

**MHMR OF TARRANT COUNTY
GRANT-FUNDED SERVICES**

**OPEN ENROLLMENT
REQUEST FOR APPLICATIONS NOTICE (“RFA NOTICE”)**

My Health My Resources of Tarrant County (“MHMR”) is a community center, a local mental health authority (“LMHA”), a local behavioral health authority (“LBHA”), a local intellectual and developmental disability authority (“LIDDA”), and a unit of local government as defined by chapter 533 and 534 of the Texas Health and Safety Code. MHMR is seeking qualified contractors (“Applicants”) to apply through its Open Enrollment procedures to provide YES Waiver services for eligible patients as specified in this RFA Notice.

Service Description:

YES Waiver services subject to this solicitation include the following, as defined in the [YES Waiver Policy Manual](#):

- Respite Services
 - In-Home
 - Out-of-Home Camp
 - Out-of-Home Licensed Child Care Center (“LCCC”)
 - Out-of-Home LCCC—Texas Rising Star (“TRS”) Provider
 - Out-of-Home Licensed Child Care Home (“LCCH”)
 - Out-of-Home Licensed Child Care Home—TRS Provider
 - Out-of-Home Registered Child Care Home (“RCCH”)
 - Out-of-Home Residential Child Care (Other)
- Specialized Therapies
 - Art Therapy
 - Music Therapy
 - Animal-Assisted Therapy
 - Nutritional Counseling
 - Recreational Therapy

Geographic Area:

Tarrant County

Procedure for Obtaining an Application:

Applicants may download a copy of the Application attached to the RFA, which will be posted on the MHMR website at <https://mhmrarrant.org/business-opportunities/>. Applicants may also request an electronic copy via e-mail at Provider.Relations@mhmrctc.org, or may pick up a paper copy from MHMR’s Provider Relations team at MHMR’s administrative office, located at 3840 Hulen Street, Fort Worth, TX 76107.

Deadline:

Open Enrollment applications are accepted on a rolling basis for each fiscal year.

The period for applications for Fiscal Year 2027 (September 1, 2026–August 31, 2027) is August 1, 2026–June 1, 2027.

**MHMR OF TARRANT COUNTY
GRANT-FUNDED SERVICES**

**OPEN ENROLLMENT
REQUEST FOR APPLICATIONS (“RFA”)**

Texas Health and Human Services Commission (“HHSC”) has granted authority to MHMR to procure contracts with qualified service providers for certain services, pursuant to [26 TAC § 301.9](#).

MHMR has evaluated the need for these services and determined that MHMR’s Open Enrollment procedures, in alignment with [26 TAC § 301.19](#), are the most appropriate method of procurement.

MHMR is requesting responses to the RFA (“Applications”) from qualified service providers (“Applicants”) for the provision of YES Waiver services as specified in this RFA.

1. Application Procedures

1.1. Application Requirements

Application must include:

- (1) Applicant’s name;
- (2) Applicant’s address;
- (3) Applicant’s telephone number;
- (4) Applicant’s email address;
- (5) Applicant’s type of business entity; and
- (6) All other information required by this RFA.

1.2. Complete Application Required

Applicants may download a copy of the Application attached to this RFA, posted on the MHMR website at <https://mhmrarrant.org/business-opportunities/>. Applicants may also request an electronic copy via e-mail at Provider.Relations@mhmrctc.org, or may pick up a paper copy from MHMR’s Provider Relations team at MHMR’s administrative office, located at 3840 Hulen Street, Fort Worth, TX 76107.

Applicants shall complete all required documents and attachments as specified in this RFA. Applicants must answer every question in the attached Application. If the question does not apply to you, mark your response as “N/A.” All supporting documentation must be attached, including the “Texas Standardized Credentialing Application,” which must be completed for each licensed individual providing services under this RFA. Failure to properly complete an Application may result in denial of your Application.

MHMR reserves the right to reject any and all Applications, to waive technicalities, and to accept any advantages deemed beneficial to MHMR and its clients.

1.3. Application Submission Instructions

Applications for services via Open Enrollment procedures are accepted on a rolling basis unless otherwise specified in the RFA Notice or this RFA. As a result, Applications need not be submitted

under seal, and sole consideration for award is whether the Applicant meets the established criteria and whether the not-to-exceed amount or service capacity has been or is anticipated to be reached.

