Co-Occurring Disorders Residential Treatment Program

Facility Checklist

- ☐ Complete, date and sign the enclosed Facility Application.
- ☐ Complete, date and sign the W-9 Form for each TIN.
- ☐ Attach a current copy of your Facility's Licenses and/or Certifications.
- ☐ Attach a copy of your Program Schedule or Program Description.
- ☐ Attach a copy of your Malpractice Insurance Face Sheet.
- ☐ Attach a list of all of your facility sites with addresses.
- ☐ Attach a copy of Clinical Descriptions of all program tracks within the facility.
- ☐ Attach a copy of your Quality Assurance/Improvement Program.
- ☐ If you answered yes to the Malpractice Claims question on page 5, Section J, please attach a letter from your staff member's 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.

Submit all documents in full to:

MHMRA of Harris County
Attn: MH Authority Support Services.
7011 Southwest Freeway
Houston, Texas 77074
Via e-mail to: mhnetworkdevelopment@mhmraharris.org

Comprehensive Psychiatric Emergency Program of MHMRA of Harris County Co-occurring Disorders Unit

PROVIDER APPLICATION

A. Principal or Owner

Last Name of Principal or Owner	First Name	Middle Initial	Professional Designation or Title of Principal or Owner

Preferred Mailing Address Line 1	Preferred Mailing Address Line 2

City	State	Zip	Telephone

Social Security Number **(REQUIRED)**	Date of Birth **(REQUIRED)**	Sex	Fax

B. Primary Facility Information

Facility Name	*# of years at this site*

Practice Address Line 1	Practice Address Line 2

City	State	Zip	Appointment Telephone

Office Manager (if applicable)	Fax Telephone

Make checks payable to (must match tax ID owner name on file with IRS for the EIN listed below)	*Type of Corporation*

Billing Address Line 1	Billing Address Line 2

City	State	Zip	Telephone

Employer Identification Number (EIN)	W-9 on file (*submit form if blank*)	Tax ID Number	NPI Number (If Any)

Hours of Operation (actual practice hours each day at this location):

Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	
From	To	From	To	From	To	From	To	From	To	From	To

Identify any foreign language(s) or sign language that you speak fluently in treating patients (select no more than 5):

- ☐ Arabic (AR)
- ☐ Chinese (CH)
- ☐ Farsi (FA)
- ☐ French (FR)
- ☐ German (GE)
- ☐ Hebrew (HE)
- ☐ Hindi (HI)
- ☐ Italian (IT)
- ☐ Japanese (JA)
- ☐ Korean (KO)
- ☐ Laotian (LA)
- ☐ Portuguese (PO)
- ☐ Russian (RU)
- ☐ Sign Language (SL)
- ☐ Spanish (SP)
- ☐ Vietnamese (VI)
- ☐ Tagalog (TA)
- ☐ Other (specify): ____________________

C. Referral Information

Identify the percentage of your bed days dedicated to the following patient population:

Population	% of Practice
Individuals with documented co-occurring substance use and psychiatric disorders	

Provide below a detailed explanation of your experience with treating the chronically mentally ill with co-occurring substance use disorders. Please specify the number of years your facility has worked with individuals with co-occurring psychiatric and substance use disorders. Please explain your procedure for handling administration of psychiatric medications. Please describe the general nature of your intense chemical dependency treatment program and your less-intensive residential treatment program. (Use additional sheets if needed.)

D. License/Certification Information

DSHS LICENSE #	Exp. Date

(NOTE: to expedite license verification, please enclose a copy of your license)

PROFESSIONAL LICENSE(S): It is the responsibility of the Provider to ensure that professional licenses of all staff members are current. Below please list the names of each employee with a license & the name of the employee's respective licensing board. Please list the license number and the expiration date of the license.

Employee Name	Name of Licensing Board	License #	Exp. Date of License

E. Malpractice Insurance

List below your most current malpractice carrier. Enclose a copy of your current policy certificate and/or declarations page showing the coverage limits and dates of coverage.

Current Carrier (Name and Certificate Number)	**Policy Number**	**Dates of Coverage**	**Coverage Limits**

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**

F. Attestation

NOTE: If "**YES**" is checked, **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:** Has the professional liability insurance coverage of any member of your staff ever

been denied, canceled, or non-renewed or initially refused upon application? ☐ Yes ☐ No

2. **License:** Have any of your employees had their professional licenses in any state revoked, suspended, placed on probation, given conditional status or otherwise limited? ☐ Yes ☐ No
   a. Has anyone on your staff every voluntarily surrendered their professional license in any state? ☐ Yes ☐ No
   b. Do any members of your staff have formal charges pending against them at this time? ☐ Yes ☐ No

3. **Criminal Offenses:** Has anyone on your staff ever been convicted of a felony involving moral or ethical turpitude or substance use or sale? ☐ Yes ☐ No
4. **Board Discipline:** Has anyone on your staff ever been the subject of disciplinary proceedings by any professional association or organization (i.e., state licensing board; county; state or national professional society, etc.? ☐ Yes ☐ No

5. **Malpractice Action:** Has any malpractice action be brought or settled against anyone on your staff in the last 5 years, or have there been any unfavorable judgment(s) against any members of your staff in any malpractice actions? ☐ Yes ☐ No
   a. To your knowledge, are any malpractice actions currently pending against any members of your staff? ☐ Yes ☐ No

6. **Neglect and Abuse**: Has your facility ever been sued for neglect or abuse? ☐ Yes ☐ No

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

____ ____________________
Signature Date (mm/dd/yy)

PARTICIPATION STATEMENT

We fully understand that if any matter stated in this application is or becomes false, MHMRA CPEP Co-Occurring Disorders Unit will be entitled to terminate the provider agreement for breach. All information submitted in this application is warranted to be true, correct and complete.

I authorize MHMRA CPEP Co-Occurring Disorders Unit to consult with the National Practitioners Data Bank, state licensing board(s), educational institutions, specialty boards, malpractice insurance carriers, and any other person or entity from whom information may be needed to complete the verification process or to obtain and verify information concerning staff membership, professional competence, character and moral and ethical qualifications, and I also authorize all of them to release such information to Client. I release MHMRA of Harris County and its employees and all those with whom MHMRA CPEP Co-Occurring Disorders Unit 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 this 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 the professional competency of this facility and its staff, the character and moral and ethical qualifications of this facility and its staff, including any information relating to any disciplinary actions or suspensions or curtailment of privileges sustained by any members of the staff, and hereby release any such person providing such information from any and all liability for doing so.

____ Date (mm/dd/yy):____/____/______
Signature of Applicant

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Name (Please Print)

Comprehensive Psychiatric Emergency Program of MHMRA of Harris County Co-occurring Disorders Unit
PROVIDER APPLICATION

RETURN COMPLETED APPLICATION TO:

MHMRA of Harris County
Attn: Attn: MH Authority Support Services
7011 Southwest Freeway
Houston, Texas 77074
Via e-mail to: mhnetworkdevelopment@mhmraharris.org

REQUIRED DOCUMENTATION TO ACCOMPANY THIS APPLICATION

- ***COPY OF CURRICULUM VITAE OF OWNER/PRINCIPAL***
- ***COPY OF CURRENT STATE LICENSE AND/OR LICENSE REGISTRATION CERTIFICATE***
- ***COPY OF CURRENT MALPRACTICE INSURANCE FACE SHEET***

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