



2519 Scripture
Denton, Texas 76201

PO Box 2346
Denton, Texas 76202

OPEN ENROLLEMENT

REQUEST FOR APPLICATION (RFA) Intellectual and Developmental Disabilities (IDD) Services #2026-04-20

APRIL 2026

**Denton County MHMR Center
contractsubmission@dentonmhmr.org**

**REQUEST FOR PROPOSALS FOR
STRATEGIC PLANNING SERVICES**

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INTRODUCTION

Denton County MHMR Center, (hereinafter referred to as (“The Center”), a Community Center and an Agency of the State of Texas, under the provisions of Chapter 534 of the Texas Health & Safety Code Ann. (Vernon 1992), and a Certified Community Behavioral Health Clinic (the “Center” or “CCBHC”) for the purpose of providing community based services currently not available to the Authority through its present staff of employees and to assemble a network of service providers to provide intellectual and developmental disabilities (IDD) services to the Priority Population of people 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.dentonmhm.com/volunteers/contract-opportunities/>. Notice is hereby given that The Center will receive applications for providers beginning **April 2026. An original of the application and (1) copy of the attachments are due to:**

ATTENTION:
Denton County MHMR Center
contractsubmission@dentonmhm.com

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 Human Services “HHSC” 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
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 Chapter 26 of the Texas Administrative Code § 301.19 & § 301.21, 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 “INDIVIDUAL” and collectively, “INDIVIDUALS” 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 an individual 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 that interest in being considered for a Contract with The Center for the purpose of offering services for individuals.

Mission Statement, Agency Principles, Vision, & Values

Mission Statement

The Center enhances the quality of the individuals served and their family members.

Our Guiding Principles

The Center, we believe these principles should guide our interactions with our INDIVIDUALS 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 Denton County MHMR 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 the applicable U.S. Government 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 statutes.

All questions and communications concerning the RFA/Open Enrollment, and process must be made in writing to the Service Contractor Administrator, Ahsan Rahman or Director of Procurement, Randi Silar only, at the following email address:

contractsubmission@dentonmhm.org.

Note: Subject line of the email must read RFA/Open enrollment – Intellectual & Developmental Disabilities (IDD) Services

Note: It is the Centers intent to respond to all appropriate questions or conversations 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 individual 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 individual access and allow individual 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 and adolescents 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 Center 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: IDD Open Enrollment

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 INDIVIDUALS. **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 laws.

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 (HHSC) 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 HHSC 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 HHSC.

People who are members of the Priority Population are eligible to receive services from the HHSC 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

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.

Specialized Services: Assessment & Treatment of Problem Behavior:

\$72.15 – one (1.0) hour

Specialized interventions by a credentialed professional to assist an individual to increase adaptive behaviors and to replace or modify maladaptive behavior that prevents or interferes with the individual's inclusion in home and family life or community life. All assessment services and treatment recommendations will use the empirically based best practices of Applied Behavior Analysis (ABA).

Supports include:

- Assessing and analyzing assessment findings so that an appropriate behavior support plan may be designed.
- Developing an individualized behavior support plan consistent with the outcomes identified in the individual's Plan of Services and Supports.
- Training and consulting with family members or other providers and, as appropriate, the individual
- Monitoring and evaluating the success of the behavioral support plan and modifying the plan as necessary.
- Providing functional assessment and treatment services to individuals with intellectual and developmental disabilities for problem behaviors that interfere with school and therapy services, Applied Behavior Analysis treatment programs, community inclusion, habilitation services or which threatens the person's placement in the community and
- Providing a detailed report of assessment findings and treatment recommendations for caregivers.
- New referrals will be evaluated within 30 days to determine the need for a customized behavioral support plan. Individuals that are determined not to require a customized behavioral support plan will be referred back to the Authority with a recommendation for alternative service/treatment strategies.
- Services will be delivered in a facility operated by the Contractor, the individual's home or other environment determined to be clinically appropriate by the Contractor.

- 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*
- Speech / Language Therapy (Circle One)
- Applies Behavior Analysis Service

***Servicers required completion of the “Texas Standardized Credentialing Application” for licenses providers:**
<https://www.dentonmhm.com/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 the Center board member or employee? Yes No

Is the business owner related to a current Center 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 HHSC, 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 individual's needs: _____

Can the Center individuals 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 INDIVIDUALS, 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/the Center 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.1**

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 individual abuse, individual 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 individual abuse, individual 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/individuals 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. INDIVIDUAL name
2. INDIVIDUAL'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 the Center individual's
7. Elopements or unauthorized departures from the program site
8. Confirmed abuse, neglect, or exploitation of the Center individuals.
9. Death or severe injury to the Center individuals' 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 the Center for any non-covered service. Applicant agrees that compensation for providing non-covered services will be solely between the individual and the Applicant. The Covered Individual must be informed in writing, before any non-covered services are provided that the Center is not responsible for payment for such services. Individuals are responsible for payment for non-covered services only if the Covered Individual consents in writing to the provision of such non-covered services. The Center is the payor of last resort. If the authorized services for a Covered Individual are currently paid for by a third-party payor, applicant may not bill both entity for the same service.

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 individual 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 (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 (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 (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 the 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 the Center means a member of the Center Board of Trustees. The Center’s Chief Executive Officer, and/or an agent of Denton County MHMR Center who exercises discretion in the planning, recommending, selecting, or contracting of the Contract. The term “local public official” with respect to the Center means a member of the Center’s Board of Trustees or another agent of the Center who exercises responsibilities beyond those that are advisory in nature.

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. Applicants 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. Applicants accept 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. As well as cancelling the RFA/Open Enrollment at any time.
6. The Application submitted by Applicant has been arrived 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)



Background and Registries Check Contractor Requirements

My signature below represents my informed consent and acknowledgment that Denton County MHMR Center is authorized to conduct background and registry checks upon execution of my contractual agreement and at any time during the term of my contract.

Contractor ID:	First Name:	Middle Name:	Last Name:
Date of Birth:	Social Security #:	Driver's License # / State:	Male / Female (circle one)
Contracted Date:	Signature:		Date:

- _____ Criminal History
- _____ DADS
- _____ Texas Health and Human Services (HHS)
- _____ Federal OIG / State OIG
- _____ CARE
- _____ SAM
- _____ MVR
- _____ NWSOP

Background check searches were completed by _____

Search results DO DO NOT contain items listed as criminal bars to employment (TX Health & Safety Code §250.006);
 The applicant WAS WAS NOT listed in the HHS registries or LEIEs searched; and
 Search results DO DO NOT contain items indicating the need for secondary administrative review.

Contracts Coordinator

Date

HR Director

Date

Comments:

<u>DATE</u>	<u>Check Ran</u> <u>By</u>	<u>DPS</u>	<u>HHS</u>	<u>CARE</u>	<u>Admin.</u> <u>Review</u>
		<input type="checkbox"/> Do Contain Bar <input type="checkbox"/> Do Not Contain Bar	<input type="checkbox"/> Finding <input type="checkbox"/> No Finding	<input type="checkbox"/> Finding <input type="checkbox"/> No Finding	<input type="checkbox"/> Yes <input type="checkbox"/> No _____ Initials
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			<input type="checkbox"/> No Finding		_____ Initials
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