



**AUSTIN TRAVIS COUNTY
MENTAL HEALTH MENTAL RETARDATION CENTER**

**REQUEST FOR APPLICATIONS
(RFA)**

**For the Open Enrollment of
Non-Traditional Family Selected Individual Service Providers of
Child and Family Services
&
Developmental Disabilities Services**

STOP

This application should only be completed by persons applying to provide non-traditional services to a single identifiable individual and/or family. If you wish to provide services to other individuals in the network, please contact the Contract Manager at (512) 483-5892 for a Network Application.

ATTACHMENT A - APPLICATION SUBMISSION CHECKLIST

The following items must be submitted with the *Individual Non-Traditional Provider (NTP) Application* for credentialing:

- Signed Application Submission Checklist and Applicant Statements. (Attachment A) (see below)
Provider Questionnaire (Attachment B) with attachments referenced.
- Service, Population and Rate Proposal. (Attachment D)
- Signed Assurances Document. (Attachment G)
- Copy of high school diploma or equivalent and/or highest degree achieved.
- Copy of Texas Driver's License.
- Copy of your automobile driving record for three years from Texas Department of Public Safety, if transporting Consumers.
- Copy of Vehicle Liability Insurance, if transporting Consumers.
- Provider In-home Service Form and supporting documents if providing services in your home. (Attachment H)
- Two completed Individual Non-Traditional Provider Reference Questionnaires. (Attachment I)
- Completed training module test, or dates scheduled to attend required training classes on Rights/Abuse and Neglect, Infection Control and Confidentiality.
- Copy of both sides of CPR card or proof of registration for CPR. (CPR must be completed within the first 60 days of service)

APPLICANT'S STATEMENTS:

I certify that the answers and information given in the application and attachments are true, correct and complete to the best of my knowledge. I hereby authorize Austin Travis County Mental Health Mental Retardation Center (ATCMHMR) to obtain any and all information required to complete a review and primary source verification of all statements contained in this application. Information and documents to be reviewed include, but are not limited to, licensure, educational information, employment, and volunteer activity. I also understand that ATCMHMR will check conviction records on non-traditional providers who apply for participation in the network. I understand that any negative conviction records may make me ineligible for participation in the network and/or lead to termination.

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

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

I understand that this application is not intended to be a contract for services.

Signature

Date

Printed Name

ATTACHMENT B- PROVIDER QUESTIONNAIRE

Provider Name: _____
(Last) (First) (Middle)

SSN: _____ D.O.B: _____ Ethnicity: _____ Gender: M F

TX Driver's License #: _____ Expiration Date: _____

Phone: _____ Fax: _____ Email: _____

Address: _____ Apt#: _____

City _____ State: _____ Zip: _____

A. Target Population

1. Indicate the population(s) to whom you wish to provide services, i.e. Developmental Disabilities and/or Child and Family Services before completing Attachment D.

2. Indicate the name of the individual and/or family to whom you are applying to provide services/supports.

B. Services

1. What services are you applying to provide, i.e. types, locations, times, rates?

2. In what languages are you able to provide services? English Spanish

Signed English American Sign Language Other: _____

3. History providing services/supports to the designated individual/family:

- a. Describe your history of working with the person or persons for whom you wish to provide services. Be specific about your history of working with the family or families, service coordinators or case managers, and as a member of an individual's planning team.

- b. Please indicate the length of the time you have known and/or been providing services/supports to this individual and/or family.

- c. Please indicate any specific life experience, exposure or training you may have had that equips you to provide services/supports to this person or family.

C. Credentialing

1. Educational Information:

All non-traditional provider services require at minimum a high school diploma or equivalent. Please attach verification that you meet this minimum educational qualification for non-traditional provider services as indicated above. For example a copy of your High School Diploma, High School transcript, GED, College diploma, or college transcript would verify that you graduated high school or received a GED.

High School or GED: YES NO
Graduation or GED Completion Date: _____
Name of High School (if applicable): _____
City: _____ State: _____ Zip: _____

2. Work Experience:

Please give a history of your work experience for the past five years. *(Use additional pages if necessary):*

Employer: _____ Date: _____ to _____
Address: _____ Phone #: _____
Job Title: _____ Supervisor's name: _____
Brief Description of Duties: _____

Employer: _____ Date: _____ to _____
Address: _____ Phone #: _____
Job Title: _____ Supervisors name: _____
Brief Description of Duties: _____

Employer: _____ Date: _____ to _____
Address: _____ Phone #: _____
Job Title: _____ Supervisor's name _____
Brief Description of Duties: _____

3. Do you qualify as a Historically Underutilized Business (HUB)? NO YES
 If YES, have you applied for certification? NO YES Certification #: _____
4. Do you have any current condition that which impairs your ability to perform the essential?
 NO YES
5. Have you received treatment for any condition, physical or mental, in the past two to five years, which would currently affect your ability to perform the essential tasks of the services, you have applied to provide with or without accommodation?
 NO YES

6. References:

Two completed **Individual Non-Traditional Provider Reference Questionnaires** (See Attachment J) must be submitted to complete the application process.

