



OPEN ENROLLMENT APPLICATION FOR ORGANIZATIONS

Helping people achieve dignity, independence, and their dreams.”

<https://communityhealthcore.com/about-us/contractors/request-for-application/>

SECTION 1: Business Contractor Information

Business Name (please print): _____

Title: _____ Representative Name: _____

Address: _____

City/State: _____ Zip/Postal Code: _____

Business Phone: _____ Cell Phone: _____

Email Address: _____

Type of Business Entity: ☐ Profit ☐ Non-Profit ☐ Governmental ☐ Other

EIN (attach copy): _____ Number of Employees Providing Service: _____

Speak any Languages Other than English that you can perform services in: ☐ Yes ☐ No

If yes, please list _____

How did you hear about us?

- ☐ Community Healthcore Website
- ☐ Current employee (please specify below)
- ☐ Job Board (please specify below)
- ☐ Job Fair (please specify below)
- ☐ Social Media (please specify below)
- ☐ Newspaper (please specify below)
- ☐ Other (please specify below)

Please specify source:

SECTION 2: Services

Applicant agrees to provide the specified community service(s) at the rate of payment described in the RFA.

Open Enrollment Applicant applying for: _____

Service definitions can be found on the RFA Posting and Instructions on the Community Healthcore website located at <http://communityhealthcore.com/about-us/contractors/request-for-application/>. Please refer to the current Request for Applications for a list of rates.

What type(s) of services is Company applying to provide?

☐ Non-Traditional ☐ Licensed or Professional

****Non-traditional services do not require a professional license or certification. Licensed or professional services do require a professional license or certification.*

✓ **Check all services that Applicant is applying to provide.**

- Is your Company applying to provide Behavioral Health Services for Adults?
☐ Yes ☐ No
- Is your Company applying to provide Child and Family Services (CFS, Children's Partnership, Youth and Family Assessment Center, Community Healthcore Family Drug Treatment Court)?
☐ Yes ☐ No

- Is your Company applying to provide Texas Health and Human Services Commission (HHSC) Services for Adults and Children? ____ Yes ____ No
- Is your Company applying to provide Child and Family Services (Early Childhood Intervention Services)? ____ Yes ____ No
- Is your Company applying to provide Child and Family Services (Youth Empowerment Services Waiver)? ____ Yes ____ No
- Is your Company applying to provide Intellectual and Developmental Disabilities Services? ____ Yes ____ No
- Is your Company applying to provide Substance Use Services? ____ Yes ____ No

SECTION 3: Geography

If services are to be provided in the Community or the Consumer's Home, to what geographic areas that Community Healthcore service, is Applicant willing to travel to provide services? Check all that apply.

General Openings

• Bowie County	• Cass County	• Gregg County
• Harrison County	• Marion County	• Panola County
• Red River County	• Rusk County	• Smith County
• Upshur County		

ECI

• Smith County	• Anderson County	• Cherokee County
Inside the Loop	• Henderson County	• Rains County
Outside the Loop	• Van Zandt County	• Wood County

Service Location(s): All that apply

- Will services be provided in the Community? ____ Yes ____ No
- Will services be provided in the Consumer's Home? ____ Yes ____ No
- Will services be provided at your Business location? ____ Yes ____ No

SECTION 4: Credentials / Certifications / Requirements (provide copies of ALL Licenses and Certifications)

Is your Business in compliance with HHSC (formerly TDMHMR Texas Department Mental Health and Mental Retardation) rules?

☐ Yes ☐ No

Licensure Status – Note: Licensed providers are MD/DO, psychologist, LPC, LCSW, LMSW, LMFT, LCDC, APN, RN, LVN, ST, PT, OT, LPA, and massage therapists. Certified providers include BCBA, Art Music, and Recreation Therapists.

☐ Licensed ☐ Certified ☐ Other

List and submit any other credentials, certifications, and/or accreditations that Applicant currently holds. This includes documents such as Health and Human Services Commission (HHSC) Licenses or Certifications, Department of State Health Services Licenses or Certifications, Department of Aging and Disability Services Licenses and Certifications, Department of Assistive and Rehabilitative Services Licenses and Certifications, etc. If none, type "Not Applicable." (Attach a separate page, if needed)

Do your Business currently have a Relias account assigned to you by Community Healthcore for provider training?

