2519 Scripture Street
Denton, Texas 76201

PO Box 2346
Denton, Texas 76202

OPEN ENROLLEMENT

REQUEST FOR APPLICATION (RFA)
Youth Empowerment Services (YES) Waiver Services

6.10.2026
June 2026 - Revised

Denton County MHMR Center
contractsubmission@dentonmhmr.org

INTRODUCTION

The Denton County MHMR Center (hereinafter referred to as "**The Center"**), a community MHMR Center and governmental unit of the State of Texas, is seeking to contract with local providers for the purpose of providing Youth Empowerment Services (YES) Waiver services to eligible residents of Denton County.

The Center is committed to supporting the health and well-being of adults and children throughout Denton County. Network providers are key to the overall success of the individuals who depend on our agency for their healthcare needs.

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 June 2026. A**pplication can be emails to the below:**

ATTENTION:
Denton County MHMR Center
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 "HHSC" designated authority established to plan, coordinate, develop policy, develop, and allocate resources, supervise, and ensure the provision of community based 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
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 $ 301.19 and 40 Texas Administrative Code 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, an "Client" and collectively, the "Client," and any party applying, and "Client") 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 interested 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.

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 the Center

- That provides effective, comprehensive and timely services to any and all persons 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 no 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 Contract Coordinator 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. Contracted qualified providers for the full YES Waiver service array.
2. Services on the IPC being provided free of any conflict of interest (i.e. services are not provided by the individual/agency developing the IPC, except as the provider of last resort).
3. Access to all services on an authorized IPC within 10 business days of the date of authorization.
4. A choice for participants of qualified providers of individual Waiver services.
5. Access to providers within 30 miles of the participant's residence (within 75 miles if the participant lives in a rural area).

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Services Sought

This RFA/Open Enrollment seek participation from Successful Applicants for the purpose of offering:

YES Waiver Services

1. Specialized Therapies:
   a. **Animal Assisted Therapy:** Animals are utilized in goal-directed treatment sessions as a modality to facilitate optimal physical, cognitive, social, and emotional outcomes of a participant, such as increasing self-esteem, increasing motivation and reducing stress. Animal-assisted therapy is delivered in a variety of settings by specifically trained individuals in association with animals that meet specific criteria and in accordance with guidelines established by the American Veterinary Medical Association.
   b. **Art Therapist:** Human service profession in which Waiver participants, facilitated by the art therapist, use of art media, the creative process, and the resulting artwork, art therapy assists the participant in exploring feelings, reconciling emotional conflicts, fostering self-awareness, managing behavior, developing social skills, improving reality orientation, reducing anxiety, and increasing self-esteem.
   c. **Music Therapist:** Musical or rhythmic interventions are utilized to assist the participant in accomplishing the restoration, maintenance, or improvement of social or emotional functioning, mental processing, or physical health. Music therapy provides a participant the opportunity to move from isolation into active participation through an increase in verbal and nonverbal communication, social expression, behavioral and social functioning, and self-awareness.
   d. **Nutrition Therapist:** Nutritional counseling assists the participant in meeting basic and/or special therapeutic nutritional needs, including, but not limited to, counseling in nutrition principles, dietary plans and food selection and economics.
   e. **Recreation Therapist:** The prescribed use of recreational and other activities as a treatment intervention that is designed to restore, remediate, or habilitate improvement in a participant's functioning and independence while reducing or eliminating the effects of the participant's serious emotional disturbance.

2. **Paraprofessional:** Services address a participant's symptom-related problems that may interfere with the individual's functioning, living, working and learning environment. These services provide opportunities for the participant to acquire and improve skills needed to function as appropriately and independently as possible. They also facilitate the participant's community integration and increases the participant's community tenure.

3. **Non-Medical Transport:** Transportation enables a YES Waiver participant to gain access to Waiver and other community services, activities, and resources. This is offered in addition to, not instead of, medical transportation required under State Medicaid Plan.

   a. Non-medical transportation enables Waiver participants to gain access to Waiver and other community services, activities, and resources, as specified by the Wraparound Plan. This service is in addition to, not instead of, medical transportation required under Title 42 CFR §431.53 and transportation services under the State Plan. Transportation services under the Waiver are offered in accordance with the Waiver participant's service plan. This service shall be made

available after other transportation already available through formal and natural supports have been exhausted.

4. **Respite:**
    a. In-Home Respite: In-Home Respite service is provided on a short-term basis because of the absence of, or need for relief for, the legally authorized representative or another primary caregiver of a Waiver participant. Services must be in the private residence of the participant or a relative of the participant other than the parents, spouse, or legal guardian.
    b. Camp Respite: Respite is furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the Waiver participant.
        i. All settings must be located in the State of Texas.
        ii. Camps must be accredited by the American Camping Association and licensed by DSHS pursuant to 25 Tex Admin. Code §§ 265.11 – 265.24
    c. Limitations: A maximum of 720 consecutive or cumulative hours (30 calendar days) of respite service of any type, or combination of any type, can be provided to a participant, each service plan year.
        i. In-Home Respite cannot be provided at the same time as:
            1. Supportive Family-Based Alternatives;
            2. Community Living Supports;
            3. Supported Employment;
            4. Employment Assistance;
            5. Non-Medical Transportation; or
            6. Paraprofessional Services.
        ii. In-Home Respite cannot be provided in a group setting. This service is intended as a one-to-one respite service for a single Waiver participant during a specific time period.
    d. HHS Respite Search

5. **Adaptive Aids:** Adaptive Aids and Supports (AA&S) are one-time goods and services that have been identified as necessary to assist the participant to remain in the home and community and avoid an out-of-home placement. In accordance with the Center for Medicare and Medicaid Services (CMS), adaptive aids must be medically necessary to treat, rehabilitate, prevent, or compensate for conditions related to the participant's mental health condition(s).

