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| DMH Logo | **STATE OF MISSOURI - DEPARTMENT OF MENTAL HEALTH – DIVISION OF DEVELOPMENTAL DISABILITIES**  **CONTRACT PROVIDER APPLICATION A** |

***Read All Materials Carefully Before Beginning***

# General Information

All individuals or organizations seeking to establish a contract with the Department of Mental Health (DMH), Division of Developmental Disabilities (Division of DD), must complete the DMH Contract Provider Application (hereafter referred to as the “provider application”). Completion of the provider application does not guarantee approval for a contract or that referrals for services will be received if a contract is established. Before beginning the provider application, refer to Division of Developmental Disabilities Directive Number 5.060, “Enrollment of New Providers” for additional information and requirements pertaining to the provider enrollment process. You may access this document at: <https://dmh.mo.gov/media/pdf/directive-5-060>

**If you are applying solely for one or more of the following services, do not use this application: complete Contract Provider Application B.**

**Employment Services (if you are currently contracted with Vocational Rehabilitation), Benefits Planning, Alternative Language Translation, Behavior Analysis Services, Interpreting, Dental, Music Therapy, Occupational Therapy, Physical Therapy, Speech Therapy, Registered Nurse, Licensed Practical Nurse, Dietician, Assistive Technology (not to include Remote Supports), Environmental Accessibility Adaptation (home modification), Personal Electronic Safety Device, and Specialized Medical Equipment and Supplies (if currently contracted with Missouri State Plan for SME).**

Parties considering submitting a provider application shall email the Division of DD Provider Enrollment Unit ([ProviderEnrollment@dmh.mo.gov](mailto:ProviderEnrollment@dmh.mo.gov)) to receive instructions. Email your intent to apply for a contract and the following information: contact’s name, email address, legal agency name (including any doing business as names), the names of owners with 5% or more interest, mailing address, phone number, service area (city/county), and the title of the service(s) you are interested in providing. A list of service titles may be found in the [DD Waiver Manual](https://dmh.mo.gov/dev-disabilities/programs/waiver/manuals).

Completion of the provider application is solely the responsibility of the applicant. Division of DD staff may provide information about the provider enrollment process and service needs but may not provide legal, technical, financial or other business information. Applicants are expected to obtain information about such topics independent of Division of DD staff and should submit their application only after thoroughly researching all business issues.

All information specified in the provider application must be included upon submission. Submission of an incomplete provider application will result in termination of the applicant’s request to establish a contract with the Division of DD.

For the purpose of the provider application, a single party proposing to provide services under their personal name is considered an individual applicant. All other applicants are considered organizations.

Upon preliminary approval, applicants will be directed to complete a Federal Bureau of Investigation (FBI) fingerprint background check. This applies to all individual applicants and members of organization applicants as specified in the provider application. The FBI background check includes a complete check of Missouri records, sex offender registry information and federal criminal history record information from all submitting law enforcement entities throughout the United States. Background reports received from the FBI are received and reviewed electronically and are not retained by DMH. Copies and details of the reports will only be disseminated directly to the subject of the report and only when necessary to challenge the findings. Refer to Appendix II for information regarding the purpose of the FBI background check, procedures to challenge the findings and notification of privacy rights.

Provider applications and related materials submitted to and accepted by the Division of DD become the property of the Division of DD and will not be returned to the applicant. The Division of DD is not responsible for making copies of provider applications. Applicants should retain a copy of all materials submitted for their records.

**Note: The Division has received a series of applications from providers who contracted with an outside entity to complete the application. While this practice is not prohibited, it does slow down the application process. The information submitted does not reflect unique agency philosophy, practices and experience.**

# Special Procedures for Employees of the State of Missouri

Applicants must disclose if they are employees of the State of Missouri. Employees of the State of Missouri must demonstrate their application, and possible resulting contract does not pose a perceived or actual conflict of interest. Section VIII of the provider application applies only to employees of the State of Missouri and contains additional requirements for Missouri State employees to assure a conflict of interest does not exist.

# Instructions for Completion of the Application Document

Reminder, before beginning the application process, review Directive Number 5.060, “Enrollment of New Providers”, located at: <https://dmh.mo.gov/media/pdf/directive-5-060>. After review of this Directive, carefully follow the instructions contained within the application document.

Application Evaluation

The completed application packet is reviewed to ensure standard requirements are met. If required components are missing, the application will ~~may~~ be denied with no further action. If required components are included, designated Regional Office staff will us a standardized scoring system ~~then~~ to rate the application. The evaluation is based on Division philosophy, applicant business practices and experience, service definition, contract requirements, an applicant’s experience supporting individuals with developmental disabilities, and industry best practice. Total points available and minimum points required to be approved for pursuit of a contract, if all other requirements are met, are represented at the end of each service type. See Appendix I for a break-down of the points available for each question.

# Attachments

The following is a list of documents you may need to submit with the application. Gathering these documents prior to filling out the application will assist you in submitting a complete application. Approval to pursue enrollment will only be granted when the following conditions are met: all attachments are submitted, all questions are answered, the proposed service aligns with a Division service and complies with HCBS rules, the staff are licensed or credentialed as required by the service definition (for example, Individualized Skill Development or employment supports), all required signatures are provided, and the application receives a score that meets or exceeds the minimum.

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|  | Verification of tax identification number in the form of a document generated by the IRS or for individuals utilizing their SSN, a copy of their social security card and driver’s license. |
|  | If incorporated, a list of the organizations Board of Directors indicating any who hold a position with the State of Missouri. |
|  | If incorporated, a resolution from the Board of Directors identifying (by name) the party appointed to enter into a contractual relationship with the Division of DD. |
|  | If partnership or LLC, attach the partnership and/or operational agreement. |
|  | Organization chart detailing percentages of ownership with SSNs, DOBs and/or EINs. (include any individual or entity with partnership interest of 5% or more direct or indirect ownership) |
|  | If you have an NPI at time of application: Verification of the NPI in the form of a document generated by the National Plan and Provider Enumeration System. If you do not have this at time of application, it will be required prior to contract implementation. |
|  | Verification of registration with Secretary of State including “Certificate of Good Standing” (unless doing business in an individuals’ legal name and is optional for not for profit and government entities) |
|  | Verification of Business License, or proof that a Business License is not required by city/county authorities. |
|  | If your organization has workers compensation and liability insurance, attach verification of policies. If you do not have these at time of application, they will be required prior to contract implementation. (not applicable to applicants applying as an individual) |
|  | If you/your organization is licensed, credentialed, accredited or certified, including licensed to provide Missouri state plan services, attach verification. |
|  | Results of the Family Care Safety Registry (FCSR) for all owners with more than 5% interest, executive directors, managing employees and program directors – dated within 60 days of submission of the application. Results = a letter from the FCSR showing either “No finding reported in the background screening.” Or if the letter shows a result, the applicant must request the details of the result and attach those results to the application. |
|  | Three letters of reference from an accrediting body, state or local funding sources, or professional references dated within the past 12 months |
|  | Business plan, balance sheet, profits and loss statement, and a cash flow statement. |
|  | Verification of financial resources to cover operating expenses for 180 days (revolving credit is not acceptable). |
|  | Proof of highest education completed for executive director/owner, program directors, degreed professional manager and other key staff indicated in the application. |
|  | Resume for executive director/owner(s), program director(s), degreed professional manager(s) and other key staff indicated in the application. |
|  | Professional license, including expiration date, for any staff proposed to work under a service requiring a professional license. |

