



RFA # MHCBT06-09

RFA Description: Adult-Cognitive Behavioral Therapy (CBT)

RFA Issued: March 2, 2010

Deadline for Submission of Application: April 15, 2010 at 2:00pm (CST)

LindaB@gcmhmr.com

**The Gulf Coast Center
Attn: Linda Bell
4444 W. Main
League City, Texas 77573**

MENTAL HEALTH GENERAL REVENUE FUNDED SERVICES

OPEN ENROLLMENT REQUEST FOR APPLICATION

The Gulf Coast Center is the Department of State Health Services designated mental health Authority established to plan, coordinate, develop policy, develop and allocate resources, supervise, and ensure the provision of community based mental health and mental retardation services for the residents of **Galveston and Brazoria Counties**, Texas.

Pursuant to Texas Administrative Code §412.60 and §412.754, **The Gulf Coast Center**, as a DSHS designated Local Authority, has the authority to assemble a network of service providers to provide the following services to the Priority Population of persons with mental illness who reside in Galveston and Brazoria Counties. The funds allocated by DSHS are referred to as General Revenue-funds. The specific services being sought under General Revenue-funded services are.

- **Cognitive Behavioral Therapy (CBT) Services (Adult Service Package 2)**
 - **CPT Code 90806**

The goals of this network are:

1. To develop a network of providers for consumers receiving certain mental health services funded by General Revenue allocations and other third party payors.
2. To increase consumer access and allow consumer choice in the selection of service providers.
3. To identify, implement and evaluate successful programs so that these efforts can be replicated.
4. To create meaningful cooperative relationships between the Local Authority and the private service providers in the local community.
5. To provide a comprehensive community treatment system in Galveston and Brazoria Counties.

I. SERVICES SOUGHT

This Request for Application seeks participation from applicants for the purpose of offering cognitive behavioral therapy (CBT counseling) services, within Galveston and Brazoria Counties for individuals with mental illness who meet the target population. Any qualified applicant can submit an application to provide the specified General Revenue funded Services.

1. **CBT Counseling (Individual):** Individual therapy focused on the reduction or elimination of a client's symptoms of mental illness and increasing the individual's ability to perform activities of daily living. Cognitive-behavioral therapy is the selected treatment model for adult counseling services. Counseling must be provided by a Licensed Practitioner of the Healing Arts (LPHA), practicing within the scope of their own license or by an individual with a master's degree in a human services field pursuing

licensure under the direct supervision of an LPHA, if not billed to Medicaid. This service includes treatment planning to enhance recovery and resiliency. Providers of CBT must complete a state approved CBT training program. CBT services are available to consumers receiving services under RDM Service Package 2 only.

- To view the RDM Clinical Guidelines including the service package definitions and service descriptions for the entire service package(s) as well as the discrete service specified in this RFP go to: <http://www.dshs.state.tx.us/mhprograms/RDMClinGuide.shtm>
2. The grid below indicates the county in which services are being sought as well as the % of services capacity the Local Authority intends to procure.

Services Sought for Galveston County	LMHA Capacity	% Capacity sought to procure
CBT-Counseling (Adult)	20	100%

Services Sought for Brazoria County	LMHA Capacity	% Capacity sought to procure
CBT-Counseling (Adult)	25	100%

4. Priority and Target Population

1. Adult Mental Health (MH) Priority Population - Adults who have severe and persistent mental illnesses such as schizophrenia, major depression, bipolar disorder, or other severely disabling mental disorders which require crisis resolution or ongoing and long-term support and treatment.
2. Adult MH Target Population - Adults who have a diagnosis of schizophrenia, bipolar disorder, and severe major depression.

Only those people referred by the Center and for who written authorization is provided to the Network Provider by the Center will be considered when making payment for services rendered.

II. MINIMUM REQUIREMENTS

At a minimum Applicants must be qualified providers. Thus they must:

1. Meet the minimum qualifications of the DSHS performance contract and local plan;
2. Demonstrate ones ability to provide services in compliance with DSHS contract requirements; and
3. Comply with RDM (Resiliency and Disease Management), including CBT guidelines.
4. Be able to provide services in the language and English proficiency as dictated by the person receiving services.
5. Engage and involve consumers, legally authorized representatives, and families in the policy and practice levels within the applicant’s organization or individual practice.
6. Have the ability to transition, at a minimum, 10% of the individuals receiving procured service and choosing Provider within first 30 days. Thereafter, transition consumers into services at a rate of 25% per month until applicant’s capacity is reached or

utilization/referrals is not indicated.

