

THE GULF COAST CENTER
INDIVIDUALS WITH DEVELOPMENTAL DISABILITY SERVICES
(IDD)
OPEN ENROLLMENT REQUEST FOR APPLICATION

Pursuant to Title 40 Texas Administrative Code §2.60, The Gulf Coast Center (Local Authority), as the Texas Department of Aging and Disability Services (DADS) designated Local Authority for Galveston and Brazoria Counties, has the authority to assemble a network of service providers to provide the following services to the Priority Population of persons with developmental disabilities who reside in Galveston and Brazoria Counties. The listed services being sought are for Local Authority General Revenue-funded services and/or the Home and Community Based (HCS) Waiver Program.

- Community Support
- Supported Employment
- Day Habilitation
- Respite
- Nursing
- Dental
- Behavioral Supports (Psychology)
- Social Work
- Dietary
- Specialized therapies – Audiology, Speech, Occupational Therapy, Physical Therapy
- Foster Care

The Local Authority is designated by DADS to plan, coordinate, develop policy, develop and allocate resources, supervise, and ensure the provision of services for individuals with intellectual and development disabilities (IDD) for the residents of Galveston and Brazoria Counties, Texas. Funds allocated by DADS are referred to as General Revenue-funds. The specific services being sought under General Revenue-funded services are community support, t, day habilitation, respite, behavioral supports and specialized therapies.

The Home and Community-based Services (HCS) program is a Medicaid waiver program that provides services and supports to eligible individuals with intellectual and developmental disabilities who either live with their family, in their own home, in a foster/companion care setting or in a residence with no more than four individuals who receive services. The specific services being sought by the Local Authority for the HCS funded services are supported employment, day habilitation, respite, foster care/companion care, nursing, dental, behavioral supports and specialized therapies and other services as indicated in Section I. below.

The goals of this network are:

1. To develop a comprehensive network of providers for consumers with intellectual and developmental disabilities receiving General Revenue and HCS funded services.
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.

I. SERVICES SOUGHT

This Request for Application seeks participation from applicants for the purpose of offering a comprehensive array of services and supports, within Galveston and Brazoria counties for individuals who meet the target population. An applicant can submit an application to provide General Revenue or HCS funded Services. The applicable services for each provider network are indicated with an “X” in the below grid. For a description of services, see Attachment A, “**SERVICE DEFINITIONS AND REQUIREMENTS**”.

	HCS Waiver Services	General Revenue Services
Community Support	X	X
Supported Employment	X	
Day Habilitation	X	X
Respite	X	X
Nursing	X	
Dietary	X	
Social Work	X	
Dental	X	
Behavioral Supports (Psychology)	X	X
Specialized Therapies* (OT,PT, Audiology, & Speech/Language Therapy)	X	X
Foster Care/Companion Care	X	

Target Population

The target population is individuals with developmental disabilities, autism and related conditions who have been identified by the Local Authority as **Priority Population**, in accordance with the definitions established by DADS (See Attachment A -

Priority Population for Individuals with Intellectual and Development Disabilities

) Designation of an individual as a member of the Priority Population must be made by the Local Authority and documented in each individual's record maintained by the Local Authority.

II. ELIGIBILITY REQUIREMENTS

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. Applicants must be approved by the Texas Department of Assistive and Rehabilitative Services (DARS) to provide Supported Employment services. Providers who do not have an agreement with DARS must complete The Gulf Coast Center Supported Employment documentation requirements and trainings or demonstrate awareness of supported employment thru other trainings or written summary of personal knowledge acceptable to local authority. See other applicant credentialing requirements in Attachment B.

III. RESPONSIBILITIES

Local Authority Responsibilities

The Local Authority which is also an HCS Program Provider for the local service area will be responsible for oversight 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 DADS, comply with the rules and standards adopted under Section 534.052 of the Texas Health and Safety Code, and Title 40 Chapter 9, of the Texas Administrative Code. The Local Authority does not guarantee any referral volume to any service provider within its Network of Providers.

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 intellectual and developmental disabilities, 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.

For applicants who will be seeking to provide supported employment services, be aware that reimbursement for supported employment services is available only if documentation from the Local Authority verifies that supported employment services have been denied or are otherwise unavailable to the consumer through the Texas Department of Assistive and Rehabilitative Services (DARS)

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

**The Gulf Coast Center
Attn: Barry Kusnerik,
7000 Ave B
Santa Fe, TX 77510
(409) 944-4449**

If you are interested in joining the IDD Services Provider network, complete the RFA in accordance with the instructions in the RFA document. Applications are being accepted thru December 15, 2011 in order to meet current deadline needs, however applications can be received and processed on an ongoing basis throughout the year

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:

There is important information that may delay the acceptance of your application. Sections A-F below are incorporated into the applications in Attachment B1, B2, and B3, please respond with as much specificity as possible. If the application itself does not provide adequate space, additional sheet(s) of paper may be used by in order to provide the necessary information. If the question/ does not apply, simply and clearly document "N/A". Interviews or site visits may be conducted to further evaluate applications.

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

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

B. QUALITY MANAGEMENT/UTILIZATION MANAGEMENT

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

C. SERVICES

1. List the services from Attachment A 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 (such as nursing services, personal attendant services, etc.). 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?
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 intellectual and developmental disabilities, autism 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 information will be obtained from consumers regarding job preferences/conditions and how this will be utilized in securing community employment. Provide copies of Provider's assessment tools for developing employment profiles, job analysis, - Label as **Exhibit VC8**.

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.

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 or Brazoria community.