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|  | **STATE OF MISSOURI - DEPARTMENT OF MENTAL HEALTH – DIVISION OF DEVELOPMENTAL DISABILITIES**  **CONTRACT PROVIDER APPLICATION A** | | | |
| **If you are applying solely for one or more of the following services, do not use this application: complete Contract Provider Application B.**  Employment Services (and currently contracted with Vocational Rehabilitation), Alternative Language Translation, Behavior Analysis Services, Counseling, Interpreting, Dental, Music Therapy, Occupational Therapy, Physical Therapy, Speech Therapy, Registered Nurse, Licensed Practical Nurse, Dietician, Assistive Technology, Environmental Accessibility Adaptation (home modification), Personal Electronic Safety Device or Specialized Medical Equipment and Supplies. | | | | |
| **SECTION I - APPLICATION** | | | | |
| **NAME, ADDRESS AND CONTACTS** | | | | |
| LEGAL NAME OF PROVIDER ENTITY OR INDIVIDUAL | | APPLICATION IS BEING FILED BY  An Organization  Individual (applicant/independent contractor has/will have no employees) | | |
| ORGANIZATION OR INDIVIDUAL MAILING ADDRESS AND INFORMATION IN MISSOURI (applicant must have an office in Missouri or a contingent state)  NA | | | | |
| Street | | City | State | ZIP code |
| Phone | | Fax | Website | |
| Primary contact | | Title/role | Phone | Email |
| ORGANIZATION, ORGANIZATION’S CORPORATE OFFICE OR INDIVIDUAL MAILING ADDRESS IF LOCATED OUTSIDE OF MISSOURI  NA | | | | |
| Street | | City | State | Zip code |
| Phone | | Fax | Website | |
| Contact person | | Title/role | Phone | Email |
| CONTACT PERSON FOR APPLICATION PROCESS IF OTHER THAN LISTED ABOVE  NA | | | | |
| Contact person | | Title/role | Phone | Email |