Notwithstanding the above, Applicants must be eligible or registered to do business in Texas. In any situation where a consortium of providers is applying, a single entity responsible for services must be identified and the financial agent must be an organization with a demonstrated ability to manage funds. See other applicant credentialing requirements in Attachment A.

III. RESPONSIBILITIES

Local Authority Responsibilities

The Local Authority will be responsible for service coordination/case management and facilitating an individual's selection of service providers, authorizing services, reviewing claims and paying for appropriate, authorized services rendered by the service providers in its Network. The Local Authority is also responsible for utilization management and quality assurance. The Local Authority ensures that contracted services addressing the needs of the Priority Population are provided as required by DSHS, comply with the rules and standards adopted under Section 534.052 of the Texas Health and Safety Code, and Chapter 412, Subchapter G of the Texas Administrative Code. The Local Authority does not guarantee any referral volume to any service provider within its Network of Providers. To review the Local Authorities FY07 Service Targets and Capacity go to <http://www.dshs.state.tx.us/mhcommunity/LPND/LMHAs/gulf-coast.shtm>

On a case-by-case basis (space permitting) the Local Authority may make available private space in one of its existing facilities for Network Providers to provide CBT. Provision of said space is for the sole purpose of convenience of the people served or to facilitate communication between the Network Provider and the Local Authority. Space will not be provided because the Network Provider has no other private space available.

Service Provider Responsibilities

The service provider will be responsible for submitting all original documentation reflecting service provision and will maintain additional secondary records regarding treatment and/or services rendered to the Local Authority's individuals with mental illness, and allow the Local Authority access to such records upon request. The service provider is required to comply with all state and federal laws regarding the confidentiality of consumers' records and nondiscrimination. The service provider will actively assist in the disbursement of consumer and advocate satisfaction surveys. The service provider will obtain prior authorization, provide acceptable levels of care, and maintain acceptable levels of liability insurance, and appropriate licenses and accreditations. The service 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 service providers. The service 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.

IV. INSTRUCTIONS FOR SUBMISSION OF APPLICATIONS

To facilitate and ensure an objective review, applicants must follow the Required Application Information (see section V) for submissions. Submissions should be limited to ten (10) pages plus attachments and forms.

Applicants must send one (1) original and two (2) copy of the application and two (2) signed assurances signature pages to:

**The Gulf Coast Center
Attn: Linda Bell
4444 W. Main
League City, Texas 77573
Contract Number 409-944-4314**

Applications may be sent by regular mail or special carrier no later than April 15, 2010 at 2:00 pm (CST).

Applications will be processed upon receipt. In the future, other open enrollment periods for services may be announced to ensure availability of adequate numbers of service providers to meet the volume of demand for services.

False statements or information provided by an applicant may result in disqualification of enrollment into the Network. The Local Authority reserves the right to reject any and all applications, to waive technicalities, and to accept any advantages deemed beneficial to the Local Authority and the individuals served.

Each prospective service provider 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.

The entire response to this Request for Application shall be subject to disclosure under the Texas Public Information Act, Chapter 552 of the Texas Government Code. If the applicant believes information contained therein is legally excepted from disclosure under the Texas Public Information Act, the applicant should conspicuously (via bolding, highlighting and/or enlarged font) mark those portions of its response as confidential and submit such information under seal. Such information may still be subject to disclosure under the Public Information Act depending on opinions from the Attorney General's office.

V. REQUIRED APPLICATION INFORMATION:

Please be sure to answer every question included in sections A-F on separate sheet(s) of paper/or provide the necessary information. If the question/necessary information does not apply, simply and clearly document "N/A". Interviews or site visits may be conducted to further evaluate applications. In addition, the attached Form(s) must be completed by each applicant.

A. BUSINESS DEMOGRAPHICS

1. The following items must be included in your response:
 - Name and title; Business Name
 - Type of legal entity (i.e., private practice, corporation, 501(c)(3))
 - Social Security Number; Tax ID Number
 - Street Address, City, & Zip
 - Business Phone Number
 - E-mail Address

- Does the provider own or lease its current business properties?
 - Other Business location in this Service Area; include name and address
- Number of years in operation as a business
- Certification Number if a Historically Underutilized Business
- Are you a Medicaid and/or Medicare Provider

2. No employee of the Local Authority or DSHS, and no member of the Local Authority's Board of Trustees can directly or indirectly receive any pecuniary interest from an award of the proposed contract. If such a situation exists, please explain in detail.

