Provider Application

Individual

Ensure all questions are answered. If a question does not apply, indicate "N/A".

I. Demographics

Provider Name:_____
Last First Middle Initial

Address:_____
Street Address City State Zip Code

Phone#: _____ Date of Birth:_____ SS#:_____

Employed by:_____ Business Phone: _____ Fax:_____

Business Address:_____
Street Address City State Zip Code

II. Conflicts of Interest

Identify any relationships between provider or provider's staff and MHMRTC employees or Board of Trustees - Current MHMRTC Board Members are: William R. Brown, Lea Ann Capel, Roy Griffin, Linda Harmon, Elaine Klos, Eva LeBlanc, Carolyn Sims, Jim Teague, and Theodis "T" Ware.

Any conflicts of interest? ❑ Yes ❑ No

If yes, please complete the Conflict of Interest Questionnaire (CIQ) located on MHMRTC's website www.mhmrtc.org under the "Conflict of Interest" section, and include it with this application.

III. Licensures/Certifications

License type: ❑ LPT ❑ OTR ❑ SLP ❑ Other:_____

State:_____ License #:_____ Issue Date:_____ Exp. Date:_____

Attach a copy of your discipline license

Do you have a valid Texas driver's license? ❑ Yes ❑ No If "No", explain:_____

Attach a copy of your Texas driver's license

IV. Service Delivery

A. Services to be provided:

❑ Physical Therapy ❑ Occupational Therapy ❑ Speech Therapy

❑ Other: _____

B. What times of day and days of the week are services available?

❑ Monday ❑ Tuesday ❑ Wednesday ❑ Thursday ❑ Friday ❑ Saturday

C. How long do people currently wait to get into your services?_____

D. How many slots/visits per day do you have available?_____
45-minute visit minimum

E. How many 45-minute slots per month do you have available?_____

F. How many 1-hour slots per month do you have available? _____

V. Experience

A. Describe your business' experience in working with infants and children (ages birth to 36 months) during the last five years: _____

_____

_____

_____

_____

B. How many hours per week do you interact with typically developing:

Birth to 1 year olds?_____

1 to 2 year olds?_____

2 to 3 year olds?_____

C. Languages Spoken: ❑ Spanish ❑ Vietnamese ❑ Other:_____

❑Functional or ❑ Fluent

D. Education/Work History: Attach a current resume or vita

VI. Clinical Skills

A. Please indicate which areas you have knowledge or experience providing services to children ages birth to 36 months:

Knowledge of	Years of Experience	N/A	Service
			Adaptive Equipment
			Apraxia
			Articulation / Intelligibility
			Assistive Technology
			Augmentative Communication
			Autism Spectrum Disorder
			Behaviors Like Biting / Self Injury / Running Away
			Brachial Plexus
			Cochlear Implants
			Cued Speech
			Discipline Techniques
			Feeding / Swallowing Disorders / Issues
			Fine Motor
			Fluency Concerns
			Gross Motor
			Hearing Impairments
			Play Development
			Sensory Integration Issues / Regulatory Issues
			Sign Language
			Sleep Issues / Problems
			Toilet Training
			Trauma
			Ventilator / Trach / Passy Muir
			Vision Impairments

B. Are you familiar with Routines Based Intervention? (explain)_____

_____

_____

_____

C. Are you familiar with Adult Learning Styles? (explain)

_____

_____

VII. Risk Assessment

A. Have you had any validated client abuse, client neglect, or client rights violations claims in the last three (3) years?

❑Yes ❑No

If yes, attach an explanation on a separate sheet.

B. Are you delinquent in the payment of any court ordered Child Support Payments?

❑Yes ❑No

C. Do you have current insurance showing liability coverage for:

Property	❑Yes*	❑No	❑N/A
Vehicles	❑Yes*	❑No	❑N/A
General Liability	❑Yes*	❑No	❑N/A
Professional Liability	❑Yes*	❑No	❑N/A
Medical Malpractice	❑Yes*	❑No	❑N/A

*If yes, attach a copy of the face sheet from the policy.

D. Have you been cited by any licensing, accrediting or certifying body in the last 5 years?

❑Yes ❑No

If yes, please explain:_____

_____

E. Have you ever been denied coverage (either initial or renewal) by any professional liability insurance carrier or has an individual policy canceled or placed an individual surcharge based on provider's individual practice?

❑ Yes ❑ No

If yes, please explain:_____

_____

_____

VIII. Health Status

A. A provider who routinely performs any job duty in proximity to any ECI child must provide evidence of negative TB testing.

Submit current TB test results

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

❑ Yes ❑ No

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

IX. Required Training Elements

Provider must demonstrate a thorough understanding of the relevant elements of reporting, investigating, and preventing abuse, neglect, and exploitation before contact with persons served and annually thereafter

Provider who routinely perform any job duty in proximity to persons served must implement and maintain personnel practices that safeguard people against infectious and communicable diseases before contact with persons served and annually thereafter.