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| **BUSINESS STRUCTURE** | | | | | | | | | | | |
| ORGANIZATION’S FEDERAL TAX IDENTIFICATION NUMBER (FEIN)  OR INDIVIDUALS’ SOCIAL SECURITY NUMBER (SSN) | | | | | | | *Attach a document generated by the IRS verifying the FEIN; label as attachment A. Individuals using their SSN provide a copy of their social security card and driver’s license.* | | | | |
| INDICATE THE PROFIT STATUS OF YOUR ORGANIZATION  FOR PROFIT  NOT FOR PROFIT | | | | | | | | | | | |
| TYPE OF BUSINESS STRUCTURE  INDIVIDUAL / INDEPENDENT CONTRACTOR (no employees)  PUBLIC ENTITY (example: public schools or colleges)  PARTNERSHIP OR MULTI-MEMBER LLC  CORPORATION OR LLC ELECTING CORPORATE STATUS  SOLE PROPRIETOR OR SINGLE-OWNER LLC  OTHER | | | | | | | *ALL BUSINESS STRUCTURES*   1. *Organization chart detailing percentages of ownership with SSNs, DOBs and/or EINs. (include any individual or entity with partnership interest of 5% or more direct or indirect ownership)*   *IF INCORPORATED, ATTACH THE FOLLOWING:*   1. *A list of your organization’s board of directors, indicating if any are employed by the State of Missouri and the name of the state agency employed by and label as attachment B.* 2. *A resolution from the board of directors identifying the party duly appointed with the authority (specific name) to enter into a contractual relationship with the Division of DD and label as attachment C.* 3. *IF A PARTNERSHIP OR LLC ATTACH An operating agreement and/or partnership agreement if applicable labelled as attachment D.* | | | | |
| APPLICANTS NATIONAL PROVIDER IDENTIFIER (NPI)  APPLICANT DOES NOT HAVE AN NPI ASSIGNED. | | | | | | | *Attach verification of the NPI in the form of a document generated by the National Plan and Provider Enumeration System (NPPES), label as attachment E.* | | | | |
| BUSINESSES CONTRACTING WITH THE DIVISION OF DD MUST PRESENT A CERTIFICATE OF GOOD STANDING FROM THE MISSOURI SECRETARY OF STATE’S OFFICE. IS YOUR BUSINESS AND THE NAME DOING BUSINESS AS PRESENTLY REGISTERED?  YES  NO  NA - If NA explain | | | | | | SOS APPLIES TO OUT OF STATE PROVIDERS AS WELL AS IN STATE.  ***SOS may not apply to individuals conducting business in their legal name, not for profit or government agencies.***  *If yes, attach verification of secretary of state Certificate of Good Standing labeled as attachment F.* | | | | | | |
| BUSINESSES CONTRACTING WITH THE DIVISION OF DD MUST HAVE A BUSINESS LICENSE IF REQUIRED BY THEIR CITY/COUNTY. DOES YOUR BUSINESS CURRENTLY HAVE A BUSINESS LICENSE?  YES  NO  NA - If NA explain | | | | | | *If yes, attach business license. If your city/county does not require a business license, attach evidence and label as attachment G.* | | | | | | |
| APPLICANTS CONTRACTING WITH THE DIVISION OF DD MUST BE CURRENT IN FILING/PAYING MISSOURI AND FEDERAL TAXES. ARE YOU/YOUR BUSINESS CURRENT WITH FILING/PAYING TAXES?  YES  NO | | | | | | | | | | | | |
| ORGANIZATIONS CONTRACTING WITH THE DIVISION OF DD MUST PROVIDE EVIDENCE OF WORKMAN’S COMPENSATION AND LIABILITY INSURANCE PRIOR TO PROVIDING SERVICES. DOES YOUR ORGANIZATION HAVE A CURRENT POLICY FOR WORKMAN’S COMPENSATION AND LIABILITY INSURANCE?  YES  NO  NA as do not and will not have employees. | | | | | | *If yes, attach verification of current Workman’s Compensation and Liability insurance policy and label as attachment H.*  *Note: In the state of Missouri, you are required to carry workers' compensation insurance if you have five or more employees, unless you are in the construction industry, then you must carry workers' compensation insurance if you have one or more employees. If your business is located outside of Missouri, you must follow worker compensation requirements for your state.* | | | | | | |
| ARE YOU/YOUR ORGANIZATION LICENSED, CREDENTIALED, ACCREDITED OR CERTIFIED, INCLUDING LICENSED TO PROVIDE MISSOURI STATE PLAN SERVICES?  YES  NO | | | | | | If yes, provide the name of the accrediting body, License or Certification Number, State in which issued, expiration date, service accredited.    *Attach a copy of most recent state plan contract, accreditation/licensure or certification report and label as Attachment I.* | | | | | | |
| HAS THE ENROLLING ENTITY ABOVE, ITS OWNERS OR ADMINISTRATORS, UNDER ANY CURRENT OR FORMER NAME OR BUSINESS IDENTITY, EVER HAD A FINAL ADVERSE LEGAL ACTION IMPOSED AGAINST IT?  YES  NO  If YES, report each final adverse legal action, when it occurred, the Federal of State Agency or the court/administrative body that imposed the action and the resolution if any. | | | | | | | | | | | | |
| **KEY STAFF AND BACKGROUND SCREENING** | | | | | | | | | | | | |
| LIST THE NAMES AND POSITIONS OF KEY PEOPLE THAT WILL BE INVOLVED WITH OR RESPONSIBLE FOR DELIVERY OF SERVICES UNDER A CONTRACT WITH DIVISION OF DD. FOR CORPORATIONS WITH OFFICES OUTSIDE OF MISSOURI, INDICATE CORPORATE CONTACT PERSON UNDER OTHER. | | | | | | | | | | | | |
| Owner(s) with 5% of more interest\* | | | | | |  | | | | | | |
| Executive director(s)\* | | | | | |  | | | | | | |
| Managing employee(s)\* | | | | | |  | | | | | | |
| Program director(s)\* | | | | | |  | | | | | | |
| Degreed Professional Manager(s) | | | | | |  | | | | | | |
| Registered Nurse  Other | | | | | |  | | | | | | |
| \*UPON PRELIMINARY APPROVAL OF THE APPLICATION, THE DIVISION WILL DIRECT THE APPLICANT TO PROCEED WITH INITIATION OF THE FBI BACKGROUND CHECK. AN FBI BACKGROUND CHECK (FINGERPRINT) IS REQUIRED FOR INDIVIDUAL APPLICANTS AND ALL OWNERS WITH MORE THAN 5% INTEREST, EXECUTIVE DIRECTORS, MANAGING EMPLOYEES AND PROGRAM DIRECTORS OF ORGANIZATION APPLICANTS. EACH PERSON FOR WHOM AN FBI CHECK WILL BE REQUIRED MUST SIGN SECTION IX AS INDICATED.  **IN THE EVENT THE REQUIRED FBI BACKGROUND CHECK RESULTS ARE NOT RECEIVED WITHIN 45 DAYS OF THE DATE ON THE REQUEST LETTER, THE APPLICATION WILL BE REJECTED.**  DO YOU AGREE TO INITIATE FBI BACKGROUND SCREENINGS UPON REQUEST?  YES  NO | | | | | | | | | | | | |
| \*INDIVIDUAL APPLICANTS AND ORGANIZATION OWNERS WITH MORE THAN 5% INTEREST, EXECUTIVE DIRECTORS, MANAGING EMPLOYEES AND PROGRAM DIRECTORS ARE REQUIRED TO REGISTER WITH THE FAMILY CARE SAFETY REGISTRY AND SUBMIT CURRENT REGISTRY RESULTS. CURRENT IS DEFINED AS DATED NO MORE THAN SIXTY DAYS PRIOR TO THE DATE THE APPLICATION WAS RECEIVED BY REGIONAL/SATTELITE OFFICE.  *Attach results of Family Care Safety Registry and label as attachment J.* | | | | | | | | | | | | |
| HAS ANY PERSON NAMED ON THIS APPLICATION OR ANYONE PART OF THE AGENCY BEEN FOUND GUILTY OF OR PLEAD GUILTY TO OR NOLO CONTENDERE TO A FELONY?  YES  NO | | | | | | *If yes, provide detailed information about the conviction including but not limited to: date, state, county, court, nature and type of offense or violation and penalty imposed.* | | | | | | |
| HAVE YOU OR ANYONE IN YOUR ORGANIZATION WHO WILL POTENTIALLY HAVE CONTACT WITH CONSUMERS HAD A CHARGE OF ABUSE OR NEGLECT SUBSTANTIATED IN ANY STATE?  YES  NO | | | | | | *If yes, provide detailed information about the charge including but not limited to: date, state, county, nature and type of abuse / neglect.* | | | | | | |
| ATTACH THREE LETTERS OF REFERENCE FROM AN ACCREDITING BODY, STATE OR LOCAL FUNDING SOURCE OR PROFESSIONAL REFERENCES. DO NOT SUBMIT PERSONAL REFERENCES. | | | | | | *List the names of the entities supplying references.*  *Professional references indicate the professional association with you/your organization. Letters should be dated within the past 12 months. Attach copies of reference letters and label as Attachment K.* | | | | | | |
| HAS ANYONE ASSISTED YOU (PAID OR UNPAID) WITH COMPLETING ANY PORTION OF THIS APPLICATION?  YES  NO | | | | | | *If yes, provide contact information for the person(s) who completed this application.* | | | | | | |
| **BUSINESS PLAN, EXPERIENCE AND EXPERTISE Possible points available in this section: 5** | | | | | | | | | | | | |
| 1. | HOW LONG HAVE YOU/YOUR ORGANIZATION BEEN PROVIDING SERVICES?  NA as new organization | | | | | | | | | | | |
| 2 | WHAT TYPES OF SERVICES AND SUPPORTS ARE PRESENTLY PROVIDED BY YOU/YOUR ORGANIZATION?  NA as new organization | | | | | | | | | | | |
| 3. | DESCRIBE IN DETAIL YOU/YOUR ORGANIZATION EXPERIENCE OPERATING A BUSINESS | | | | | | | | | | | |
| 4. | WHAT DO YOU EXPECT YOUR INITIAL CAPACITY TO BE (NUMBER OF INDIVIDUALS SERVED) FOR EACH SERVICE YOU PROPOSE TO PROVIDE? | | | | | | | | | | | |
| 5. | **FOR EXISTING BUSINESSES** - ATTACH A COPY OF THE ORGANIZATION’S BUSINESS PLAN INCLUDING A BALANCE SHEET, INCOME STATEMENT, AND CASH FLOW STATEMENT. ***LABEL AS ATTACHMENT L***  **FOR NEW BUSINESSES** - ATTACH A COPY OF THE ORGANIZATION’S BUSINESS PLAN INCLUDING A PROJECTED BALANCE SHEET, INCOME STATEMENT, AND CASH FLOW STATEMENT. ***LABEL AS ATTACHMENT L.*** | | | | | | | | | | | |
| 6. | IF A CONTRACT IS ESTABLISHED WITH YOU/YOUR ORGANIZATION, PAYMENT FOR SERVICES MAY NOT BE RECEIVED FOR UP TO 180 DAYS FROM THE DATE OF SERVICE INITIATION OR MAY PERIODICALLY BE DELAYED AS CONTRACTORS ARE PAID IN ARREARS. THE COSTS YOU WILL INCUR WILL VARY DEPENDING ON THE SERVICE(S) PROPOSED AMY MAY INCLUDE STAFFING, PURCHASING/LEASING PROPERTY, UTILITY COSTS, FURNISHINGS, FOOD/SUPPLIES, TRANSPORTATION, ETC. | | | | | *Estimate your cost for the operation of your business for period of 180 days and explain how you will address cash flow during this time period. For example, the minimum amount required to support one individual receiving ISL services for 180 days is $191,000.00.*  *Attach verification of financial resources to cover operating expenses for 180 days and label as Attachment M. Verification must be in the form of a current (within 30 days of submission of application) letter from an accredited bank or other financial institution documenting a line of credit, business loan or availability of funds. Revolving credit or a loan from a private source is not recognized.* | | | | | | |
| 7. | LIST ALL CITIES AND STATES WHERE YOU/YOUR ORGANIZATION PREVIOUSLY OR CURRENTLY CONDUCT BUSINESS. INCLUDE ANY  NAME YOUR ORGANIZATION IS “DOING BUSINESS AS”.  NA | | | | | | | | | | | |
| Name of Organization | | | Address | | | | | | Phone | Dates of Service | |
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| 8. | IF YOU/YOUR ORGANIZATION CURRENTLY HAS OR HAS EVER HAD A CONTRACT FOR SERVICES OR BEEN EMPLOYED WITH ANY STATE AGENCY IN THE UNITED STATES, ENTER THE INFORMATION BELOW.  *Ie.Contracts/employment with DMH,DHSS, Children’s Services, etc*.  NA | | | | | | | | | | | |
| Agency Name | Position Held | Dates of contract or employment | | Name of contact/ supervisor | | | Contact/ supervisor’s phone | Reason for contract / employment terminations | | | |
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| 9. | IF ADMINISTRATION OF THE ORGANIZATION HAS EVER CONTRACTED WITH OR BEEN EMPLOYED BY ANY DIVISION OF DEVELOPMENTAL DISABILITIES CONTRACTED PROVIDER, ENTER THE INFORMATION BELOW.  NA | | | | | | | | | | | |
| Agency Name | Position Held | Dates of contract or employment | | Name of contact/ supervisor | | | Contact/ supervisor’s phone | Reason for contract / employment terminations | | | |
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| 10. | DOES THE OWNER, ADMINISTRATOR AND MANAGING STAFF RESIDE WITHIN 1 HOUR OF THE AREA THEY ARE PROPOSING TO SERVE?  YES  NO | | | | | *If you answered “No”, describe in detail your plan to ensure the health and safety of the individuals served and oversight/supervision of staff providing the service.* | | | | | | |
| **STAFF EXPERIENCE AND EXPERTISE Possible points available in this section: 4** | | | | | | | | | | | | |
| 11. | LIST THE NAME(S) OF EACH **EXECUTIVE DIRECTOR/OWNER**. *(INDIVIDUAL APPLICANTS SKIP 13-16)* | | | | |  | | | | | | |
| DESCRIBE (IN DETAIL) THE EDUCATIONAL BACKGROUND(S) OF EACH **EXECUTIVE DIRECTOR/OWNER**. | | | | | *Attach documentation of educational background and label as Attachment N.* | | | | | | |
| DESCRIBE (IN DETAIL) THE NUMBER OF YEARS AND TYPE OF EXPERIENCE(S) EACH **EXECUTIVE DIRECTOR/OWNER** HAS RELATIVE TO THE FIELD OF DEVELOPMENTAL DISABILITIES AND THE SERVICES PROPOSED. | | | | | *Attach resume to document experience and label as N.* | | | | | | |
| 12. | LIST THE NAME(S) OF EACH **PROGRAM DIRECTOR AND/OR MANAGING EMPLOYEE**.  NA | | | | |  | | | | | | |
| DESCRIBE (IN DETAIL) THE EDUCATIONAL BACKGROUND(S) OF THE **PROGRAM DIRECTOR AND/OR MANAGING EMPLOYEE**. | | | | | *Attach documentation of educational background and label as Attachment O.* | | | | | | |
| DESCRIBE (IN DETAIL) THE NUMBER OF YEARS AND TYPE OF EXPERIENCE(S) THE **PROGRAM DIRECTOR AND/OR MANAGING EMPLOYEE** HAS RELATIVE TO THE FIELD OF DEVELOPMENTAL DISABILITIES AND THE SERVICES PROPOSED. | | | | | *Attach resume to document experience and label as O.* | | | | | | |
| 13. | LIST THE NAME(S) OF EACH **DEGREED PROFESSIONAL MANAGER.**   NA | | | | |  | | | | | | |
| DESCRIBE (IN DETAIL) THE EDUCATIONAL BACKGROUND(S) OF THE **DEGREED PROFESSIONAL MANAGER.** | | | | | *Attach documentation of educational background and label as Attachment P.* | | | | | | |
| DESCRIBE (IN DETAIL) THE NUMBER OF YEARS AND TYPE OF EXPERIENCE(S) THE **DEGREED PROFESSIONAL MANAGER** HAS RELATIVE TO THE FIELD OF DEVELOPMENTAL DISABILITIES AND THE SERVICES PROPOSED. | | | | | *Attach resume to document experience and label as P.* | | | | | | |
| 14. | LIST THE NAME(S) OF EACH **REGISTERED NURSE.**  NA | | | | |  | | | | | | |
| DESCRIBE (IN DETAIL) THE EDUCATIONAL BACKGROUND(S) OF THE **REGISTERED NURSE.** | | | | | *Attach documentation of educational background and label as Attachment Q.* | | | | | | |
| DESCRIBE (IN DETAIL) THE NUMBER OF YEARS AND TYPE OF EXPERIENCE(S) THE **REGISTERED NURSE** HAS RELATIVE TO THE FIELD OF DEVELOPMENTAL DISABILITIES AND THE SERVICES PROPOSED. | | | | | *Attach resume to document experience and label as Q.* | | | | | | |
| 15. | LIST THE NAME(S) OF OTHER CRITICAL PERSONNEL.  NA | | | | |  | | | | | | |
| DESCRIBE (IN DETAIL) THE EDUCATIONAL BACKGROUND(S) OF THE **OTHER CRITICAL PERSONNEL.** | | | | | *Attach documentation of educational background and label as Attachment R.* | | | | | | |
| DESCRIBE (IN DETAIL) THE NUMBER OF YEARS AND TYPE OF EXPERIENCE(S) THE **OTHER CRITICAL PERSONNEL** HAVE RELATIVE TO THE FIELD OF DEVELOPMENTAL DISABILITIES AND THE SERVICES PROPOSED. | | | | | *Attach resume to document experience and label as R.* | | | | | | |