B. QUALITY MANAGEMENT/UTILIZATION MANAGEMENT

List all licenses, credentials, certifications, and/or accreditations the organization currently holds. Provide copies of documents regarding DSHS, DADS, DARS or DOL status if applicable.

C. SERVICES

1. List the services from Attachment C1 that the organization/provider would offer under this proposal. Identify geographical areas to be covered, where services are offered and the times of day and days of the week the services would be available. Describe any specialized services you provide. Detail the specific population to be served under this proposal. Include ages to be served as well as ability to serve individuals with multiple challenges. What is your capacity? How do you plan on transitioning consumers to your services? How do you plan on transitioning Local Authority staff to your employ, if applicable?

2. Describe any “after hours” system for responding to consumer needs. Can consumers access services outside usual business hours? Are Services provided outside the M-F 8-5 periods? Are services offered on holidays?

3. Is the organization’s staff current with inservice training as required by the credentialing/licensing agency or the local authority (if currently under contract as a service provider)?

4. Describe the organization’s/provider’s experience in working with persons with mental illness and related conditions over the last five years. How have services been made accessible for those who are difficult to reach, either due to geography or dissatisfaction with service delivery?

5. Describe the organization’s/provider’s history of working with persons who are not compliant with treatment. Describe the organization’s/provider’s ability to treat persons with disabilities. Detail the specific population to be served under this proposal. Include ages and levels of severity.

6. 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 ability to work with persons with physical impairments and adaptive equipment. Describe how the organization/provider ensures cultural competency on the part of staff with regard to ethnic, racial, religious and sexual orientation differences.

7. Describe the facility(ies) proximity to public transportation.

8. Describe how you engage and involve consumers, legally authorized representatives, and families in the policy and practice levels within the applicant's organization or individual practice.

D. FINANCIAL

1. Is the organization/provider incorporated as "Profit", "Not-for-profit", or "Other"? If "other", please explain.

2. Describe any arrangements to subcontract part or all of these services. Name all subcontractors and provide information on their staff credentials, licenses and certifications.

3. Provide a copy of a Certified External Audit for the past three years. label as **Exhibit VD3**

4. Provide a copy of the most recent Tax Statement (IRS Form 1120, Form 990 as applicable). label as **Exhibit VD4**

5. Provide a current Financial Statement including Cash Flow. label as **Exhibit VD5**

6. Submit the most current Annual Report available. label as **Exhibit VD6**

7. Provide evidence of continued financial viability to ensure your capabilities to support this service. label as **Exhibit VD7**

E. RISK ASSESSMENT

1. Has the organization/provider had any abuse, neglect, exploitation or other rights violations claims in the last seven (7) years? If so, explain in detail. Describe or attach any policies and procedures regarding consumer abuse, consumer neglect, or rights violations and the training of staff on these issues. If attaching policies and procedures, label as **Exhibit VE1**.

2. Does the organization/provider have a Letter of Good Standing that 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 and label as **Exhibit VE2**. Is the Provider delinquent in the payment of any Child Support Payments? If so, explain.

3. Provide a Certificate of Insurance showing liability insurance coverage (property and vehicles, including riders) and including directors' and officers' professional liability, errors and omissions, general liability, and medical malpractice insurance - Label as **Exhibit VE3**.

4. Provide the name of Workers' Compensation carrier if the organization/provider has Workers' Compensation coverage, or self funding documents if self funded - Label as **Exhibit VE4**.

5. Are employees or agents of the organization bonded? What is your policy regarding criminal history checks on employees?

6. Describe any contracts, Memoranda of Understanding, or employment relationship the organization/provider has with other state, city or county agencies in the Galveston and Brazoria

community.

F. INFORMATION SYSTEMS

Can the organization's/provider's information system report the following categories? How is data transmitted electronically? Can it create flat ASCII files -- fixed field or comma delimited? Describe the frequency with which client data is input into the system and available for reporting. If the system does not provide the following, please describe the ability to generate and report this data on a weekly basis. Are HCFA 1500's or UB 92's currently used to bill for services? Are claims submitted on paper or electronically? Indicate if the organization/provider would like information about using the Local Authority's software system to record and report required information.

Include a sample report as **Exhibit VF** with same or similar fields identified below.

