MHMRA of Harris County
Network Management
Facility/Group Checklist

☐ Complete, date and sign the Facility Application.

☐ Attach Texas Standard Application (2007 version) for Licensed individuals – MDs, Physician Assistants, APNs, LPCs, LMFTs, LCSWs and Psychologists etc. If you are a QMHP, follow instructions below for bachelor level staff only.

- *If you had a gap of more than 6 months in employment, please attach a detailed written explanation*
- *If you answered yes to any malpractice questions, please attach a letter from your attorney, a copy of the complaint and the judgment, the name of the malpractice carrier that handled the claims and the firm representing the carrier.*

☐ Complete, date and sign the W-9 Form for each Tax Identification Number (TIN)

☐ Attach a copy of your JACHO Certification.

☐ Attach a copy of your CARF Certification.

☐ Attach a current copy of your Facility's Licenses and/or Certifications. Please include any Medicaid/Medicare Licenses and all other applicable licenses held by the facility that relate to the contracted services.

☐ Attach a copy of your Program Schedule or Program Description.

☐ Attach a copy of your Malpractice Insurance Face Sheet with the limits of liability.

☐ Attach a list of all of your facility sites with addresses.

☐ Attach a list of Psychiatrists/others with Professional Credentials with admitting privileges.

☐ Attach a copy of your Utilization Review Program.

☐ Attach a copy of Clinical Descriptions of all program tracks within the facility.

☐ Attach a copy of your Quality Assurance/Improvement Program.

☐ Attach Exhibits A-U (Note: Exhibit H and M should be complete)

☐ Attach Program brochures if available

If you have any questions, please call: 713-970-3400 (option 4)

Send the application along with the required documents by mail to:

MHMRA of Harris County
Attn: Sharon Brauner, C.P.M., A.P.P., Senior Purchasing Coordinator
7011 Southwest Freeway
Houston, TX 77074
Ofc: (713) 970 – 7279
Fax: (713) 970 – 7682
Email: Sharon.brauner@mhmraharris.org
CC: Nina.cook@mhmraharris.org

☐ ***For QMHPs only (Bachelor Level staff only)***

Degree: _____
Date of degree: _____
Attach a copy of transcript from an accredited college or university if degree is <u>not</u> in social fields: psychology, social work, medicine,

nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention; or a Registered Nurse.

MHMRA of Harris County
Network Management
Facility/Group Application

A. General Information:

Facility Legal Name			Does the facility have a University Association? If yes, please name	
Preferred Mailing Address Line 1			Preferred Mailing Address Line 2	
Name of Chief Executive Officer:				
City	State	Zip	County	Contact Person
Name of Chief Executive Officer				
Physical Address			Physical City, State & Zip	
Is your service address different from physical address? If yes, list it below: Address _____ City_____ State_____ Zip Code_____			Telephone Fax	
Email Address				
Are you a Medicare Provider? ___Y ___N If yes, please provide your Group or Individual Provider number.			Are you a Medicaid Provider? ___Y ___N If yes, please provide your Group or Individual Provider number.	
Your Medicare/UPIN Number			Your Medicaid Number	
Do you qualify as a Historically Underutilized Business (HUB)? ____Yes ____No If yes, Certification#			Federal Tax ID# _____ Tax Code [Example: 501© (3)] _____	
☐ Psychiatric Hospital ☐ Hospital with Psychiatric Unit ☐ Residential Facility ☐ Other Please check which is the most appropriate description:			Indicate who is your corporate owner (if applicable)	
Is this office handicapped accessible? Yes __ No __			Is this office accessible to public transportation? Yes __ No __	

Please list any certifications or accreditations, if applicable: □ JCAH □ ICF/MR □ CARF □ HCS □ HCSO □ CLASS □ ACDD □ TRC □ ECI □ TEA □ DOL □ other, please specify: _____

B. Demographic Data: The following information is requested for demographic purposes only. This data will not be part of the credentialing process. The information will only be used to supply aggregate data to the state government as part of a government contract. This information will not be used for any other purposes.