Electronic submission is preferred. Completed Applications may be submitted electronically to MHMR's Provider Relations team at Provider.Relations@mhmrtc.org with subject line "[Applicant Name] YES Waiver Open Enrollment Application."

Paper submissions must be prominently labeled "YES Waiver Open Enrollment Application," must include an electronic copy of the submission (flash drive), and must be submitted to the following address:

ATTN: Provider Relations
MHMR of Tarrant County
3840 Hulen Street
Fort Worth, Texas 76107

Paper submissions may be delivered in person, by USPS, or by common carrier.

Applicant is solely responsible to ensure that Application is submitted to MHMR, and MHMR accepts no liability for technological errors preventing transmission of an email, loss of application in the mail, or any other failures attributable to a third party.

1.4. Receipt of Application

MHMR will notify an Applicant when its Application is received. This notification may be sent to the contact who submitted the Application via email, using listed return address, or by any method for listed contacts within the Application.

1.5. Questions

Questions regarding this RFA and the application process should be directed to MHMR's Provider Relations team at Provider.Relations@mhmrtc.org.

2. Award Procedures

2.1. Clarification or Confirmation of Submitted Information

MHMR may obtain clarification or confirmation of all information submitted in an Application.

2.2. Acceptance of Application and Contract Award

Applications will be accepted and will result in a contract under the same terms and conditions specified in this RFA between MHMR and Applicant.

Applications will be accepted when:

- (1) Applicant provides complete and accurate information pursuant to RFA requirements; and
- (2) Applicant meets the qualifications pursuant to RFA requirements and completes all MHMR-required processes.

2.3. Application or Contract Denial

MHMR reserves the right to not evaluate incomplete Applications. False statements by any Applicant may disqualify the Application. Interviews or site visits may be conducted to further evaluate Applications.

Applications may be denied and a contract shall not be awarded when Application is not completed; Applicant, at MHMR's sole discretion, is not qualified to provide the services; or Applicant does not complete MHMR-required processes.

In addition, this RFA may include a monetary not-to-exceed or service capacity, reflecting the cumulative amounts available to all successful Applicants. Applications may be denied for a specified contract period if the not-to-exceed amount or service capacity has been reached or authorized services indicate that the not-to-exceed amounts or service capacity will be reached before the Application is successfully processed and contract is executed.

3. Standard RFA Terms and Conditions

3.1. Submission of Application Binding; Irrevocable Offer

By submitting an Application, Applicant agrees to all the terms and conditions of this RFA and makes an irrevocable offer for a period of one hundred-twenty (120) days after submission.

3.2. Pre-Authorization of All Services Required

All services pursuant to this RFA must be pre-authorized. Pre-authorization is based on patient utilization and need, in accordance with their plan of care.

3.3. No Guarantee of Volume of Services

Acceptance of an Application and execution of a subsequent contract does not guarantee a minimum referral volume, does not guarantee a minimum amount or number of authorized services, and does not guarantee a minimum amount of payment.

Notwithstanding the above statement, all services that are referred and authorized shall be paid at the rates specified in this RFA.

3.4. Assurances

By submitting an Application under this RFA, Applicant agrees and assures MHMR that:

- (1) Applicant is not currently held in abeyance or barred from award of a federal or state contract; and
- (2) Applicant is currently in good standing for state tax, under [Chapter 171, Tax Code](#), pursuant to Texas Business Corporation Act, Article 2.45.
- (3) Applicant has received all addenda and attachments to the Application as distributed by MHMR.
- (4) Applicant has not and shall not induce any person or firm to submit or not to submit an Application.
- (5) There are no conflicts of interest in violation of applicable regulatory guidance, as identified in the Application, or such conflicts have been disclosed.

- (6) The rates listed in *Table 1* are full payment for the services, and Applicant is not entitled to additional compensation or compensation for non-covered services.
- (7) Applicant accepts the terms, conditions, criteria, and requirements set forth in this RFA.
- (8) Applicant accepts MHMR's right to alter the timetables for procurement as set forth in the RFA.
- (9) Application has been submitted independently without consultation, communication, or agreement for the purpose of restricting competition.
- (10) Unless otherwise required by law, the information in the Application has not been knowingly disclosed by Applicant to any other Applicant prior to the notice of intent to award.
- (11) Applicant is solely responsible for its own costs incurred in the preparation of the Application and other associated costs, and MHMR shall not be responsible for payment of these costs.
- (12) MHMR may complete background checks on Applicant staff and verify all information contained in the Application.
- (13) The contact information listed in the Application, including address for notices, is current and correct.