1. Payor source
2. Patient name
3. Patient date of birth
4. Patient Social Security Number
5. Patient Ethnicity
6. Patient Home address
7. Full diagnosis (all 5 axes and/or ICD-9) including GAF score
8. Number of days from Local Authority referral to client's first visit
9. Admissions and Discharges to all services
10. Average Length of Stay by service
11. Number, type, and duration of services (by CPT or Local Authority codes)
12. Treating professional and credentials of that professional for each service
13. Readmission rates by service
14. Current Treatment Plan date
15. Authorization number
16. Number of no shows per service, showing total appointments scheduled by service
17. Description of each complaint received from Local Authority clients, identifying those resolved to the individual's satisfaction within 14 days from the date of complaint
18. Number, type and severity of medication errors and adverse drug reactions for Local Authority clients
19. Against Medical Advice discharges of Local Authority clients
20. Deaths and suicide attempts of Local Authority clients
21. Serious injury or illness of Local Authority clients
22. Confirmed abuse, neglect, or exploitation of Local Authority clients
23. Allegations of homicide/attempted homicide/threat with a plan by an Local Authority client

G. RATE AND METHOD OF PAYMENT

Applicant agrees, for those services it is submitting an application, to accept the fees listed below as payment in full for approved consumer services. The Applicant will not submit a claim or bill or collect compensation from Local Authority for any service which it has not submitted an application, or been approved, or contracted to provide. Applicant is responsible for collecting the designated co-payment from the client. Applicant may not submit a claim or bill or collect compensation from a client greater than the co-payment established by the Local Authority.

Applicant must coordinate benefits for the clients such that all other possible sources of payment must be pursued and denied or exhausted prior to billing the Local Authority. Applicant agrees that compensation for providing services not covered by its application will be solely between the consumer and the Applicant. The consumer must be informed in writing before any services are provided, that the Local Authority is not responsible for payment for such services. Consumers are responsible for payment for those services only if the consumer consents in writing to the provision of such noncovered services.

If the Applicant becomes a Service Provider in the Local Authority’s network, said Service Provider shall be reimbursed for services described in the schedules below.

Services Sought for Galveston County	Rate of Reimbursement	Minimum Billable Unit of Service	Payment Method
CBT-Counseling (Adult) CPT code 90806	\$45	45 minutes per 45 minute Unit of Service	General Revenue/Medicaid minus Admin Fee

Services Sought for Brazoria County	Rate of Reimbursement	Minimum Billable Unit of Service	Payment Method
CBT-Counseling (Adult) CPT code 90806	\$45	45 minutes per 45 minute Unit of Service	General Revenue/Medicaid minus Admin Fee

- **Local Authority does not pay for “no show” or cancelled appointments.**
- **Pre-Approved Travel reimbursement for travel outside the Provider’s geographic area using the Local Authority’s standards for mileage assessments is a rate of .505¢ per mile.**

VI. ASSURANCES (for signature copy see Attachment C2)

Applicant must assure the following:

1. That all addenda, exhibits and/or attachments to the Application as distributed by the Local Authority have been received.
2. That the criteria for approval are met.
3. That the applicant is not currently held in abeyance or barred from the award of a federal or state contract.
4. That the applicant is not currently delinquent in its payments of any franchise tax or state tax owed to the state of Texas, pursuant to Texas Business Corporation Act, Texas Civil Statutes, Article 2.45.
5. 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 application document.
6. The Applicant does not discriminate in its services or employment practices on the basis or race, color, religion, sex, national origin, disability, veteran status, or age.
7. That no employee of the Local Authority or DSHS and no member of the Local Authority’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.
8. Applicant accepts the terms, conditions, criteria, and requirements set forth in the Application.
9. Applicant accepts the Local Authority’s right to cancel the Application at any time prior to contract award.
10. Applicant accepts the Local Authority’s right to alter the timetables for procurement as set forth in the Application.

11. The application submitted by the Applicant has been arrived at independently without consultation, communication, or agreement for the purpose of restricting competition.
12. 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 prior to the notice of intent to award.
13. 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.
14. Local Authority has the right to complete background checks and verify information.
15. The individual signing this document and the contract is authorized to legally bind the Applicant.
16. The address submitted by the Applicant to be used for all notices sent by the Local Authority is current and correct.

ATTACHMENT A Credentialing Criteria

The following criteria, information and components are required for a service provider to be included in the Local Authority's network of providers.