Provider must receive, read, and understand the MHMRTC Compliance Plan. Provider will agree to abide by the principles contained in the Compliance Plan, including its responsibility to report any known or suspected violations of the Plan.

Required training is listed and described in the ECI Provider Manual, which is available on MHMRTC's website, under the Contract Provider Services section: http://www.mhmrtc.org/MC/

If Provider's Cardiopulmonary Resuscitation (CPR) certification is current and was instructed by the American Heart Association (AHA) or the American Red Cross Skills Based CPR/AED/First Aid trainings (MHMRTC's two approved courses), then Provider is not required to take the class again; however, the Provider must submit proof of the current, approved CPR training.

X. Criminal History

Initial Background Check

Provisions of the Texas Administrative Code (TAC), Title 40, §108.310, effective September 1, 2013 require that applicants to be cleared initially by a federal fingerprint-based criminal background check prior to that person's direct contact with children or families. This process will be complete through the credentialing process (see page 11). Detailed information is available in ECI's Provider Manual.

Annual Background Checks

Subsequent background checks will be performed annually through the Texas Department of Public Safety (DPS). The DPS Verification form (on the following page) must be completed to acknowledge that the applicant is aware that an annual criminal history background check will be run.

DPS Computerized Criminal History (CCH) Verification

(AGENCY COPY)

I, _____, have been notified that a computerized criminal
APPLICANT or EMPLOYEE NAME (Please print)
history (CCH) verification check will be performed by accessing the Texas Department of Public Safety Secure Website and will be based on name and DOB information I supply.

Because the name based information is not an exact search and only fingerprint record searches represent true identification to criminal history, the organization (as listed below) conducting the criminal history check is not allowed to discuss any information obtained using this method, therefore the agency may offer the opportunity to have a fingerprint search performed to clear any misidentification based on the name search, if the search provides a criminal report I know could not be mine.

For the fingerprinting process I will be required to submit a full and complete set of my fingerprints for analysis through the Texas Department of Public Safety AFIS (automated fingerprint identification system). I have been made aware that in order to complete this process I must have the correct fingerprinting (FAST) form from this agency, make an online appointment, submit a full and complete set of my fingerprints, and pay a fee of $9.95 to the fingerprinting services company, L1Enrollment Services.

Once this process is completed and the agency receives the data from DPS, the information on my fingerprint criminal history record may be discussed with me.

(This copy must remain on file by your agency. Required for future DPS Audits)

_____
Signature of Applicant or Employee

_____
Date

MHMR of Tarrant County / ECI
Agency Name (Please print)

_____
Agency Representative Name (Please print)

_____
Signature of Agency Representative

_____
Date

Please:
Check and Initial each Applicable Space

CCH Report Printed:

YES ☐ NO ☐ _____ initial

Purpose of CCH: _____

Hire ☐ Not Hired ☐ _____ initial

Date Printed:_____ _____ initial

Destroyed Date:_____ _____ initial

Retain in your files

XI. Personal Attestation

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

❑Yes ❑No

If yes, please explain fully on a separate sheet.

I hereby attest to the following (indicate with a ✓mark):

❑ 1. I do not currently use any illegal drug.

❑ 2. I have reported accurately and completely any reasons for any inability to perform the essential functions of my profession with or without accommodation.

❑ 3.I have reported accurately any history of loss of license and/or felony convictions.

❑ 4. I have reported accurately any history of loss or limitation of privileges or disciplinary activity.

❑ 5. I have reported accurately my chronological work history.

❑ 6. I consent to the inspection of records and documents pertinent to this application, including the release by any person to MHMRTC of all information that may reasonably be relevant to an evaluation and verification of this application or evaluation of professional competence, including, but not limited to, consultation with any other health professionals or institutions with which I have been or am currently associated.

❑ 7. The information submitted in and with this application is complete and correct to the best of my knowledge.

XII. Assurances Statement

Provider assures the following (indicate with a ✓mark):

❑ 1. That all addenda and attachments to this application as distributed by ECI have been received.

❑ 2. That provider has read the ECI Provider Manual (on MHMRTC's website: http://www.mhmrtc.org/MC/) and understands its requirements, terms, and conditions.

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

- ❑ 4. Provider does not discriminate in its services or employment practices on the basis or race, color, religion, sex, national origin, disability, veteran status, or age.

- ❑ 5. That no employee of ECI or MHMRTC, and no member of ECI's Board of Trustees will directly or indirectly receive any pecuniary interest from an award of the proposed contract. If the provider is unable to make the affirmation, then the provider must disclose any knowledge of such interests.

- ❑ 6. Provider accepts the terms, conditions, criteria, and requirements set forth in this application.

- ❑ 7. Provider accepts ECI's right to cancel this application at any time prior to contract award.

- ❑ 8. Provider accepts ECI's right to alter the timetables for procurement.

- ❑ 9. This application submitted by provider has been arrived at independently without consultation, communication, or agreement for the purpose of restricting competition.

- ❑ 10. Unless otherwise required by law, the information in this application submitted by provider has not been knowingly disclosed by provider to any other provider prior to the notice of intent to award.