F. INFORMATION SYSTEMS

Can the organization/provider information system report the following categories of data?

1. Consumer name
2. Admissions and Discharges to services
3. Date, Number, type, and duration of services (by Local Authority service codes)
4. Number and types of restraints authorized by behavior intervention plan
5. Number, type and severity of medication errors/adverse drug reactions for Local Authority consumers
6. Deaths and suicide attempts of Local Authority consumers
7. Serious injury or illness of Local Authority consumers
8. Confirmed abuse, neglect, or exploitation of Local Authority consumers
9. Allegations of homicide/attempted homicide/threat with a plan by a Local Authority consumer

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 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 services authorized for a consumer are currently paid for by Texas Department of Assistive and Rehabilitative Services (DARS), applicant may not bill both agencies for the service. (DARS) funding for the service must be exhausted prior to submitting claims to the Local Authority.

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.

Funding Source : GENERAL REVENUE

Community Support Services (non-traditional provider only)

<u>Service</u>	<u>Hrly rate</u>	<u>Timeframes</u>
• Community Support	\$13/hr	as requested

Day Habilitation

<u>Service</u>	<u>.50 unit= min. 2 hrs</u>	<u>1 unit=5 hrs direct service</u>
	Rate	Rate
• Day Habilitation	\$ 13.50	\$ 27.00

Occupational Therapy

<u>Service</u>	<u>Assessment/Evaluation Rate</u>	<u>Treatment rate</u>
Occupational Therapy	\$150.00	\$100.00/session

Physical Therapy

<u>Service</u>	<u>Assessment/Evaluation Rate</u>	<u>Treatment rate</u>
Physical Therapy	\$150.00	\$100.00/session

Speech/Language Therapy

<u>Service</u>	<u>Assessment/Evaluation Rate</u>	<u>Treatment rate</u>
Speech/Language Therapy	\$150.00	\$100.00/session

Behavioral Therapy

<u>Service</u>	<u>Assessment/Eval Rate</u>	<u>BCBA hrly rate</u>	<u>Therapist hrly rate</u>	<u>Clinic hrly rate</u>
• Behavior Therapy	\$315.00	\$105.00	\$35.00	\$45.00

Respite (non-traditional provider only)

Funding Source: General Revenue

<u>Service</u>	<u>Rate</u>	<u>Description</u>
• Respite		
○ Standard respite	\$10.00/hr	up to 24 hrs per calendar day
○ Medical/behavioral need	\$15.00/hr	up to 24 hrs max per calendar day
○ Intense Medical/behavioral need		- determined on a case by case basis

Funding Source: HCS

Supported Employment Services

<u>Service</u>	<u>Hrly rate</u>	<u>Description</u>
• Supported Employment	\$28.14/hr	Supports on the job

<u>Service</u>	<u>Hrly rate</u>	<u>Timeframes</u>
• Community Support	19.05	as requested

Funding Source: HCS

<u>Level of Need 1 Unit Rate</u>			
<u>Service</u>	<u>.50 unit</u>	<u>.75 unit</u>	<u>1 unit</u>
• Day Habilitation	\$10.48	\$15.72	\$20.95

<u>Level of Need 5 Unit Rate</u>			
<u>Service</u>	<u>.50 unit</u>	<u>.75 unit</u>	<u>1 unit</u>
• Day Habilitation	\$11.66	\$17.49	\$23.32

<u>Level of Need 8 Unit Rate</u>			
<u>Service</u>	<u>.50 unit</u>	<u>.75 unit</u>	<u>1 unit</u>
• Day Habilitation	\$14.11	\$21.17	\$28.22

<u>Level of Need 6 Unit Rate</u>			
<u>Service</u>	<u>.50 unit</u>	<u>.75 unit</u>	<u>1 unit</u>
Day Habilitation	\$19.03	\$28.55	\$38.05

Other Services

Funding Source: HCS only

<u>Service</u>	<u>Rate</u>	<u>Description</u>
▪ Respite		
○ In-Home	\$15.28	hr up to 10 hrs max per calendar day
○ Facility-based	\$15.28	hr up to 10 hrs max per calendar day
		Rate
• Foster Care/Companion Care	LON 1 - \$47.24	
	LON 5 - \$50.89	
	LON 8 - \$69.19	
	LON 6 - \$94.81	
• Psychology/Behavioral	\$72.15	
• Dietary	\$48.07	
• Nursing		
○ RN	\$40.98	
○ Specialized RN	\$47.13	
○ LVN	\$26.97	
○ Specialized LVN	\$31.02	
•		
• Social Work services	\$44.30/hr	
• Specialized Therapies		up to \$1,000.00 Dental
• Audiology,	\$45.52	
• Occupational Therapy	\$68.97	
• Physical Therapy	\$73.25	
• Speech/Language Therapy	\$69.78	

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 DADS 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

Priority Population for Individuals with Intellectual and Development Disabilities

The Priority Population for developmental disabilities services includes those persons who *request* and *need* services and possess one or more of the following conditions:

- * Mental retardation, as defined by Section 591.003 (13), Title 7, Health and Safety Code
- * Autism as defined in the current edition of the Diagnostic and Statistical Manual (DSM)
- * Pervasive Developmental Disorder (PDD) as defined in the current edition of the DSM
- * * Eligibility for OBRA '87 mandated services for mental retardation or a related condition as per specific legislation.

