

## Co-Occurring Disorders Residential Treatment Program

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### 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](mailto: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):

- |  |  |   |   |                                       |
|--|--|---|---|---------------------------------------|
| <input type="checkbox"/> Arabic (AR)     | <input type="checkbox"/> Chinese (CH)    | <input type="checkbox"/> Farsi (FA)             | <input type="checkbox"/> French (FR)        | <input type="checkbox"/> German (GE)  |
| <input type="checkbox"/> Hebrew (HE)     | <input type="checkbox"/> Hindi (HI)      | <input type="checkbox"/> Italian (IT)           | <input type="checkbox"/> Japanese (JA)      | <input type="checkbox"/> Korean (KO)  |
| <input type="checkbox"/> Laotian (LA)    | <input type="checkbox"/> Portuguese (PO) | <input type="checkbox"/> Russian (RU)           | <input type="checkbox"/> Sign Language (SL) | <input type="checkbox"/> Spanish (SP) |
| <input type="checkbox"/> Vietnamese (VI) | <input type="checkbox"/> Tagalog (TA)    | <input type="checkbox"/> Other (specify): _____ |   |                                       |





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- 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 ever 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.

\_\_\_\_\_  
Signature of Applicant

Date (mm/dd/yy): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

\_\_\_\_\_  
Name (Please Print)

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**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@mhmrharris.org](mailto:mhnetworkdevelopment@mhmrharris.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*