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

- ❑ 12. ECI has the right to complete background checks and verify information.

- ❑ 13. The individual signing this document and the contract is authorized to legally bind provider.

- ❑ 14. The address submitted by provider is current and correct; this address will be used by ECI for all notices.

XIII. DARS/ECI TKids

Complete the Contractor Information form on the following page with data that is required by DARS/ECI.

CONTRACTOR INFORMATION AND UPDATE FORM
FOR TKIDS

Name:

(Last) (First) (Middle Initial)

Race/Ethnicity: *(Circle Appropriate):*
American Indian/Alaska Native Asian/Pacific Islander Black/African American Hispanic/Latino White

SS#: *(last 4 digits only)* ____ ____ ____ ____	Start Date:	College Graduated From / Location Degree(s): + year(s) graduated

TKIDS CREDENTIALS
Please re-submit this section if your credentials change during your contract with ECI.

- ❑ BCBA
- ❑ OT - Occupational Therapist
- ❑ OTA - Occupational Therapy Assistant
- ❑ PT - Physical Therapist
- ❑ PTA - Physical Therapy Assistant
- ❑ RN ❍Associates ❍Bachelors ❍Masters
- ❑ SLP - Speech Language Pathologist
- ❑ SLP - CFY
- ❑ SLPA - Assistant in Speech Pathology
- ❑ Other:

State License # / Effective Date / Expiration Date:

For SPLA, PTA, COTA
Supervisor's Name & Credentials:

PHONE #:	Have you worked at another ECI Program? ❑Yes ❑No If Yes - Which Program?

HULEN STAFF COMPLETE THE FOLLOWING FOR CONTRACT STAFF

Credentialing Application	Returned	To Credentialing	Approved	Contract Coversheet	Contract Log

HULEN STAFF COMPLETE THE FOLLOWING AND ROUTE TO NEXT PERSON

Enter into TKIDS [Deborah]	Entered in CMHC [Deborah]	Contractor ID #

Staff Licensure Code Entered: Professional	07 - LCSW	08 - LBSW	13 - LPC	16 - LMSW	17 - RD/LD	19 - OTR/LOT
	21 - LPT	23 - SLP	29 - RN	34 - LPC-I	39 - Psych Assoc	44 - Para
	51 - Other	52 - EIS-EL	53 - EIS-FQ	60 - LPTA	63 - COTA	65 - SLPA

REVISED 11/3/11 KAC

XIV. Signature

I hereby certify that the information provided by me on this application is true and correct.

By Individual:_____
Print Name

By Individual:_____ Date:_____
Signature

XV. Submission Attachments

Ensure copies of the following are enclosed, indicating with a check mark for "Not Applicable" or "Attached":

N/A or Attached

- ❑ ❑ Conflict of Interest Questionnaire (Section II)
- ❑ ❑ Texas Discipline License (Section III)
- ❑ ❑ Texas Driver's License (Section III)
- ❑ ❑ Vita or Resume (Section V)
- ❑ ❑ Explanation of validated client abuse, client neglect, or client rights violations (Section VII)
- ❑ ❑ Property Insurance Face Sheet (Section VII)
- ❑ ❑ Vehicle Insurance Face Sheet (Section VII)
- ❑ ❑ General Liability Insurance Face Sheet (Section VII)
- ❑ ❑ Professional Liability Insurance Face Sheet (Section VII)
- ❑ ❑ Medical Malpractice Insurance Face Sheet (Section VII)
- ❑ ❑ TB Test Results (Section VIII)
- ❑ ❑ Explanation of Health Issues (Section VIII)
- ❑ ❑ CPR Card (Section IX)
- ❑ ❑ Explanation of reasons unable to perform essential functions (Section XI)

This Provider Application is not complete until all required documents have been submitted.

XVI. Submission Instructions

Submit this application by U.S. mail, hand delivery, carrier, fax, or email electronically to:

Laura Kender, Chief of ECI
ECI of North Central Texas
3880 Hulen Street, Suite #400
Fort Worth, TX 76107
817-569-5301

False statements on this proposal by prospective providers may disqualify enrollment.

ECI reserves the right to reject any and all applications, to waive technicalities, and to accept any advantages deemed beneficial to the ECI program and its clients.

XVII. Next Steps

Credentialing:

Prior to providing services, new providers must complete a Credentialing Application, which is available on MHMRTC's website **www.mhmrtc.org**, under the "Contracted Provider Services" section, where instructions and contact information is also available, as well as in the ECI Provider Manual.

Continuing providers must be re-credentialed every three years by MHMRTC's Credentialing Department. It is the individual's responsibility to forward their renewed license to the Credentialing Department in a timely manner to avoid disruption of services. Services cannot be provided without a valid license.

Billing:

For providers who do not already have a Texas Provider Identifier (TPI) number or a National Provider Identifier (NPI) number, a Medicaid Provider Enrollment Application must be completed to obtain both TPI number and a NPI number.

Instructions and contact information is available in the ECI Provider Manual located at **www.mhmrtc.org** under the "Contracted Provider Services" section.