1. Minimum requirements for all services being sought:

- Age of staff must be over 18, has a high school diploma or a General Education Development(GED) credential; or has documentation of a proficiency evaluation of experience and competence to perform the job tasks that includes:
 - written competency-based assessment of the ability to document service delivery and observations of the individuals to be served; and
 - at least three personal references from persons not related by blood that indicate the ability to provide a safe, healthy environment for the individuals being served.
- Current drivers license for each person that will potentially provide transportation to Local Authority consumers.
- Current Insurance Verification including:
 - Professional and general liability
 - Vehicle (if transporting consumers is likely), **complete Attachment C3**
 - Workers Compensation
- Verification of criminal history checks for all staff potentially working with Local Authority consumers.
- Life Safety code review for site assessment if not certified by a state agency.
- If applicable, documentation from certifying agency:
 - Texas Department of State Health Services
 - Texas Department of Assistive and Rehabilitative Services (DARS)

2. Additional required information:

A. **Qualifications of Providers SP-2 for CBT (Services must be delivered by staff with these MINIMUM qualifications)**

1. Masters Degree from an accredited institution of higher education

2. At least one (1) of the following licenses:

- Licensed Professional Counselor (LPC)
- Licensed Clinical Social Worker (LMSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Psychologist

3. Current Texas Driver's License and auto insurance in accordance with Texas law (if providing consumer transportation)

Subject Area	TAC	
Abuse, Neglect, Exploitation	4.12G.309(b) annually 419.L464 (a)(1)(D) 412 L.411 (a)(6)	NEO/book and exam
Consumer Rights, Confidentiality	414.A.1, 404E.165 annually 412G.309 (c) (e) &303 (36) 401G.464(c)	NEO/book and exam
HIV/AIDS, Infection Control	405.L.285(b); 412G.308(d) FY09 Performance Contract Confidentiality Section 10.07	NEO/book and exam

Safety & Emergency	412G.308(a)(1)&(b)	NEO/book and exam
Cultural Competency	412G.303(15), 412G.306(6), 412G3.10(d), 412G3.10(e)(3)	NEO/book and exam
Screening & Intervention	412G.303(40), 412.312(c)	MH on the job training
Suicide & Homicide	412 G.303 (40), 412 G. 312 (c)	MH on the job training
PMAB	412.G312(a) (1) (C) 412 G303 (40), 415 F.257(b) 414L.560 (b), Annually	NEO/in house course
Psychoactive Medications/Pharmacology	412.G 312.(a) (1) (c) 412 G 303 (40), 4141.405 consent	NEO/book and exam
Charges for Community Based Services	412.C.111, annually	MH on the job training
CPR	412G.303 (14), 415F.257 (b) 412 G.312 (a) (1) (b)	current CPR AHA or Red Cross card
First Aid	412 G 303(14), 415 F.257 (b) 412 G.312 (a) (1) (b)	current First Aid AHA or Red Cross card
Seizures	412 G.303 (14), 415 F.257 (b) 412 G. 312 (a) (1) (b)	Included in NEO First Aid
Community Support Service Availability		MH On the job training
Advocacy for Individual		MH On the job training
Crisis Prevention & Management		MH On the job training
Computer Security/HIPAA	Agency standard for billing	NEO/in house course
COPS-D – on line		On line
CBT – on line	(pending)	On line

Are you authorized to prescribe medications? Yes No

If yes, Prescription Authorization Number: _____ Expiration Date: _____

SUPERVISORY STATUS

List any licenses or professional organizations for which you are an approved supervisor.

GOVERNMENT PROGRAM PARTICIPATION

Medicare provider Yes No If Yes, PIN #: _____ Group #: _____

Medicaid provider Yes No If Yes, State of Texas #: _____

Champus provider Yes No If yes, #: _____ Expiration Date: _____

EDUCATION HISTORY

Undergraduate, graduate and postgraduate/professional training. You may submit a current resume or vita to meet this requirement.

School Name		Degree		Year Received	
City/State/Country		Major			
School Name		Degree		Year Received	
City/State/Country		Major			
School Name		Degree		Year Received	
City/State/Country		Major			
School Name		Degree		Year Received	
City/State/Country		Major			
School Name		Degree		Year Received	
City/State/Country		Major			
School Name		Degree		Year Received	
City/State/Country		Major			

Physician graduate medical training:

Medical School:		
From ____/____	To ____/____	Institution:
Street Address:		
City, State, Zip:		Country:
Internship:		
From ____/____	To ____/____	Institution:
Street Address:		
City, State, Zip:		Country:
Residencies:		
From ____/____	To ____/____	Institution:
Street Address:		
City, State, Zip:		Country:
From ____/____	To ____/____	Institution:
Street Address:		
City, State, Zip:		Country:
Fellowship:		
From ____/____	To ____/____	Institution:
Street Address:		
City, State, Zip:		Country:

If you are a foreign medical school graduate, are you certified by the Education Council for Foreign Medical Graduates (ECFMG)?