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| **SECTION II – HOME AND COMMUNITY BASED SERVICES RULE** | | | | | | | | |
| **EFFECTIVE MARCH 17, 2014, THE CENTER FOR MEDICAID AND MEDICARE SERVICES (CMS) PUBLISHED A FINAL RULE REGARDING CHANGES TO HOME AND COMMUNITY BASED WAIVER SERVICES (HCBS WAIVER). THE RULE IS COMMONLY REFERRED TO AS THE FINAL HCBS RULE. IN MISSOURI, THIS AFFECTS ALL HOME AND COMMUNITY BASED WAIVER PROGRAMS.**  **CMS INTENT OF THE RULE**  “To ensure that individuals receiving services and supports through the Medicaid’s home and community-based service (HCBS) programs have full access to benefits of community living and are able to receive services in the most integrated setting” “designed to improve the quality of services for individuals receiving HCBS”  CMS Fact Sheet: Summary of Key Provisions of the 1915(c) Home and Community-Based Services (HCBS) Waivers Final Rule:  • CMS is moving away from defining home and community-based settings by “what they are not,” and toward defining them by the nature and quality of participants’ experiences.  • The home and community-based setting provisions in this final rule establish a more outcome-oriented definition of home and community-based settings, rather than one based solely on a setting’s location, geography, or physical characteristics.  • Requires states to submit a plan to ensure compliance of the final rule  Consumers and Advocates  • Individuals have the right to receive services in the community to the same degree as those not receiving HCB waiver services:  o Individuals must be allowed to select the services they receive, where they live among available options, and the providers of those services.  o Individuals have the freedom to control their own schedules, personal resources, and other aspects of their living arrangement.  o Individuals must be treated with dignity and respect and be free from coercion or restraint.  Final HCBS Rule Setting Requirements 42 CFR 441.301(c)(4)  • HCBS Rule requires that an HCB Waiver Service setting:  o Is fully integrated in and supports access to the greater community  o Provides opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources  o Ensures the individual receives services in the community to the same degree of access as individuals not receiving Medicaid home and community-based services  o Is selected by the individual from more than one setting option, including non-disability specific settings and an option for a private room in a residential setting  o Supports individual choice of services and supports  o Ensures privacy, dignity, respect, and freedom from coercion and restraint  o Optimizes individual initiative, autonomy, and independence in making life choices  o Facilitates individual choice regarding services and supports and who provides them  • Provider Owned or Controlled Residential Settings Requirements  o Individuals have:  o privacy in their homes  o choice of roommates  o freedom to furnish and decorate their sleeping or living areas within the lease or other agreement  o freedom and support to control their schedules and activities and have access to food any time  o visitors at any time  o Homes have lockable entrance doors, with the individual and appropriate staff having keys to doors as needed  o Specific dwelling is owned, rented, or occupied under a legally enforceable agreement  o Same responsibilities and protections from eviction as all tenants under landlord tenant law  o Any modification of the additional conditions must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:  • Identify a specific and individualized assessed need.  • Document the positive interventions and supports used prior to any modifications to the person-centered service plan.  • Document less intrusive methods of meeting the need that have been tried but did not work.  • Include a clear description of the condition that is directly proportionate to the specific assessed need.  • Include regular collection and review of data to measure the ongoing effectiveness of the modification.  • Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.  • Include the informed consent of the individual.  • Include an assurance that interventions and supports will cause no harm to the individual.  Final HCBS Rule Setting Requirements 42 CFR 441.301(c)(5)  • Settings that are not home and community based:  o Nursing Facility  o Institution for mental diseases (IMD)  o Intermediate care facility for individuals with intellectual disabilities (ICF/ID)  o Hospital  o Any other locations that have qualities of an institutional setting, as determined by the Secretary Settings presumed not to be HCB (Heightened Scrutiny)  o Settings located in a publicly or privately-operated facility providing inpatient institutional treatment  o Settings on the grounds of, or adjacent to, a public institution  o Settings with the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCB services  Characteristics of Settings that Isolate People from the Broader Community  • The setting is designed to provide people with disabilities multiple types of services and activities on-site, including housing, day services, medical, behavioral and therapeutic services, and/or recreational activities  • People in the setting have limited, if any, interaction with the broader community  • Settings that use/authorize interventions/restrictions that are used in institutional settings or are deemed unacceptable in Medicaid institutional settings (e.g., seclusion)  • Farmstead or disability-specific farm community  • Gated/secured “community” for people with disabilities  o These communities typically consist primarily of people with disabilities and the staff that work with them  • Residential schools  o These settings incorporate both the educational program and the residential program in the same building or in buildings in close proximity to each other  Guidance for achieving Home and Community Based Services (HCBS) compliance and be found at <https://dmh.mo.gov/dd/hcbs.html>  **ARE YOU IN DISAGREEMENT WITH ANY OF THE RULE DESCRIBED?**  YES  NO ***If yes, explain*** | | | | | | | | |
| **SECTION III – INDIVIDUAL RIGHTS** | | | | | | | | |
| **STATEMENT OF RIGHTS** | | | | | | | | |
| INDIVIDUALS RECEIVING SERVICES FROM THE DIVISION OF DEVELOPMENTAL DISABILITIES HAVE RIGHTS THAT MAY NOT BE LIMITED OR RESTRICTED AS WELL AS SPECIFIC RIGHTS THAT MAY BE RESTRICTED WITH DUE PROCESS. IT IS THE RESPONSIBILITY OF THE CONTRACTED PROVIDER TO ENSURE INDIVIDUALS ARE INFORMED OF AND EDUCATED ON THEIR RIGHTS UPON ENTRY INTO SERVICES AND AT LEAST ANNUALLY THEREAFTER.  REVIEW THE FOLLOWING INFORMATION REGARDING INDIVIDUAL RIGHTS AND RESPOND TO THE NEXT QUESTION.  Section 630.110, RSMo – Patient’s Rights and Limitations <http://revisor.mo.gov/main/OneSection.aspx?section=630.110&bid=30756&hl=patient%u2044rights>  Section630.115, RSMo – Guaranteed Rights to all DMH Consumers <http://revisor.mo.gov/main/OneSection.aspx?section=630.115&bid=30757>  9 CSR 45-3.030 – Individual Rights <https://www.sos.mo.gov/cmsimages/adrules/csr/current/9csr/9c45-3.pdf>  42 CFR 441.301 – Contents of Request for a Waiver <https://www.govregs.com/regulations/expand/title42_chapterIV_part441_subpartG_section441.301#title42_chapterIV_part441_subpartG_section441.301>  **ARE YOU IN DISAGREEMENT WITH ANY OF THE RIGHTS?**  YES  NO ***If yes, explain*** | | | | | | | | |
| **SECTION IV – REGION AND SERVICES** | | | | | | | | |
| INDICATE ALL DIVISION OF DEVELOPMENTAL DISABILITIES REGION(S) YOU PROPOSE TO SERVE. | | | | | | | | |
| KANSAS CITY REGIONAL OFFICE  ALBANY SATELLITE OFFICE | | CENTRAL MO REGIONAL OFFICE  KIRKSVILLE SATELLITE OFFICE  ROLLA SATELLITE OFFICE | SIKESTON REGIONAL  OFFICE  POPLAR BLUFF SATELLITE OFFICE | | | SPRINGFIELD REGIONAL OFFICE  JOPLIN SATELLITE OFFICE | ST. LOUIS COUNTY  REGIONAL OFFICE  ST. LOUIS TRI-COUNTY REGIONAL OFFICE  HANNIBAL SATELLITE OFFICE | |
| **CERTIFIED, ACCREDITED AND RELATED SERVICES \*** If your organization is applying solely for employment services and you have a Vocational Rehabilitation contract *do not use this application*: complete Contract Provider Application B.  Complete Section V of the Provider Application if applying for one or more of the following services: | | | | | | | | |
| * Community Networking * Crisis Services * Day Habilitation * Employment (Prevocational, Career Planning, Job Development and Supported Employment)\* * Individual Skill Development | | | | * Personal Assistant * Residential: Shared Living (Host & Companion Home) * Residential: Individualized Supported Living * Respite Care: In‐Home * Respite Care: Out‐of‐Home * Respite: Temporary Residential | | | | |
| **PROFESSIONAL SERVICES** If you are solely applying for services indicated by an \* and are not applying for services in section V or VII, do not use this application: complete contract Provider Application B.  Complete Section VI of the Provider Application if applying for one or more of the following services: | | | | | | | | |
| * Alternative Language Translation\* * Behavioral Supports: Behavior Analysis Services\* * Benefits Planning * Community Specialist * Interpreting\* * Parent/Caregiver Training * Support Broker | | | | * Professional Assessment and Monitoring: RN\* * Professional Assessment and Monitoring: LPN\* * Professional Assessment and Monitoring: Dietician\* * Therapy: Music Therapy\* * Therapy: Occupational Therapy\* * Therapy: Physical Therapy\* * Therapy: Speech Therapy\* | | | | |
| **NON-TREATMENT SUPPORT SERVICES** If applying for Transportation solely related to the ISL service, this section is not required questions in Section V shall apply.  Complete Section VII of the Provider Application if applying for one or more of the following services: | | | | | | | | |
| * Transportation | | | | * Other – specify: | | | | |
| **SECTION V – CERTIFIED, ACCREDITED AND RELATED SERVICES** | | | | | | | | |
| If your organization is applying solely for employment services *and* you have a Vocational Rehabilitation contract *do not use this application*: complete Contract Provider Application B. | | | | | | | | |
| **SERVICE PROPOSAL POSSIBLE POINTS AVAILABLE IN THIS SECTION: 20** | | | | | | | | |
| 16. | Indicate the certified, accredited or related service(s) you propose to provide: | | | | | | | |
|  | Day Habilitation  Community Networking  Employment Services  Individual Skill Development  Personal Assistant Services | | | | Residential: Shared Living (Host & Companion Home)  Residential: Individualized Supported Living  Respite Care: In‐Home  Respite Care: Out‐of‐Home  Respite: Temporary Residential Service  Other – specify: | | | |
| 17. | State you / your organization’s mission statement. | | | | | | | |
| 18. | Describe the service(s) you propose to provide through this contract with enough detail to show compliance with waiver service definition. | | | | | | | |
| 19. | Describe how you / your organization will ensure individuals receive services in the community to the same degree as those not receiving services. | | | | | | | |
| 20. | Describe how you / your organization will ensure you / your agency support individual choice of services and supports. | | | | | | | |
| 21. | Describe how you / your organization provides opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources. | | | | | | | |
| 22. | Describe your organization’s plan to provide services in compliance with the HCBS requirements in Section II. | | | | | | | |
| 23. | Describe how you / your organization will ensure HCBS and Individual Rights are understood and implemented by all employees. | | | | | | | |
| 24. | Describe what should be considered when supporting individuals with challenging behaviors. | | | | | | | |
| 25. | Describe your / your organization’s experience and skills that will enable you to work with individuals and families to develop plans that address challenging behaviors. | | | | | | | |
| 26. | Do you have training in MANDT, NCI, CPI, or Tools of Choice? If yes, indicate type of training and attach evidence labelled as S. | | | | | | | |
| 27. | Describe what should be considered when supporting individuals with significant medical needs. | | | | | | | |
| 28. | Describe you / your organization’s number of years of experience and the experience/skills that will enable you to work with individuals and families to develop plans that address significant medical support needs. | | | | | | | |
| 29. | Describe specialized training you / your organization has in supporting individuals with significant medical needs. This does not include C.N.A., C.M.T., First Aide, CPR or Med Aid. | | | | | | | |
| **SECTION V - CERTIFIED, ACCREDITED AND RELATED SERVICES SCORING** | | | | | | | | |
| Business Plan, Experience and Expertise (from Section 1) | | | | | | | | 5 points |
| Staff Education and Expertise (from Section 1) | | | | | | | | 4 points |
| Service Proposal | | | | | | | | 20 points |
| Section V Grand Total | | | | | | | | 29 points |
| Minimum points required to be approved for pursuit of contract if all other requirements are met. | | | | | | | | 20 points |