The presence of Intellectual and Developmental Disabilities must be determined through DADS eligibility determination process or through the use of assessments performed by qualified professionals as per interagency memoranda of understanding. Diagnoses of autism or PDD must be reviewed and endorsed by the Local Authority. For persons with intellectual and developmental disabilities, autism, or PDD, the priority population includes only those individuals whose needs for services can be most appropriately met through programs currently or potentially offered by the DADS system rather than some other service system. Services are to be offered in coordination with efforts of other agencies to ensure that all services are provided by agencies as required by laws, rules, and regulations. The priority population does not include anyone whose service needs may be most appropriately met through other means, as determined by DADS. Persons who are members of the Priority Population are eligible to receive services from the DADS system. Since resources are insufficient to meet all the service needs of all the members of the Priority Population, services are provided to meet the most intense needs first.

SERVICE DEFINITIONS AND REQUIREMENTS

A) COMMUNITY LIVING SERVICES

2. **Supported employment** - service component provides on-going individualized supports needed by an individual to sustain paid work in an integrated work setting.
 - (1) An individual receiving supported employment is:
 - a. compensated directly by the individual's employer in accordance with the Fair Labor Standards Act; and
 - b. employed in an integrated work setting by an employer that has no more than one employee or 3.0% of its employees with disabilities unless the individual's PDP indicates otherwise or the employer subsequently hires an additional employee with disabilities who is receiving services from a provider other than the individual's program provider or who is not receiving services.
 - (2) Supported employment may only be provided when the service has been denied or is otherwise unavailable to an individual through a program operated by a state rehabilitation agency or the public school system.
 - (3) Supported employment is provided away from the individual's place of residence.
 - (4) Supported employment does not include payment for the supervisory activities rendered as a normal part of the business setting.
 - (5) Supported employment does not include services provided to an individual who does not require such services to continue employment.
3. **Day Habilitation.** assists an individual to acquire, retain, or improve self-help,

socialization, and adaptive skills necessary to live successfully in the community and participate in home and community life and does not include services that are funded under §110 of the Rehabilitation Act of 1973 or §602(16) and (17) of the Individuals with Disabilities Education Act.

- (1) The day habilitation service component provides:
 - a. individualized activities consistent with achieving the outcomes identified in the individual's PDP;
 - b. activities necessary to reinforce therapeutic outcomes targeted by other waiver service components, school, or other support providers;
 - c. services in a group setting other than the individual's home for normally up to five days a week, six hours per day;
 - d. personal assistance for individuals that cannot manage their personal care needs during the day habilitation activity;
 - e. assistance with medications and the performance of tasks delegated by a registered nurse in accordance with state law; and
 - f. transportation during the day habilitation activity necessary for the individual's participation in day habilitation activities.
- (2) The day habilitation component may not be provided at the same time supported employment is provided to an individual who has obtained employment.

4. Respite – is provided for the planned or emergency short-term relief of the unpaid caregiver of an individual.

- (1) The respite service component provides individuals:
 - a. assistance with activities of daily living and functional living tasks;
 - b. assistance with planning and preparing meals;
 - c. transportation or assistance in securing transportation;
 - d. assistance with ambulation and mobility;
 - e. assistance with medications and performance of tasks delegated by a Registered Nurse in accordance with state law;
 - f. habilitation and support that facilitate:
 - (i) an individual's inclusion in community activities, use of natural supports and typical community services available to all people;
 - (ii) an individual's social interaction and participation in leisure activities; and
 - (iii) development of socially valued behaviors and daily living and independent living skills.
- (2) Reimbursement for respite provided in a setting other than the individual's residence includes payment for room and board.
- (3) Respite is provided on an hourly or daily unit basis.
- (4) If for HCS services, respite may be provided in the individual's residence or, if following certification are met, in other locations:

If respite is provided in the residence of another individual, the program provider must obtain permission from that individual or the individual's LAR and ensure that the interdisciplinary team for each individual makes a determination that the respite visit will cause no threat to the health, safety and welfare, or rights and needs of that individual;

If respite is provided in the residence of another individual, the provider must ensure that:

- (i) no more than three individuals receiving HCS program services and persons

receiving similar services for which the provider is reimbursed are served in a residence in which HCS foster/companion care is provided;

(ii) no more than three individuals receiving HCS program services and persons receiving similar services for which the provider is reimbursed are served in a residence in which only supervised living is provided; and

(iii) no more than four individuals receiving HCS program services and persons receiving similar services for which the provider is reimbursed are served in a residence in which residential support is provided;

5. **Community Support** - The community support service component provides services and supports in an individual's home and at other community locations that are necessary to achieve outcomes identified in an individual's person-directed plan (PDP).

- (1) The community support service component provides habilitative or support activities that:
 - a. provide or foster improvement of or facilitate an individual's ability to perform functional living skills and other activities of daily living;
 - b. assist an individual to develop competencies in maintaining his or her home life;
 - c. foster improvement of or facilitate an individual's ability and opportunity to:
 - (i) participate in typical community activities including activities that lead to successful employment;
 - (ii) access and use of services and resources available to all citizens in the individual's community;
 - (iii) interact with members of the community;
 - (iv) access and use available services or supports for which the individual may be eligible; and
 - (v) establish or maintain relationships with people, who are not paid service providers, that expand or sustain the individual's natural support network.
- (2) The community support service component provides assistance with medications and the performance of tasks delegated by a registered nurse in accordance with state law.
- (3) The community support service component does not include payment for room or board.
- (4) The community support service component may not be provided at the same time that the respite, day habilitation, or supported employment service component is provided.
- (5) The community support service component is reimbursed on an hourly basis.