In addition to the foregoing, by submitting a bid, Applicant agrees that it has reviewed, understands, and agrees to MHMR's Uniform Assurances, available at https://mhmrarrant.org/wp-content/uploads/Uniform-Assurances_.pdf, the contents of which are hereby incorporated into this RFA.

3.5. Certain Actions Prohibited

Applicant is prohibited from offering any gift with a value in excess of \$10 to potential patients.

Applicant is prohibited from soliciting potential patients through direct mail, telephone, email, or any other marketing method.

3.6. Minimum Licensing and Credentialing; MHMR Credentialed Providers

By submitting an Application, Applicant agrees that all services specified in this RFA shall be provided by appropriately licensed and credentialed providers.

Providers may be required to undergo MHMR's credentialing process, and Applicant agrees to provide all requisite information requested by MHMR to complete this process. Providers must be at least eighteen (18) years of age and may not have a history of convictions of crimes relevant to their duties, including convictions related to:

- Sexual offences;
- Drug-related offences;
- Homicide;
- Theft;
- Assault;
- Battery; or
- Any other crime involving personal injury or threat to another person.

To the extent required by applicable contractual or regulatory requirements, services may not be authorized unless Applicant staff have successfully completed credentialing requirements, and payment of services may be contingent upon Applicant having successfully credentialed at least one (1) provider under an awarded contract.

Applicant may discharge and hire providers throughout the duration of any awarded contract. Applicant has an ongoing obligation to notify MHMR as soon as possible and in no event later than thirty (30) days when a provider is discharged or hired. Applicant will indicate in its notice the effective date of discharge for any provider. If MHMR paid Applicant for services delivered by a discharged employee after the effective date of discharge provided in the notice, Applicant shall be responsible for repayment of such fees and shall notify MHMR immediately upon discovery of any billing errors or continued payments for discharged employees.

New providers shall be credentialed in accordance with the terms of this RFA, and Applicant shall be required to complete MHMR's credentialing process for each provider.

3.7. Citizenship and Immigration Status

Sole-Proprietor or Self-Employed Applicants must submit documentation establishing their identity and eligibility to work in the United States, in accordance with I-9 requirements. Acceptable documents include those specified on [Form I-9 Acceptable Documents](#).

Incorporated Applicants or Applicants with employees must submit a screenshot or copy of their "Maintain Company" page from the [E-Verify](#) website.

MHMR may request a screenshot of Applicant's three (3) most recent new hires as indicated by a State auditor.

3.8. MHMR Responsibilities

MHMR shall be responsible for making referrals, authorizing services, reviewing claims, and paying for appropriate, authorized services rendered by the Applicant.

MHMR oversees utilization management and quality assurance.

As applicable, the length and type of service will be determined in collaboration with the patient, patient's family (when appropriate), the Applicant, and MHMR.

All services contracted by MHMR are reviewed for effectiveness and continued value to the patient and patient's family (when appropriate). Reauthorization of any service is subject to the same review.

MHMR ensures that services are provided in accordance with applicable contractual and regulatory requirements.

3.9. Applicant Responsibilities

The Applicant shall be responsible for providing the services specified in this RFA as authorized by MHMR and specified in the patient's plan of care, as applicable.

Applicant shall maintain all records regarding services rendered to individuals referred by MHMR for the duration of the contract term and for a period of seven (7) years thereafter. Upon MHMR's request, Applicant shall allow MHMR immediate access during regular business hours to such records.

Applicant shall comply with all State and Federal laws regarding the confidentiality of patients' records and nondiscrimination, and shall complete MHMR's Business Associate Agreement (BAA) and HHSC's Data Use Agreement (DUA).

Applicant shall perform criminal history checks on employees to ensure that individuals convicted of crimes against persons, as specified in this RFA, are not allowed to work with MHMR patients.

Applicant shall obtain prior authorization, provide acceptable levels of care, maintain acceptable levels of liability insurance and appropriate licenses and accreditations.

