name:**