Exhibit H

Detailed information needed from Provider:

A. GENERAL

1. **Capacity/Transition**. What is your capacity?

Identify the percentage of your practice time dedicated to the following patient population and modality categories:

Population	% of Practice	Business Lines	% of Practice
Child (up to age 12)		Group Health (PPO)	
Adolescent (13 - 17)		Capitation (HMO)	
Adult (18 - 64)		Medicaid	
Geriatric (65+)		Medicare	
		Other	

2. **Experience with providing Mental Health Services:**
Provide detailed explanation of your experience with treating the chronically mentally ill with diagnosis of MDD<50/ Schizophrenia/Bipolar for each age level:

CHILD (up to age 12)
ADOLESCENT (13 - 17)
ADULTS (18- 64)
GERIATRICS (65+)

3. How do you plan on transitioning consumers to your services? Please answer the following questions in relation to transitioning consumers to your facility.

a) Meet appointment timeframes for routine, urgent, emergent appointments per the TAC requirements.
b) Ensure after hours availability for emergency care (information in how to obtain that care).
c) Request case management for cases needing additional service linkage/monitoring from MHMRA Authority.
d) Demonstrate good faith efforts to engage patients in care with subsequent documentation of these efforts.
e) Communicate to the LMHA when patients cannot be located so additional case management resources can be deployed.
f) Offer patient choice to change providers at each treatment plan review AND provide LMHA handout for patient to make independent choice at any time if applicable.

g) Communicate to the LMHA when a consumer is choosing to transfer providers within 2 business days if applicable.
h) Communicate to the LMHA when a patient needs are not being met and another level of care is needed or TRAG assessment indicates another SP that provider is not contracted to perform if applicable.

4. **Training.** List current staff training requirements and frequencies. Training that is duplicated at your organization/providers can be substituted for these sessions as long as it meets the course objective. Substitution reviews must be approved by Quality Management.

5. **Noncompliance.** Describe the organization's/provider's history of working with persons who are not compliant with treatment. Describe the organization's/provider's ability to treat persons with disabilities. Detail the specific population to be served under this proposal. Include ages and levels of severity. How have services been made accessible for those who are difficult to reach, either due to geography or dissatisfaction with service delivery?

6. **Special Needs**. Describe the organization's/provider'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 the organization's ability to work with persons with physical impairments and adaptive equipment. Describe how the organization/provider ensures cultural competency on the part of staff with regard to ethnic, racial, religious and sexual orientation differences.

7. **Transportation**. Describe the facility (ies) proximity to public transportation.

B. FINANCIAL

1. **Business Status**. Is the organization/provider incorporated as "Profit", "Not-for-profit", or "Other"? If "other", please explain.

2. **Subcontractors.** Describe any arrangements to subcontract part or all of these services. Name all subcontractors and provide information on their staff credentials, licenses and certifications.

3. **CEA.** Provide a copy of a Certified External Audit for the past three years. Label as **Exhibit I.**

4. **Taxes.** Provide a copy of the most recent Tax Statement (IRS Form 1120, Form 990 as applicable). Label as **Exhibit J.**

5. **Financial Statement.** Provide a current Financial Statement including Cash Flow. Label as **Exhibit K.**

6. **Report.** Submit the most current Annual Report available. Label as **Exhibit L.**

7. **Viability**. Provide evidence of continued financial viability to ensure your capabilities to support this service. **Completion of the Cash Flow Projection template labeled as Exhibit M is required.** The Cash Flow Projection is for the contract period. This will indicate the financial viability of the business to pursue its contracted obligations during the contract period. All should be attached as explanatory notes for the projection as well as any other additional financial viability materials-all labeled as **Exhibit M.**

C. RISK ASSESSMENT

1. **Violations** (including abuse, neglect, exploitation, or other rights violations). If individual or organization has had any violations, explain in detail. Describe or attach any policies and procedures regarding consumer abuse, consumer neglect, or rights violations and the training of staff on these issues. If attaching policies and procedures, label as **Exhibit N**.

2. **Taxes.** Does the organization/provider have a Letter of Good Standing that verifies that it is not delinquent in State Franchise Tax? Corporations that are non-profit or exempt from Franchise Tax are not required to have this letter, but will have a 501C IRS Exemption form from the Comptroller's Office. Attach and label

as **Exhibit O**. Is the Provider delinquent in the payment of any Child Support Payments? If so, explain.

3. **Liability Coverage**. 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, and medical malpractice insurance - Label as **Exhibit P**.

4. **Workers Compensation**. Provide the name of Workers' Compensation carrier if the organization/provider has Workers' Compensation coverage, or self funding documents if self funded - Label as **Exhibit Q**.