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| **SECTION VI – PROFESSIONAL AND THERAPEUTIC SERVICES** | | | |
| *If applying for services in Section VI in addition to services in Section V, complete number 31 and proceed to next section. Scoring in Section V shall apply.*  *If you are solely applying for services indicated by an \* and are not applying for services in Section V or VII,*  *do not use this application: complete contract provider application B.* | | | |
| **SERVICE PROPOSAL POSSIBLE POINTS AVAILABLE IN THIS SECTION: 2** | | | |
| 30. | Indicate the professional and therapeutic service(s) you propose to provide. | | |
|  | Alternative Language Translation \*  Behavioral Supports: Behavior Analysis Services \*  Benefits Planning\*  Community Specialist  Interpreting \*  Parent/Caregiver Training  Professional Assessment and Monitoring: Dietician \* | Professional Assessment and Monitoring: RN \*  Professional Assessment and Monitoring: LPN \*  Support Broker  Therapy: Music Therapy\*  Therapy: Occupational Therapy \*  Therapy: Physical Therapy \*  Therapy: Speech Therapy \*  Other – Specify: | |
|  | *There must be at least one professional employed for each of the services indicated to contract for that service.*  *Attach resume for each individual proposed to work under contract for the Division of DD (if not included in Section 1 Staff Experience and Expertise) and label as Attachment T.*  *\*Attach verification that each professionally licensed staff proposed to work under contract with Division of DD (if not included in Section 1 Staff Experience and Expertise) is registered with Missouri Division of Professional Registration and label as Attachment T.* | | |
| 31. | State you/your organization’s mission statement. | | |
| 32. | Describe (in detail) the service/program you/your organization’s provides relative to the specific service(s) indicated in 30. | | |
| **SECTION VI – PROFESSIONAL AND THERAPEUTIC SERVICES SCORING** | | | |
| Business Plan, Experience and Expertise (from Section 1) | | | 5 points |
| Staff Experience and Expertise (from Section 1) | | | 4 points |
| Service Proposal | | | 2 points |
| Section VI Grand Total | | | 11 points |
| Minimum points required to be approved for pursuit of a contract if all other requirements are met. | | | 7 points |
| **SECTION VII – NON-TREATMENT SUPPORT SERVICES** | | | |
| If applying for Transportation solely related to the ISL service, Section VII is not required. Scoring in Section V shall apply. | | | |
| 33. | Indicate the non-treatment support services(s) you propose to provide.  Transportation  Other – specify: | | |
| **SECTION VII – NON-TREATMENT SUPPORT SERVICES** | | | |
| Business Plan, Experience and Expertise (from Section 1) | | | 5 points |
| Staff Experience and Expertise (from Section 1) | | | 4 points |
| Section VII Grand Total | | | 9 points |
| Minimum points required to be approved for pursuit of a contract if all other requirements are met. | | | 6 points |

