Denton County
MHMR Center

2519 Scripture
Denton, Texas 76201

PO Box 2346
Denton, Texas 76202

OPEN ENROLLEMENT

REQUEST FOR APPLICATION (RFA)
Intellectual and Developmental Disabilities (IDD) Services

February 2025

Denton County MHMR Center
Attn: Natalee Galvan
contractsubmission@dentonmhmr.org

REQUEST FOR PROPOSALS FOR
STRATEGIC PLANNING SERVICES

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INTRODUCTION

The Denton County MHMR Center (hereinafter referred to as "The Center"), Texas Department of Aging and Disability Services (DADS) has authorized Denton County MHMR, 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 Denton County.

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 Denton County.

There is no guarantee of a 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.

Open enrollment documents are posted on The Center's website at https://www.dentonmhmr.org/volunteers/contract-opportunities/. Notice is hereby given that The Center will receive applications for providers beginning **February 2025**. **An original of the application and (1) copy of the attachments are due to:**

ATTENTION:
Denton County MHMR Center
Natalee Galvan
contractsubmission@dentonmhmr.org

Center Background & General Information

Denton County MHMR Center or "Local Authority" (Local Mental Health Authority "LMHA and Local Intellectual and Developmental Disability Authority "LIDDA") is the Texas Health and Humas Services "HHS" designated authority established to plan, coordinate, develop policy, develop, and allocate resources, supervise, and ensure the provision of community based mental health and intellectual and developmental disability (IDD) Services for the residents of Denton County, Texas. The Center receives funding from many diverse sources that enable it to provide a variety of services for people who have needs related to behavioral health and/or intellectual/developmental disabilities. A board of Directors appointed by the Denton County Commissioners court governs The Center.

2519 Scripture Street Denton, Texas 76201
2509 Scripture Street, Suites 100, 101, 103, and 104, Denton Texas 76201
1614 Scripture Street Denton, Texas 76201
3835 Morse Street, Denton, Texas 76208
3827 Morse Suite 101, Denton, Texas 76208 and
1001 Cross Timbers Suites 1250 and 1040, Flower Mound, Texas 75028

(The Center is exempt from State and local sales tax and federal excise tax)

Pursuant to 25 Texas Administrative Code $ 412.5 and 40 Texas Administrative Code $2.55, the LMHA and LIDDA have the authority to acquire services to address needs of mental health and/or intellectual/developmental disabilities needs by certain procurement methods. This Request for Applications (RFA)/Open Enrollment invites and encourages the submission of applications (each, an "Application" and collectively, the "Applications," and any party applying, and "Applicant") from those interested in entering one or more contracts (each a "Contract" and collectively the "Contracts") with The Center. Each qualified Applicant(s) under this RFA/Open Enrollment (each a "Successful Applicant" and collectively, the "Successful Applicants") will be eligible to enter a Contract with The Center to provide one or more of the community-based services.

The individual who will be served under this arrangement each, a "Client" and collectively, "Clients" must always (a) meet the then current requirements of the funder of the services, and (b) reside in Denton County, Texas. An individual's designation as a client may only be made by the Local Authority and must be documented in their record. This RFA/Open Enrollment invites the submission of Applications from those interest in being considered for a Contract with The Center for the purpose of offering services for Clients.

Mission Statement, Agency Principles, Vision, & Values

Mission Statement

Denton County MHMR Center enhances the quality of the individuals serves and their family members.

Diversity, Equity, and Inclusion

At our Center, diversity and inclusion are an integral part of our mission and values. We strive to support an inclusive culture that celebrates, encourages, and supports our diverse staff and the community that we serve. When individuals feel respected and included, everyone can work collaboratively to create an innovative work atmosphere and a person-centered treatment environment for the individuals serves and their families.

Our Guiding Principles

Denton County MHMR Center we believe these principles should guide our interactions with our clients and with interactions between our staff.