    All AA&S requests must be individualized, developed through the wraparound process with the Child and Family Team (CFT), and be connected to a strategy to assist the participant in meeting their treatment goals. During the monthly CFT, the Wraparound facilitator must document and show evidence that the AA&S is being utilized and monitored for efficacy.
    a. Special Requirements
        i. Some AA&S requests may require additional evidence of medical necessity to be approved.
    b. Restrictive Interventions
        i. Some adaptive aids may be considered a restrictive intervention. Examples of restrictive interventions include, but are not limited to:
            1. door or window alarms added to a participant's environment;
            2. security cameras;
            3. locked access;

4. restricted access to personal property.

c. When the request is considered a restrictive intervention, the Comprehensive Waiver Provider must inform the participant of their rights, including how to report abuse, neglect, and exploitation. The informed consent and explanation of rights must be included in the participant's Crisis and Safety Plan and the Wraparound Plan of Care.

d. **Form 2812 - Youth Empowerment Services (YES) Waiver Adaptive Aids & Supports (AA&S) Request Form**

6. **Minor Home Modifications:**
   1. Minor Home Modifications are services related to addressing the Waiver participant's need(s) that arise as a result of their SED and are medically necessary.
   2. These services contribute to the functioning of the Waiver participants in the community and thereby assist Waiver participants in avoiding institutionalization.
   3. These services include home accessibility/safety adaptations (i.e., physical adaptations) to the Waiver participant's residence, required by the Waiver participant's service plan, that are necessary to ensure the health, welfare, and safety of the participant.
   4. Minor home modifications must be age appropriate and related to specific therapeutic goals. The provider agency will be required to maintain written documentation of reasonable cost for services.
   5. Home accessibility adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of Waiver services.
   6. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the participant.
   7. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).
   8. Minor home modifications include, but are not limited to:
      a. alarm systems;
      b. alert systems;
      c. other safety devices.
   9. Form 2813 - Youth Empowerment Services (YES) Waiver Minor Home Modification (MHM) Request

7. **Family Supports:**
   1. Family supports provides peer mentoring and support to the primary caregivers; engages the family in the treatment process; models self-advocacy skills; provides information, referral and non-clinical skills training; maintains engagement; and assists in the identification of natural/non-traditional and community support systems. Family Supports are peer-to-peer mentoring services and are not clinical skills training.

8. **Community Living Support (CLS):**

   1. Community living support are provided to the Waiver participant and family to facilitate the Waiver participant's achievement of documented goals for community inclusion and remaining in their home. The supports may be provided in the Waiver participant's residence or in community settings (including but not limited to libraries, city pools, camps, etc.) Community living supports provide assistance to the family caregiver in the disability-related care of the Waiver participant, while facilitating the Waiver participant's independence and integration into the community. The training in skills related to activities of daily living, such as personal hygiene, household chores, and socialization may be included, if these

skills are affected by the Waiver participant's SED. Community living supports may also promote communication, relationship-building skills, and integration into community activities. These supports must be targeted at enabling the Waiver participant to attain or maintain their maximum potential. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings.

9. **Pre-Engagement Fee:**
   1. The Pre-Engagement Fee provides reimbursement for the provider's efforts in completing an assessment that is not eligible for reimbursement through another Medicaid program orfor individuals who are not eligible for the YES Waiver.
      a. LMHA's can request reimbursement for the time spent enrolling people in Medicaid through the special income group through the waiver who are ultimately denied Medicaid enrollment.
   2. The Pre-Engagement Fee is a one-time payment.

ELIGIBILITY REQUIREMENTS

To be eligible to receive a contract with the Local Authority, an Applicant must:

1. Provide services in Denton County, with the exception of Respite – Out-of-Home Camp.

2. Retain, or retain professionals that hold, valid Texas licenses and/or certifications to the extent required to perform services.

3. Maintain and cause personnel providing services under the Agreement to maintain, at its sole cost and expense or the cost and expense of its personnel, policies of general liability, professional liability, and Workers Compensation insurance coverage in order to insure Applicant against any claim for damages arising in connection with Applicant's responsibilities or the responsibilities of Applicant's personnel under the Agreement. Businesses or professionally licensed applicants must maintain a minimum coverage of 1 million dollars per occurrence, 1 million dollars aggregate, and 1 million dollars umbrella. Applicant must name The Center as "Additional Insured" on the policy commencing at the beginning of the contract. Applicants providing transportation to individuals receiving services must also provide automobile liability insurance that meets the minimum standard set by the Texas Department of Public Safety.

4. Demonstrate the ability to provide services in accordance with community standards and the most recent version of the YES Waiver Policy Manual.

