

PROPOSAL

I. Demographics

Provider Name: _____
Last First Middle Initial

Date of Birth: _____ SS#: _____ or Business Tax ID#: _____

Name of Business or Employed by: _____

Business Address: _____
Street Address City State Zip Code

County: _____ Business Phone: _____ Fax: _____

Email Address: _____

Payment Address: _____
Street Address City State Zip Code

Historically Underutilized Business: Yes No
If yes, how many years in operation as HUB?: _____

Eligible to be certified as HUB? Yes No

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: [Carolyn Sims](#), [Theodis "T" Ware](#), [William R. Brown](#), [Linda Harmon](#), [Elaine Klos](#), [Lea Ann Capel](#), [Eva LeBlanc](#), [Roy Griffin](#) and [Jim Teague](#).

Any conflicts of interest? Yes No
If yes, please complete the Conflict of Interest Questionnaire (CIQ) located on MHMRTC's website www.mhmrtc.org under the "Conflict of Interest" section, and include it with this Proposal.

III. Licensures/Certifications

Identify license types:

LPT OTR SLP-CFY / SLP-CCC RD/LD
 RN LPC-I / LPC LCSW Other: _____

State: _____ License #: _____ Issue Date: _____ Exp. Date: _____

State: _____ License #: _____ Issue Date: _____ Exp. Date: _____

State: _____ License #: _____ Issue Date: _____ Exp. Date: _____

State: _____ License #: _____ Issue Date: _____ Exp. Date: _____

IV. Service Delivery

A. Services to be provided:

- Physical Therapy Occupational Therapy Speech Therapy
- Nutrition Nursing Infant Mental Health

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? _____

V. Experience

A. Describe your experience in working with infants and children (ages 0 to 36 months) during the last five years (or attach resume or vita with this information): _____

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) _____

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

VII. Financial

Is the provider/business incorporated?

Yes No

If yes: For Profit Not-for-Profit Other

If other, explain: _____

VIII. Risk Assessment

A. Has provider 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. Is provider delinquent in State franchise tax?

Yes No

Organizations must 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.

C. Is provider delinquent in the payment of any court ordered Child Support Payments?

Yes No

D. Does each of provider's location(s) have general liability insurance coverage?

Yes No

E. Does provider have current insurance showing liability coverage for:

Property Yes* No
Vehicles Yes* No
General Liability Yes* No
Professional Liability Yes* No
Medical Malpractice Yes* No

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

F. Has the provider been cited by any licensing, accrediting or certifying body in the last 5 years?

Yes No

If yes, please explain: _____

G. Has provider 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: _____

IX. Health Status

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 page

X. Rate Schedules

A. Standard Rates

Service	Rate	
Physical Therapy Evaluation or Arena	\$72.50	per Evaluation Visit
Physical Therapy Services or IFSP	\$65.00	per 45 Minute Therapy Visit
Occupational Therapy Evaluation or Arena	\$72.50	per Evaluation Visit
Occupational Therapy Services or IFSP	\$60.00	per 45 Minute Therapy Visit
Speech Therapy Evaluation or Arena	\$72.50	per Evaluation Visit
Speech Therapy Services or IFSP	\$55.00	per 45 Minute Therapy Visit
Nutrition Evaluation or Arena	\$72.50	per Evaluation Visit
Nutrition Services or IFSP	\$65.00	per Service Visit
Infant Mental Health Evaluation or Arena	\$65.00	per Evaluation Visit
Infant Mental Health Services or IFSP	\$55.00	per Service Visit
Nurse as Second Discipline at Arena	\$65.00	per Arena
Nurse as Second Discipline at IFSP	\$55.00	per IFSP
Nursing / ECI Screening Packet	\$45.00	per Service Visit

B. Flat Rates

Service	Rate	
Arena & IFSP completed at the same meeting for all disciplines	\$100.00	per 1 hour
Arena & IFSP completed at the same meeting for all disciplines	\$125.00	per 1½ hour
Arena & IFSP completed at the same meeting for all disciplines	\$150.00	per 2 hour
Consultation *	\$25.00	per hour
No Show when provider drives to a home and no one is there	\$10.00	per “No Show”

**Consultation consists of phone calls and other required contact with families, ECI staff, doctors, and other professionals; this DOES NOT include scheduling or other coordination activities.*

Please note that visits include travel and paperwork; ECI does not pay for that time separately.

ECI does not pay for cancellations.

XI. Required Training Elements

Provider, its employees and agents 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, its employees and agents 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, its employees and agents 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.

Training classes and costs (that will be paid by ECI) are listed below:

Class	Cost to ECI	Time Required to Complete	How Often
AIDS / HIV Disease / Infection Control	\$40.00	Self-paced	Annual Refresher (self-paced)
Client Rights / Abuse-Neglect	\$40.00	4 hours	Annual Refresher (self-paced)

Class	Cost to ECI	Time Required to Complete	How Often
Compliance	\$20.00	1 hour	Annual Refresher (self-paced)
Confidentiality / Privacy / HIPPA	\$20.00	1 hour	Annual Refresher (self-paced)
CPR* / First Aid / Seizures	\$50.00	6 hours	Every 2 years

*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, the provider must submit proof of current CPR training.

ECI does not pay providers to attend required training. Classes will be taken on provider's own time and is a requirement to contract with ECI. Unlike other divisions at MHMRTC, ECI will not charge for required classes.

Provider will be billed for classes for which they registered, but did not attend, unless the Training Center receives a cancellation notice at least twenty-four (24) hours prior to the scheduled class.

Provider, its employees and agents will receive the following training on site from ECI program staff:

- SAL Training
- ECI Philosophy
- Documentation of Evaluations and Progress Notes
- Childhood Illnesses (read and sign annually)

XII. 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 proposal, including the release by any person to MHMRTC of all information that may reasonably be relevant to an evaluation and verification of this proposal 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 proposal is complete and correct to the best of my knowledge.

XIII. Assurances Statement

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

- 1. That all addenda and attachments to this Proposal as distributed by ECI have been received.
- 2. No attempt will be made by provider to induce any person or firm to submit or not to submit a proposal, unless so described in the proposal document.
- 3. 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.
- 4. 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.
- 5. Provider accepts the terms, conditions, criteria, and requirements set forth in this Proposal.
- 6. Provider accepts ECI's right to cancel this Proposal at any time prior to contract award.
- 7. Provider accepts ECI's right to alter the timetables for procurement.
- 8. This Proposal submitted by provider has been arrived at independently without consultation, communication, or agreement for the purpose of restricting competition.
- 9. Unless otherwise required by law, the information in the proposal submitted by provider has not been knowingly disclosed by provider to any other provider prior to the notice of intent to award.
- 10. No claim will be made for payment to cover costs incurred in the preparation of the submission of the proposal or any other associated costs.
- 11. ECI has the right to complete background checks and verify information.
- 12. The individual signing this document and the contract is authorized to legally bind provider.
- 13. The address submitted by provider is current and correct; this address will be used by ECI for all notices.

Print provider's name: _____

Provider's signature: _____ Date: _____