1. Could you or your business be defined as a Significant Traditional Provider as defined by the Texas Department of Health and Human Services? ☐ Yes ☐ No

   Significant Traditional Providers are defined as providers in a county that, when listed by provider type in descending order by the amount of recipient or enrollee billings provided the top 80 percent of recipient or enrollee billings for the Texas Medicaid Program.

2. Could your business be classified as a business owned by women, as defined by the Department of Minority Enterprises? ☐ Yes ☐ No

   Women Owned Business is defined as a business enterprise of which women own at least 50%or, in the case of a publicly owned business, where women own at least 51% of stock.

3. Could your business be classified as a minority owned business, as defined by the Department of Minority Enterprises? ☐ Yes ☐ No

   Minority Owned Business is defined as a business enterprise that is owned and controlled by one or more socially and/or economically disadvantaged persons. Such disadvantages may arise from cultural, racial, chronic economic circumstances or background or other similar cause.

4. If you answered yes to question 3 about minority owned businesses, which of the following categories would it fall under?

☐ Caucasian	☐ Native American or Alaskan Native	☐ Asian or Pacific Islander
☐ Black (African, Jamaican, West Indian descent)	☐ Hispanic (Mexican, Puerto Rican, South American)	☐ Other (specify)

C. Payee Information

Make checks payable to (must match tax ID owner name on file with IRS)		Type of Corporation
Billing Address Line 1	Billing Address Line 2	
City	State	Zip

D. Referral Information

Identify the percentage of your practice time dedicated to the following patient population and modality categories (must total 100%):

Population	% of Practice
Young Child (0-5)	
Child (6-12)	
Adolescent (13 – 17)	
Adult (18 – 64)	
Geriatric (65+)	

Business Lines	% of Practice
Group Health (PPO)	
Capitation (HMO)	
Medicaid	
Medicare	
Other	

E. Services

1. List Insurance: HMO's, PPO's, EAP's and employer groups for which you currently provide services.

Insurance: HMO, PPO, EAP or Employer Group

Types of Services: ___Adult ___Children ___Adult & Child ____Pharmacological ___Rehab Services ___Psychotherapy ___Day Program for Skills Training ___Site Based Habilitation ___Early Child Intervention ___In-Home & Family Support ___Telemedicine ___Residential Services ___Supported Housing ___Respite Services ___ACT Team Services ___Counseling ___Consumer Peer Support ___Supported Employment ___Other

_____

Specialty Areas:

Please check each area in which your program is qualified.

___Autism ___Elderly Services ___Mobility Impairment
___Criminal Justice ___Family Support ___Substance Abuse
___Developmental Disabilities ___Sign Language/Deaf Culture Proficiency ___HIV/AIDS Issues
___Dual Diagnosis (MR/MI) ___Homeless Services ___Other_____

2. Check all that apply and indicate # of beds and average length of stay (LOS).

ER Evaluations			Psych Services **Acute** / **Sub-Acute**						Chemical Dependency			
Psych	CD	Both	Adult	Adol	Child	Adult	Adol	Child	Detox	Rehab	Adult	Adol

3. Types of Programs (indicate average length of treatment)

Programs	Adult			Adolescent			Child		
Partial Hospital (with medical monitoring)	M/H	C/D	Both	M/H	C/D	Both	M/H	C/D	Both
Average length of Treatment									

	Day	Evening	Please indicate hours:
Intensive Outpatient			
	Day	Evening	Please indicate hours:
Outpatient			

4. Special Services (check all that apply):

Service	Notes
Involuntary Admission ☐ yes ☐ no	
Locked Units ☐ yes ☐ no	
Detox for Alcohol ☐ yes ☐ no	
Detox for Drugs ☐ yes ☐ no	

5. Other:

What ancillary services are available at your facility? _____
Do you have a rotating physician on-call operation? ☐ yes ☐ no
How often are attending physicians required to see patients? _____ visits per 7 – day week.
How often are family therapy sessions held?

