



# Provider Application

## Individual

*Ensure all questions are answered. If the question does not apply, indicate "N/A".*

### I. Demographics

Provider Name: \_\_\_\_\_  
Last First Middle Initial

Address: \_\_\_\_\_  
Street Address City State Zip Code

Phone#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Employed by: \_\_\_\_\_ Business Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Business Address: \_\_\_\_\_  
Street Address City State Zip Code

### II. Conflicts of Interest

Identify any relationships between provider or provider's staff and MHMRTC employees or Board of Trustees - Current MHMRTC Board Members are: [William R. Brown](#), [Lea Ann Capel](#), [Roy Griffin](#), [Linda Harmon](#), [Elaine Klos](#), [Eva LeBlanc](#), [Carolyn Sims](#), [Jim Teague](#), and [Theodis "T" Ware](#).

Any conflicts of interest?  Yes  No

If yes, please complete the Conflict of Interest Questionnaire (CIQ) located on MHMRTC's website [www.mhmrtc.org](http://www.mhmrtc.org) under the "Conflict of Interest" section, and include it with this application.

### III. Licensures/Certifications

License type:  LPT  OTR  SLP  Other: \_\_\_\_\_

State: \_\_\_\_\_ License #: \_\_\_\_\_ Issue Date: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

**Attach a copy of your discipline license**

Do you have a valid Texas driver's license?  Yes  No If "No", explain: \_\_\_\_\_

**Attach a copy of your Texas driver's license**

## IV. Service Delivery

A. Services to be provided:

Physical Therapy       Occupational Therapy       Speech Therapy

Other: \_\_\_\_\_

B. What times of day and days of the week are services available?

Monday    Tuesday    Wednesday    Thursday    Friday    Saturday

C. How long do people currently wait to get into your services? \_\_\_\_\_

D. How many slots/visits **per day** do you have available? \_\_\_\_\_  
45-minute visit minimum

E. How many 45-minute slots **per month** do you have available? \_\_\_\_\_

F. How many 1-hour slots **per month** do you have available? \_\_\_\_\_

## V. Experience

A. Describe your business' experience in working with infants and children (ages birth to 36 months) during the last five years: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

B. How many hours **per week** do you interact with typically developing:

Birth to 1 year olds? \_\_\_\_\_

1 to 2 year olds? \_\_\_\_\_

2 to 3 year olds? \_\_\_\_\_

C. Languages Spoken:  Spanish    Vietnamese    Other: \_\_\_\_\_

Functional      or       Fluent

D. Education/Work History: **Attach a current resume or vita**

## VI. Clinical Skills

A. Please indicate which areas you have knowledge or experience providing services to children ages birth to 36 months:

Knowledge of	Years of Experience	N/A	Service
			Adaptive Equipment
			Apraxia
			Articulation / Intelligibility
			Assistive Technology
			Augmentative Communication
			Autism Spectrum Disorder
			Behaviors Like Biting / Self Injury / Running Away
			Brachial Plexus
			Cochlear Implants
			Cued Speech
			Discipline Techniques
			Feeding / Swallowing Disorders / Issues
			Fine Motor
			Fluency Concerns
			Gross Motor
			Hearing Impairments
			Play Development
			Sensory Integration Issues / Regulatory Issues
			Sign Language
			Sleep Issues / Problems
			Toilet Training
			Trauma
			Ventilator / Trach / Passy Muir
			Vision Impairments

B. Are you familiar with Routines Based Intervention? (explain) \_\_\_\_\_

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C. Are you familiar with Adult Learning Styles? (explain)

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## VII. Risk Assessment

A. Have you had any validated client abuse, client neglect, or client rights violations claims in the last three (3) years?

Yes  No

If yes, attach an explanation on a separate sheet.

B. Are you delinquent in the payment of any court ordered Child Support Payments?

Yes  No

C. Do you have current insurance showing liability coverage for:

Property	<input type="checkbox"/> Yes*	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Vehicles	<input type="checkbox"/> Yes*	<input type="checkbox"/> No	<input type="checkbox"/> N/A
General Liability	<input type="checkbox"/> Yes*	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Professional Liability	<input type="checkbox"/> Yes*	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Medical Malpractice	<input type="checkbox"/> Yes*	<input type="checkbox"/> No	<input type="checkbox"/> N/A

\*If yes, attach a copy of the face sheet from the policy.

D. Have you been cited by any licensing, accrediting or certifying body in the last 5 years?

Yes  No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

E. Have you ever been denied coverage (either initial or renewal) by any professional liability insurance carrier or has an individual policy canceled or placed an individual surcharge based on provider's individual practice?