- Assumes Good Intentions
- Understanding You is Important
- Share Knowledge and Resources
- Create a Safe Space
- Good Ideas Can Come from Anywhere at Any Time
- Strive for Continual Improvement

The Center's Values are:

We respect each individual's unique and special concerns by providing assistance to best fit their needs, that enhances their ability to live a full and dignified life, and that celebrates the contributions all individuals make to our community. Our core values are:

- Individual Worth
- Integrity
- Community Inclusion
- Opportunity
- Compassion
- Dignity
- Choice

The Center's Vision Statement is:
We envision a DCMHMR Center

- That provides effective, comprehensive, and timely services to any and all people in need.
- Where a qualified, motivated, and caring staff strive to make a difference in the lives of those they serve.
- That offers state-of-the-art, high-quality facilities to assist individuals in living full and productive lives.

General Information

The Center is wholly committed to equal opportunity for all potential respondents and does not discriminate, limit, segregate, or classify any individual or vendor with respect to respondent's compensation, terms, conditions, or award of contract because of race, color, religion, gender, national origin, age, disability, political affiliation, sexuality, or other classifier defined by Local, State, and Federal Law.

The Center reserves the right to modify the general description and scope of services contained in the RFA/Open Enrollment by notifying potential applicants of any modifications.

If any of the provisions of the RFA/Open Enrollment conflict with applicable laws, rules, regulations, and/or other codes of professional ethics, the latter shall prevail over the provisions of the RFA/Open Enrollment.

The Center shall not reimburse potential contractors for any expenses incurred preparing applications in response to this request.

Any information that the respondent deems to be proprietary or otherwise confidential in the text of the application should be marked with red brackets or otherwise clearly designated as such. However, respondents are advised that the Center may disclose such proprietary information to appropriate parties if required to do so by applicable Texas open meetings and public record statues.

All questions and communications concerning the RFA/Open Enrollment, and process must be made in writing to the Procurement Analyst & Contract Developer only, at the following email address:

contractsubmission@dentonmhmr.org.

Note: Subject line of the email must read RFA/Open enrollment – Yes Waiver

Note: It is the Centers intent to respond to all appropriate questions or convers received.

Purpose of the RFA/Open Enrollment

1. To provide a comprehensive community system of services and support.
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.

Target Population

The target population recipients are adults, adolescents, and children who have been identified 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 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 intellectual 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 people 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.

Request for Application

As a result of the passage of HB 2377, of the 74th legislature, the Texas Health and Human Services Commission has mandated that LIDDA's assembling a network of service providers to serve people with intellectual and developmental disabilities. The DCMHMR Board of Directors has requested that the Executive Director develop a network of qualified providers willing to provide the following services sought for people with intellectual and developmental disabilities and/or related conditions in the least restrictive environment and the most integrated setting within the community.

INSTRUCTIONS FOR SUBMISSION FOR APPLICATIONS

To facilitate and ensure an objective review, Applicants must follow these instructions for submission. Denton County MHMR Center (The Center) expressly reserves the right to reject any application that is not submitted according to the instructions below.

Applicants must email (1) original of the completed application and one (1) copy of all applicable attachments to:

Email: contractsubmission@dentonmhmr.org Subject: _____

Applicants must follow the attached outline for submissions to facilitate objective review. The Center reserves the right to reject any and all applications, to waive technicalities, and to accept any advantages deemed beneficial to the Center and its clients. **Please be sure to answer every question. If the question does not apply to your or your organization, simply and clearly document "N/A".**

False statements or false information provided by an Applicant may result in disqualification from or termination of enrollment into the network. In accepting applications, The Center reserves the right to reject any and all Applications, to waive formalities and reasonable irregularities in submitted documents, and to waive any requirements in order to take the action which it deems to be in the best interest of the Local Authority. The Center will not pay for any costs incurred by Applicants in the preparation and submission of a response to this RFA.

