Emergence Health Network
as the Local Mental Health Authority

Request for Application
Open Enrollment

Children and Adolescent Mental Health Services

August 5, 2013

Emergence Health Network (Local Authority) is the Department of State Health Services (DSHS) designated mental health Authority established to plan, coordinate, develop policy, develop and allocate resources, supervise, and ensure the provision of community based mental health and intellectual and developmental disability services for the residents of El Paso County, Texas.

The Local Authority’s Mission is:
Emergence Health Network ensures superior recovery-based services for mental health, developmental disability, and related conditions for the people of El Paso County.

The Local Authority’s Philosophy is:
- Engage our customers by communicating the benefits of services and recovery
- Celebrate our customers’ strengths when participating in services
- Foster hope in every service delivered
- Demonstrate evidence of our customers’ successes toward recovery
- Recognize our customers and staff for all achievements made

Pursuant to Texas Administrative Code §412.55 and 412.754, the Local Mental Health Authority has the authority to acquire community services for individuals with mental illness by certain procurement methods. This Request for Applications (RFA) requests proposals from interested persons and organizations (Applicants) for the purpose of entering into one or more contracts (Contracts) to provide effective, evidenced-based behavioral health services to children and adolescent clients with mental health illness. The individuals to be served under this arrangement must meet the DSHS definition for the Priority Population for Mental Health, which is included as Attachment A, and must also reside in El Paso County (Clients). This Request for Application is a client choice driven system and there is no warranty or guarantee that successful Applicant will be utilized by a client or any number of clients.

The goals of any/each Contract awarded under the RFA are:
1. To provide needed community mental health services as described in Attachment B.
2. To identify, implement and evaluate successful Services based on Client outcomes so that these efforts can be replicated.
To create meaningful collaborations between the Local Authority and the health care providers in the community.

4. To provide quality clinical care and achieve the desired outcomes at the most efficient cost possible.

5. To provide smooth transitioning of clients to ensure continuity of care, clinical outcomes, and customer service are not adversely affected.

Successful Applicants will provide Services that build upon and augment existing community resources and that provide for or enhance an existing continuum of care for Clients. The Local Authority will use a pre-defined process to review all proposals at “arms-length”, to insure that there is no conflict of interest. Preference will be given to Applicants that are able to provide Services that address the issues of client choice, quality, clinical decision making, and ultimate cost-benefit while assuring adherence to existing standards of care and service definitions.

**Target Population**

The target population for this RFA consists of individuals with mental illness who have been identified by the Local Authority as Priority Population, in accordance with the definitions established by DSHS. (See Attachment A.) Designation of an individual as a member of the Priority Population must be made by the Local Authority and documented in that individual’s record.

**Eligible Applicants**

Applicants must be eligible to do business in Texas, and be registered with the Texas Secretary of State to the extent required by Texas law. Professionals must hold valid Texas licenses and/or certifications to the extent required to perform any individual component of the Services. In the situation where a consortium of providers is applying, a single entity responsible for the services delivered must be identified and the financial agent must be an organization with a demonstrated ability to manage funds.

**Local Authority Responsibilities**

The Local Authority ‘s responsibilities will include, but are not limited to, making appropriate referrals for services, reviewing claims and paying for appropriate, authorizing services rendered by the Successful Applicant. The Local Authority is also responsible for utilization management and quality assurance. The Local Authority ensures that the services address the needs of the Priority Population as required by the State Authority, and that those services comply with the rules and standards adopted under Section 534.052 of the Health and Safety Code. The Local Authority directs its activities based on its mission and values which can be found in on page 1 of this RFA.

The Local Authority will be responsible for determining a client meets the Priority Population definition. The Local Authority must complete a Uniform Assessment on each
client and identify the services to be provided. Clients determined to need these services will be offered a choice of providers from the Network.

All services must be authorized by the Utilization Management staff. Quality Management staff will perform regular reviews of clinical services and program standards.