- a) You (the applicant) must complete and sign Section I on both references and then list your reference person's name.
- b) Then you give or mail the Reference Questionnaires to each of your two reference persons to complete Section II.
- c) Instruct your reference persons to mail the completed Reference Questionnaire to the address at the bottom of the Reference Questionnaire. If one or both of your reference person(s) have already completed the Reference Questionnaire, you can attach one or both of them to this application.

List below names of persons completing the reference questionnaires and their phone numbers (required):

1. Reference Name: _____ Phone Number: _____
2. Reference Name: _____ Phone Number: _____

Please send completed application and supporting documentation to:

**Contract Manager
 ATCMHMR
 5225 N. Lamar
 Austin, Texas 78751**

ATTACHMENT D

SERVICE, POPULATION, AND RATE PROPOSAL

The Service, Population and Rate Proposal sheet must be answered completely and returned with the application.

Please select the program area(s) serving the population(s) to whom you wish to provide services, i.e. Developmental Disabilities Services and/or Child and Family Services. Place a check mark by the service(s) you are applying to provide to individuals in this population.

Austin Travis County Mental Health Mental Retardation Center (ATCMHMR) is the payer of last resort. As appropriate, all network participants must bill all eligible services to Medicaid, Medicare or third party insurers, prior to submitting claims to ATCMHMR.

Developmental Disabilities Services	Check each service you are applying to provide	Reimbursement Rate
Community Supports		\$16.00 per hour
Daily Respite		\$80.00 per day
Hourly Respite		\$8.50 per hour

Child and Family Services	Check each service you are applying to provide	Reimbursement Rate
Mentoring		\$25.00 per hour
Tutoring		\$25.00 per hour
Daily Respite		\$130.00 per day
Hourly Respite		\$13.00 per hour
Parent Coaching		\$25.00 per hour
Behavioral Aide		\$25.00 per hour

Provider Name: _____

ATTACHMENT G

This document must be signed by the applicant and submitted with the application.

Applicant Assures the Following:

1. The applicant does not discriminate in its service on the bases of race, color, religion, sex, national origin, disability, veteran status, or age.
2. Applicant accepts any and all terms, conditions, criteria, and requirements set forth in the RFA.
3. Applicant accepts ATCMHMR's right to cancel the RFA at any time prior to contract award(s).
4. No claim will be made for payment to cover costs incurred in the preparation of the submission of the application or any other associated cost.
5. That Applicant agrees to follow all applicable federal, state, county, local, Department of State Health Services (DSHS), Department of Aging and Disability Services (DADS), and Austin Travis County Mental Health Mental Retardation Center (ATCMHMR) Provider Network policies and procedures.
6. That no employee of ATCMHMR, DSHS, or DADS, and no member of the ATCMHMR Board of Directors will directly or indirectly receive any pecuniary interest from an award of the proposed contract(s). If the Applicant is unable to make the affirmation, the Applicant must disclose any knowledge of such interests.
7. That Applicant shall disclose whether the Applicant has either been an employee or an officer of ATCMHMR within the past two (2) years preceding the date of submission of the application. If such employment has existed, or at term of office served, the application shall state the nature and time of the affiliations as defined. If no such affiliation exists, the Applicant shall so state in the application.
8. That Applicant shall identify any officer or employee of ATCMHMR who has financial interest in the Applicant or who is related within the second degree by consanguinity or affinity to a person having such financial interest. Such disclosure shall include a complete statement of the nature of such financial interest and the relation ship, if applicable. Moreover, the Applicant shall state whether the applicant knowingly has had a personal relationship with employees or officers of ATCMHMR within the past two (2) years. If there is no such conflict of interest as defined, the Applicant shall so state in the application.
9. The Applicant shall disclose the name of every ATCMHMR key person with whom the Applicant is doing business or has done business with during the 365 day period immediately prior to the date on which the application is due; or the Applicant shall state that the natural person executing the application has no knowledge of any key person with whom the Applicant is doing business or has done business with during the 365 days prior to the immediate date on which the application is due whose names are not disclosed in the application.

APPLICANT SIGNATURE

DATE

ATTACHMENT H

If you are applying to provide respite and/or childcare services in your home, please complete the following:

1. How long have you lived in your current residence? No. of Years _____ and Months: _____
2. What type of residence? House Duplex Town home Apartment
3. Do you rent or own? Rent Own
4. How many persons live with you? _____ How many family members? _____ How many non-family? _____

A. HOUSEHOLD CRIMINAL HISTORY CHECK

In order to conduct Criminal History Checks, list the persons residing in your household over age 16 other than yourself. All information requested is required.

Name	Gender (M/F)	Ethnicity	Date of Birth (MM/DD/YY)	Social Security Number
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____

Use additional pages if necessary

B. NON TRADITIONAL PROVIDER RESIDENCE SITE REVIEW

Provider is required to have a **Residence Site Review** if services are to be performed in your home. A copy of the Non Traditional Provider Residence Site Review form will be mailed or faxed to you once your completed application is received and reviewed by ATCMHMR. Then the Contract Manager will contact you to schedule the review. Once the review is completed, the Contract Manager will submit a copy of the review to you, and also to the Credentialing Department to be added to your application. You cannot be approved as a network provider until this is completed with a passing score.