Each Applicant is responsible for ensuring that documents for potential enrollment are submitted completely and on time. The Local Authority expressly reserves the right not to evaluate any enrollment documents that are incomplete or late. Any attached form(s) must be completed by each Applicant to be considered for possible enrollment in the network.

Each Applicant shall be subject to disclosure under the Texas Public Information Act, Chapter 552 of the Texas Government Code, **except for trade secrets and confidential information contained in the Application and clearly identified by the Applicant as such with blue ink**. Such information may still be subject to disclosure under the Public Information Act and other applicable law.

Attachment A

Intellectual and Developmental Disabilities (IDD) Priority Population

The Priority Population for intellectual and developmental disabilities (IDD) services includes those people 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 the 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 people 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 the 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.

People 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

Day Habilitation

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

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 access 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.

- APPLICATION -

Please indicate the service(s) you are applying for by checking in the box(es) below.

Refer to Attachment B for descriptions of services and rates.

Intellectual and Development Disabilities (IDD) Services
OPEN ENROLLMENT

[ ] Day Habilitation
[ ] Specialized Therapies*
[ ] Occupational Therapy
[ ] Speech / Language Therapy

***Servicers required completion of the "Texas Standardized Credentialing Application" for licenses providers:**
https://www.dentonmhmr.org/volunteers/contract-opportunities/

BUSINESS DEMOGRAPHICS

Organization/Individual Name:_____
DBA: _____Federal Tax ID #_____
Agency NPI Number: _____ Business Address:_____
Contact/Title: _____ Email Address: _____
Address: _____Phone:_____Fax: _____

Executive Director-Owner/Title:_____Email Address: _____
Address: _____Phone:_____Fax: _____

Service Contact/Title: _____Email Address: _____
Address: _____Phone:_____Fax: _____

Billing Contact/Title: _____Email Address: _____
Address: _____Phone:_____Fax: _____

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 DCMHMR board member or employee? □Yes □No

Is the business owner related to a current DCMHMR board member or employee? □Yes □No

If yes, who: _____

Owners/Partners:

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

Number of years in operation as a business: _____

Languages services provided in: _____

Organization/individual certified as/or eligible to be a Historically Underutilized Business: Yes___ No _____ (*If certified, provide Certification Number):* _____

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:

_____

_____

_____

SERVICES

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 support, etc.)

_____

_____

_____

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

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:_______

How many individuals can the organization/provider serve: _______________________

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

____

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

____

____

____

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

____

Describe the organization's/provider's experience in working with people with mental health or intellectual and developmental disabilities (IDD), autism, and related conditions over the last five (5) years:

_____

_____

_____

Describe the organization's/provider's ability to work with persons who are hearing impaired, persons who have limited language skills, and persons who speak a language other than English:

_____

_____

_____

Describe the organization's/provider's experience in working with people with physical impairment and adaptive equipment:

_____

_____

_____

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

_____

_____

_____

Describe any "after hours" system for responding to client needs: _____

Can DCMHMR clients access services outside usual business hours: _____

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

_____

EXPERIENCE

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

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:

_____

_____

_____

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

_____

_____

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

_____

Describe abilities/experience working with diverse groups of individuals with regards to ethnic, racial, religious, and sexual orientation: *(Attach additional pages as necessary)*

_____

_____

Describe any limitations on capacity to serve the population (age ranges, total number of clients, geographical region, etc.): *(Attach additional pages as necessary)*

_____

_____

Describe approach to working with individuals who are non-compliant with treatment: *(Attach additional pages as necessary)*

_____

_____

QUALITY MANAGEMENT/UTILIZATION MANAGEMENT

Describe how organization/individual protects the security of individuals receiving services and their protected information. Attach any policies and procedures organization has implemented related to this area: *(Attach additional pages as necessary)*