**Rate Schedule**

<table>
<thead>
<tr>
<th></th>
<th>Medicaid</th>
<th>General Revenue</th>
<th>Third Party Payor other than Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOCYC</td>
<td>Current Effective Medicaid Rate</td>
<td>Current Effective Medicaid Rate</td>
<td>Current Reimbursement Rate</td>
</tr>
<tr>
<td>LOC1</td>
<td>Current Effective Medicaid Rate</td>
<td>Current Effective Medicaid Rate</td>
<td>Current Reimbursement Rate</td>
</tr>
<tr>
<td>LOC2</td>
<td>Current Effective Medicaid Rate</td>
<td>Current Effective Medicaid Rate</td>
<td>Current Reimbursement Rate</td>
</tr>
<tr>
<td>LOC3</td>
<td>Current Effective Medicaid Rate</td>
<td>Current Effective Medicaid Rate</td>
<td>Current Reimbursement Rate</td>
</tr>
<tr>
<td>LOC4</td>
<td>Current Effective Medicaid Rate</td>
<td>Current Effective Medicaid Rate</td>
<td>Current Reimbursement Rate</td>
</tr>
</tbody>
</table>

**Successful Applicant Responsibilities**

The Successful Applicant(s) shall maintain all records regarding treatment and/or services to Clients under this Contract for a period of seven (7) years, and must allow the Local Authority immediate access during regular business hours to such records upon request. Successful Applicant(s) will be required to comply with all state and federal laws regarding the confidentiality of clients’ records and nondiscrimination. Successful Applicant(s) must comply with all applicable requirements of the Local Authority’s then-current contract with DSHS. Successful Applicant(s) must also agree that their names may be used, along with descriptions of the facilities, care, and services in information distributed by the Local Authority in the list of its providers. Successful Applicant(s) will actively assist in the disbursement of Client and advocate satisfaction surveys. Successful Applicant(s) must develop a method to resolve disagreements with clients and stakeholders which will include client involvement. The process for Client appeals and dispute resolution must be approved by the Local Authority. Successful Applicant(s) will be responsible for peer review and quality management. Successful Applicant(s) must agree to mediation if unable to resolve disputes with the Local Authority. Successful Applicant(s) must conform to all guidelines set forth in the Provider Manual which is available for review upon request. Successful Applicant(s) will cooperate and assist with and will not at any time prevent or hinder a client from changing providers. Provider and its employees, as applicable, are responsible, at Provider’s sole expense, to comply with all training requirements Local Authority mandates for Successful Applicant.
Proposal Instructions

Applicants must follow the attached outline for submissions to facilitate objective review.

Applicant shall submit its original application, identified as the original, and five (5) additional copies by mail or in person to the address below no later than the closing date of 5:00 p.m., Mountain Standard Time, ________, 2013 to:

Emergence Health Network
Cynthia Moreno, Administrative Director of Quality Management
1600 Montana
El Paso, TX  79902

Proposals must be received sealed. Proposals may be withdrawn at any time prior to the Proposal Submission Date, provided that Local Authority is notified of any such withdrawal in a writing signed by the Applicant certifying authenticity. Alterations may be made before the official opening time provided such alterations are provided in writing and signed by the Applicant certifying authenticity. Local Authority reserves the right to reject any and all Proposals, to waive technicalities, and to accept any advantages deemed beneficial to the Local Authority and its clients. It is our intent to evaluate proposals, and negotiate costs and/or services in order to achieve the best value for Local Authority clients. The negotiation process will be done in a confidential manner with no disclosures being made to other Applicants until after the Contract(s) is awarded.

Timetable:

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
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<tbody>
<tr>
<td>TBD</td>
<td>RFA Issuance</td>
</tr>
<tr>
<td>TBD</td>
<td>Applications due; 5:00 pm MST</td>
</tr>
<tr>
<td>TBD</td>
<td>Applications opened; review begins</td>
</tr>
<tr>
<td>TBD</td>
<td>Recommendation presented to Emergence Health Network Board of Trustees</td>
</tr>
<tr>
<td>TBD</td>
<td>Proposed start date</td>
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</table>

Emergence Health Network reserves the right to modify these dates according to the Emergence Health Network Board of Trustees meeting schedule and at the discretion of the Emergence Health Network Chief Executive Officer. Contract negotiations and Board of Trustees approval may take up to 90 days. Training and credentialing may take an additional 60 days as certain trainings must be provided prior to delivery of service.

