



# COMPREHENSIVE PSYCHIATRIC EMERGENCY PROGRAMS – CRITICAL TIME INTERVENTION Provider Application

## D. Payee Information

<b>Make checks payable to</b> (must match tax ID owner name on file with IRS for the TIN listed below)			Type of Corporation
Billing Address Line 1		Billing Address Line 2	
City		State	Zip
Employer Identification Number (EIN)	W-9 on file (submit form if blank)	Tax Identification Number (TIN)	NPI Number (If Any)

Do you accept MHMRA’s Daily rate of \$27 a day up to 90 days and are you willing to negotiate a rate if/when a resident acquires income/benefit and he/she chooses to retain housing at your facility?  Yes  No

## E. Facility Information

1. Identify the percentage of your facility dedicated to the following residents (must total 100%):

Residents	% of Facility	Diagnoses	% of Facility
Young Child (0-5)		Mental Health	
Child (6-12)		Substance Abuse	
Adolescent (13 - 17)		Developmental Disability/MR	
Adult (18 - 64)		Other	
Geriatric (65+)			

2. Please indicate any disorders or types of residents that you will not accept for treatment:


3. The facility will allow MHMRA of Harris County CTI staff to make visits to residents’ rooms in the facility?

Yes  No

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**F. Special Services** (check all that apply):

Services		Notes
<b>1. Meals:</b>		
• Three meals a day are provided	<input type="checkbox"/> Yes <input type="checkbox"/> No	
• Community kitchen with each resident participating in meal preparation	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>2. Security:</b>		
• Perimeter Fenced?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
• Security Guard on site?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
• Cameras on site?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
• Sign-in and Sign-out?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
• Curfew?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
♦ If yes, are residents free to exit building during emergencies?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
♦ Does the facility have locked units that prevent client from leaving facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
• Onsite facility staff available to residents 24 hours a day, seven days a week?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>3. Transportation:</b>		
• Provided by the facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
• Easily accessible / Near public transportation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>4. Classes &amp; Groups</b>		
• GED classes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
• Job skills training?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
• Groups?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
• Day program?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>5. Medication</b>		
• Monitoring of self-administering of medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>6. Facility Licensure Level</b>	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	
<b>7. Amenities</b>		
• Does the facility supply residents with toiletries?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
• Does the facility supply bedding?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
• Does the facility supply laundry expenses and machines?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>8. Other ancillary services:</b>		

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**G. Assisted Living Facility License Information**

DADS LICENSE #	Exp. Date

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

**H. General Liability**

- List below your most current General Liability Insurance 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 insurance carrier who has provided coverage for your General Liability 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

- All facilities willing to work with MHMRA of Harris County must have MHMRA of Harris County named as an additional insured on your certificate of insurance.
  - Are you willing to name MHMRA of Harris County as an additional insured on your certificate of insurance?  
 Yes                       No

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**I. Managed Care Contacts**

Please note who the appropriate contact person is:

<b>Admissions Contact Name</b>	<b>Phone</b>
<b>Operations/Facility Manager</b>	<b>Phone</b>

**J. 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. **Facility License:** Has your facility license ever been denied, revoked or suspended?  Yes     No
  - a. How many facilities do you operate? \_\_\_\_\_
  - b. Are any of these facilities not licensed by the **DADS**?  Yes     No
2. **License:** Have you or any of your employees had their professional licenses in any state revoked, suspended, paced 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?  No

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

\_\_\_\_\_  
Signature

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

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**PARTICIPATION STATEMENT**

We fully understand that if any matter stated in this application is or becomes false, MHMRA CPEP Critical Time Intervention Program 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 Critical Time Intervention Program to consult with the state licensing board(s), general liability 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 Critical Time Intervention Program 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: Critical Time Intervention Program  
7200 North Loop East  
Second Floor  
Houston, TX 77028**