_____

_____

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

_____

_____

Describe how organization/individual prevents, identifies, and reports abuse, neglect, exploitation and rights violations pertaining to individuals receiving services, including the training of staff on these issues. Attach any policies and procedures organization has implemented related to this area: *(Attach additional pages as necessary)*

_____
_____

Describe how organization/individual identifies, controls, avoids, minimizes, and/or eliminates unacceptable risks to individuals receiving services and liability to the organization/individual.
Attach any policies and procedures the organization has implemented related to this area:
(Attach additional pages as necessary)

_____
_____

FINANCIAL
Is the organization/provider incorporated as "Profit," "Not-for-profit," or "Other?"
(If yes, attach a valid 501C IRS Exemption Form)
If "Other," please explain: _____

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:

_____
_____

Provide name of Workers' Compensation carrier if organization has Workers' Compensation coverage or self-funding documents if self-funded: _____
Has the organization/provider declared any type of bankruptcy in the prior seven (7) years?

_____
_____

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:

_____

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:

_____
_____
_____
_____

Is the organization/provider currently under investigation, or have a license or accreditation revoked by any state/federal/DCMHMR or licensure agency, within the last five (5) years_____
If yes, please explain:

_____
_____

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

_____
_____

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:

_____
_____

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***

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

_____
_____

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:

_____

_____

_____

Describe anyone working for the organization/provider providing direct care or in management have any felony convictions? _____ If yes, explain:

_____

_____

_____

PROFESSIONAL LIABILITY INSURANCE

Organization and licensed/certified professionals must have professional liability insurance with limits of at least one (1) million each occurrence and three (3) million aggregate. **Please attach policy certificate showing effective date and expiration date of coverage, per occurrence amount and aggregate amount.**

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.***

RISK ASSESSMENT

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 of a retention of people with criminal histories:

_____

_____

_____

Has the organization/provider or its employees had any validated 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 in these issues:

_____

_____

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.

INFORMATION SYSTEMS

Organization/individual must have and maintain internet access and a current email account in order to be eligible to be a party to a contract.

a. Does organization/individual have internet access and a valid email address: Yes No

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 DCMHMR clients
7. Elopements or unauthorized departures from the program site
8. Confirmed abuse, neglect, or exploitation of DCMHMR clients.
9. Death or severe injury to DCMHMR clients occurring at program site.

RATE SCHEDULE

Applicants agree 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 DCMHMR 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 DCMHMR 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. DCMHMR 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 entity for the same service.

Attachment C

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 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 so, please explain._____

Do you know sign language? ____Yes, ____No If so, please explain._____

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.**

Dates (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 to meet this requirement.**

1. _____

Employer name Address City, State, Zip Code

_____

Position title/description From - To

2. _____

Employer name Address City, State, Zip Code

_____

Position title/description From - To

3. _____

Employer name Address City, State, Zip Code

_____

Position title/description From - To

4. _____

Employer name Address City, State, Zip Code

_____

Position title/description From - To

5. _____

Employer name Address City, State, Zip Code

_____

Position title/description From - To

Have you ever been terminated with cause from any human service agency?

____Yes, ____No If so, please explain._____

Attachment D

ATTESTATION

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

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

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 accurately reported any history of felony convictions or client abuse and neglect.
- I have accurately reported any chronological work history.
- I consent to the inspection of records and documents pertinent to this Application, including the release by any person to Denton County My Health My Resources Center, *dba* Denton MHMR Center (the Center) of all information that may reasonably be relevant to an evaluation and verification of this Application or evaluation of professionals or institutions with which Organization/Individual has been or is currently associated.
- The information submitted in and with the application is complete and correct to the best of my knowledge.

_____

Signature of Individual or Organization's Authorized Representative

_____

Date

_____

Printed Name

_____

Title (if applicable)

_____

Organization/Program Name (if applicable)

Attachment E

GENERAL AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned Individual, or authorized representative of Organization (acting on Organization's behalf), hereby authorize Denton County My Health My Resource Center *dba* Denton County MHMR Center (The Center) to obtain any and all information required to complete a review and primary source verification of Organization/Individual's credentials. Information and documents to be reviewed include, but are not limited to, licensure/certification, accreditations, education, and claims made against licensure/certification, malpractice insurance and claims.