5. Comply with all state and federal laws regarding the confidentiality of records of individuals served and nondiscrimination.

6. Have and maintain sufficient internet access and a current email account.

7. Notwithstanding the above, be registered to do business in Texas. In any situation in which a consortium of providers intends to submit a single Application in response to this RFA, a single entity responsible for Services must be identified to be the party to the Contract, and must demonstrate, to the Local Authority's reasonable satisfaction, the ability to manage funds.

Specialized Therapies:

1. The Center shall provide the following staff trainings:
    a. reporting of abuse, neglect, or exploitation; behavior management; crisis and safety planning; critical incident reporting; restraint; HIPAA; and first aid and CPR (cost to Applicant may apply).
    b. The Center shall maintain and monitor staff qualifications and training records for HHSC review.

Respite – In-Home:

1. The Center shall provide the following staff trainings:
    a. reporting of abuse, neglect, or exploitation; behavior management; crisis and safety planning; critical incident reporting; restraint; HIPAA; and first aid and CPR (cost to Applicant may apply).
2. The Center shall monitor staff qualifications for HHSC review.
   The Center shall perform a Building Safety and Environmental Health Checklist prior to the provision of services.
3. The Center shall provide a copy of each participant's Crisis and Safety Plan.

Respite – Out-of-Home Camp:

4. The Center shall maintain and monitor records of criminal history and abuse registry checks for HHSC review.
5. The Center shall provide a copy of each participant's Crisis and Safety Plan.

Service Provider Responsibilities:

All Service Types:

1. Applicant agrees that its name, contact information and certain other pertinent information may be used, along with a description of its facilities, care, and services in any information distributed by The Center listing its Network Providers.
2. Applicant shall provide services outlined in HHSC: YES Waiver Policy & Procedure Manual, which can be found at: https://hhs.texas.gov/sites/default/files/documents/doing-business-with-**hhs/provider-portal/behavioral-health-provider/yes/yes-policy-manual.pdf.**
3. Applicant shall provide acceptable levels of care in accordance with community standards and the most recent version of the YES Waiver Policy Manual.
4. Applicant shall submit services notes to The Center, as set forth in Exhibit B.
5. Applicant shall implement and monitor services in accordance with individual's service authorization.
6. Applicant shall submit a Critical Incident Report to the Wraparound facilitator within 24 hours of finding out an incident occurred.
7. Applicant shall notify The Center of regulatory reviews/audits and make those findings available to The Center, and

Specialized Therapies:

1. Applicant shall ensure that all staff members, volunteers, interns, and direct service providers receive training on Applicant's policies and procedures, including, but not limited to: reporting of abuse, neglect or exploitation; behavior management; crisis and safety planning; critical incident reporting; restraint; HIPAA; and first aid and CPR; in accordance with 26 TAC §301.305 and 26 TAC §301.331.
2. Applicant shall ensure that, prior to providing Wavier services and/or participating on a Child and

Family Team (CFT), staff receive:
   a. YES Waiver provider service training (https://yeswaivertraining.uthscsa.edu/);
3. Applicant shall provide to The Center completed credentialing for each professional, including subcontractors, providing services under this Agreement.
4. Applicant shall participate in Child and Family Team (CFT) meetings.

Respite – In-Home:

1. Applicant shall ensure that all staff members, volunteers, interns, and direct service providers receive training on Applicant's policies and procedures, including, but not limited to: reporting of abuse, neglect or exploitation; behavior management; crisis and safety planning; critical incident reporting; restraint; HIPAA; and first aid and CPR; in accordance with 26 TAC §301.305 and 26 TAC§301.331.
2. Applicant shall ensure that, prior to providing Wavier services and/or participating on a Child and Family Team (CFT), staff receive:
   a. YES Waiver provider service training (https://yeswaivertraining.uthscsa.edu/); and
   b. Respite In-Home only: Electronic Visit Verification (EVV) training https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care- roviders/resources/electronic-visit-verification/training-materials-resources
3. Applicant shall provide to The Center completed credentialing for each professional, including subcontractors, providing services under this Agreement.
4. Applicant shall provide services:
   a. Within the State of Texas; and
   b. In the private residence of:
      1 in the participant; or
      2 a relative of the participant other than the parents, spouse, legal guardian, or LAR.
5. Applicant shall ensure that a Building Safety and Environmental Health Checklist has been completed prior to the provision of services.
6. Applicant shall maintain a copy of each participant's Crisis Safety Plan.
7. Applicant shall utilize the EVV system to record service data.
8. Applicant shall be responsible for ensuring & maintaining access to the EVV system through Applicant's Smartphone.

Respite – Out-of-Home Camp:

1. Applicant shall ensure that all staff members, volunteers, interns, and direct service providers receive training on Applicant's policies and procedures.
2. Applicant shall maintain, and provide to The Center upon request, completed credentialing for each professional, including subcontractors, providing services under this Agreement.
3. Applicant shall adhere to 25 TAC 265, Subchapter B.
4. Applicant shall maintain a copy of each participant's Crisis Safety Plan.

Service Provider Prohibited Activities:

Respite – In-Home:

1. Applicant shall not provide services at the same time as:
    a. Supportive Family-Based Alternatives;
    b. Community Living Supports;
    c. Supported Employment;
    d. Employment Assistance;
    e. Non-medical Transportation; or
    f. Paraprofessional Service.
2. Applicant shall not provide services in a group setting.