3.10. Use of Name; Public Posting

MHMR is required to publicly list its providers under contract. As a result, MHMR may use Applicant's name, logo, and description of its facilities, care, and services in such listing without prior approval. To the extent a resulting contract with a Sole Proprietor or Self-Employed Applicant includes peer support services, Applicant affirms that, by submitting an Application, it is giving consent to MHMR to post its name on MHMR's website. This consent may be revoked in writing at any time.

Applicant may not use MHMR's name, logo, or other information in any marketing materials or publications without MHMR's express, written approval.

3.11. Public Information Act

MHMR is subject to the Public Information Act, [Texas Government Code Chapter 552](#). As a result, information submitted in your Application may be subject to disclosure. Any information contained in the Application that is deemed to be proprietary or confidential in nature must clearly be so designated in the Application. Such information may still be subject to disclosure under the Public Information Act, upon a determination from the Attorney General's Office. Applicant shall be solely responsible for asserting any arguments or claims to the Attorney General's Office to withhold its information, and a determination from the Attorney General's Office is binding.

3.12. Subcontracts

Subcontracting an awarded contract under this RFA is not permitted without express, written authorization from MHMR.

Any approved subcontractor shall be contracted under the same terms and conditions as those in this RFA and subsequent awarded contract.

As applicable, MHMR shall pay Applicant, and Applicant shall be solely responsible for distributing funds to subcontractor. MHMR shall not be liable for direct payment of a subcontractor under any circumstances.

3.13. RFA and Contract Terms Non-Negotiable

The terms of this RFA, including any rates set forth herein, are non-negotiable to provide fair and equitable opportunity among Applicants, in conformance with applicable regulations.

Successful Applications resulting in contract award shall contain the same terms and conditions as set forth in this RFA, and requests to amend a resulting contract shall not be considered except as otherwise permitted by this RFA and resulting contract.

In any event, all contracts awarded to successful Applicants shall contain the same terms and conditions.

4. Scope of Work

4.1. Description of Services; Patient Eligibility; Rate of Payment

Applicants shall review the service descriptions in this RFA and indicate in its Application the service(s) for which it wishes to be considered. Applicants should carefully review the services to confirm that its staff is qualified and properly credentialed to deliver the service. To the extent that there are different requirements for the services, Applicant may be required to submit additional documentation.

YES Waiver services are paid at the rates prescribed in [Appendix E: Billing](#), as prescribed by HHSC.

The below *Table 1* lists all services subject to this RFA, their descriptions, eligible patients, and rate of payment. Any external links referenced below are hereby incorporated by reference and made a part of this RFA and any resulting awarded contract.

All services are to be delivered in accordance with the relevant referenced contractual, regulatory, and supplemental guidance.

Table 1

Service	Description	Patient Eligibility	Rate
Respite – In-Home	Respite Services, § 7000 YES Waiver Policy Manual (p. 174)	Participant Eligibility, § 2000 YES Waiver Policy Manual (p. 11)	\$5.22 per unit in accordance with Appendix E - Billing (p.31)
Respite – Out-of-Home Camp	Respite Services, § 7000 YES Waiver Policy Manual (p. 177)	Participant Eligibility, § 2000 YES Waiver Policy Manual (p. 11)	\$2.46 per unit in accordance with Appendix E - Billing (p.33)
Respite – Out-of-Home Licensed Child Care Center (“LCCC”)	Respite Services, § 7000 YES Waiver Policy Manual (p. 179)	Participant Eligibility, § 2000 YES Waiver Policy Manual (p. 11)	Preschool Age: \$5.32 per unit in accordance with Appendix E - Billing (p.34) School Age: \$5.17 per unit in accordance with Appendix E - Billing (p.34)
Respite – Out-of-Home LCCC – Texas Rising Star (“TRS”) Provider	Respite Services, § 7000 YES Waiver Policy Manual (p. 180)	Participant Eligibility, § 2000 YES Waiver Policy Manual (p. 11)	Preschool Age: \$5.61 per unit in accordance with Appendix E - Billing (p.36) School Age: \$5.54 per unit in accordance with Appendix E - Billing (p.36)
Respite – Out-of-Home Licensed Child Care Home (“LCCH”)	Respite Services, § 7000 YES Waiver Policy Manual (p. 181)	Participant Eligibility, § 2000 YES Waiver Policy Manual (p. 11)	Preschool Age: \$4.90 per unit in accordance with Appendix E - Billing (p.37) School Age: \$4.86 per unit in accordance with Appendix E - Billing (p.37)
Respite – Out-of-Home Licensed Child Care Home – TRS Provider	Respite Services, § 7000 YES Waiver Policy Manual (p. 182)	Participant Eligibility, § 2000 YES Waiver Policy Manual (p. 11)	Preschool Age: \$5.17 per unit in accordance with Appendix E - Billing (p.38) School Age: \$5.62 per unit in accordance with Appendix E - Billing (p.38)
Respite – Out-of-Home Registered Child Care Home (“RCCH”)	Respite Services, § 7000 YES Waiver Policy Manual (p. 183)	Participant Eligibility, § 2000 YES Waiver Policy Manual (p. 11)	Preschool Age: \$4.75 per unit in accordance with Appendix E - Billing (p.40)