I, the undersigned Individual or authorized representative of Organization, hereby release from liability and hold harmless for the consequences of any disclosure, to the fullest extent permitted by law, the named references in this Application and Denton County My Health My Resource *dba* Denton County MHMR Center (The Center) for their written and oral statements, decisions, and actions in connection with evaluating Organization/Individual's Application for network approval including, without limitation, Organization/Individual's experience, competencies and qualifications, health status, emotional stability, professional ethics, and character. Organization/Individual hereby releases 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. Organization/Individual also released from any liability any and all individuals and organizations who provide information in good faith and without malice concerning the above release items.

A photostat, electronic or facsimile copy of this original statement constitutes Organization/Individual's written authorization and requests to release any and all documentation relevant to Denton County My Health My Resource Center *dba* Denton County MHMR Center credentialing and/or network approval process. Such photostat, electronic or facsimile copy shall have the same force and effect as the signed original.

_____

Signature of Individual or Organization's Authorized Representative

_____

Date

_____

Printed Name

_____

Title (if applicable)

_____

Organization/Program Name (if applicable)

Attachment F

ASSURANCES DOCUMENT

For purposes of this ***Attachment F***, the term "local government officer" with respect to Denton County MHMR Center means a member of Denton County MHMR Center Board of Trustees (see ***Attachment H***), Denton County MHMR Center's Chief Executive Officer (see ***Attachment H***), and/or an agent of Denton County MHMR Center who exercises discretion in the planning, recommending, selecting, or contracting of the Contract (see ***Attachment H***). The term "local public official" with respect to Denton County MHMR Center means a member of Denton County MHMR Center's Board of Trustees (see ***Attachment H***), or another agent of Denton County MHMR Center who exercises responsibilities beyond those that are advisory in nature (see ***Attachment H***).

The term "family member" means a person related to another person within the first degree by consanguinity or affinity, as described by Subchapter B, Chapter 573 of the Texas Government Code. The term "family relationship" means a relationship between a person and another person within the third degree by consanguinity or the second degree by affinity, as those terms are defined by Subchapter B, Chapter 573, Texas Government Code.

Applicant Assures the Following:

1. Applicant has received all addenda and attachments to the RFA/Open Enrollment as distributed by Denton County MHMR Center.

2. Applicant will not make any attempt to induce any person or firm to submit or not submit an Application.

3. Applicant will ensure that no person on the basis of race, color, national origin, religion, sex, age, sexual orientation, gender identity, genetic characteristics, veteran status, disability or political affiliation, will be excluded from participation in, be denied the benefits of, or be subject to discrimination with respect to any Contract, under any of the policies of HHSC or Denton County MHMR Center. Applicant does not discriminate in its service or employment practices on the basis of race, color, religion, sex, sexual orientation, genetic characteristics, national origin, disability, veteran status, age, or political affiliation.

4. Applicant accepts the terms, conditions, criteria, and requirements set forth in the RFA/Open Enrollment.

5. Applicant accepts Denton County MHMR Center's right to alter the timetables for procurement as set forth in the RFA/Open Enrollment.

6. The Application submitted by Applicant has been arrived at independently without consultation, communication, or agreement for the purpose of restricting competition.

7. Unless otherwise required by law, the information in the Application submitted by Applicant has not been knowingly disclosed by Applicant to any other Applicant.

8. No claim will be made for payment to cover costs incurred in the preparation or the submission of the Applicant or any other associated costs.

9. The individual signing this Assurances Document is authorized to legally bind the Applicant

10. Applicant agrees to follow all applicable federal, state, county, and local laws, regulations, codes, standards, and all applicable Denton County MHMR Center policies and procedures if chosen as the Successful Applicant.