Respite – Out-of-Home Camp:

1. Applicant shall not provide services at the same time as:
    a. Supportive Family-Based Alternatives;
    b. Community Living Supports;
    c. Supported Employment;
    d. Employment Assistance;
    e. Non-medical Transportation; or
    f. Paraprofessional Service.
2. Federal financial participation is not to be claimed for the cost of room and board, except when provided as part of respite care furnished in a facility approved by the state that is not a private residence

RESPONSIBILITIES

The Center Systems Responsibilities:

All Service Types:

1. The Center shall maintain a Waiver Inquiry phone number.
2. The Center shall maintain an Inquiry List of individuals interested in YES Waiver services.
3. The Center shall provide initial eligibility and enrollment services for consumers, including:
    a. YES Assessment and Clinical Eligibility;
    b. Verification of Medicaid benefits or application assistance;
    c. Communication of the initial authorization and assessment information.
4. The Center shall provide service authorization throughout the contract.
5. The Center may provide assistance in renewing Medicaid benefits in accordance with HHSC rules.
6. The Center shall be responsible for receiving services notes and entering into agency Electronic Health Record (EHR) and Clinical Management for Behavioral Health Services (CMBHS).
7. The Center shall monitor Applicant's compliance with the contract and evaluate the applicant's provision of services, including:
    a. competency of the applicant to provide care;
    b. consumers' access to services;
    c. safety of the environment in which services are provided;
    d. continuity of care;
    e. compliance with the performance expectations (referenced in §301.07(b)(13) of this title (relating to Provisions for Community Services Contracts));
    f. satisfaction of consumers and family members with services provided; and

g. utilization of resources

Right to Reject Responses

The Center expressly reserves the right to reject any and all Responses submitted. All such responders shall be afforded fair and equal treatment. Responders that address only part of the requirement contained in RFA/Open enrollment may not be considered. The Center may also choose to cancel the RFA/Open Enrollment solicitation without awarding a contract.

Conditions & Procedures for Submission of Response

Responses and any related material submitted in response to the RFA/Open enrollment become property of The Center and will not be returned. **ANY INFORMATION SUBMITTED BY RESPONDERS THAT IS CONSIDERED CONFIDENTAIL SHOULD BE CLEARLY MARKED AS SUCH IN RED ON THE PAGES WHERE THAT INFORMATION IS CONTAINED.** However, The Center is subject to the Texas Public Information Records Act as well as applicable Federal Freedom of Information requirement and maybe required to disclose some of all the information contained in the response.

Qualified Service Activities:

To be a qualified service provider, one must:

1. Be a staff member or contractor of the program provider;
2. Be paid by the program provider to provide the particular service being claimed;
3. Not be disqualified by this section to provide the particular service being claimed;
4. Not have been convicted of an offense listed under Texas Health and Safety Code§250.006;
5. Not be listed as unemployable in the Employee Misconduct Registry or revoked in the Nurse Aid Registry, which are maintained by the Texas Department of Human Services; and

Animal-Assisted Therapy:

1. Utilize animals that meet specific criteria for the program, they are associated with and be trained
   a. **in accordance with guidelines established by the American Veterinary Medical Association;**
2. Be a licensed professional, with documented training and experience relative to the specific service provided. These may include a: clinical social worker; professional counselor; marriage and family therapist; registered nurse; vocational nurse; physical therapist; occupational therapist; or dietitian; or
   a. Be appropriately trained and obtain certification through a YES Waiver endorsed certification program specific to the type of program and animal(s) involved (Pet Partners program; Equine Assisted Growth and Learning Association (EAGALA); Professional Association of Therapeutic Horsemanship (PATH) International; Trauma Focused Equine Assisted Psychotherapy (TF- EAP); or other certification program subject to approval by the HHSC YES Wavier Department, upon request by the CWP or the WPO.);
3. Received YES Wavier provider training;
4. Received training in: Critical Incident Reporting; Reporting of Abuse, Neglect or Exploitation; Restraint and Restrictive Interventions; HIPAA Training; DFPS Trauma Informed Care; Crisis and Safety Planning; and First Aid and CPR.

Art Therapy:

1. Be a licensed professional with documented training and experience relative to the specialized therapy being provided. This may include a: clinical social worker; professional counselor; marriage and family therapist; drama therapist; registered nurse; vocational nurse; physical therapist; occupational therapist; or dietitian; or
   a. Be certified by the Art Therapy Credentials Board (ATR-BC).
2. Received YES Wavier provider training;
3. Received training in: Critical Incident Reporting; Reporting of Abuse, Neglect or Exploitation; Restraint and Restrictive Interventions; HIPAA Training; DFPS Trauma Informed Care; Crisis and Safety Planning; and First Aid and CPR.

Music Therapy:

1. Be a licensed professional, with documented training and experience relative to the specific service provided. These may include a: clinical social worker; professional counselor; marriage and family therapist; registered nurse; vocational nurse; physical therapist; occupational therapist; or dietitian; or
   a. Be certified by the Certification Board for Music Therapists (MT-BC).
2. Received YES Wavier provider training;
3. Received training in: Critical Incident Reporting; Reporting of Abuse, Neglect or Exploitation; Restraint and Restrictive Interventions; HIPAA Training; DFPS Trauma Informed Care; Crisis and Safety Planning; and First Aid and CPR.