6. **Foster Care/Companion Care** this component provides:

- (1) direct personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene);
- (2) assistance with meal planning and preparation;
- (3) securing and providing transportation;
- (4) assistance with housekeeping;
- (5) assistance with ambulation and mobility;
- (6) reinforcement of counseling and therapy activities;
- (7) assistance with medications and the performance of tasks delegated by an RN;
- (8) supervision of individuals' safety and security;
- (9) facilitating inclusion in community activities, use of natural supports, social interaction, participation in leisure activities, and development of socially valued behaviors; and
- (10) habilitation, exclusive of day habilitation;

B) PROFESSIONAL AND TECHNICAL SUPPORT SERVICES

1. **Nursing services** - component provides treatment and monitoring of health care procedures as prescribed by a physician or medical practitioner or as required by standards of professional practice or state law to be performed by licensed nurses.
 - (1) The nursing service component includes:
 - a. administration of medication;
 - b. monitoring an individual's use of medications;
 - c. monitoring an individual's health data and information;
 - d. assisting an individual or LAR to secure emergency medical services for the individual;
 - e. making referrals for appropriate medical services;
 - f. performing health care procedures as ordered or prescribed by a physician or medical practitioner or as required by standards of professional practice or law to be performed by licensed nursing personnel; and
 - g. delegating and monitoring tasks assigned to other service providers by a registered nurse in accordance with state law.
 - (2) The nursing service component is reimbursed on an hourly unit basis.

2. **Behavioral (Psychology) Service** - component provides specialized interventions that assist an individual to increase adaptive behaviors to replace or modify maladaptive or socially unacceptable behaviors that prevent or interfere with the individual's inclusion in home and family life or community life. The component is reimbursed on an hourly unit basis and includes:
 - (1) assessment and analysis of assessment findings of the behavior(s) to be targeted necessary to design an appropriate behavioral support plan;
 - (2) development of an individualized behavioral support plan consistent with the outcomes identified in the individual's PDP;
 - (3) training of and consultation with the LAR, family members, or other support providers and, as appropriate, with the individual in the purpose/objectives, methods and documentation of the implementation of the behavioral support plan or revisions of the plan;
 - (4) monitoring and evaluation of the success of the behavioral support plan implementation; and
 - (5) modification, as necessary, of the behavioral support plan based on documented outcomes of the plan's implementation.

3. **Specialized Therapies** - service component provides assessment and treatment by licensed Social Workers, Occupational Therapists, Physical Therapists, Speech and Language Pathologists, Audiologists, and Dietitians and includes training and consultation with an individual's LAR, family members or other support providers. Specialized therapies are reimbursed on an hourly unit basis.

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 Certificate of Liability Insurance Verification including:
 - Professional and General liability
 - Vehicle (if transporting consumers is likely), **complete Attachment C3**
 - Workers Compensation (if applicable)
- Completion of DADS required minimum training for each staff potentially working with Local Authority consumers.
- Non-traditional provider shall meet state minimum training requirements as determined by the Local Authority and any additional training requirements will be determined by individual(s) served.
- Verification of criminal history, nurse aide registry and employee misconduct registry checks for all staff potentially working with Local Authority consumers.
- Life Safety code review for site assessment if not certified by a state agency.
Annual Fire Marshall Inspection reports
- If applicable, documentation from certifying agency:
 - Texas Department of Assistive and Rehabilitative Services (DARS)

2. Additional required information:

- A. Community Support Services funded under General Revenue & HCS must also provide:
 - If applicant is an individual, complete Attachment B1.
 - If applicant is an organization or program with staff then Attachment B3.
- B. Supported Employment Services under HCS must also provide:
 - If applicant is an individual, complete Attachment B1.
 - If applicant is an organization or program with staff then Attachment B3.
 - Texas Department of Assistive and Rehabilitative Services (DARS) (if DARS certified)
- C. Day Habilitation Services under General Revenue or HCS must also provide:
 - If applicant is an individual, complete Attachment B1.
 - If applicant is an organization or program with staff then Attachment B3.
- D. Respite Services under General Revenue or HCS must also provide:
 - If applicant is an individual, complete Attachment B1.
 - If applicant is an organization or program with staff then Attachment B3
- E. Foster Care Services under HCS must also provide:
 - If applicant is an individual, complete Attachment B1
- F. Nursing Services under HCS must also provide:

- **Complete Attachment B2**
 - licensed as a registered nurse by the Board of Nurse Examiners for the State of Texas; or
 - licensed as a vocational nurse by the Board of Vocational Nurse Examiners for the State of Texas.
- G. Dental Services under HCS must also provide:
- **Complete Attachment B2**
 - currently licensed by the Texas State Board of Dental Examiners.
- H. Behavioral Support Services under General Revenue & HCS must also provide:
(Psychology Services)
- **Complete Attachment B2**
 - licensed as a psychologist by the Texas State Board of Examiners of Psychologists;
 - licensed as a psychological associate by the Texas State Board of Examiners of Psychologists and working under the supervision of a licensed psychologist;
 - licensed as a psychological associate by the Texas State Board of Examiners of Psychologists or certified as a DADS-certified psychologist in accordance with §415.161 of this title (relating to DADS -certified psychologists) and working in a public agency; or
 - Certified as a behavior analyst by the Behavior Analyst Certification Board, Inc.
- I. Specialized Therapies under General Revenue & HCS must also provide:
Includes Social Work, Occupational Therapy, Physical Therapy, Dietary, Audiology/Speech
- **Complete Attachment B2**
 - Licensed by the appropriate State of Texas licensing authority for the specific therapeutic service provided by the provider.