11. No employee, local government officer or any family member thereof has directly or indirectly received any gift(s) with an aggregate value of more than $100 in the 12-month period preceding the date the local government officer becomes aware that Denton County MHMR Center is considering entering into a Contract with Applicant, but excluding a political contribution defined by Title 15 of the Texas Election Code, or food accepted as a guest. If Applicant is unable to make this affirmation, then Applicant must disclose any knowledge of such interests by including a completed Form CIQ, a copy of which is attached to this ***Attachment F,*** with the submitted Applicant. *See* ***Attachment H.***

12. Applicant does not have a family relationship with a local government officer of Denton County MHMR Center. If such family relationship exists, Applicant must disclose any knowledge of such relationships by including a completed Form CIQ, a copy of which is attached to this Assurances Document with the submitted Applicant. *See* ***Attachment H****.*

13. Applicant does not have any employment or business relationship with any corporation or other business entity with respect to which any local public official of Denton County MHMR Center or any family member thereof serves as an employee, officer or director, or holds an ownership interest and no local public official of Denton County MHMR Center or family member thereof has an employment or business relationship with Applicant, or holds an ownership interest in Applicant. If Applicant is unable to make this affirmation, then Applicant must disclose any knowledge of such relationships in a written statement included with this signed Assurances Document.

14. Applicant shall disclose in a written statement included with this signed Assurances Document whether any of the directors or personnel of Applicant has either been an employee or a trustee of Denton County MHMR Center within the past two (2) years preceding the date of submission of the Application. This requirement applies to all personnel, whether or not identify as a Key Person. If such employment has existed, or any term of office been served, include in the written statement the nature and time of the affiliations as defined.

15. Applicant does not have any employment or business relationship with any corporation or other business entity with respect to which any local government officer of Denton County MHMR Center either serves as an employee, officer or director, or holds an ownership interest of one percent or more, and no local public official of Denton County MHMR Center or family member thereof has an employment or business relationship with Applicant, or holds an ownership interest in Applicant. If the Applicant is unable to make this affirmation, then the Applicant must disclose any knowledge of such relationships by including a completed form CIQ, a copy of which is attached to this ***Attachment F***, with the submitted Applicant. *See* ***Attachment H****.*

16. No former employee or officer of HHSC and/or Denton County MHMR Center directly or indirectly aided or attempted to aid in procurement of Applicant's service.

17. No local government officer or family member thereof is receiving or is likely to receive taxable income, other than investment income, from Applicant. If Applicant is unable to make this affirmation, then Applicant must disclose any knowledge of such relationships by including a completed form CIQ, a copy of which is attached to this ***Attachment F***, with the submitted Application. *See* ***Attachment H****.*

18. Under Section 231.006, Family Code, the vendor or applicant certifies that the individual or business entity named in this contract, bid, or application is not ineligible to receive the specified grant, loan, or payment and acknowledges that this contract may be terminated and payment may be withheld if this certification is inaccurate. For purposes of the foregoing sentence, "vendor or applicant" shall mean Applicant; contract, bid or application shall mean the Application; and "this contract" shall mean any Contract awarded to a Successful Applicant pursuant to this RFA/Open Enrollment.

19. Applicant is not currently held in abeyance or barred from the award of a federal or state contract.

20. Applicant is currently in good standing for payment of all applicable state tax.

21. Applicant is in good standing with all state and federal funding and regulatory agencies; is not currently debarred, suspended, or otherwise excluded from participation in federal, state, county or city contract or grant programs; is not delinquent on any repayment agreements; has not had a required license or certification revoked; has not had a contract terminated by HHSC; and has not voluntarily surrendered an obligation issued by HHSC or any other entity within the past three (3) years.

22. Applicant agrees to provide the Services described in this RFA/Open Enrollment at the rate(s) of payment described in the Application.