			School Age: \$3.83 per unit in accordance with Appendix E - Billing (p.40)
Respite – Out-of-Home RCCH – TRS Provider	Respite Services, § 7000 YES Waiver Policy Manual (p. 184)	Participant Eligibility, § 2000 YES Waiver Policy Manual (p. 11)	Preschool Age: \$4.99 per unit in accordance with Appendix E - Billing (p.41) School Age: \$4.08 per unit in accordance with Appendix E - Billing (p.41)
Respite – Out-of-Home Residential Child Care (Other)	Respite Services, § 7000 YES Waiver Policy Manual (p. 185)	Participant Eligibility, § 2000 YES Waiver Policy Manual (p. 11)	Foster Family: \$88.62 per unit in accordance with Appendix E - Billing (p.42) Child Placing Agency: \$67.98 per unit in accordance with Appendix E - Billing (p.42)
Specialized – Art Therapy	Respite Services, § 7000 YES Waiver Policy Manual (p. 190)	Participant Eligibility, § 2000 YES Waiver Policy Manual (p. 11)	\$19.36 per unit in accordance with Appendix E - Billing (p.44)
Specialized – Music Therapy	Respite Services, § 7000 YES Waiver Policy Manual (p. 193)	Participant Eligibility, § 2000 YES Waiver Policy Manual (p. 11)	\$19.36 per unit in accordance with Appendix E - Billing (p.44)
Specialized – Animal-Assisted Therapy	Respite Services, § 7000 YES Waiver Policy Manual (p. 188)	Participant Eligibility, § 2000 YES Waiver Policy Manual (p. 11)	\$19.36 per unit in accordance with Appendix E - Billing (p.44)
Specialized – Nutritional Counseling	Respite Services, § 7000 YES Waiver Policy Manual (p. 195)	Participant Eligibility, § 2000 YES Waiver Policy Manual (p. 11)	\$13.82 per unit in accordance with Appendix E - Billing (p.44)
Specialized – Recreational Therapy	Respite Services, § 7000 YES Waiver Policy Manual (p. 197)	Participant Eligibility, § 2000 YES Waiver Policy Manual (p. 11)	\$19.36 per unit in accordance with Appendix E - Billing (p.44)

4.2. Applicant Eligibility and Credentials

Applicants shall be registered to do business in the State of Texas and shall provide evidence of registration with the Texas Secretary of State with its Application.

Applicants shall have a Tax Identification Number and shall provide a copy of its W-9, signed and dated within twelve (12) months prior to the Application submission date.

Applicant staff providing services pursuant to a contract awarded under this RFA must hold valid Texas licenses and certifications as required by State law and regulation. Applicant agrees that all staff performing services shall abide by MHMR's credentialing requirements.

If a consortium of providers submits a single Application, a single entity responsible for services must be identified in the Application.

Applicants must have a demonstrated ability to manage funds and must include a copy of Applicant's current annual report or comparable documentation. A formal letter from Applicant's CPA is an acceptable alternative for non-public entities but must include a financial solvency statement confirming financial adequacy to meet expenditures for a minimum of one year.

Applicant shall address in its proposal how it will meet the cultural and linguistic needs of patients served and how it will involve patients and, as appropriate, their legally authorized representatives and families at the policy and practice levels within Applicant's organization.

All Applicant credentialing shall comply with the requirements of the [YES Waiver Policy Manual](#) for that applicable service.