Yes  No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## VIII. Health Status

A. A provider who routinely performs any job duty in proximity to any ECI child must provide evidence of negative TB testing.

Submit current TB test results

B. Do you currently have any medical and/or psychiatric problem, including substance abuse, that affects your ability to perform the essential functions of your profession, with or without accommodation?

Yes  No

If yes, please provide a full explanation on a separate sheet.

## IX. Required Training Elements

Provider must demonstrate a thorough understanding of the relevant elements of reporting, investigating, and preventing abuse, neglect, and exploitation before contact with persons served and annually thereafter

Provider who routinely perform any job duty in proximity to persons served must implement and maintain personnel practices that safeguard people against infectious and communicable diseases before contact with persons served and annually thereafter.

Provider must receive, read, and understand the MHMRTC Compliance Plan. Provider will agree to abide by the principles contained in the Compliance Plan, including its responsibility to report any known or suspected violations of the Plan.

Required training is listed and described in the ECI Provider Manual, which is available on MHMRTC's website, under the Contract Provider Services section: <http://www.mhmrtc.org/MC/>

If provider's Cardiopulmonary Resuscitation (CPR) certification is current, and was instructed by the standards set by the American Heart Association (MHMRTC's approved method), then provider is not required to take the class again; however, **provider must submit proof of current CPR training.**

## X. Personal Attestation

Are there any reasons you would be unable to perform the essential functions required with or without accommodation?

Yes  No

If yes, please explain fully on a separate sheet.

I hereby attest to the following (indicate with a ✓ mark):

1. I do not currently use any illegal drug.

- 2. I have reported accurately and completely any reasons for any inability to perform the essential functions of my profession with or without accommodation.
- 3. I have reported accurately any history of loss of license and/or felony convictions.
- 4. I have reported accurately any history of loss or limitation of privileges or disciplinary activity.
- 5. I have reported accurately my chronological work history.
- 6. I consent to the inspection of records and documents pertinent to this application, including the release by any person to MHMRTC of all information that may reasonably be relevant to an evaluation and verification of this application or evaluation of professional competence, including, but not limited to, consultation with any other health professionals or institutions with which I have been or am currently associated.
- 7. The information submitted in and with this application is complete and correct to the best of my knowledge.

## **XI. Assurances Statement**

Provider assures the following (indicate with a ✓ mark):

- 1. That all addenda and attachments to this application as distributed by ECI have been received.
- 2. That provider has read the ECI Provider Manual (on MHMRTC's website: <http://www.mhmrtc.org/MC/>) and understands its requirements, terms, and conditions.
- 3. No attempt will be made by provider to induce any person or firm to submit or not to submit an application, unless so described in the application document.
- 4. Provider does not discriminate in its services or employment practices on the basis or race, color, religion, sex, national origin, disability, veteran status, or age.
- 5. That no employee of ECI or MHMRTC, and no member of ECI's Board of Trustees will directly or indirectly receive any pecuniary interest from an award of the proposed contract. If the provider is unable to make the affirmation, then the provider must disclose any knowledge of such interests.
- 6. Provider accepts the terms, conditions, criteria, and requirements set forth in this application.

- 7. Provider accepts ECI's right to cancel this application at any time prior to contract award.
- 8. Provider accepts ECI's right to alter the timetables for procurement.
- 9. This application submitted by provider has been arrived at independently without consultation, communication, or agreement for the purpose of restricting competition.
- 10. Unless otherwise required by law, the information in this application submitted by provider has not been knowingly disclosed by provider to any other provider prior to the notice of intent to award.
- 11. No claim will be made for payment to cover costs incurred in the preparation of the submission of this application or any other associated costs.
- 12. ECI has the right to complete background checks and verify information.
- 13. The individual signing this document and the contract is authorized to legally bind provider.
- 14. The address submitted by provider is current and correct; this address will be used by ECI for all notices.

## **XII. DARS/ECI TKids**

Complete the Contractor Information form on the following page with data that is required by DARS/ECI.