THE GULF COAST CENTER
INDIVIDUAL PROVIDER APPLICATION FOR NON-LICENSED PROVIDERS

Section A: General Information

Provider Name _____

Last First MI

Social Security Number or Federal Tax ID Number: _____

Date of Birth _____ US Citizen _____

Male/Female _____

Do you qualify as a Historically Underutilized Business (HUB)? Yes No

If yes, have you applied for certification? Yes No If yes, Certification # _____

Section B

Indicate location where services are provided: office facility home Local Authority

Locations – Please Specify Preferred Mailing Address

Property owned or leased _____

Office Name _____ Office Hours: Mon _____

Address _____ Tue _____

_____ Wed _____

Telephone# _____ Thurs _____

E-Mail _____

Fax # _____ Fri _____

After Hours Phone Service: Name _____ Phone _____

1. 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.

2. List the services from Attachment A 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 (such as nursing services, personal attendant services, etc.). 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?

3. Describe the organization's/provider's experience in working with persons with intellectual and development disabilities, autism 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?

4. Describe how information will be obtained from consumers regarding job preferences/conditions and how this will be utilized in securing community employment. Provide copies of Provider's assessment tools for developing employment profiles, job analysis, - Label as **Exhibit VC8**.

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 ability to work with individuals with physical impairments or adaptive equipment

7. Do you provide emergency or after hours services or on Holidays? ___ Yes ___ No
If yes, please explain including telephone. # _____

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

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

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

11. 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**.

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

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

Section C: Education History

1.

Undergraduate	Address	Degree	From	To
---------------	---------	--------	------	----

2.

Graduate	Address	Degree	From	To
----------	---------	--------	------	----

3. Please list any certifications or accreditations, if applicable: JCAHO ف ICF/MR ف CARF ف HCS ف HCSO ف CLASS ف ACDD ف DARS ف ECI ف TEA ف Other, please specify:_____

4. Please list any licensure specifying the license #, licensing agency as well as level(s) of service

as applicable: _____

5. In what languages, including American Sign Language or Signed English, are staff able to provide services? _____

Section D: Employment History

1. _____
- | Employer Name | Address | City,State,Zip | From | To |
|---------------|---------|----------------|------|----|
|---------------|---------|----------------|------|----|
2. _____
- | Employer Name | Address | City,State,Zip | From | To |
|---------------|---------|----------------|------|----|
|---------------|---------|----------------|------|----|
3. _____
- | Employer Name | Address | City,State,Zip | From | To |
|---------------|---------|----------------|------|----|
|---------------|---------|----------------|------|----|
-

Section E: Operations Information

1. Do you have a client appeals process? **Yes or No**
2. Do you have an incident report process? **Yes or No**
3. Do you have a confidentiality/client rights process? **Yes or No**
4. Do you have an internal quality improvement process? **Yes or No**
5. Do you have an internal utilization management process? **Yes or No**
6. Do you have a customer/consumer satisfaction measure? **Yes or No**
7. Do you have a service outcome measure? **Yes or No**
8. Do you maintain a file on each person receiving services? **Yes or No**
9. Please mark which of the following training you have received:
- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Client Rights/Confidentiality | <input type="checkbox"/> Pharmacology |
| <input type="checkbox"/> Abuse/Neglect/Exploitation reporting | <input type="checkbox"/> First Aid |
| <input type="checkbox"/> Verbal & Physical Mgmt of Aggressive behavior (PMAB) | <input type="checkbox"/> CPR |
| <input type="checkbox"/> Medication Administration | |
10. Will or do you wish to provide services to more than 1 person **Yes or No**
11. Do you know the person(s) you will be working with **Yes or No**
If yes, how long have you known them. _____
12. Have you ever provided services to individuals with disabilities before? **Yes or No**
If yes, explain _____
-

Section F. Information Systems

Can the organization/provider information system report the following categories of data?

1. Consumer name
2. Admissions and Discharges to services
3. Date, Number, type, and duration of services (by Local Authority service codes)
4. Number and types of restraints authorized by behavior intervention plan
5. Number, type and severity of medication errors/adverse drug reactions for Local

- Authority consumers
6. Deaths and suicide attempts of Local Authority consumers
 7. Serious injury or illness of Local Authority consumers
 8. Confirmed abuse, neglect, or exploitation of Local Authority consumers
 9. Allegations of homicide/attempted homicide/threat with a plan by a Local Authority consumer

Section G: Adverse/Disciplinary Actions

Have you relinquished, withdrawn, or failed to proceed with an application for one of the following reasons described to avoid an adverse action, to preclude an investigation, or while under investigation relating to professional conduct or job performance.

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

1. Have you ever had participation in Medicare, Medicaid, CHAMPUS, or other government programs restricted, sanctioned or limited? **Yes or No**
2. Have you ever been assessed a penalty by the Medicaid, Medicare, or CHAMPUS programs? **Yes or No**
3. Have you been convicted of or pleaded no contest to any criminal charges brought against you? **Yes or No**
4. Have you been convicted of or pleaded no contest to a drug or alcohol related offense? **Yes or No**
5. Has a peer review organization or similar federal, state, or military agency sanctioned you? **Yes or No**
6. Have you ever had any felony convictions? **Yes or No**
7. Have you ever been found to be the perpetrator of a confirmed case of abuse or neglect? **Yes or No**

Section H: Insurance Information

Type of Liability Coverage: ف Professional ف General ف Auto ف Other

(Attach all Certificates of Liability Label as **Exhibit VE3**)