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| **SECTION VIII – CONFLICT OF INTEREST** | |
| **DISCLOSURE OF STATE OF MISSOURI EMPLOYMENT** | |
| Is the applicant or any key member of the applying organization an employee of the State of Missouri?  YES  NO  **If yes, complete the conflict of interest for State of Missouri employees section. If no, proceed to section IX.** | |
| **CONFLICT OF INTEREST FOR STATE OF MISSOURI EMPLOYEES** | |
| FOR EMPLOYEES OF THE STATE OF MISSOURI | STATE THE DEPARTMENT, DIVISION AND FACILITY THAT EMPLOYEES YOU AND YOUR POSITION    DESCRIBE YOUR PRIMARY JOB DUTIES AS AN EMPLOYEE OF THE STATE OF MISSOURI |
| **REVIEW THE FOLLOWING INFORMATION PERTAINING TO CONFLICT OF INTEREST FOR EMPLOYEES OF THE STATE OF MISSOURI**  **Conflict of interest is any action you take in your official capacity resulting in financial gain to yourself, your family, or any business in which you have an interest. This includes performing any paid services for the department other than your official duties; selling, renting, or leasing property to the department; or trying to influence official decisions, which will result in financial gain to yourself or your family or a business in which you have an interest. You may not work for private gain on state property or use other state employees, supplies or equipment for your private gain.**  The Division of DD contract for service providers states:  1. The contractor hereby agrees that at the time of the submission of their proposal the contractor has no other contractual relationships that create any actual conflict of interest. The contractor agrees that during the term of the contract neither the contractor nor any of its employees shall acquire any other contractual relationships, which would create such a conflict.  2. In accordance with the Revised Statutes of the State of Missouri, no official or employee of the Department or public official of the State of Missouri who exercises any functions or responsibilities in the review or approval of the Scope of Work covered by the contract shall acquire any personal interest, directly or indirectly, in the contract or proposed contract.  3. In accordance with state and federal laws and regulations, state executive order or regulations, the contractor agrees that it presently has no interest and shall not acquire any interest, directly or indirectly, which would conflict in any manner or degree with their performance of the contracted services. The contractor agrees that no person having such interest shall be employed or conveyed an interest, directly or indirectly, in the contract.  4. The contractor agrees that no Missouri state employee shall help the contractor obtain this contract or participate in the performance of this contract if such involvement will constitute a conflict of interest. Written approval shall be obtained from the director of the Department before any state employee may be involved in the performance of this contract.  5. The contractor agrees that no Missouri state employee shall be compensated under this contract for duties performed in the course of his/her state employment. A state employee shall not use state facilities or materials for personal gain relating to the performance of this contract.  6. The contractor represents itself to be an independent contractor offering such services to the general public and shall not represent itself or its employees as employees of the State of Missouri.  7. If the contractor is a not-for-profit agency, board members must abstain from voting on any funding proposal in which they have administrative control or a monetary interest with the proposed grantee. Board members who have such an interest and participate in discussion prior to a vote must disclose such interest in a meeting of the board prior to such discussion.  I have read and understand the content of section viii of the provider application and declare no conflict as defined in section viii of the provider application exists. I also understand that in accordance with item four above, approval from the director of the department of mental health will be required before a contract can be issued.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Print Name Print Title  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature Date | |