6. Operations Information

Do you have a client appeals process?	___Yes	___No	If yes, Staff/Contact_____ Phone#_____Fax_____
Do you have an incident report process?	___Yes	___No	If yes, Staff/Contact_____ Phone#_____Fax_____
Do you have a confidentiality/client rights process?	___Yes	___No	If yes, Staff/Contact_____ Phone#_____Fax_____
Do you have an internal quality improvement process?	___Yes	___No	If yes, Staff/Contact_____ Phone#_____Fax_____
Do you have an internal utilization management process?	___Yes	___No	If yes, Staff/Contact_____ Phone#_____Fax_____
Do you have a customer/satisfaction measure?	___Yes	___No	If yes, Staff/Contact_____ Phone#_____Fax_____
Do you have a service outcome measure?	___Yes	___No	If yes, Staff/Contact_____ Phone#_____Fax_____
Does your program have a current operating plan and budget?	___Yes	___No	
Do you maintain a file on each client?	___Yes	___No	

Is your program in compliance with all local city, state and federal codes and local statues 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.
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 Service or any equivalent state Agency?
___Yes / ___No

F. Staffing Information

1. Check medical staffing model:

☐ Staff (Hospital Employees) ☐ Contractual ☐ Mixed Model

2. Staff Includes:

☐ Psychiatrists	☐ Psychologists	☐ Licensed Mental Health Counselors
☐ Licensed Marriage & Family Therapists	☐ Addictionologists	☐ Advanced Nurse Practitioners
☐ Licensed Social Workers	☐ Other (List)	

3. Intake Process:

Do you have a 24 hour intake process? ☐ yes ☐ no	
If yes, what is the educational background of the personnel managing this operation (check all that applies)?	☐ No formal training and/or license ☐ Bachelors level ☐ Masters level (not licensed) ☐ Masters level (licensed) ☐ LPN ☐ RN ☐ Mental Health Tech. ☐ Doctorate level

4. Emergency Room Services:

Do you have emergency room services or after hours services? ☐ yes ☐ no	
If yes, please explain including telephone# _____ _____ If no, which acute care hospital(s) provide emergency services for your facility? _____	
Is your relationship contractual? ☐ yes ☐ no	
If yes, what is the medical staffing model (check all that applies)?	☐ Staff (Hospital Employees) ☐ Contractual ☐ Mixed Model
Do you provide emergency or after hours services? ☐ yes ☐ no If yes, please explain including telephone#	

G. Treatment Teams:

Please indicate the composition of your treatment teams:

☐ Psychiatrists – Number _____	☐ Psychologists – Number _____
☐ Licensed Marriage & Family Therapists – Number _____	☐ Addictionologists – Number _____
☐ Licensed Social Workers – Number _____	☐ Advanced Nurse Practitioners – Number _____
☐ Licensed Mental Health Counselors - Number _____	☐ Other – specify

How often are treatment teams required to meet? _____ times per week.
At what point during hospitalization does discharge planning begin?

Who is involved in coordinating discharge planning?

H. Contacts - Please note who the appropriate contact person is:

Admissions Contact Name	Phone
Medical Director for Psychiatric Services	**Phone**
Medical Director for Substance Abuse Services	**Phone**
Utilization Review Director	**Phone**
Case Manager	**Phone**

I. Malpractice Insurance – Type of Liability Coverage: **□Professional □ General □ Auto □ Other**

List below your current malpractice insurance carrier. Enclose a copy of your current policy certificate and/or declarations page showing the coverage limits and dates of coverage. Please note that MHMRA requires a minimum 1,000,000/3,000,000 malpractice insurance.