C. FIRE INSPECTION

Providers doing services in the provider's residence are required to obtain a Fire Inspection by contacting the Austin Fire Department Fire Prevention Division at (512) 448-8300 to schedule. The completed Fire Inspection form will be given to you by the Fire Department. Submit the completed form with this application.

D. HOMEOWNER'S INSURANCE

Providers doing services in the provider's residence are required to submit a copy of their **Homeowner's Liability Insurance Policy or HOB-T** (Homeowners Tenant coverage with liability). Please attach a copy of your Certificate of Insurance page that needs to include the (a) name of the person or household covered, (b) type of insurance and (c) expiration date.

ATTACHMENT I – REFERENCE

The named applicant has applied for admission to ATCMHMR’s provider network and has given a release (Section I below) for you to complete the Reference Questionnaire in Section II below. Thank you.

Section I (to be completed by applicant before applicant sends directly to reference person) Reference #1

This reference below is for (name of applicant): _____

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

Signature of Applicant: _____ **Date:** _____

Reference below is to be completed by (name of reference person): _____

Section II (to be completed by the person completing the reference below and then mail to ATCMHMR)

Name: _____

Street Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____ Email: _____

How long have you known this applicant? _____

What is your relationship to the applicant? Supervisor Colleague Other _____

Briefly describe circumstances through which you have current knowledge of the applicant’s skills & competence:

Your Current Position (if applicable): _____ Organization: _____

Please rate the applicant on each element below (superior, adequate, unsatisfactory or unable to evaluate):

Element	Superior	Adequate	Unsatisfactory	Unable to Evaluate
1. Professional Judgment				
2. Sense of Responsibility/Reliability				
3. Competence/Skills/Knowledge				
4. Quality/Appropriateness of Services				
5. Ability to Work with Others				
6. Rapport with Consumers				
7. Service Documentation				
8. Written & Verbal Communication Skills				
9. Ability to work under pressure				
10. Dependability				
11. Ability to maintain regularly scheduled working hours				
OVERALL EVALUATION (ATCMHMR use)				

I recommend... I do not recommend... I am unable to evaluate this individual...

Comments: _____

I certify the above information is true and correct: _____
Signature of Person Providing Reference Date

To verify this reference, I can best be contacted by: Phone Email Other: _____
 (Check your phone number, email, address above in top box for accuracy/completeness so that we may reach you)

PLEASE RETURN COMPLETED REFERENCE TO: Credentialing Department, ATCMHMR, P. O. Box 3548, Austin, TX 78764-3548
FOR QUESTIONS CALL: Credentialing Department at 445-7787

ATTACHMENT I – REFERENCE QUESTIONNAIRE

The named applicant has applied for admission to ATCMHMR's provider network and has given a release (Section I below) for you to complete the Reference Questionnaire in Section II below. Thank you.

Section I (to be completed by applicant before applicant sends directly to reference person)	Reference #2
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This reference below is for (name of applicant): _____

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

Signature of Applicant: _____ **Date:** _____

Reference below is to be completed by (name of reference person): _____

Section II (to be completed by the person completing the reference below and then mail to ATCMHMR)

Name: _____

Street Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____ Email: _____

How long have you known this applicant? _____

What is your relationship to the applicant? Supervisor Colleague Other _____

Briefly describe circumstances through which you have current knowledge of the applicant's skills & competence:

Your Current Position (if applicable): _____ Organization: _____

Please rate the applicant on each element below (superior, adequate, unsatisfactory or unable to evaluate):

Element	Superior	Adequate	Unsatisfactory	Unable to Evaluate
12. Professional Judgment				
13. Sense of Responsibility/Reliability				
14. Competence/Skills/Knowledge				
15. Quality/Appropriateness of Services				
16. Ability to Work with Others				
17. Rapport with Consumers				
18. Service Documentation				
19. Written & Verbal Communication Skills				
20. Ability to work under pressure				
21. Dependability				
22. Ability to maintain regularly scheduled working hours				
OVERALL EVALUATION (ATCMHMR use)				

I recommend... I do not recommend... I am unable to evaluate this individual...

Comments: _____

I certify the above information is true and correct: _____
Signature of Person Providing Reference Date

To verify this reference, I can best be contacted by: Phone Email Other: _____
 (Check your phone number, email, address above in top box for accuracy/completeness so that we may reach you)

PLEASE RETURN COMPLETED REFERENCE TO: Credentialing Department, ATCMHMR, P. O. Box 3548, Austin, TX 78764-3548
FOR QUESTIONS CALL: Credentialing Department at 445-7787

Division Contacts

Toni Perkins
External Resource Coordinator
Child and Family Services
804-3172

Lisa Shelby
Contract Monitor
Developmental Disabilities Services and Child and Family Services
483-5891

Nancy Jones
Credentialing Coordinator
445-7787

Network Contract Coordinator
Developmental Disabilities and Child and Family Services
483-5892