Mental Health-Friendly Workplace:

A. On September 22, 2005, the Emergence Health Network Board of Trustees approved a Resolution for the Designation of Mental Health Friendly Workplace. This
Resolution directs all Emergence Health Network awarded contracts are evaluated for best value, to include the Respondents ability to demonstrate a Mental Health-Friendly Workplace. For the purpose of this Request for Application, Emergence Health Network will review the following elements of a Mental Health-Friendly Workplace:

1. Respondent welcomes all qualified job applicants and diversity is valued;
2. Respondent includes health care that treats mental illnesses with the same urgency as physical illness;
3. Respondent has programs and/or practices that promote and support employee health-wellness and/or work-life balance;
4. Respondent provides training for managers and front-line supervisors in mental health workplace issues;
5. Respondent safeguards confidentiality of employee health information;
6. Respondent provides an Employee Assistance Program (EAP) or other appropriate referral resources to assist managers and employees;
7. Respondent supports employees who seek treatment or who require hospitalization or disability leave;
8. Respondent ensures “exit with dignity” as a priority, should it become essential for an employee to leave his or her employment;
9. Respondent has reasonable accommodations policy of the Americans with Disabilities Act (ADA); and
10. Respondent provides all-employee communication that promotes an accepting, anti-stigmatizing, anti-discriminating working environment.

B. There is no single “right” picture of a Mental Health-Friendly Workplace. Factors that have a bearing on what will work best for any given business include:

- The leadership, goals, and values of the business;
- The culture of the business sector;
- The culture of the community in which the business operates;
- The size of the business; and
- The resources that can be brought to bear from service vendors, the community, and the employees themselves.

C. Whether your business is looking at its mental health friendliness for the first time or taking stock of how well current programs and practices are working, it is important to come back to these questions:

- What elements of a Mental Health-Friendly Workplace are already in place?
- How are they working?
D. Specific practices and policies in a workplace that values the health of its employees can be observed, including, of course, practices and policies that promote their mental health and well-being. These practices can positively affect productivity, cost-containment of health care, and employee retention in fact, the entire culture of the business. Some businesses will recognize many of the indicators as descriptors of their own organizations; others will read them as a list of desirable options or components for building a Mental Health-Friendly Workplace. Any business that thinks of itself as being mental health-friendly will have a number of these elements in place.

Proposal Outline

Throughout this Proposal Outline, provide detailed information regarding the scope of the Applicant’s business. Questions fall under the following sections:

I. Business Demographics
II. Organizational Structure
III. Quality Management/Utilization Management
IV. Services
V. Budget/Financial
VI. Risk Profile
VII. Managed Care Profile
VIII. Information System
IX. Statement
X. Mental Health Friendly Workplace
XI. Assurances Document

Two Attachments are provided as information regarding the Local Authority which may assist in developing the Proposal.
Attachment A -- Priority Population Definitions
Attachment B -- Service Descriptions and Information

Application shall address one of the following service options:
<table>
<thead>
<tr>
<th>Service Options</th>
<th>Level of Cares</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1</td>
<td>YC,1</td>
</tr>
<tr>
<td>Option 2</td>
<td>YC,1,2</td>
</tr>
<tr>
<td>Option 3</td>
<td>YC,1,2,3</td>
</tr>
</tbody>
</table>

Please be sure to answer every question. If the question does not apply to the Applicant, simply and clearly document “N/A”. Scoring and evaluation is based on completed questions. ALL unanswered questions will be considered omissions. Please limit responses to each question to one double spaced page if possible. Answer all questions in the order of this proposal outline. Use the forms attached or prepare responses in the same format. Clearly designate each item in the document as it appears in this outline (by number, letter, and question). Place tab dividers at the beginning of each section (Roman Numerals) to match those shown above in this Proposal Outline section. The document should be double spaced, type size at least 10 pitch. The Local Authority reserves the right to review only completed Proposals. The Local Authority reserves the right to hold subsequent face to face or telephone interviews for clarification and/or negotiation purposes. Interviews will not be solicited for the purpose of completing incomplete proposals. Multiple omissions and/or incomplete responses may result in disqualification. All supporting documentation should be attached to the appropriate section of the Proposal and in the order described in this Proposal Outline section.

Questions regarding this proposal should be emailed to Lupita Pena, lpena@ehnelpaso.org. Questions should reference the line number from the RFA. Amendments including questions and answers will be distributed to all those known to have received a copy of the RFA from the Local Authority. Applicants must acknowledge receipt of the amendments and consider these in the final proposal.

False statements by any Applicant may disqualify the Proposal. The Local Authority reserves the right to reject any or all Proposals and reopen the RFA process in total.

Interviews or site visits may be conducted to further evaluate competitive proposals, to negotiate rates, and to select one or more Proposals for award. In this situation, no Applicant will be given information, support, or resources that will give the Applicant a competitive advantage over the other Applicants.