5. **Bond.** Are employees or agents of the organization bonded? What is your policy regarding criminal history checks on employees?

6. **MOU**. Describe any contracts, Memoranda of Understanding, or employment relationship the organization/provider has with other state, city or county agencies in the Harris County community.

7. No employee of the Local Authority or DSHS, and no member of the Local Authority's Board of Trustees can directly or indirectly receive any pecuniary interest from an award of the proposed contract. If such a situation exists, please explain in detail. Label as **Exhibit R.**

D. INFORMATION SYSTEMS

Can the organization/provider information system report the following categories of data? Label as **Exhibit S.**

a) Consumer name
b) Admissions and Discharges to services
c) Date, Number, type, and duration of services (by Local Authority service codes)
d) Number and types of restraints authorized by behavior intervention plan
e) Number, type and severity of medication errors/adverse drug reactions for Local Authority consumers
f) Deaths and suicide attempts of Local Authority consumers
g) Serious injury or illness of Local Authority consumers
h) Confirmed abuse, neglect, or exploitation of Local Authority consumers
i) Allegations of homicide/attempted homicide/threat with a plan by a Local Authority consumer

E. INSURANCE COVERAGE

1. What type of insurance do you accept? Please list all types.

____
____
____
____

2. Have you ever been denied coverage (either initial or renewal) by any professional liability insurance carrier or had an individual policy cancelled or individual surcharge placed on you based on your individual practice and/or application? _____Yes _____No

3. Have you filed a claim under your general, professional auto or other liability insurance in the last three years? ___Yes ___No

F. Additional Disclosure Information

1.	Do you have a consumer appeals process?	Yes or No
2.	Do you have an incident report process?	Yes or No
3.	Do you have a confidentiality/consumer rights process?	Yes or No
4.	Do you have an internal quality improvement process?	Yes or No

5. Do you have an internal utilization management process? Yes or No
6. Do you have a consumer satisfaction measure? Yes or No
7. Do you have a service outcome measure? Yes or No
8. Do you maintain a file on each person receiving services? Yes or No
9. Do you have a disaster response plan? Yes or No

G. RISK PROFILE

1. Attach a copy of Proposer's Risk Management Plan and a copy of your Security Manual/Procedures –Label as **Exhibit T**.

2. Does anyone working for Proposer providing direct care or in management have any criminal convictions? If yes, explain. Describe the process, if any, for checking on previous convictions of employees or applicants for employment. (See Local Authority's Bars to Employment).
   Attach any policies and procedures regarding the hiring and retention of persons with criminal histories – Are criminal history checks done on all Proposer staff at least annually? Label as **Exhibit T1**.

3. Has Proposer had any judgments or settlements entered against it in the last ten (10) years? If yes, describe in detail. Has either the Proposer or any of its employees ever had any validated/confirmed fraud, client abuse, client neglect, or rights violations claims? If yes, describe 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/or the Employee Misconduct Registry. Describe or attach any current policies and procedures regarding client abuse, client neglect, or rights violations and the training of staff on these issues – Label as **Exhibit T2**.

4. Has Proposer been placed on vendor hold within the past five (5) years by any funding agency or company? If yes, describe in detail. Is Proposer currently held in abeyance or barred from the award of a federal or state contract? Has this occurred in the last 5 years? If yes, describe in detail. Has Proposer or any of its affiliates ever had contracts cancelled by state, federal or local governmental entities? If yes, describe in detail. Has the proposer ever been investigated by the state or federal investigation agencies related to OIG compliance. Label **Exhibit T3**.

5. Has Proposer ever filed bankruptcy? If yes, describe in detail. Has Proposer ever defaulted on any business lease arrangement? If yes, describe in detail. Label **Exhibit T4**.

6. Has Proposer ever been investigated for any HIPAA violations, confidentiality, or security breaches in relations to Provider's health record? Provide the details and the disposition of such investigations. **Exhibit T5.**

7. Attach any policies and procedures regarding medical records, prescription pad, and medication management, storage, security and access; infection control (including TB screening), food preparation, handling and service; required postings for client rights protection, and emergency contact, fire drill compliance – Label as **Exhibit U**.

8. Provide description of consumer complaint process. Label as **Exhibit U1.** Within last 2 years.
   - Number and duration of all incidents of Client restraint and seclusion.
   - Number, type, and severity of medication errors and adverse drug reactions for Clients.
   - Elopements, unauthorized departures, and Against Medical Advice discharges of Clients.
   - Deaths (all causes) and suicide attempts of Clients.
   - Serious injury or illness of Clients.
   - Confirmed abuse, neglect or exploitation of Clients.
   - Allegations of homicide/attempted homicide/ threat with a plan by a Client.
   - Fire drills with evacuation scores