**MHMR OF TARRANT COUNTY
GRANT-FUNDED SERVICES
YES WAIVER**

**OPEN ENROLLMENT
APPLICATION**

1. Business Demographics

1.1. Applicant Profile

Legal Name: SSN/TIN:

DBA: Type of Business Entity:

Address:

City: State: Zip:

Business Phone: Fax #:

Administrative Contact: Title:

Phone: Email:

Billing Contact: Title:

Phone: Email:

Billing Address *(if different from above)*:

City: State: Zip:

1.2. W-9

Attach your W-9. Signature must be within the prior twelve (12) months from the date of Application. Label as 1.2.

W-9 attached? Yes ☐ No ☐

1.3. Business locations in the Geographic Area (*as specified in the RFA Notice*):

Address 1:

City: State: Zip:

Address 2:

City: State: Zip:

Address 3:

City: State: Zip:

Address 4:

City: State: Zip:

Attach additional addresses as separate attachment if necessary. Label as 1.3.

Additional addresses attached? Yes ☐ No ☐

1.4. Accommodations Offered

Indicate whether you provide any of the following:

- | | | | | |
|---|-----|--------------------------|----|--------------------------|
| 1. TTY/TTD (Hearing Impaired Services/Capabilities) | Yes | ☐ | No | ☐ |
| 2. American Sign Language | Yes | ☐ | No | ☐ |
| 3. Handicap Accessibility | Yes | ☐ | No | ☐ |
| 4. Public Transportation Access | Yes | ☐ | No | ☐ |
| 5. Bilingual Services (<i>please list below</i>): | Yes | ☐ | No | ☐ |

1.5. Owners/Partners:

	Name	% Ownership	If Corporate, List Organization
1.			
2.			
3.			
4.			

Attach additional owners as separate attachment if necessary. Label as 1.5.

Additional owners attached? Yes ☐ No ☐

1.6. Veteran Heroes United in Business (VetHUB):

Is your business VetHUB Certified? Yes ☐ No ☐

If yes, please indicate the name of the certifying agency:

Certificate #: Expiration Date:

1.7. Conflicts of Interest :

In accordance with the conflict of interest standards at [26 TAC § 301.7](#) and MHMR policy, no MHMR employee, officer, [Board](#) member, or Related Person* may receive a pecuniary interest from an award of a contract, including an existing or anticipated relationship as specified below:

- | | |
|--|---|
| • Employment with Applicant | • Paid consultation with Applicant |
| • Membership on Applicant's Board of Directors | • Ownership of 10% or more of the voting stock of shares of Applicant |
| • Ownership of 10% or more or \$5,000 or more of the fair market value of Applicant | • Income from Applicant exceeds 10% of the employee, officer, Board member, or Related Person's gross income for the previous year. |

Should such a relationship exist, please specify below:

*Related Person refers to an MHMR employee, officer, or Board member's partner/spouse, person related within second degree of consanguinity (blood related within two generations), or person related within the second degree of affinity (relationship created by marriage within two generations). For avoidance of doubt, Related Persons includes adoptive families.

2. QUALITY MANAGEMENT/UTILIZATION MANAGEMENT

2.1. Licenses, Credentials, Certifications, Accreditations

Provide copies of all licenses, credentials, certifications, and/or accreditations the organization or provider currently holds relative to this Application. Label as 2.1.

2.2. Patient Satisfaction

Provide or attach a summary of the most recent patient satisfaction surveys or other on-going efforts to obtain and evaluate patient satisfaction. Describe how this information was obtained and how it is used to improve quality, if attaching label as 2.2.:

2.3. Critical Incidents

Describe or attach your process to track, monitor and investigate critical incidents (e.g., serious injuries, serious medication errors, patient deaths, etc.), if attaching label as 2.3:

Additional description attached? Yes ☐ No ☐

3. Services

3.1. Service Selection

Please indicate the service(s) you are applying for by checking in the box(es) below.
Refer to *Table 1* for descriptions of services and rates.