Yes No N/A If yes: Certification # _____ Date issued: _____

If English is NOT your native language, have you supplied English proficiency results as a condition of licensure to the Texas licensing board?

Yes No N/A If yes, please attach a copy.

CURRENT HOSPITAL AFFILIATIONS

List your current primary hospital affiliation first, then all others:

Affiliated since: ____/____	Admitting privileges? <input type="checkbox"/> Yes <input type="checkbox"/> No	Status: <input type="checkbox"/> Active <input type="checkbox"/> Courtesy <input type="checkbox"/> Consulting
Hospital:	City, State, Zip	
Affiliated since: ____/____	Admitting privileges? <input type="checkbox"/> Yes <input type="checkbox"/> No	Status: <input type="checkbox"/> Active <input type="checkbox"/> Courtesy <input type="checkbox"/> Consulting
Hospital:	City, State, Zip	
Affiliated since: ____/____	Admitting privileges? <input type="checkbox"/> Yes <input type="checkbox"/> No	Status: <input type="checkbox"/> Active <input type="checkbox"/> Courtesy <input type="checkbox"/> Consulting
Hospital:	City, State, Zip	
Affiliated since: ____/____	Admitting privileges? <input type="checkbox"/> Yes <input type="checkbox"/> No	Status: <input type="checkbox"/> Active <input type="checkbox"/> Courtesy <input type="checkbox"/> Consulting
Hospital:	City, State, Zip	

Other: _____

PROFESSIONAL REFERENCES

Please provide the **Professional Reference Questionnaire** (Form A-1) to three (3) behavioral health care providers who have personal knowledge of your current clinical abilities, ethical character, health status, and other qualifications to practice. At least one individual must not be currently associated with you in a professional practice.

Please emphasize to these references the need for their prompt completion and return of the form directly to the Local Authority at the address on the bottom of the form.

WORK HISTORY - For the past 10 years or since completion of highest degree, graduate school or medical school. You may submit a current resume or vita to meet this requirement.

1.	Employer name	Address	City, State, Zip
	Position title/description	From	To
2.	Employer name	Address	City, State, Zip
	Position title/description	From	To
3.	Employer name	Address	City, State, Zip
	Position title/description	From	To
4.	Employer name	Address	City, State, Zip
	Position title/description	From	To
5.	Employer name	Address	City, State, Zip
	Position title/description	From	To
6.	Employer name	Address	City, State, Zip
	Position title/description	From	To

MALPRACTICE CLAIMS HISTORY

Have you had or do you currently have any claims pending or closed during the past 5 years?

Yes No If yes, please supply the following information:

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
4. Completed Professional Liability Case Report form (Form A-2) for each claim

LIABILITY INSURANCE COVERAGE

Does each of your practice locations have **general liability** insurance coverage? Yes No

Professional Liability Insurance Coverage

Current Company _____

Address _____

City _____ State _____ Zip Code _____

Policy # _____ Effective Coverage Date ____/____/____

Expiration Date ____/____/____ Retroactive Coverage to ____/____/____

Amount of Coverage \$ _____ per occurrence \$ _____ aggregate

Type of policy: Claims made Occurrence

Do you participate in any state-funded liability pool? Yes No

If yes, please indicate which state(s) and provide the name of the fund and a brief summary of its coverage.

Have you ever been denied coverage (either initial or renewal) by any professional liability insurance carrier or had an individual policy canceled or individual surcharge placed on you based on your individual practice?
Yes No

If yes, please explain:

ADVERSE/DISCIPLINARY ACTIONS

Have any of the following ever been or are currently in the process of being denied, revoked, suspended, reduced, limited, censured, placed on probation or not renewed? Have you relinquished, withdrawn, or failed to proceed with an application for one of the following to avoid an adverse action, to preclude an investigation, or while under investigation relating to professional conduct?

Please provide a full explanation on a separate sheet for any "yes" responses.