23. Applicant is a reputable company regularly engaged in providing products and/or services necessary to meet requirements, specifications, terms, and conditions of the RFA/Open Enrollment.

24. Denton County MHMR has the right to complete background checks and verify information.

25. The address submitted by the Applicant to be used for all notices sent by Denton County MHMR is current and correct.

26. Applicant has the necessary experience, knowledge, abilities, skills, and resources to satisfactorily perform the requirements, specifications, terms, and conditions of the RFA/Open Enrollment.

27. This Application shall remain in full force and effect until August 1st, 2027, and may be accepted by Denton County MHMR Center at any time prior to this date.

28. The requirements of Subchapter J, Chapter 552, Government Code, may apply to the Contract and Applicant agrees that the Contract can be terminated if the Applicant knowingly or intentionally fails to comply with a requirement of that Subchapter.

_____	_____	_____
Signature of Authorized Representative	Title (if applicable)	Date

Attachment G

CERTIFICATION REGARDING LOBBYING, GRANTS, LOANS, & COOPERATIVE AGREEMENTS

The undersigned certifies, to the best of his or her knowledge and belief that:

1. No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or an employee of any agency, a member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

2. If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress an officer or employee of Congress or an employee of a member of Congress in connection with this federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

3. The undersigned shall require that the language of this certification be included in the award documents for all sub awards at all tiers (including subcontractors, subgrant, and contracts under grants, loans, and cooperative agreements) and that all sub recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

_____

Signature of Individual or Organization's Authorized Representative

_____

Date

_____

Printed Name

_____

Title (if applicable)

_____

Organization/Program Name (if applicable)

Attachment H

EXECUTIVE LEADERSHIP TEAM

TITLE	NAME	BUSINESS ADDRESS	BUSINESS PHONES #
Executive Director	Pam Gutierrez	2519 Scripture St, Denton, TX 76201	(940)381-5000
Chief Operations Officer	Fonny Cooper Wright	2519 Scripture St, Denton, TX 76201	(940)381-5000
Chief Financial Officer	Michelle Conrad	2519 Scripture St, Denton, TX 76201	(940)381-5000
Chief Medical Officer	Dr. Meena Vyas	2519 Scripture St, Denton, TX 76201	(940)381-5000
Chief Human Resources Officer	Erin Posey	2519 Scripture St, Denton, TX 76201	(940)381-5000
Chief Clinical Officer	Wakeelah Adelegan	2519 Scripture St, Denton, TX 76201	(940)381-5000
Chief Technology Officer	Ritch Wright	2519 Scripture St, Denton, TX 76201	(940)381-5000
Senior Director of Nursing	Azeb Abate	2519 Scripture St, Denton, TX 76201	(940)381-5000
Senior Director of IDD Services	Wesley Warren	2519 Scripture St, Denton, TX 76201	(940)381-5000
Senior Director of Community Integration Services	Karen Simmons-Clifton	2519 Scripture St, Denton, TX 76201	(940)381-5000
Senior Director of Crisis Services	Dallas Hamilton	2519 Scripture St, Denton, TX 76201	(940)381-5000
Senior Director of QM/UM	Veronica Armendariz	2519 Scripture St, Denton, TX 76201	(940)381-5000
Senior Director of Behavioral Health	Jessica Pham	2519 Scripture St, Denton, TX 76201	(940)381-5000
Senior Director of Clinical Services	Sharon Jones	2519 Scripture St, Denton, TX 76201	(940)381-5000
Director of Procurement	Randi Silar	2519 Scripture St, Denton, TX 76201	(940)381-5000
Director of Facilities	Alex Wright	2519 Scripture St, Denton, TX 76201	(940)381-5000
HR Director	Jennifer Akcali	2519 Scripture St, Denton, TX 76201	(940)381-5000
Assistant Medical Director	Rohini Ravindran	2519 Scripture St, Denton, TX 76201	(940)381-5000
Clinical Operations Director	Sarah Yeoman	2519 Scripture St, Denton, TX 76201	(940)381-5000
Controller	Margie Lea	2519 Scripture St, Denton, TX 76201	(940)381-5000
Director of Behavioral Health	Melodye McKaye	2519 Scripture St, Denton, TX 76201	(940)381-5000
Executive Assistant	Taylor Warren	2519 Scripture St, Denton, TX 76201	(940)381-5000
Billing Director	Judith Michael	2519 Scripture St, Denton, TX 76201	(940)381-5000