Current Carrier (Name and Address)	**Policy Number**	**Dates of Coverage**	**Coverage Limits** **Per Occurrence Aggregate**

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

- Has your facility/group filed a claim under your general, professional auto or other liability insurance in the last three years? ___Yes ___No
- Are there any claims pending against your facility/organization? ___Yes ___No
- Has your program/organization's liability/malpractice coverage ever been denied, cancelled or non-renewed? ___Yes ___No
- Has your facility/organization ever had their license(s), applicable certifications of accreditations, terminated, restricted, or voluntarily relinquished? ___Yes ___No
- Has the facility/organization been sanctioned, placed on probation, placed on vender hold or lost accreditation, licensure or certification status during the last three years? ___Yes ___No

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

In the space provided below, list the name and address of the malpractice carrier who has provided coverage for you for the most recent five (5) year period. **If there has been more than one carrier, please indicate the dates of coverage with each carrier, and the reason for changing carriers.**

Carrier (Name and Address)	**Policy Number**	**Dates of Coverage**	**Reason for Changing Carriers**

J. Malpractice Claims History

Has your facility had any Malpractice Claims that are pending or closed during the past five (5) years? Yes ☐ No ☐

If yes, please attach the following information:

A. A letter from your attorney explaining the facts of the case.
B. A copy of the complaint and a copy of the judgement.
C. The name of the malpractice carrier that handled the claims and the firm representing the carrier.

K. Hospital Privileges

List below current hospital privileges. If privileges are restricted, please explain on an attached page. If you are not on staff at a hospital, please indicate the name of the physician who admits your patients in the space below.

Primary Admitting Facility	Address	Type of Privilege
		☐Full admitting ☐Other

Other Hospital Privileges	Address	Type of Privilege
		☐Full admitting ☐Other
		☐Full admitting ☐Other

Physician Who Admits Your Patients	Physician Phone Number	Facility Name

L. Treatment Specialties

Age Range Treated:

☐ 0-3 years old	☐ 3-5 years old	☐ 6-9 years old	☐ 10-12 years old
☐ 13-20 years old	☐ 21-64 years old	☐ 65-80 years old	☐ 80 + years old

Areas of Expertise: (Please check areas in which you have particular expertise.)

☐ ADHD	☐ Adolescent Behavior Problems	☐ Adjustment Disorder	☐ Affective Disorder
☐ Antisocial Behavior	☐ Alzheimer's	☐ Anxiety/ Panic/ Phobia	☐ Eating Disorders
☐ Behavior Disorders	☐ Behavior Therapy	☐ Bipolar Disorder	☐ Borderline Personality
☐ Child Abuse	☐ Chronic Pain Disorder	☐ Cognitive Behavioral	☐ Conduct Disorder
☐ Crisis/ Trauma Victims	☐ Dementia	☐ Depressive Disorders	☐ Developmental Disorders

☐ Dissociative Disorders	☐ EAP	☐ Eating Disorders	☐ Employee Meditation
☐ Forensics	☐ Gambling Addictions	☐ Gay/Lesbian Issues	☐ Grief Reaction
☐ Handicapped	☐ Head Trauma	☐ HIV/AIDS	☐ Impulse Control Disorders
☐ Learning Disorders	☐ Marital/ Divorce Issues	☐ Men's Issues	☐ Mood Disorders
☐ Personality Disorders	☐ Post Traumatic Stress DO	☐ Psychopharmacology	☐ Psychotic Disorders
☐ Rape Intervention/Crisis	☐ Relational Problems	☐ Religious Therapy	☐ Sexual Abuse
☐ Sexual Disorders	☐ Sleep Disorders	☐ Substance Abuse	☐ Women's Issues
☐ Workers Comp	☐ Other (specify):		

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

Are you able to provide any of the following services?

☐ Services for hearing impaired
☐ Services for adults with Serious Mental Illness (SMI)
☐ Services for children who are Seriously Emotionally Disturbed (SED)
☐ Services for patients with multi-cultural issues
☐ Services for Non-English speaking patients

Please indicate any disorders or types of patients that you will not accept for treatment:

M. 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 this facility, I consent to all MHMRA of Harris County to inspect records and documents pertinent to this application.