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| **SECTION IX– APPLICANT SIGNATURES** |
| ***Both signature sections must be completed. The first section, “Application Certification” must be completed by the owner or executive director if one was appointed by the Board to enter into contract with the Division of DD. The person signing this section may be the same or different from the person submitting the application. The second section, “FBI Background Check Acknowledgement” must be completed by each person who is the subject of the FBI background check.*** |
| **Application Certification:**  My signature below authorizes any former or current employers/contractors to furnish the Department of Mental Health with any or all of information concerning my previous employment and releases any former or current employer from all liability for any damages in furnishing such information.  I hereby certify that this application contains no willful misrepresentation or falsification and the information given by me is true and complete to the best of my knowledge and belief. I am aware that should investigation at any time disclose any such misrepresentation or falsification as to material fact, my application will be rejected and/or contract voided.  I acknowledge that if a contract is established with me/my organization, payment for services may not be received for up to 90 days from the date of service initiation.  I further acknowledge that I have read and understand the information contained in Sections II and III pertaining to the HCBS Settings Rule and Individual Rights, and that I/my organization shall provide services in compliance with these Rules.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Print Name Print Title  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature Date |
| **FBI Background Check Acknowledgement:**  I acknowledge I have read, and I understand the information contained in Appendix III pertaining to FBI background checks.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Print Name Print Title  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature Date  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Print Name Print Title  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature Date  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Print Name Print Title  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature Date  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Print Name Print Title  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature Date  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Print Name Print Title  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature Date  *If additional signature lines are needed, duplicate this page.* |

**Appendix I**

**Application Scoring**

While each question on the application is required, only specific questions are rated. Approval to pursue enrollment will only be granted when the following conditions are met: all attachments are submitted, all questions are answered, the proposed service aligns with a Division service and complies with HCBS rules, the staff are licensed or credentialed as required by the service definition (for example, Individualized Skill Development or employment supports), all required signatures are provided, and the application receives a score that meets or exceeds the minimum.