## CONTRACTOR INFORMATION AND UPDATE FORM FOR TKIDS

Name:		
(Last)	(First)	(Middle Initial)

Race/Ethnicity: <i>(Circle Appropriate):</i>				
American Indian/Alaska Native	Asian/Pacific Islander	Black/African American	Hispanic/Latino	White

SS#: <i>(last 4 digits only)</i>	Start Date:	College Graduated From / Location
_____		Degree(s): + year(s) graduated

**TKIDS CREDENTIALS**

*Please re-submit this section if your credentials change during your contract with ECI.*

<input type="checkbox"/> BCBA
<input type="checkbox"/> OT - Occupational Therapist
<input type="checkbox"/> OTA - Occupational Therapy Assistant
<input type="checkbox"/> PT - Physical Therapist
<input type="checkbox"/> PTA - Physical Therapy Assistant
<input type="checkbox"/> RN <input type="radio"/> Associates <input type="radio"/> Bachelors <input type="radio"/> Masters
<input type="checkbox"/> SLP - Speech Language Pathologist
<input type="checkbox"/> SLP - CFY
<input type="checkbox"/> SLPA - Assistant in Speech Pathology
<input type="checkbox"/> Other:

<b>State License # / Effective Date / Expiration Date:</b>
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**For SPLA, PTA, COTA  
Supervisor's Name & Credentials:**

PHONE #:	Have you worked at another ECI Program? <input type="checkbox"/> Yes <input type="checkbox"/> No    If Yes - What Program?
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**HULEN STAFF COMPLETE THE FOLLOWING FOR CONTRACT STAFF**

Credentialing Application	Returned	To Credentialing	Approved	Contract Coversheet	Contract Log
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**HULEN STAFF COMPLETE THE FOLLOWING AND ROUTE TO NEXT PERSON**

Enter into TKIDS [Deborah]	Entered in CMHC [Deborah]	Contractor ID # [Kelly]				
Staff Licensure Code Entered:	07 - LCSW 21 - LPT 51 - Other	08 - LBSW 23 - SLP 52 - EIS-EL	13 - LPC 29 - RN 53 - EIS-FQ	16 - LMSW 34 - LPC-I 60 - LPTA	17 - RD/LD 39 - Psych Assoc 63 - COTA	19 - OTR/LOT 44 - Para Professional 65 - SLPA

REVISED 11/3/11 KAC

### XIII. Signature

I hereby certify that the information provided by me on this application is true and correct.

By Individual: \_\_\_\_\_  
*Print Name*

By Individual: \_\_\_\_\_ Date: \_\_\_\_\_  
*Signature*

### XIV. Submission Attachments

Ensure copies of the following are enclosed, indicating with a check mark for "Not Applicable" or "Attached":

N/A or Attached

- Conflict of Interest Questionnaire (Section II)
- Texas Discipline License (Section III)
- Texas Driver's License (Section III)
- Vita or Resume (Section V)
- Explanation of validated client abuse, client neglect, or client rights violations (Section VII)
- Property Insurance Face Sheet (Section VII)
- Vehicle Insurance Face Sheet (Section VII)
- General Liability Insurance Face Sheet (Section VII)
- Professional Liability Insurance Face Sheet (Section VII)
- Medical Malpractice Insurance Face Sheet (Section VII)
- TB Test Results (Section VIII)
- Explanation of Health Issues (Section VIII)
- CPR Card (Section IX)
- Explanation of reasons unable to perform essential functions (Section X)

***This Provider Application is not complete until all required documents have been submitted.***

## **XV. Submission Instructions**

Submit this application by U.S. mail, hand delivery, carrier, fax, or electronically to:

**Debbie Lisheron, Chief of ECI  
ECI of North Central Texas  
3880 Hulen Street, Suite 400  
Fort Worth, TX 76107  
817-569-5301**

False statements on this proposal by prospective providers may disqualify enrollment.

ECI reserves the right to reject any and all applications, to waive technicalities, and to accept any advantages deemed beneficial to the ECI program and its clients.

## **XVI. Next Steps**

### **Credentialing:**

Prior to providing services, new providers must complete a Credentialing Application, which is available on MHMRTC's website [www.mhmrtc.org](http://www.mhmrtc.org), under the "Contracted Provider Services" section, where instructions and contact information is also available, as well as in the ECI Provider Manual.

Returning providers must be re-credentialed every three years by MHMRTC's Credentialing Department. It is the individual's responsibility to forward their renewed license to the Credentialing Department in a timely manner to avoid disruption of services. Services cannot be provided without a valid license.

### **Billing:**

For providers who do not already have a Texas Provider Identifier (TPI) number or a National Provider Identifier (NPI) number, a Medicaid Provider Enrollment Application must be completed to obtain both TPI number and a NPI number.

Instructions and contact information is available in the ECI Provider Manual located at [www.mhmrtc.org](http://www.mhmrtc.org) under the "Contracted Provider Services" section.