Each Applicant who submits a complete Proposal but is not awarded a Contract will be notified in writing that the proposal is no longer being considered.

Following Contract award, the contents of all proposals may be made available upon written request. Therefore, any information contained in the proposal that is deemed to be proprietary in nature must clearly be so designated in the proposal. Such information may still be subject to disclosure under the Public Information Act depending on opinions from the Attorney General’s office.
I. Business Demographics

Name ____________________________________________________________

Title of Business ___________________________________________________

SS# ___________________________ and/or Tax ID _________________________

Address ____________________________________________________________

City ___________________________________________ County ______________

Zip Code ________________________

Business Phone _________________________ Fax # _________________________

Website address_______________________________________________________

Contact Person _______________________________________________________

Title __________________________________________________________________

Phone # ___________________________ Fax # _____________________________

Billing Address if Different From Above (include Street, City, State, and Zip Code)

_____________________________________________________________________

Billing Manager _______________________________________________________

Phone # ___________________________ Fax # _____________________________

Other Business Locations in this Market Area: (include Street, City, County, and Zip)

1. __________________________________________________________________

2. __________________________________________________________________

3. __________________________________________________________________

4. __________________________________________________________________

Provide a map of locations which specifies the Services provided, capacity and languages
spoken (by Service) at each location - Label as Exhibit IA.

Other Owners/Partners:

<table>
<thead>
<tr>
<th>Name</th>
<th>% Ownership</th>
<th>If corporate, list organization</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

1. __________________________________________________________________

2. __________________________________________________________________

3. __________________________________________________________________

4. __________________________________________________________________

Type of organization (i.e., non-profit corporation, limited liability company, general
partnership, etc.) :

_____________________________________________________________________

_____________________________________________________________________

Provide a copy of Provider’s Articles of Incorporation and 501(c)(3) certificate, or other
bylaws/governing documents as appropriate – Label as Exhibit IB.

Years in Operation ____________________________________________________

Hours of Operation ____________________________________________________
II. Organizational Structure

A. Attach a copy of the organizational chart, including names, titles and vacant positions, clearly indicating who will be the main point of contact with respect to any Contract -- Label as Exhibit IIA

B. List the names and business affiliations of board members or other governing body:

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

III. Quality Management/Utilization Management

A. List all licenses, credentials, certifications, and/or accreditations the Applicant currently holds related to the Services. Provide copies of all licenses, certifications, accreditations -- Label as Exhibit IIIA.

B. Provide a copy of the staff roster and their corresponding education and license credentials. Designate if they are full time, part time, or on call. Label as Exhibit IIIB.

C. Attach the Applicant’s Quality Assurance/Management Plan and Quality Management Program Reports for the last six (6) months -- Label as Exhibit IIIC.

D. Describe the Applicant’s internal utilization management procedures. Describe methods for ensuring that individuals are receiving services in accordance with internal standards of care. Provide copies of recent reports to payors showing the Applicant’s performance relative to its utilization management requirements -- Label as Exhibit IIID.

E. Provide a summary of the most recent client satisfaction surveys or other ongoing efforts to obtaining and evaluate client satisfaction -- Label as Exhibit IIIE. Describe how this information was obtained.
IV. Services

A. Describe how Applicant will communicate with the Local Authority regarding the Client referral process, specifically what are the parameters around access.

B. Describe in detail the array of Behavioral Health Services the Applicant would offer under its Proposal. Identify units of Service, where Services are offered, who would provide Services (education and credentials), and the times of day and days of the week the Services would be available. Indicate the capacity of all services. Include a copy of Services schedules and descriptions -- Label as Exhibit IV.

C. Describe the frequency and type of in-service training currently offered by the Applicant or provided to employees including, but not limited to, training related to patient rights and standards of services.

D. Describe the Applicant’s experience in working with Medicaid and in providing services for persons with severe and persistent mental illness 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 the service delivery system?

E. Describe the Applicant’s history of working with this population on an outpatient basis and experience of working with persons who are not compliant with treatment. Describe the ability to treat persons with disabilities and persons with multiple diagnoses of a developmental disability-mental illness-substance abuse. Detail the specific population the Applicant intends to serve under this Proposal. Include ages and level of severity.

F. Describe the Applicant’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 how the Applicant ensures cultural competency on the part of staff with regard to ethnic, racial, religious and sexual orientation differences.