Nutritional Therapy:

1. Be a person who is a registered, licensed, or provisionally licensed dietitian by the Texas Board of Examiners of Dietitians;
2. Received YES Wavier provider training;
3. Received training in: Critical Incident Reporting; Reporting of Abuse, Neglect or Exploitation; Restraint and Restrictive Interventions; HIPAA Training; DFPS Trauma Informed Care; Crisis and Safety Planning; and First Aid and CPR.

Recreational Therapy:

1. Be a licensed professional, with documented training and experience relative to the specific service provided. These may include a: clinical social worker; professional counselor; marriage and family therapist; registered nurse; vocational nurse; physical therapist; occupational therapist; or dietitian; or
   a. Be certified by the national Council of Therapeutic Recreation Certification (CTRS); or be certified as a Texas Certified Therapeutic Recreation Specialist (TRS/TXC).
2. Received YES Wavier provider training;
3. Received training in: Critical Incident Reporting; Reporting of Abuse, Neglect or Exploitation; Restraint and Restrictive Interventions; HIPAA Training; DFPS Trauma Informed Care; Crisis and Safety Planning; and First Aid and CPR.

Respite – In-Home:

1. Be at least 18 years of age;
2. Have a current Texas driver’s license;
3. Not be a natural or adoptive parent, spouse, legal guardian, or LAR;
4. Received EVV training;
5. Received YES Wavier provider training;

6. Received training in: Critical Incident Reporting; Reporting of Abuse, Neglect or Exploitation; Restraint and Restrictive Interventions; HIPAA Training; DFPS Trauma Informed Care; Crisis and Safety Planning; and First Aid and CPR.

Respite – Out-of-Home:
1. Be at least 18 years of age;
2. Have a current Texas driver's license.

To be a qualified program provider, the day or overnight camp must:
3. Be licensed by the state of Texas, or
4. Be accredited by the American Camp Association (ACA).

Minor Home Modification:
1. Minor Home Modifications must be age appropriate and related to specific therapeutic goals. The Waiver Provider is required to maintain written documentation of reasonable cost for services. Adaptive Aids and Supports and Minor Home Modifications have a collective limit of $5,000 annually. If the cost is over $500.00, obtain three bids. Costs for all waiver services cannot exceed the individual annual cost ceiling established under the waiver.
2. Received YES Wavier provider training;
3. Received training in: Critical Incident Reporting; Reporting of Abuse, Neglect or Exploitation; Restraint and Restrictive Interventions; HIPAA Training; DFPS Trauma Informed Care; Crisis and Safety Planning; and First Aid and CPR.

Family Supports:
1. Family support provider must: have a high school diploma, or a high school equivalency certificate issued in accordance with the law of the issuing state; and
2. Pass a criminal history and effectively with Waiver participants and their families.
3. In addition to at least one of the following:
   a. one cumulative year of receiving mental health community services for a mental health disorder; or
   b. one cumulative year of experience navigating the mental health system as the parent or primary caregiver of a child/youth receiving mental health community services; and
   c. be under the direct clinical supervision of a master's level therapist and receive, at a minimum, an hour of monthly supervision. The supervisor must document and maintain all supervision notes in the family support provider file.
4. Received YES Wavier provider training;
5. Received training in: Critical Incident Reporting; Reporting of Abuse, Neglect or Exploitation; Restraint and Restrictive Interventions; HIPAA Training; DFPS Trauma Informed Care; Crisis and Safety Planning; and First Aid and CPR.

Adaptive Aids:
1. May be provided by service and equipment suppliers or specialized groups approved by the waiver provider agency and DSHS. Adaptive Aids and Supports and Minor Home Modifications combined limit of $5,000 for minor home modifications and AA&S, per 365-day IPC period. The amount approved cannot exceed the annual cost limit. If the cost is over $500.00, obtain three bids. Costs for all waiver services cannot exceed the individual annual cost ceiling established under the waiver.
2. Received YES Wavier provider training;

3. Received training in: Critical Incident Reporting; Reporting of Abuse, Neglect or Exploitation; Restraint and Restrictive Interventions; HIPAA Training; DFPS Trauma Informed Care; Crisis and Safety Planning; and First Aid and CPR.

Paraprofessional:

1. Be at least 18 years of age;
2. Have received:
    a. A high school diploma; or a high school equivalency certificate issued in accordance with the law of the issuing state;
    b. have a minimum of one year of documented full-time experience working with the SED population. Experience may be considered if the documented experience includes activities that are comparable to services specified under the service description;
    c. demonstrate competency in the provision and documentation of the specified or comparable service. Competency is assessed and documented by the Waiver Provider agency and reviewed by HHSC;
3. Pass a criminal history and background check;
4. Be under the direct clinical supervision of a master's level therapist and receive, at a minimum, one hour of monthly supervision.
5. Received YES Wavier provider training;
6. Received training in: Critical Incident Reporting; Reporting of Abuse, Neglect or Exploitation; Restraint and Restrictive Interventions; HIPAA Training; DFPS Trauma Informed Care; Crisis and Safety Planning; and First Aid and CPR.