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| **Questions** | **Summary of Scoring** |
| 3 | Experience operating a business is rated based on the answer to the question and verification in resume.  0 Pt. = Under 1 yr. 1 Pt. = 1 to 3 years 2 Pt. = 3 to 5 years 3 Pt. = 5+ years |
| 5 | Business plan and operation budget.  0 Pt = No plan or budget 1 Pt = Plan and budget submitted 2 Pt = Plan, budget and financial resources are sufficient |
| 11-15 | Each staff indicated in the application is assessed points for education and experience relative to the field of DD. Education minimum required for non-licensed professionals is high school diploma or GED.  Education: 0 Pt = Min Required 1 Pt = Exceeds Min  Experience: 0 Pt = Under 1 yr. 1 Pt = 1 to 3 years 2 Pt = 3 to 5 years 3 Pt = 5 + years |
| 17-24 and 27 | Each question has a maximum of 2 points possible based on ½ point for each concept identified in the applicant’s response. |
| 25 and 28 | Each question has a maximum of 2 points based on amount of experience described.  0 PT = Under 1 year 1 PT = 1-3 years 2 PT = 3+years |
| 26 and 29 | Each question gains the applicant 1/2 point if answer described any recognized training that exceeds the minimum training standard. |
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| **SECTION IV – CERTIFIED, ACCREDITED AND RELATED SERVICES SCORING** | |
| Business Plan, Experience and Expertise (sum of questions 3-6) | 5 points |
| Staff Experience and Expertise (Add educational and experience scores for each position listed then [average](#average" \o "example:  application indicates an executive director, professional manager and an RN.  Total points between the three is 11.  Divide by 3 staff = 3.66) scores for items 11-15.) | 4 points |
| Service Proposal (sum of questions 17-29) | 20 points |
| Section IV Grand Total | 29 points |
| Minimum points required to be approved for pursuit of contract if all other requirements are met | 20 points |
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| **SECTION V – PROFESSIONAL AND THERAPEUTIC SERVICES SCORING** | |
| Business Plan, Experience and Expertise (sum of questions 3-6) | 5 points |
| Staff Experience and Expertise (Add educational and experience scores for each position listed then [average](#average) scores for items 11-15) | 4 points |
| Service Proposal (question 31) | 2 points |
| Section V Grand Total | 11 points |
| Minimum points required to be approved for pursuit of a contract if all other requirements are met | 7 points |

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| **SECTION VI – NON-TREATMENT SUPPORT SERVICES SCORING** | |
| Business Plan, Experience and Expertise (sum of questions 3-6) | 5 points |
| Staff Experience and Expertise (Add educational and experience scores for each position listed then [average](#average) scores for items 11-15.) | 4 points |
| Section VI Grand Total | 9 points |
| Minimum points required to be approved for pursuit of a contract if all other requirements are met. | 6 points |

**Appendix II**

**FBI Background Check**

**Applicant Notification of Purpose, Challenge of Findings and Privacy Information**

Governmental agencies that conduct a national fingerprint-based criminal history record check on an applicant for noncriminal purposes are obligated to ensure the applicant receives certain notification and information. By signing the **Contract Provider Application,** you acknowledge that you, as the subject of the FBI background check, understand the following:

* Your fingerprints will be used to check the criminal records history of the FBI.
* The results of the FBI criminal history check will be used as part of the determination of the suitability of your application to become a contract provider for the Missouri Department of Mental Health, Division of Developmental Disabilities.
* You have the right to challenge the information in the FBI record as outlined below in the section entitled “Noncriminal Justice Applicant’s Privacy Rights”.
* The information received from the FBI background check will be used solely for the purpose of evaluating the **Contract Provider Application** and will not be disseminated outside the Department of Mental Health.

In addition, by signing the **Contract Provider Application** you acknowledge you, as the subject of the FBI background check, have received the following privacy information:

**NONCRIMINAL JUSTICE APPLICANT’S PRIVACY RIGHTS**

As an applicant who is the subject of a national fingerprint-based criminal history record check for noncriminal justice purpose (such as an application for a job or license, an immigration or naturalization matter, security clearance, or adoption), you have the following rights:

* You must be notified that your fingerprints will be used to check the criminal history of record of the FBI.
* If you have a criminal history record, the officials making a determination of your suitability for the job, license, or other benefit must provide you the opportunity to complete or challenge the accuracy of the information in the record.
* The officials must advise you that the procedures for obtaining a change, correction, or updating of you criminal history record are set forth at Title 28, Code of Federal Regulations (CFR), Section 16.34.
* If you have a criminal history record, you should be afforded a reasonable amount of time to correct or complete the record (or decline to do so) before the officials deny you the job, license, or other benefit based on information in the criminal history record. (See 28 CFR 50.12(b).)
* You have the right to expect that officials receiving the results of the criminal history record check will use it only for the authorized purposes and will not retain or disseminate it in violation of federal statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council. (See 5 U.S.C. 552a(b); 28 U.S.C. 534(b); 42 U.S.C. 14616, Article IV(c); 28 CFR 20.21(c); 20.33(d), and 906.2(d).)
* If agency policy permits, the officials may provide you with a copy of your FBI criminal history record for review and possible challenge. If agency policy does not permit it to provide you a copy of the record, you may obtain a copy of the record by submitting fingerprints and a fee to the FBI. Information regarding this process may be obtained at <http://www.fbi.gov/about-us/cjis/background-checks>.
* If you decide to challenge the accuracy or completeness of your FBI criminal history record, you should send your challenge to the agency that contributed the questioned information to the FBI. Alternatively, you may send your challenge directly to the FBI. The FBI will then forward your challenge to the agency that contributed the questioned information and request the agency to verify or correct the challenged entry. Upon receipt of an official communication from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency. (See 28 CFR 16.30 through 16.34.)

**STATE AND FEDERAL RAP BACK PRIVACY NOTICE**

Applicants submitting their fingerprint images to the Central Repository for a fingerprint based criminal record check are advised that their fingerprint images will be retained in state and federal biometrics databases, pursuant to Section 43.540 RSMo. If the submitting agency participates in the State or State and National Rap Back Programs, fingerprint images will be submitted, searched and retained for the purpose of being searched against future submissions to the State and National Rap Back programs; fingerprint searches will also include latent print searches.

The “Missouri Rap Back Program” and “National Rap Back Program” shall include any type of automatic notification made by the State Missouri and\or the Federal Bureau of Investigation through the Missouri State Highway Patrol to a qualified entity indicating that an applicant who is employed, licensed, or otherwise under the purview of the qualified entity has been arrested for a reported criminal offense and the fingerprints for that arrest were forwarded to the Central Repository of the Federal Bureau of Investigation by the arresting agency.

If you have questions regarding the FBI Background check, contact the Provider Relations staff at the local Regional Office.