G. Describe or attach policies and procedure which describe any process the Applicant presently has to receive communication from clients, family members and advocates, and to receive and resolve complaints and grievances.

H. Describe any process to transition clients from the Applicant’s services as their level of functioning improves.

I. Describe the facility(ies) proximity to public transportation or the Applicant’s ability to facilitate access to public transportation.

J. Describe how you will engage and involve clients, legally authorized representatives, and families at the policy and practice levels within your organization.
K. Describe the transition plan between service levels you intend to utilize for Clients.

L. Describe how you will meet the cultural and linguistic needs of the clients in the Local Authority's local service area.

M. Describe where and when you will provide Services within the Local Authority's local service area, and how persons with disabilities will be able to access those Services.

V. Budget/Financial

A. Attach copies of the Applicant’s last three years audited financial reports -- Label as Exhibit VA2.

B. Does Applicant own or lease current business properties? If leasing properties, note the upcoming expiration date of the leases.

C. Describe any arrangements to subcontract part or all of these services. All subcontracts must be approved by the Local Authority, in its sole discretion. Name all proposed subcontractors and provide information on their staff credentials, licenses and certifications.

D. If an individual, are any Child Support Payments delinquent? If so, explain in detail.

VI. Risk Profile

A. Attach a copy of the Risk Management Plan - Label as Exhibit VIA.

B. Is Applicant currently under investigation, or had a license or accreditation revoked, by any state/federal/local authority or licensure agency, within the last five (5) years? If yes, explain in detail.

C. Does anyone working for Applicant providing direct care or in management have any felony convictions? If yes, explain. Describe the process, if any, for checking on previous convictions of employees or applicants for employment. Attach any policies and procedures regarding the hiring and retention of persons with criminal histories -- Label as Exhibit VIB. Are criminal history checks done on all Applicant staff annually?

D. Has Applicant had any judgments or settlements entered against it in the last ten (10) years? If so, explain in detail.

E. Has either the Applicant or any of its employees had any validated fraud, client abuse, client neglect, or rights violations claims in the last three (3) years? If so, explain in detail. Describe the process, if any, for checking on previous confirmed fraud, client abuse, client, neglect, or rights violations of employees or applicants for employment, such
as through CANRS, the Nurse Aide Registry, and the Employee Misconduct Registry.
Describe or attach any current polices and procedures regarding client abuse, client
neglect, or rights violations and the training of staff on these issues -- Label as Exhibit
VIC.

F. Has Applicant been placed on vendor hold within the past five (5) years by any
funding agency or company? If yes, explain.

G. Does Applicant have a Letter of Good Standing which verifies that it is not
delinquent in payment of Texas State Franchise Tax? Corporations that are non-profit or
exempt from Franchise Tax are not required to have this letter, but instead must submit a
501C IRS Exemption form from the Comptroller Office. Attach and label as Exhibit VID.

H. Is Applicant currently held in abeyance or barred from the award of a federal or
state contract? Has this occurred in the last 5 years? If so, explain.

I. Has Applicant ever filed bankruptcy? If yes, describe in detail.

J. Has Applicant ever defaulted on any business lease arrangement? If so, describe
in detail.

K. 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, workers compensation and medical
malpractice insurance -- Label as Exhibit VIE.

J. Attach any policies and procedures regarding medical records security –
Label as Exhibit VIFProvide the name of Workers’ Comp carrier if Applicant has
Workers’ Comp coverage or self funding documents if self funded -- Label as Exhibit
VIF.

VII. Managed Care Profile

A. Describe your background and depth of experience with all of the managed care
companies with which Applicant currently contracts or has previously contracted. Include
the duration of any relationships, numbers of clients served and specific services provided
to managed care companies.

B. Provide Applicant’s Medicaid Provider number(s). Have these ever been
suspended or revoked? If so, explain.

C. Provide Applicant’s Medicare Provider number(s). Have these ever been
suspended or revoked? If so, explain.

D. Has Applicant ever been dropped from a managed care network? If so, explain.
E. Submit contact information from at least three (3) entities for which Applicant has provided services similar to the Services within the past two years -- Label as **Exhibit VIIA**.

F. Describe any contracts, Memoranda of Understanding, or employment relationships Applicant has with other state, city or county agencies in the El Paso County health care community.

**VIII. Information Systems**

Applicant shall be required to utilize LMHA’s Anasazi system to record behavioral health service delivery.