Non-Medical Transport:

1. Be over the age of 18;
2. Have a valid Texas driver's license and insurance appropriate to the vehicle used to provide the transportation; and be a:
    a. Member of the Waiver Provider agency staff; or
    b. Direct service provider subcontracted with the Waiver Provider agency.
3. Pass a criminal history and background check;
4. Received YES Wavier provider training;
5. Received training in: Critical Incident Reporting; Reporting of Abuse, Neglect or Exploitation; Restraint and Restrictive Interventions; HIPAA Training; DFPS Trauma Informed Care; Crisis and Safety Planning; and First Aid and CPR.

Community Living Support:

1. Has a bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major, in accordance with 25 TAC §412.316(d), in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention;
2. Is a registered nurse (RN);
3. has completed an alternative credentialing process identified by the Department of State Health Services;
4. Has a master's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling,

sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention;

5. Received YES Wavier provider training;
6. Received training in: Critical Incident Reporting; Reporting of Abuse, Neglect or Exploitation; Restraint and Restrictive Interventions; HIPAA Training; DFPS Trauma Informed Care; Crisis and Safety Planning; and First Aid and CPR.

Payments/Rates:

Successful Applicants will be paid on a fee for service rate, based on HHSC rates:

Service	Unit	Rate
Animal-Assisted Therapy	15 minutes	$19.36
Art Therapy	15 minutes	$19.36
Music Therapy	15 minutes	$19.36
Nutritional Therapy	15 minutes	$13.82
Recreational Therapy	15 minutes	$19.36
Respite – In-Home	15 minutes	$5.22
Respite – Out-of-Home Camp	Ceiling per Hour	$9.84
Community Living Support	15 minutes	$25.02
Paraprofessional	15 minutes	$6.15
Non-Medical Transport	Per Miles	$0.55
Family Supports	15 minutes	$6.25
Minor Home Modifications	Encounter	
Adaptive Aids	Encounter	

Specialized Therapies:
Group setting services using the following formula:

a) Number of providers x Time spent delivering service(s) ÷ Number of participants served = Billable Time;

Child and Family Team Meeting:

a. In-Person Participation – Maximum of one hour, for each CFT meeting attended;
b) Phone-Participation, if therapist must travel 50 miles or more to attend – Maximum of one hour, for each CFT meeting attended;
c) Phone-Participation, if therapist must travel 49 miles or less to attend – Maximum of one unit, or one 15-minute increment, for each CFT meeting attended.

And based upon receipt of required documentation, as described below:

1. Written documentation to support a service claim for authorized service, in the form and format prescribed by the Center, and must include:
    a. Participant name;
    b. Medicaid ID#;
    c. Codes required for the Center EHR data entry;
    d. Date of contact with the participant
    e. Start and stop time of contact with participant;

f. Service name and description;
g. Service location;
h. Training methods used;
i. Need identified in the Wraparound Plan that the service will address;
j. Use of adaptive aids and supports, if applicable;
k. Transportation services, if applicable;
l. Participant response to the service provided;
m. Progress or lack of progress with service;
n. Summary of activities, meals, and behaviors observed during the service and how these activities directly impact the identified need that the service addresses; and activities directly impact the identified need that the service addresses; and
o. Direct service provider's printed name, signature and credentials.

2. Written documentation must be submitted within seven (7) business days after each contact that occurs.

Processing

1. Applicant shall bill the Center in the form and format prescribed by the Center.
2. Invoices must be submitted by the 3rd calendar day of the month following the month of services
   a. Shall be accepted up to sixty (60) days past the deadline, provided that the written documentation was submitted within the stipulated timeframe. Invoices shall not be accepted after sixty (60) days past the invoice submission deadline.
   b. Invoices shall be accepted up to thirty-five (35) days past the end of the fiscal year period, provided that the written documentation was submitted within the stipulated timeframe. Invoices shall not be accepted after thirty-five (35) days past the end of the fiscal year period.
3. Applicant shall not assess additional charges to a participant, any member of participant family, or any other party, including third-party payer, except as permitted by federal and/or state law, rule, regulation or the Medicaid State Plan.
4. Applicant shall forfeit payment for service if:
   a. Not identified on the participants Wraparound Plan;
   b. Not previously approved on the participant service authorization;
   c. Exceeding the limits authorized by HHSC;
   d. Provided on a date in which an active IPC was not in place;
   e. Provided outside of the participant's Wavier eligibility;
   f. Provided prior to employee credentialing; or
   g. Written documentation is incomplete or does not match.
   h. Respite – In-Home only: Units do not match the units on the Electronic Visit Verification (EVV) visit transaction.
5. The Center will pay Applicant promptly after receipt of payment from HHSC.

,

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 with the instructions below.
Applicants must email one copy of the completed application.

Email: contractsubmission@dentonmhmr.org Subject: RFA - YES Wavier 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 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.