Description	Yes	No
License/registration to practice in any state	<input type="checkbox"/>	<input type="checkbox"/>
DEA/controlled substance registration	<input type="checkbox"/>	<input type="checkbox"/>
Membership on any hospital staff	<input type="checkbox"/>	<input type="checkbox"/>
Clinical privileges at any hospital	<input type="checkbox"/>	<input type="checkbox"/>
Participation in Medicare, Medicaid, CHAMPUS, or other government programs	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been assessed a penalty by the Medicaid, Medicare, or CHAMPUS programs?	<input type="checkbox"/>	<input type="checkbox"/>
Non-hospital practice affiliation or authorization to provide services	<input type="checkbox"/>	<input type="checkbox"/>
Board certification	<input type="checkbox"/>	<input type="checkbox"/>
Military, state, or federal agency	<input type="checkbox"/>	<input type="checkbox"/>
Health-related professional society membership or fellowship	<input type="checkbox"/>	<input type="checkbox"/>
Have you been convicted of or pleaded no contest to any criminal charges (other than motor vehicle violations) brought against you?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been convicted of or pleaded no contest to a drug- or alcohol-related offense?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been sanctioned by a peer review organization or similar federal, state, or military agency?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any felony convictions?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been found to be the perpetrator of a confirmed case of client abuse or neglect?	<input type="checkbox"/>	<input type="checkbox"/>

HEALTH STATUS

Do you currently have any medical and/or psychiatric problem, including substance abuse, that affects your ability to perform the essential functions of your profession, with or without accommodation?

Yes No

If yes, please provide a full explanation on a separate sheet.

ATTESTATION

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

Yes No If yes, please provide explain fully on a separate sheet.

I hereby attest to the following:

- I do not currently use any illegal drug.
- I have reported accurately and completely any reasons for any inability to perform the essential functions of my profession with or without accommodation.
- I have reported accurately any history of loss of license and/or felony convictions.
- I have reported accurately any history of loss or limitation of privileges or disciplinary activity.
- I have reported accurately my chronological work history.
- I consent to the inspection of records and documents pertinent to this application, including the release by any person to the Local Authority of all information that may reasonably be relevant to an evaluation and verification of this application or evaluation of professional competence, including, but not limited to, consultation with any other health professionals or institutions with which I have been or am currently associated.
- The information submitted in and with this application is complete and correct to the best of my knowledge.

Print practitioner's name: _____

Practitioner's signature: _____ Date: _____

General Authorization for Release of Information

I, _____ (print name) hereby authorize _____ *Center* to obtain any and all information required to complete a review and primary source verification of my/our credentials. Information and documents to be reviewed include, but are not limited to, licensure/certification, accreditations and claims made against licensure/certification, malpractice insurance and claims.

I hereby release from liability any and all individuals and organizations reviewing this application for their acts performed in good faith and without malice in connection with evaluating this application and the credentials and qualifications. I also release from any liability any and all individuals and organizations 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 my written authorization and request to release any and all documentation relevant to The Gulf Coast Center credentialing and/or network approval process. Such Photostat, electronic or facsimile copy shall have the same force and effect as the signed original.

Print practitioner's name: _____

Practitioner's signature: _____ Date: _____

References

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

Print practitioner's name: _____

Practitioner's signature: _____ Date: _____

	Name	Address	Phone Number
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

FORM A-2 PROFESSIONAL LIABILITY CASE REPORT

Case Number _____ Carrier _____

Date of Incident ____/____/____ Date Claim Filed ____/____/____

Date Closed, if applicable ____/____/____

What is/was your role in the case? Primary defendant Co-defendant Other (please explain)

Other parties named in the case: _____

Current status of the case as it relates to YOU:

Dropped Dismissed, with prejudice

Settled out of court Dismissed, without prejudice

Judgment for Plaintiff: Settlement / Court award (judge or jury)

Amount paid: \$ _____ Amount attributed to your involvement \$ _____

Judgment for Defendant

Pending Date of last contact with plaintiff's attorney ____/____/____

CASE DETAILS:

What was your exact role in the client's care? Attending Consultant

Other _____

What is the alleged harm to the client? _____

What were you alleged to have done incorrectly or to have failed to do? _____

Describe the client's condition and related effects of the alleged harm: _____

Describe any other details you believe are pertinent to the case: _____

FORM A-1 PROFESSIONAL REFERENCE QUESTIONNAIRE

Professional reference being provided for: _____

Referenced provided by:

Name _____ Title _____

Place of Employment _____

Street Address: _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

License(s) _____ Education _____

How long have you known this provider on a professional basis? _____

Briefly describe the circumstances through which you have current knowledge of the provider's clinical skills and competence: _____

Please rate the provider on each element below:

Element	Above Average/ Excellent	Average	Below Average	No Information
Clinical knowledge				
Clinical judgment				
Responsiveness to client needs				
Thoroughness in care				
Quality/appropriateness of client care outcomes				
Resource use				
Rapport with clients				
Professional ethics				

Do you have direct knowledge of any physical/emotional/mental health problems, including alcohol or drug dependencies, or other problems which impair the provider's ability to perform the essential functions of his/her profession, with or without accommodation? Yes No

If yes, please explain: _____

 Signature

 Date

Credentiaing Coordinator

PLEASE RETURN THIS FORM TO:

ATTACHMENT C
Miscellaneous Required Forms

ALL OF THE FORMS IN ATTACHMENT C MUST BE INCLUDED IN YOUR SUBMISSION IN ORDER FOR THE OPEN ENROLLMENT APPLICATION TO BE CONSIDERED.