1. Type of Insurance: _____
 Insurance Carrier _____ Expiration _____
 Address: _____
 City _____ State _____ Zip _____ Phone _____
 Policy # _____ Coverage Limits: Per Occurrence \$ _____ Aggregate\$ _____
2. Type of Insurance: _____
 Insurance Carrier _____ Expiration _____
 Address: _____
 City _____ State _____ Zip _____ Phone _____
 Policy # _____ Coverage Limits: Per Occurrence \$ _____ Aggregate\$ _____

If more than one type of insurance, please indicate type and above information on a separate sheet of paper

3. Have you filed a claim under your general, professional auto or other liability insurance in the last three years? ___Yes ___No
4. Are there any claims pending against you ___Yes ___No
5. Has your liability/malpractice coverage ever been denied, cancelled, or non-renewed? ___Yes ___No
6. Have you ever had your license(s), applicable certifications of accreditations, terminated, restricted, or voluntarily relinquished? ___Yes ___No
7. Have you been sanctioned, placed on probation, placed on venter hold or lost accreditation, licensure or certification status during the last 3 years? ___Yes ___No

If you answered Yes to any of the above questions, please explain on a separate sheet of paper.

Section I: 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.

Applicant's signature: _____ Date: _____

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

Section J: Attestation

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

Yes____ No____ If yes, please provide explanation 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 or 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 Gulf Coast Center of all information that may reasonable 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. I understand that any information contained in this application which subsequently is found to be false could result in a denial of the application or termination from network participation.

Applicant's signature: _____ Date: _____

Printed Name: _____

Section K: General Authorization for Release of Information

I, _____(print name) hereby authorize The Gulf Coast 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.

Applicant's signature: _____

Date: _____

Printed Name: _____

ATTACHMENT B2
THE GULF COAST CENTER
INDIVIDUAL PROVIDER APPLICATION FOR LICENSED PRACTITIONERS

Section A: General Information

Provider Name _____
Last First MI
 Social Security Number: _____ Degree _____
 Date of Birth _____ US Citizen? _____
 Male/Female _____

Section B: Locations

Please Specify Preferred Mailing Address

Office Name _____ Office Hours: Mon _____
 Address _____ Tue _____
 _____ Wed _____
 Telephone# _____ Thurs _____
 Fax # _____ Fri _____
 After Hours Phone Service: Name _____ Phone _____

Section C: Licensure/Certifications

(Attach a copy of your current state License.)

License type (check all that apply) Physician Physician Asst. ANP RN LVN
 Psychologist LMSW-ACP LPC LMFT LCDC

Other _____

State _____ License# _____ Expiration Date _____
 State _____ License# _____ Expiration Date _____
 State _____ License# _____ Expiration Date _____

Section D: Licensed Medical Professionals

(Attach copy of DEA, DPS and Board Certification)

Physicians:

DEA State _____ License # _____ Expiration Date _____
 Federal _____ License# _____ Expiration Date _____
 DPS License# _____ Expiration Date _____

Board Certified Yes No Board Eligible? Yes No

If you are Board Certified by the American Board of Psychiatry and Neurology (ABPN),

American Osteopathic Board of Neurology and Psychiatry (AOBNP), or the American Society of Addiction Medicine (ASAM), please complete the chart below, circling the appropriate certifying board:

Specialty	Certifying Board		Certification #	Year Certified	Expiration Date
Psychiatry	ABPN	AOBNP			
Addiction	ABPN				
Child	ABPN				
Child and Adolescent	ABPN				

CURRENT PROFESSIONAL ASSOCIATION/SOCIETY MEMBERSHIPS:

Physician Assistants and Advanced Nurse Practitioners:

- Are you authorized to prescribe medications: ____ Yes ____ No
- If yes, Prescription Authorization Number: _____ Exp. Date: _____

Section E: Government Program Participation

Medicare provider # _____
 Medicaid provider# _____

Section F: Education History

- | Undergraduate | Address | Degree | From | To |
|---------------|---------|--------|------|----|
| | | | | |
- | Graduate | Address | Degree | From | To |
|----------|---------|--------|------|----|
| | | | | |
- | Medical School | Address | Degree | From | To |
|----------------|---------|--------|------|----|
| | | | | |
- | Internship | Address | Degree | From | To |
|------------|---------|--------|------|----|
| | | | | |
- | Residency | Address | Degree | From | To |
|-----------|---------|--------|------|----|
| | | | | |
- | Residency | Address | Degree | From | To |
|-----------|---------|--------|------|----|
| | | | | |
- | Fellowship | Address | Degree | From | To |
|------------|---------|--------|------|----|
| | | | | |

If you are a foreign medical school graduate, are you certified by the Education Council for

Foreign Medical Graduates (ECFMG)?

___Yes___No

Section G: Employment History

(If a physician, since completion of medical school or post graduate school)

1. _____
Employer Name Address City,State,Zip From To

2. _____
Employer Name Address City,State,Zip From To

3. _____
Employer Name Address City,State,Zip From To

4. _____
Employer Name Address City,State,Zip From To

5. _____
Employer Name Address City,State,Zip From To

6. _____
Employer Name Address City,State,Zip From To

Section H: Hospital Affiliation

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

Name of Hospital	Type of Privileges
_____	Full___Courtesy___Restricted___Other___
_____	Full___Courtesy___Restricted___Other___
_____	Full___Courtesy___Restricted___Other___

Section I: Professional 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.

Applicant's signature: _____ Date: _____

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

Section J: 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.