- APPLICATION -

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

YES Waiver Services

***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

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):*_________________________

SERVICES

Place a check mark in the box beside the services organization/individual is applying to provide.
Contract exhibits, along with rates, for each service can be found at:

YES WAIVER SERVICES

Service	Indicate if applying to provide this service
Animal-Assisted Therapy	
Art Therapy	
Music Therapy	
Nutritional Therapy	
Recreational Therapy	
Respite – In-Home	
Respite – Out-of-Home Camp	
Minor Home Modifications	
Community Living Support	
Adaptive Aids	
Paraprofessional	
Non-Medical Transport	
Family Supports	

Will all services contracted for under this RFA be provided by organization/individual: Yes No
Please provide a full explanation for any "No" response: (Attach additional pages as necessary)

____

____

Will the organization/provider have qualified staff available to administer medications or to supervise individuals in the self-administration of medication? Yes No

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:_______

How many individuals can the organization/provider serve?: ________________________

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

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

Can DCMHMR clients access services outside usual business hours? ___________________________

EXPERIENCE

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 the organization's/provider's experience in working with persons with mental illness, in 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 persons with physical impairments and adaptive equipment:
____
____

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)*

____
____

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

____
____

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

____
____

Are all staff and contractors current on all training required by the credentialing/licensing agency and/or the Texas Administrative Code as described in contract exhibit(s) and YES Waiver Policy Manual: Yes No

If no, what is the plan for ensuring all staff and contractors receive training before service initiation: *(Attach additional pages as necessary)*

____
____

SERVICE LOCATION

If services are to be provided in a facility owned/rented by the organization/individual:

a. Attach a Certificate of Insurance with effective and expiration dates showing current General Liability insurance coverage limit;
b. Attach a Fire Inspection (current within 1 year) by applicable local fire authority;
c. Attach a Certificate of Occupancy;
d. Is the building accessible for individuals with disabilities: Yes No
e. How close is the facility to public transportation: _________________________

QUALITY MANAGEMENT/UTILIZATION MANAGEMENT

List all licenses, credentials, certifications, and/or accreditations currently held by organization/individual *(Provide copies as applicable):*____

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 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 organization has implemented related to this area: *(Attach additional pages as necessary)*

____
____

Provide name of Workers' Compensation carrier if organization has Workers' Compensation coverage or self-funding documents if self-funded: ____

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.***

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:

____

____

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 had 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 organization/individual meet standard federal guidelines for Medicaid and Medicare: Yes No

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.***

Does the organization/provider have a "Letter of Good Standing" which verifies that it is not delinquent in State Franchise Tax?___________________

RISK ASSESSMENT

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

____

____

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 on these issues:

____

____

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. Client name
2. Client' s DCMHMR 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 serious 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 entities for the same service.

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 reported accurately any history of felony convictions or client abuse and neglect.
- I have reported accurately 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)

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 request 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)

ASSURANCES DOCUMENT

Applicant assures the following:

1. That all addenda and attachments to the Application as distributed by MHMR have been received.

2. No attempt will be made by the Applicant to induce any person or firm to submit or not to submit an application, unless so described in the response document.

3. The Applicant does not discriminate in its services or employment practices based on race, color, religion, sex, national origin, ethnicity, disability, veteran status, or age.

4. That no employee of Denton County MHMR and/or no member of Denton County MHMR's Board of Trustees will directly or indirectly receive any pecuniary interest from an award of the proposed contract. If the applicant is unable to make the affirmation, then the applicant must disclose any knowledge of such interests.

5. All cost and pricing information is reflected in the Application response document or attachments.

6. Applicant accepts the terms, conditions, criteria, and requirements set forth in the Application.

7. Applicant accepts Denton County MHMR's right to cancel the Application at any time prior to contract award.

8. Applicant accepts Denton County MHMR's right to alter the timetables for procurement as set forth in the Application.

9. The application submitted by the Applicant has arrived independently without consultation, communication, or agreement for the purpose of restricting competition.

10. Unless otherwise required by law, the information in the application submitted by the Applicant has not been knowingly disclosed by the Applicant to any other Applicant(s) prior to the notice of intent to award.

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

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

13. The individual signing this document and the contract is authorized to legally bind the Applicant.

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

______________________________ ____________________ ____________________

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

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, sub grant, 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 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)

ORGANIZATIONAL APPLICATION CHECKLIST

Submission Date: ______________________

Name of Organization/Individual: _______________________________			
LIST	**YES**	**NO**	**N/A**
REQUIRED FOR ALL APPLICANTS:			
Application Checklist (*this page*)			
Application – 1 Original			
Attestation			
General Authorization for Release of Information			
Assurances Document			
Certification Regarding Lobbying, Grants, Loans, & Cooperative Agreements			
General Liability Insurance Coverage (*if applicable*)			
Fire Inspection(s) – current within 1 year (*if applicable*)			
Certificate(s) of Occupancy (*if applicable*)			
Auto Liability Insurance Coverage (*if applicable*)			
Professional Liability Insurance Coverage (*if applicable*)			
IRS Tax Exemption Form or proof of Status as Governmental Entity (*if applicable*)			
Workers' Compensation Coverage (*if applicable*)			
Adverse Actions explanation (*if applicable*)			
Affiliations Information (*if indicated on Assurances*)			
Financial Interest Information (*if indicated on Assurances*)			
Key Persons Disclosure (*if indicated on Assurances)*			
Driver's License* (*Individual Applicants only*)			
Professional License/Certification* (*Individual Applicants only*)			
Form W-9			