Chair, Finance Committee Chair, Facilities & Assets Committee	Dianne Hickey		
Vice Chair, Finance Committee, Facilities & Assets Committee	Arthur K. Sayre		
Board Secretary – Ad Hoc Committee	Judi Swayne		
Board Member – Personnel Committee	Cynthia Jones		
Board Member – Facilities & Assets Committee	Douglas Lee		
Board Member – Vice Chair Personnel Committee	Jack Phillips		
Board Member – Chair Facilities & Assets Committee	Ron Marchant		
Vice Chair of the Personnel Committee	Linda Holloway, PHD		
Ad Hoc Committee Chair	Patti Dunn		
Facilities & Assets Committee	Leah Strittmatter		
Board Member	Isabel Hernandez		

Attachment I

CRIMINAL BACKGROUND CHECK FORM

LEGAL NAME: FIRST:_____ **LAST:** _____

SOCIAL SECURITY #:_____ DATE OF BIRTH: _____

GENDER:_____ RACE:_____ EMAIL ADDRESS: _____

MAILING ADDRESS: _____

CITY:_____ STATE:_____ ZIP:_____ PHONE #: _____

LIST ALL THE STATES YOU HAVE LIVED IN THE LAST TWO YEARS (INCLUDING TX): _____

In addition to obtaining criminal history record information from TDPS, local authorities must obtain criminal history information for applicants who have lived outside of the State of Texas at any time during the two years preceding the contract through the FBI using a complete set of fingerprints on the official FBI card. DCMHMR Center assumes no liability nor responsibility should the results of this background check, nurse aid registry check, misconduct registry check, or debarred vendor check divulge that the applicant is ineligible for consideration as a provider of services.

With the below signature, I give Denton County MHMR Center my permission to run the above-described background check, as well as the nurse aide registry, misconduct registry check and debarred vendor check. I also declare my full understanding that the above test will be performed by Denton County MHMR Center on an annual basis. If the LEIE check applies, the LEIE check will be performed by Denton County MHMR Center on a monthly basis.

_____ _____

Signature of Contractor *Date*

If Provider, its officers, employees, or agents have a conviction as described in this section, then Agreement may be terminated without prior notice. For the purpose of this Agreement, convictions of criminal offenses which constitute an absolute bar to employment are (a) criminal homicide; (b) kidnapping, unlawful restraint, and smuggling of persons; (c) continuous sexual abuse of young child or children or indecency with a child; (d) sexual assault; (e) aggravated assault; (f) injury to a child, elderly individual, or disabled individual; (g) abandoning or endangering child; (h) aiding suicide; (I) agreement to abduct from custody; (j) sale or purchase of child; (k) arson; (l) robbery; (m) aggravated robbery; (n) indecent exposure; (o) improper relationship between educator and student; (p) improper photography or visual recording; (q) deadly conduct; (r) aggravated sexual assault; (s) terroristic threat; (t) exploitation of child, elderly individual, or disabled individual; (u) online solicitation of a minor; (v) money laundering; (w) Medicaid fraud; (x) obstruction or retaliation; (y) cruelty to livestock animals or cruelty to no livestock animals; or (z) 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 by this subsection. A person may not serve in a position the duties of which involve direct contact with an individual receiving services before the fifth (5th) anniversary of the date the person is convicted of (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 a peace officer; or (g) disorderly conduct.