1. License/registration to practice in any state Yes___ No___
 2. DEA/controlled substance registration Yes___ No___
 3. Membership on any hospital staff Yes___No___
 4. Clinical privileges at any hospital Yes___No___
 5. Participation in Medicare, Medicaid, or other government programs Yes___No___
 6. Have you ever been assessed a penalty by the Medicaid, Medicare or any other government program? Yes___ No___
 7. Non-hospital practice affiliation or authorization to provide services Yes___No___
 8. Board certification Yes___No___
 9. Military, state or federal agency Yes___ No___
 10. Health-related professional society membership or fellowship Yes___No___
 11. Have you been convicted of or pleaded no contest to any criminal charges (other than motor vehicle violations) brought against you? Yes___No___
 12. Have you been convicted of or pleaded no contest to a drug or alcohol related offense? Yes___ No___
 13. Have you been sanctioned by a peer review organization or similar federal, state, or military agency? Yes___No___
 14. Have you ever had any felony convictions? Yes___No___
 15. Have you ever been found to be the perpetrator of a confirmed case of client abuse or neglect? Yes___No___
-

Section K: 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 accommodations? Yes___No___

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

Section L: Professional Liability Insurance Coverage

(Attach a copy of the declaration page of your current Professional Liability Insurance Coverage)

Company Name_____

Address_____

City_____ State_____ Zip Code_____

Policy Number_____ Coverage Limit_____ Expiration_____

Have you ever been denied coverage (either initial or renewal) by any professional liability insurance carrier or had an individual policy cancelled or individual surcharge placed on you based on your individual practice? Yes___ No___

If yes, please explain: _____

Section M: 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.

Section N: Attestation

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

Yes____ No____ If yes, please provide explanation 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 or 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 Gulf Coast Center of all information that may reasonable 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. I understand that any information contained in this application which subsequently is found to be false could result in a denial of the application or termination from network participation.

Applicant’s signature: _____ Date: _____

Printed Name: _____

Section O: General Authorization for Release of Information

I, _____(print name) hereby authorize The Gulf Coast 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.

Applicant's signature: _____

Date: _____

Printed Name: _____

**ATTACHMENT B3
THE GULF COAST CENTER
PROVIDER PROGRAM APPLICATION**

Section A: GENERAL INFORMATION

1. Name of Program/Provider _____
2. Name of Chief Executive Officer _____
3. Contact Person _____ Title _____
4. Business Address _____
City _____ State _____ Zip Code _____

Phone _____ Fax _____
E-Mail _____
5. List location where services are provided ___ Office ___ Home ___ local authority
Facility
6. Property owned or leased _____
7. Number of years in business _____
8. Is your Service Address* different from Business address? ___ Yes ___ No
If Yes, list it below:
Address _____
City _____ State _____ Zip Code _____
9. Do you qualify as a Historically Underutilized Business (HUB)? ___ Yes ___ No
If yes, have you applied for certification? ___ Yes ___ No If yes, Certification# _____
Incorporated _Yes No
Social Security # or Federal Tax ID # _____ Tax Code [Example: 501(c)(3)]

10. Please list any certifications or accreditations, if applicable: ڤ JCAHO ڤ ICF/MR ڤ CARF ڤ
HCS ڤ HCSO ڤ CLASS ڤ ACDD ڤ DARS ڤ ECI ڤ TEA ڤ DOL ڤ Other, please
specify: _____
11. Describe any contracts, Memoranda of Understanding, or employment relationship the
organization/provider has with other state, city or county agencies in the Galveston or
Brazoria community.

12. 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.

13. Please list any licensure specifying the license #, licensing agency as well as level(s) of service as applicable:

14. List the services from Attachment A 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 (such as nursing services, personal attendant services, etc.). 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?

15. Describe the organization's/provider's experience in working with persons with with intellectual and development disabilities, autism 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?

16. Describe how information will be obtained from consumers regarding job preferences/conditions and how this will be utilized in securing community employment. Provide copies of Provider's assessment tools for developing employment profiles, job analysis, - Label as **Exhibit VC8**.

17. 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.

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

19. Describe ability to work with individuals with physical impairments or adaptive equipment

20. In what languages, including American Sign Language or Signed English, are staff able to provide services? _____

21. Are employees or agents of the organization bonded? What is your policy regarding criminal history checks on employees ___ Yes ___ No

22. Do you provide emergency or after hours services or on Holidays? ___ Yes ___ No
If yes, please explain including telephone.# _____

23. 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. _____

24. Are you a Medicaid provider? _____ Yes ___ No
If Yes, Group or Individual Provider # _____

25. Are you a Medicare provider? _____ Yes ___ No
If Yes, Group or Individual Provider # _____

26. Types of Services:

___ Adult	___ Attendant Care Services	___ Parent Coaching
___ Children	___ Community Inclusion	___ Respite
___ Adult & Child.	___ Day Program for Skills Training (IDD)	
	___ Site-Based Habilitation.	
	___ Early Childhood Intervention	___ Specialty Services: Deaf
	___ In-Home & Family Support	___ Specialty Services: Deaf/Blind
	___ Individual Competitive Employment	___ Supported Employment
	___ Individualized Habilitation.	___ Supported Living
	___ Residential Services	___ Vocational Training
	___ Behavior Consultation.	___ Other _____

Section B: Specialty Areas:

Please check each area in which your program is qualified.