- C1. Designation of services sought**
- C2. Assurances page for signature**
- C3. Vehicle Safety Report**
- C4. Staff Roster**

**ATTACHMENT C1
DESIGNATION OF SERVICES**

Please indicate with a “√” which services you are submitting this request for application. The “X” indicates whether the service is being sought under this RFA. If there is no “X”, you can not submit an application for the service. Failure to “√” a service may require you to submit another application or wait for the next open enrollment period (which has not been established).

Services Sought for Brazoria County	Rate of Reimbursement	Indicate (√) services you are submitting this application
CBT-Counseling (Adult)	\$45	

Services Sought for Galveston County	Rate of Reimbursement	Indicate (√) services you are submitting this application
CBT-Counseling (Adult)	\$45	

The undersigned hereby certifies that he/she has the authority over all of the proposal/application documents and agrees to abide by the terms, certifications and conditions including the rate of reimbursement indicated within the RFA:

Authorized Signature: _____

Printed Name: _____

Title: _____

Date: _____

ATTACHMENT C2: ASSURANCES

Applicant must assure the following:

1. That all addenda, exhibits and/or attachments to the Application as distributed by the Local Authority have been received.
2. That the criteria for approval are met.
3. That the applicant is not currently held in abeyance or barred from the award of a federal or state contract.
4. That the applicant is not currently delinquent in its payments of any franchise tax or state tax owed to the state of Texas, pursuant to Texas Business Corporation Act, Texas Civil Statutes, Article 2.45.
5. 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 application document.
6. The Applicant does not discriminate in its services or employment practices on the basis or race, color, religion, sex, national origin, disability, veteran status, or age.
7. That no employee of the Local Authority or DSHS, and no member of the Local Authority’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.
8. Applicant accepts the terms, conditions, criteria, and requirements set forth in the Application.
9. Applicant accepts the Local Authority’s right to cancel the Application at any time prior to contract award.
10. Applicant accepts the Local Authority’s right to alter the timetables for procurement as set forth in the Application.
11. The application submitted by the Applicant has been arrived at independently without consultation, communication, or agreement for the purpose of restricting competition.
12. 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 prior to the notice of intent to award.
13. 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.
14. Local Authority has the right to complete background checks and verify information.
15. The individual signing this document and the contract is authorized to legally bind the Applicant.
16. The address submitted by the Applicant to be used for all notices sent by the Local Authority is current and correct.

Signature Authority for the Applicant

Title of the Organization/Provider

Date _____

**ATTACHMENT C3
VEHICLE SAFETY REPORT**

This form must be completed for each vehicle which may be used while transporting individuals receiving services.

Vehicle Custodian/owner: _____ Phone#: _____

License Plate Number: _____ Mileage: _____

Type and Model of Vehicle: _____

Name of Insurance Carrier: _____

Items To Be Checked:

Required for individuals safety and comfort

Inspection sticker expiration date: _____
Current insurance card in vehicle? Yes or No
A/C and Heating systems are operable? Yes or No
Jumper cables in vehicle? Yes or No or n/a
First aid kit in vehicle? Yes or No
Seat belts all lock Yes or No
Condition of tires, including spare: Ok or need replacing _____
Lights (head, tail, backup, turn) Ok or need replacing _____
Mileage of last oil change: _____ and does not exceed 3500 miles
Mileage of last transmission service: _____ and does not exceed 30,000 miles
Interior of vehicle, condition Ok or need cleaning _____
Fluid levels: Ok or need refilling or service

Additional recommended

Fire extinguisher in vehicle? Yes or No
Fire extinguisher secured? Yes or No or n/a
Flash light w/charged batteries? Yes or No or n/a
First aid kit secured? Yes or No or n/a
Biohazard kit in vehicle? Yes or No
Biohazard kit secured? Yes or No or n/a
Seat belt Saf-Cut installed Yes or No

I realize I am responsible for obtaining the necessary repairs or equipment to insure the vehicle is in a safe condition to transport individuals receiving services. I also realize the Local Authority at any time may inspect my vehicle at anytime to ensure validity of the information provided.

Vehicle custodian/Owner

Title

Date