☐ Yes ☐ No

Have you completed any required Community Healthcore provider training?

☐ Yes, I am a new provider, but I have completed some or all of the required training. See attached.

☐ Yes, I am a renewing provider and I have submitted training records to a Community Healthcore staff member upon the previous request.

☐ No, I have registered for upcoming training or will register for upcoming training. I understand that required Community Healthcore provider training must be completed prior to any contract(s) being awarded.

Community Healthcore Providers are required through this Open Enrollment to currently complete service-specific training. Any specific training and reimbursement will be specified in the contract.

SECTION 5: Other Provider Details

Describe any contracts, Memorandum of Understanding, or employment relationships that Applicant has with another state, city, or county agencies in Bowie, Cass, Gregg, Harrison, Marion, Red River, Rusk, Smith, and/or Upshur County. (Attach separate page, if needed)

Is the Business certified to be a Historically Underutilized Business? ☐ Yes ☐ No (If yes, attach HUB)

Is Business a Medicaid and/or Medicare Provider? ☐ Yes ☐ No

Is the Business excluded from performing services under any Governmental Programs or any other Government-sponsored program, including Medicaid and/or Medicare programs in any state?

☐ Yes ☐ No

Adverse Actions

Has Business ever been a party to a contract or held an employee position that was terminated for cause, relinquished or withdrawn; or failed to proceed with an application to avoid an adverse action, to preclude an investigation, or while under investigation relating to professional conduct?

Yes ☐ No ☐

Has participation in Medicare, Medicaid, or other government programs as a provider ever been or is it currently in the process of being denied, revoked, suspended, reduced, limited, censured, placed on probation, reprimanded, sanctioned, disqualified, fined, placed under board order, or not renewed?

Yes ☐ No ☐

Has a Business ever been assessed a penalty by Medicaid, Medicare, or any government program?

Yes ☐ No ☐

Has Business ever been sanctioned by a peer review organization or similar federal, state, regulatory program, or military agency?

Yes ☐ No ☐

Has a Business ever been found to be the perpetrator of a confirmed case of client abuse, neglect, or exploitation?

Yes _____ No _____

Is Business currently under investigation, or has Business had a license or accreditation revoked, by any state/federal/local authority or licensure agency, within the last five (5) YEARS?

Yes _____ No _____

Has Business had any judgments or settlements entered against it in the last ten (10) years?

Yes _____ No _____

Has Business been placed on vendor hold within the past five (5) years by any funding agency or company?

Yes _____ No _____

Is the Business subject to any levy by a governmental agency including but not limited to the IRS?

Yes _____ No _____

Transporting:

Businesses that will be transporting consumers must meet Safe Driving Standards. If any provider has four (4) or more points on their current DPS past 3-year driver records, then they CAN NOT TRANSPORT CONSUMERS.

Will Business be transporting consumers? ____ Yes ____ No

Do the Business (owner, employees) have Poor Driver's Violations? ____ Yes ____ No

Provide a list of drivers and copies of their Driver's License (**each individual will need to fill out the Criminal History form attached**):

Provide a copy of an accident report for accident violations where your business was determined to not be at-fault (if applicable).

Barred from driving? ____ Yes ____ No Date on DPS Driver Record _____

Insurance: Effective Date _____ Expiration Date _____

Provide copies of the following:

- Current DPS 3-year driver record.
- Texas Auto liability coverage in limits required by the State of Texas with effective and expiration dates
- Current Driver's License

SECTION 6: Assurance

The applicant is not currently held in abeyance or barred from the award of a Federal or State contract. The applicant is currently in good standing with the State of Texas and has paid all applicable taxes that are currently due. If applicant cannot make both assurances, please explain why (use separate paper if necessary).

SECTION 7: Submitted Documents

- Open Enrollment Application
- Background Check Form (Included in this package - completed by each individual who will be providing service at Community Healthcore facilities)
- Conflict of Interest (Included in package)
- Copy of Current Professional Certificate of Insurance
- Other documents asked for in the application (copy of current professional license, permit or certification - for each individual who will be providing service at Community Healthcore facilities)
- W-9

SECTION 8: Certify

I CERTIFY that all the information provided by me in connection with this application, whether on this application or not, is true and complete, and I understand that any misstatement, falsification, or omission of information shall be grounds for a refusal to consider, or if engaged, termination.

Signature

Date