☐ Respite – In-Home	☐ Respite – Out of Home Camp	☐ Respite – Out of Home LCCC	☐ Respite – Out of Home LCCC-TRS
☐ Respite – Out of Home LCCH	☐ Respite – Out of Home LCCCH-TRS	☐ Respite – Out of Home RCCH	☐ Respite – Out of Home Other

☐

Art Therapy

☐

Music Therapy

☐

Animal-Assisted
Therapy

☐

Nutritional
Counseling

☐

Recreational
Therapy

*Services require completion of the “Texas Standardized Credentialing Application” for each licensed provider: <http://www.mhmrtarrant.org/Business-Opportunities/Credentialing>

Total number of services selected

3.2. Administration/Supervision of Medication

Does Applicant have qualified staff available to administer medications or to supervise individuals in the self-administration of medication?

3.3. Service Capacity

How many individuals can the organization/provider serve?:

3.4. Wait Time

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

3.5. Service Population

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

3.6. Service Restrictions

Are there any restrictions on who the organization/provider will serve?

If yes, please explain:

3.7. Service Availability

What times of day and what days of the week are services available? Complete a schedule for each service. *Attach additional schedules as 3.7.*

Service Type:													
Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
hrs:		hrs:		hrs:		hrs:		hrs:		hrs:		hrs:	
Service Type:													
Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
hrs:		hrs:		hrs:		hrs:		hrs:		hrs:		hrs:	
Service Type:													
Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Sunday	
hrs:		hrs:		hrs:		hrs:		hrs:		hrs:		hrs:	

Additional schedules attached? Yes ☐ No ☐

3.8. Service Experience

Describe the organization's/provider's experience in working with persons with mental illness, over the last five (5) years:

3.9. Accommodations Experience

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

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

3.10. Specialized Services

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

3.11. After Hours Access

Describe any “after hours” system for responding to patient needs:

Can MHMR patients access services outside usual business hours?

3.12. Employee Training

Describe or attach (Label as 3.12.) the organization’s/provider’s in-service training requirements for employees:

4. FINANCIAL

4.1. Incorporated Status

Is the organization/provider incorporated as “Profit,” “Not-for-profit,” or “Other?”

Profit ☐ Non-Profit ☐ Other: ☐

If “Other,” please explain:

4.2. Financial Solvency

Does the organization/provider have sufficient reserves or line of credit to operate during the time period between billing and receiving reimbursement from third party payors?

Yes ☐ No ☐

If not, please explain:

Has the organization/provider declared any type of bankruptcy in the prior seven (7) years?

Yes ☐ No ☐

If yes, please explain:

Has the organization/provider received a “qualified” opinion on a financial statement in the past three (3) years?

Yes ☐ No ☐

If yes, please explain:

Does the most recent audit report have any material instance of non-compliance with standard accounting practice?

Yes ☐ No ☐

If yes, please explain:

4.3. Subcontracts

Describe any arrangements to subcontract part or all of these services. Name all subcontractors and attach information on their staff credentials, licenses and certifications (Attach as 4.3):

4.4. Investigations; Revocation of License, Accreditation

Is the organization/provider currently under investigation, or had a license or accreditation revoked by any state/federal/local licensure or accreditation agency, within the last five (5) years?

Yes ☐ No ☐

If yes, please explain:

4.5. Judgements or Settlements

Has the organization/provider had any judgments or settlements against it within the last ten (10) years?

Yes ☐ No ☐

If yes, please explain:

4.6. Vendor Hold

Has the organization/provider been placed on “vendor hold” by any agency or governmental entity in the past three (3) years?

Yes ☐ No ☐

If yes, please explain:

4.7. Certificate of Account Status

Attach Applicant’s “Certificate of Account Status” , verifying that it is not delinquent in State Franchise Tax. For non-profit corporations or Applicants exempt from Franchise Tax, attach Applicant’s 501C IRS Exemption form from the Comptroller’s Office. Label as 4.7.

4.8. Child Support Delinquency

Is the organization/provider delinquent in the payment of any court-ordered Child Support Payments?

Yes ☐ No ☐

If yes, please explain:

4.9. Abeyance or Bar from Federal/State Award

Is the organization/provider currently held in abeyance or barred from the award of a federal or state contract?

Yes ☐ No ☐

If yes, has this occurred in the last five (5) years?

Yes ☐ No ☐

If yes, please explain:

4.10. Community Relationships

Describe any contracts, Memoranda of Understanding, or employment relationship the organization or provider has with other state, city, county, or other local agencies in the Tarrant County community.