- | | | |
|---|---|--|
| <input type="checkbox"/> Autism | <input type="checkbox"/> Elderly Services | <input type="checkbox"/> Mobility Impairment |
| <input type="checkbox"/> Criminal Justice | <input type="checkbox"/> Family Support | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Developmental Disabilities | <input type="checkbox"/> Sign Language/Deaf culture Proficiency | <input type="checkbox"/> HIV/AIDS Issues |
| <input type="checkbox"/> Dual Diagnosis(IDD/MI) | <input type="checkbox"/> Homeless Services | <input type="checkbox"/> Other _____ |

Describe additional services, specialties or areas of expertise:

Section C: Operations Information

1. Do you have a client appeals process? Yes No
If Yes, Staff/Contact _____
Phone# _____ Fax _____
2. Do you have an incident report process? Yes No
If Yes, Staff/Contact _____
Phone# _____ Fax _____
3. Do you have a confidentiality/client rights process? Yes No
If Yes, Staff/Contact _____
Phone# _____ Fax _____
4. Do you have an internal quality improvement process? Yes No
If Yes, Staff/Contact _____
Phone# _____ Fax _____
5. Do you have an internal utilization management process? Yes No
If Yes, Staff/Contact _____
Phone# _____ Fax _____
6. Do you have a customer/consumer satisfaction measure? Yes No
If Yes, Staff/Contact _____
Phone# _____ Fax _____
7. Do you have a service outcome measure? Yes No
If Yes, Staff/Contact _____
Phone# _____ Fax _____
8. Please mark which of the following training you or all of your direct care staff receive:
 Client Rights/Confidentiality Pharmacology
 Abuse/Neglect/Exploitation reporting First Aid
 Verbal & Physical Mgmt of Aggressive behavior (PMAB) CPR
 Medication administration
9. Does your program have a current operating plan and budget? Yes No

10. Can the organization/provider information system report the following categories of data?
1. Consumer name
 2. Admissions and Discharges to services
 3. Date, Number, type, and duration of services (by Local Authority service codes)
 4. Number and types of restraints authorized by behavior intervention plan
 5. Number, type and severity of medication errors/adverse drug reactions for Local Authority consumers
 6. Deaths and suicide attempts of Local Authority consumers
 7. Serious injury or illness of Local Authority consumers
 8. Confirmed abuse, neglect, or exploitation of Local Authority consumers
 9. Allegations of homicide/attempted homicide/threat with a plan by a Local Authority consumer
11. Is your program in compliance with all local city, state and federal codes and local statutes as applicable to your program including health codes, fire/safety codes, etc? If no, please submit reasons and plan of correction on a separate sheet of paper. ___Yes ___No

If you answer Yes to the following questions, please explain on a separate sheet of paper.

12. Have you or any of your direct care staff ever had a confirmed allegation that you/they engaged in any class of client abuse/client neglect by the Department of Family and Protective Services or any equivalent state Agency in the past 7 years? ___Yes ___No

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**

13. Have you or any of your staff been convicted of a felony against a person or property? ___Yes ___No

Section D: Insurance Information (Attach all Certificates of Liability Label as **Exhibit VE3**)

Type of Liability Coverage: Professional General Auto Other WCI (if/app)

1. Type of Insurance: _____
 Insurance Carrier _____ Expiration _____
 Address: _____
 City _____ State _____ Zip _____ Phone _____
 Policy # _____ Coverage Limits: Per Occurrence \$ _____ Aggregate\$ _____

2. Type of Insurance: _____
 Insurance Carrier _____ Expiration _____
 Address: _____
 City _____ State _____ Zip _____ Phone _____
 Policy # _____ Coverage Limits: Per Occurrence \$ _____ Aggregate\$ _____

If more than one type of insurance, please indicate type and above information on a separate sheet of paper

3. Have you filed a claim under your general, professional auto or other liability insurance in the last three years? Yes No
4. Are there any claims pending against your program/organization? Yes No
5. Has your program/organization's liability/malpractice coverage ever been denied, cancelled, or non-renewed? Yes No
6. Have you ever had your program/organization's license(s), applicable certifications of accreditations, terminated, restricted, or voluntarily relinquished? Yes No
7. Has the program been sanctioned, placed on probation, placed on venter hold or lost accreditation, licensure or certification status during the last 3 years? Yes No

If you answered Yes to any of the above questions, please explain on a separate sheet of paper.

Section E: Program Application Required Documentation

- Photocopies of certification and accreditation materials
- Photocopies of program license(s)
- Photocopies of general and professional, liability coverage
- Program brochures(s) if available

Section F: Program Application Required Certification Statement

I certify that the information provided in this application is correct to the best of my knowledge. I understand that any information contained in this application which subsequently is found to be false could result in denial of the application or termination from network participation.

On behalf of myself, I consent to allow The Gulf Coast Center to inspect records and documents pertinent to this application.

Signature of Person or Program Representative

Date

Printed name of Person or Program Representative

Title of Representative
(if applicable)

Section G: General Authorization For Release Of Information

I, _____(print name) hereby authorize The Gulf Coast 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.

Applicant's signature: _____ Date: _____

Printed Name: _____

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).

	HCS Waiver	Indicate (√) services you are submitting this application	General Revenue	Indicate (√) services you are submitting this application
Community Support	X		X	
Employment Assistance				
Supported Employment	X			
Day Habilitation	X		X	
Respite	X		X	
Foster Care/ Companion Care	X			
Social Work	X			
Nursing	X			
Dietary	X			
Dental	X			
Behavioral Supports (Psychology)	X		X	
Audiology	X		X	
Speech/Language Therapy)	X		X	
Occupational Therapy	X		X	
Physical Therapy	X		X	

Signature of Applicant

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 DADS, 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

**ATTACHMENT C4
STAFF ROSTER**

Applicant: _____

Date: _____

STAFF NAME	POSITION	DATE OF LAST CRIMINAL HX CHECK	DATE GRADUATED HS OR GED	PROFESSIONAL LICENSE/DEGREE	TDL EXP. DATE