_____ _____
Signature of Person or Facility/Group Representative Date

_____ _____
Printed name of Person or Facility/Group Representative Title of Representative

_____
Facility or Group Name

N. General Authorization for Release of Information

General Authorization for Release of Information

I, _____(print name) hereby authorize MHMRA of Harris County 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 that 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 MHMRA of Harris County credentialing and /or network approval process. Such Photostat, electronic or facsimile copy shall have the same force and effect as the signed original.

Signature of Person or Facility Representative: _____Date: _____

Printed Name: _____

O. Attestation

Facility/Group Name_____

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

I hereby attest to the following:
☐ 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 this application or termination from network participation.

NOTE: If "**YES**" is checked to any of the questions listed below, **please explain fully** on a separate sheet. Documentation is required if you have malpractice claims pending or settled in the past five (5) years (include any settlements/adjudication's, original complaint and final disposition). Your signed statement regarding the alleged incident will suffice for pending cases.

1. **Insurance Coverage:** 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 and or application? ☐ Yes ☐ No

2. **License:** Has any of your licensed staff's medical or professional license in any state or any applicable certifications or accreditations ever been revoked, suspended, placed on probation, conditional status, or limited? ☐ Yes ☐ No

   a. Has any of your licensed or medical staff ever voluntarily surrendered their license? ☐ Yes ☐ No

3. **Hospital Sanctions:** Has any of your licensed or medical staff surrendered their clinical privileges upon threat of censure, restriction, suspension or revocation of such privileges? ☐ Yes ☐ No

4. **Medicare/Medicaid**: Has any of your licensed or medical staff ever been fined, penalized, had an arrangement suspended, been expelled from participation or had criminal charges brought against your organization/facility by Medicare or Medicaid, CHAMPUS, or other government programs restricted, sanctioned or limited. ☐ Yes ☐ No

5. **Malpractice Action:** Has any malpractice action against any of licensed or medical staff been brought or settled in the last 5 years or has there been any unfavorable judgment(s) against them in a malpractice action ☐ Yes ☐ No

   a. To your knowledge, is any malpractice action against any of your licensed or medical staff currently pending. ☐ Yes ☐ No

6. Has any of your licensed or medical staff 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. ☐ Yes ☐ No

7. Has any of your licensed or medical staff had any of the following ever been or are currently in the process of being denied, revoked, suspended, reduced, limited, censure, place on probation or not renewed. ☐ Yes ☐ No

I hereby attest that the information above is true and correct.

Signature Date (mm/dd/yy)

Printed Name: _____

_____
Facility or Group Name

P. PARTICIPATION STATEMENT

I fully understand that if any matter stated in this application is or becomes false, MHMRA of Harris County will be entitled to terminate my provider agreement for breach. All information submitted by me in this application is warranted to be true, correct and complete.
I authorize MHMRA of Harris County to consult with the National Practitioners Data Bank, state licensing board(s), educational institutions, specialty boards, malpractice insurance carriers, Educational Council for Foreign Medical Graduates, hospitals, professional references and any other person or entity from whom/which information may be needed to complete the credentialing process or to obtain and verify information concerning my membership, professional competence, character and moral and ethical qualifications, and I also authorize all of them to release such information to the client. I release MHMRA of Harris County and its employees and all those whom MHMRA of Harris County contacts from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application.

I consent to the release by any person to MHMRA of Harris County of all information that may reasonably be relevant to an evaluation of my professional competency, character and moral and ethical qualification, including any information relating to any disciplinary action or suspension or curtailment of privileges, and hereby release any such person providing such information from any and all liability for doing so.

Signature of Applicant Date (mm/dd/yy):___/___/_____

Name (Please Print)

_____
Facility or Group Name