**IX. Statement**

Provide a statement detailing why Applicant’s services best meet the needs of persons with behavioral and primary health concerns. Identify any best practices Applicant is currently utilizing in delivering services similar to the Services sought under this RFA.

List any workload measures or data collected and used that pertains to positive outcomes for this population. Describe training provided to the family members of persons who meet the definition for the Priority Population. Describe how Applicant links services or provides continuity of care with other providers. Describe how Applicant collaborates and shares data with other providers and any limits on this sharing.

State the current organizational mission, values and ethics. Cite any contradictions that may exist between the Applicant’s mission and that of the Local Authority. Attach a copy of the mission, values and ethics -- Label as **Exhibit IX**.

**X Mental Health-Friendly Workplace**

The Applicant shall submit narrative demonstrating its commitment as a Mental Health-Friendly Workplace. Please provide in detail all the elements identified in Section entitled Mental Health-Friendly Workplace.
Applicant assures the following:

1. That all addenda and attachments to the RFA as distributed by the Local Authority and designated by the checklist have been received.

2. No attempt will be made by the Applicant to induce any person or firm to submit or not to submit a proposal, unless so described in your response document.

3. The Applicant does not discriminate in its services or employment practices on the basis of race, color, religion, sex, national origin, disability, veteran status, or age.

4. All cost and pricing information is reflected in the RFA response documents or attachments.

5. Applicant accepts the terms, conditions, criteria, and requirement set forth in the RFA.

6. Applicant accepts the Local Authority’s right to cancel the RFA at any time prior to Contract award.

7. Applicant accepts the Local Authority’s right to alter the time tables for procurement as set forth in the RFA.

8. The Proposal submitted by the Applicant has been arrived at independently without consultation, communication, or agreement for the purpose of restricting competition.

9. Unless otherwise required by law, the information in the Proposal submitted by the Applicant has not been knowingly disclosed by the Applicant to any other Applicant prior to the notice of intent to award.

10. No claim will be made for payment to cover costs incurred in the preparation of the submission of the Proposal or any other associated costs.

11. Local Authority has the right to complete background checks and verify information.

12. The individual signing this document and the Contract is authorized to legally bind the Applicant.

13. The address submitted by the Applicant to be used for all notices sent by the Local Authority is current and correct.

14. No employee of the Local Authority or DSHS, and no member of the Local Authority’s Board 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.

15. That the Respondent is not currently held in abeyance or barred from the award of a federal or state contract.
16. That the Respondent 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.

17. Applicant shall disclose whether any of the directors or personnel of Applicant has either been an employee or a trustee of Local Authority within the past two (2) years preceding the date of submission of the Proposal. This requirement applies to all personnel, whether or not identified as key personnel. If such employment has existed, or at term of office served, the Proposal shall state in an attached writing the nature and time of the affiliations as defined.

18. Applicant shall identify in an attached writing any trustee or employee of Local Authority who has a financial interest in Applicant or who is related within the second degree by consanguinity or affinity to a person having such financial interest. Such disclosure shall include a complete statement of the nature of such financial interest and the relationship, if applicable. Moreover, Applicant shall state in an attached writing whether any of its directors or personnel knowingly has had a personal relationship with employees or officers of Local Authority within the past two (2) years.

19. No former employee or officer of DSHS, DADS, and/or Local Authority directly or indirectly aided or attempted to aid in procurement of Applicant’s service.

20. Applicant shall disclose in an attached writing the name of every Local Authority key person with whom Applicant is doing business or has done business during the 365 day period immediately prior to the date on which the Proposal is due; failure to include such a disclosure will be a binding representation by Applicant that the natural person executing the Proposal has no knowledge of any key persons with whom Applicant is doing business or has done business during the 365 day period prior to the immediate date on which the Proposal is due.

21. Under Section 231.006, Family Code, the vendor or applicant certifies that the individual or business entity named in this contract, bid, or application is not ineligible to receive the specified grant, loan, or payment and acknowledges that this contract may be terminated and payment may be withheld if this certification is inaccurate. For purposes of the foregoing sentence, “vendor or applicant” shall mean Applicant; contract, bid or application shall mean the Proposal; and “this contract” shall mean any Contract awarded to the Successful Applicant.

_____________________________  __________________________ _______  
Signature Authority for the Provider  Title of Organization   Date  

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Mental Health
Priority Population Definition

The Priority Population for mental health services as defined by DSHS consists of children/youth ages 3 through 17 with a diagnosis of mental illness (excluding a single diagnosis of substance abuse, IDD, autism or pervasive development disorder) who exhibit serious emotional, behavioral or mental health disorders and who:

1. Have a serious functional impairment; or
2. Are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms; or
3. Are enrolled in a school system’s special education program because of serious emotional disturbance.