5. RISK ASSESSMENT

5.1. Felony Convictions of Applicant Employees

Does anyone working for the organization/provider providing direct care services or in management have any felony convictions?

Yes ☐ No ☐

If yes, please explain:

5.2. Background Checks

Describe the process, if any, the organization/provider uses to check on previous convictions of employees. Describe or attach any policies and procedures regarding the hiring and retention of persons with criminal histories. Label as 5.2.

5.3. Abuse, Neglect, Exploitation; Client Rights Violations

Has the organization/provider or its employees had any validated client abuse, client neglect, or rights violations claims in the last three (3) years?

Yes ☐ No ☐

If yes, explain in detail:

Describe or attach any current policies and procedures regarding client abuse, client neglect, or rights violations and the training of staff on these issues. Label attachments as 5.3:

5.4. Certificate of Insurance

Provide a Certificate of Insurance showing liability insurance coverage (property and vehicles, including riders) and include directors' and officers' professional liability, errors and omissions, and general liability insurance. Label as 5.4.

5.5. Worker's Compensation

Provide the name of Workers' Compensation carrier if the organization/provider has Workers' Compensation coverage, or self-funding documents if self-funded. Label as 5.5.

5.6. Malpractice Claims

Does the organization/provider currently have any malpractice claims pending or closed during the past five (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.

Attach as 5.6.

6. INFORMATION SYSTEMS

Can the organization/provider report data by the following categories?:

1. Client name
2. Client's MHMR identification number
3. Date, number, type, and duration of services rendered
4. Authorization number
5. Amount to be paid
6. If medications are administered or supervised, number, type, and severity of medication errors and adverse drug reactions for MHMR clients
7. Elopements or unauthorized departures from the program site
8. Confirmed abuse, neglect, or exploitation of MHMR clients.
9. Death or serious injury to MHMR clients occurring at program site

Yes ☐ No ☐

If no, briefly describe steps Applicant intends to take to be able to report this data:

7. RATE SCHEDULE

By submitting this Application, Applicant agrees to accept the fees for the applicable service(s) in *Table 1* as payment in full for authorized services pursuant to this RFA. The Applicant will not submit a claim or bill or collect compensation from MHMR for any non-covered service. Applicant agrees that compensation for providing non-covered services will be solely between the patient and the Applicant. The Covered Individual must be informed in writing, before any non-covered services are provided, that MHMR is not responsible for payment for such services. Clients are responsible for payment for non-covered services only if the patient consents in writing to the provision of such non-covered services. MHMR is the payor of last resort. If the services authorized for a patient are currently payable by a third-party payor, applicant may not bill both entities for the same service.

8. ACKNOWLEDGEMENT

MHMR IN ITS SOLE AND ABSOLUTE DISCRETION SHALL HAVE THE RIGHT TO AWARD CONTRACTS FOR ANY OR ALL SERVICES LISTED IN EACH APPLICATION AND SHALL HAVE THE RIGHT TO REJECT ANY AND ALL APPLICATIONS AS SPECIFIED IN THE RFA.

THIS SUBMISSION IS GUARANTEED AS AN IRREVOCABLE OFFER VALID FOR 120 CALENDAR DAYS AFTER THE DATE OF SUBMISSION.

BY RETURNING THIS PROPOSAL COMPLETED, APPLICANT CERTIFIES THAT IT HAS READ, UNDERSTOOD, AND AGREED TO THE TERMS CONTAINED HEREIN. APPLICANT HAS HAD THE OPPORTUNITY TO CONSULT WITH LEGAL COUNSEL REGARDING THE DOCUMENTS AND WAIVES ANY CLAIM, OBJECTION, OR DEFENSE ON THE GROUNDS THAT THE DOCUMENTS HAVE NOT BEEN REVIEWED BY LEGAL COUNSEL. APPLICATION MAY BE CONSIDERED INVALID IF NOT RETURNED.

BY SIGNING BELOW, THE AUTHORIZED REPRESENTATIVE SIGNATORY IS AFFIRMING THAT IT IS AUTHORIZED ON BEHALF OF APPLICANT TO LEGALLY BIND APPLICANT.

Name and Address of Applicant

Authorized Representative

Applicant (Entity) Name

Authorized Signature

Number/Street Address

Typed or Printed Name

City, State, Zip Code

Title

Telephone Number

Fax Number

E-mail Address