**Organization staff credentials and Individual training proofs to be submitted post contract execution, but prior to service delivery.*

Local Authority's Bars to Workforce/Contracting

The names of all Denton County MHMR prospective workforce and contract providers are cleared through a pre-employment/contracting criminal history and registry clearance. The clearance will search data from the Texas Department of Public Safety, the U.S. Department of Health and Human Services Office of the Inspector General (OIG) List of Excluded Individuals, the Texas Department of Human Services Nurse Aide Registry and Employee Misconduct Registry, and the Texas Department of State Health Services Client Abuse and Neglect Reporting System. Additionally, a Federal Bureau of Investigation (FBI) fingerprint clearance is conducted for those individuals who have resided outside the state of Texas within the past two years of Application. A conviction for any of the offenses listed below is a bar to employment with and/or providing contracted services for Local Authority:

- Kidnapping and unlawful restraint (Penal Code, Chapter
- 20); Criminal homicide (Penal Code, Chapter 19);
- Indecency with a child (Penal Code, §21.11) or continuous sexual abuse of young child or children (Penal Code, §21.02);
- Sexual assault (Penal Code, §22.011);
- Aggravated assault (Penal Code, §22.02);
- Injury to a child, elderly individual, or disabled individual (Penal Code,
- §22.04); Abandoning or endangering a child (Penal Code, §22.041);
- Aiding suicide (Penal Code, §22.08),
- Agreement to abduct from custody (Penal Code,
- §25.031); Sale or purchase of a child (Penal Code, §25.08);
- Arson (Penal Code, §28.02);
- Robbery (Penal Code, §29.02);
- Aggravated robbery (Penal Code, §29.03);
- Indecent exposure (Penal Code, §21.08);
- Improper relationship between educator and student (Penal Code,
- §21.12); Improper photography or visual recording (Penal Code, §21.15);
- Deadly conduct (Penal Code, §22.05);
- Aggravated sexual assault (Penal Code,
- §22.021); Terrorist threat (Penal Code, §22.07);
- Online solicitation of a minor (Penal Code,
- §33.021); Money laundering (Penal Code, §34.02);
- Medicaid fraud (Penal Code, §35A.02);
- Cruelty to animals (Penal Code, §42.09); or

- 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 under this paragraph; and
- A conviction of any of the following offenses during the five years before proposed employment or contract issuance:
  1. Assault that is punishable as a Class A misdemeanor or as a felony (Penal Code, §22.01);
  2. Burglary (Penal Code, §30.02);
  3. Theft that is punishable as a felony (Penal Code, Chapter 31);
  4. Misapplication of fiduciary property or property of a financial institution that is punishable as a Class A misdemeanor or felony (Penal Code, §32.45);
  5. Securing execution of a document by deception that is punishable as a Class A misdemeanor or a felony (Penal Code, §32.46),
  6. False identification as a peace officer (Penal Code, §37.12); or
  7. Disorderly conduct (Penal Code, §42.01(a)(7), (8), or (9)).

In addition, the following will apply to all Applicants:

1. A conviction of other types of criminal offenses may be considered a bar to employment or contracting with Local Authority, in Local Authority's discretion.
2. Identification of a revoked license in the Nurse Aide Registry; or
3. Identification as "unemployable" in the Employee Misconduct Registry

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:____

DATE	Check Ran By	DPS	HHS	CARE	Admin. Review
		☐ Do Contain Bar ☐ Do Not Contain Bar	☐ Finding ☐ No Finding	☐ Finding ☐ No Finding	☐ Yes ☐ No ________ Initials
		☐ Do Contain Bar ☐ Do Not Contain Bar	☐ Finding ☐ No Finding	☐ Finding ☐ No Finding	☐ Yes ☐ No ________ Initials
		☐ Do Contain Bar ☐ Do Not Contain Bar	☐ Finding ☐ No Finding	☐ Finding ☐ No Finding	☐ Yes ☐ No ________ Initials
		☐ Do Contain Bar ☐ Do Not Contain Bar	☐ Finding ☐ No Finding	☐ Finding ☐ No Finding	☐ Yes ☐ No ________ Initials
		☐ Do Contain Bar ☐ Do Not Contain Bar	☐ Finding ☐ No Finding	☐ Finding ☐ No Finding	☐ Yes ☐ No ________ Initials
		☐ Do Contain Bar ☐ Do Not Contain Bar	☐ Finding ☐ No Finding	☐ Finding ☐ No Finding	☐ Yes ☐ No ________ Initials
		☐ Do Contain Bar ☐ Do Not Contain Bar	☐ Finding ☐ No Finding	☐ Finding ☐ No Finding	☐ Yes ☐ No ________ Initials
		☐ Do Contain Bar ☐ Do Not Contain Bar	☐ Finding ☐ No Finding	☐ Finding ☐ No Finding	☐ Yes ☐ No ________ Initials
		☐ Do Contain Bar ☐ Do Not Contain Bar	☐ Finding ☐ No Finding	☐ Finding ☐ No Finding	☐ Yes ☐ No ________ Initials

		☐ Do Contain Bar ☐ Do Not Contain Bar	☐ Finding ☐ No Finding	☐ Finding ☐ No Finding	☐ Yes ☐ No _________ Initials