The following information must be used to operationalize these definitions to determine if an individual meets this definition. Only the Local Authority may determine an individual is a member of the Priority Population.

Service Determination

In targeting services to the Priority Population, the choice of and admission to services is determined jointly by the person seeking services and the Local Authority. Criteria used to make these determinations are the diagnosis, the level of functioning of the individual (GAF Score), the needs of the individual, and the availability of resources.

DSHS Funding

Funds appropriated by the Legislature for mental health services may be spent only to provide services to the Priority Population. Successful Applicants who wish to offer services to people other than those in the Priority Population may do so using non-departmental funds.
<table>
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<tr>
<th>Population</th>
<th>If the person is ...</th>
<th>And has a ...</th>
<th>And ...</th>
<th>And ...</th>
<th>Then the person is ...</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children</strong></td>
<td>less than 18 years old</td>
<td>DSM-IV diagnosis other than or in addition to: * substance abuse * mental retardation * autism or * pervasive developmental disorder</td>
<td>has a functional impairment (GAF of 50 or less either currently or in the past year)</td>
<td></td>
<td>initially eligible for DSHS state-funded MH services.</td>
</tr>
<tr>
<td></td>
<td>less than 18 years old</td>
<td>DSM-IV diagnosis other than or in addition to: * substance abuse * mental retardation * autism or * pervasive developmental disorder</td>
<td>has been determined by the school system to have a serious emotional disturbance</td>
<td></td>
<td>initially eligible for DSHS state-funded MH services.</td>
</tr>
<tr>
<td></td>
<td>less than 18 years old</td>
<td>DSM-IV diagnosis other than or in addition to: * substance abuse * mental retardation * autism or * pervasive developmental disorder</td>
<td>is at risk of disruption of the preferred living situation due to psychiatric symptoms</td>
<td></td>
<td>initially eligible for DSHS state-funded MH services.</td>
</tr>
</tbody>
</table>
As previously stated, application shall address **one** of the following service options:

<table>
<thead>
<tr>
<th>Service Options</th>
<th>Level of Cares</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1</td>
<td>YC,1</td>
</tr>
<tr>
<td>Option 2</td>
<td>YC,1,2</td>
</tr>
<tr>
<td>Option 3</td>
<td>YC,1,2,3</td>
</tr>
</tbody>
</table>

**Reference to Children and Adolescent TRR Clinical Guidelines:**
(See UM Guidelines FY2014 CMH)

Documentation for services provided as Rehabilitative Services for Persons with Mental Illness must be completed prior to the submission of a claim for payment. Each service unit requires at least minimal documentation of certain key elements:

<table>
<thead>
<tr>
<th>Element #</th>
<th>Key Documentation Element</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>With whom the contact occurred (the consumer or other person). If a person other than the consumer was contacted, the note must identify the consumer on whose behalf the contact was made.</td>
</tr>
<tr>
<td>2</td>
<td>Description of the service that was provided</td>
</tr>
<tr>
<td>3</td>
<td>The date and time of day that the service was delivered (i.e., the start time)</td>
</tr>
<tr>
<td>4</td>
<td>The amount of time that the service was provided. (If the providers want to record both start and stop times, the amount of service will be inferred.)</td>
</tr>
<tr>
<td>5</td>
<td>Who provided the services. This is indicated by the signature of the service provider on the progress note. The signature must include the credentials of professions who deliver a service. In day programs, the person initiating the progress note must sign the note. Day programs must also maintain staff rosters for review.</td>
</tr>
<tr>
<td>6</td>
<td>The setting in which the service was provided (e.g., home, shelter, job site, school, clubhouse, etc.).</td>
</tr>
<tr>
<td>7</td>
<td>The goal or objective of the treatment plan addressed by the service.</td>
</tr>
<tr>
<td>8</td>
<td>Progress or lack of progress in achieving treatment goals/objectives.</td>
</tr>
</tbody>
</table>
Selection and Notification of Award

Emergence Health Network Chief Executive Officer shall convene a committee to make the evaluation of applications that result in the recommendation for the selection for award. The successful Respondent shall receive a written notice of award from Emergence Health Network no later than ten (10) days after selection for award.