**5.1 SIL OPEN ENROLLMENT APPLICATION, ATTACHMENTS**

**AND REQUIRED FORMS**

# INSTRUCTIONS

### Applicant must read all of the Open Enrollment HHS0001478 posted on the ESBD or HHS Enrollment Sites before completing this Application.

### Application must be completed and signed in Section V (Certification) for it to be accepted by DFPS.

### DFPS considers a complete answer to be a written or typed response that is legible.

### Responding with “Not Applicable” is only an appropriate response when a question or form does not apply to the Applicant.

### Responding by only “cutting and pasting” from information in the Open Enrollment may not be considered a complete response.

### Applicant will provide the information in the body of the Application unless otherwise instructed to include it as an Attachment (See File Folder 2 in Appendix A).

### Applicant will complete the forms listed, see Required Forms (See File Folder 3 in Appendix A).

### Applicant will submit Application in its entirety and all required documents in File Folders 1-3 in Appendix A to [DFPS24HourResidentialApplications@dfps.texas.gov](mailto:DFPSResident@dfps.texas.gov).

### If DFPS has difficulty accessing the Applicant’s documents, the Applicant will be required to re-submit documents as directed by DFPS.

### For ECM Services.

* + If you have a contract executed before May 29, 2020, and want to provide ECM services, then you will only have to complete Addendum to the SIL Open Enrollment Application to Provide ECM Services (See Appendix B).
  + If you are a new applicant and want to apply to provide ECM, complete all sections of the Application including the areas that are marked with ECM.

**SECTION I – APPLICANT INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Legal Name of Applicant |  | | |
| Office Address |  | | |
| City, State, Zip |  | | |
| Phone |  | Fax |  |
| Contact Person |  | Title |  |
| Contact's E-mail |  | | |
| Vendor ID Number | If Applicant is not already a vendor with the State of Texas, leave blank and ensure completion of Form AP-152 found in Appendix B File Folder 3 | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Doing Business As Name (DBA) or Parent Organization- Indicate if different from Legal Name above    Attach applicable documents as provided for in File Folder A of Appendix B | | | | |
| Mailing Address - If different from Office Address above  Applicant:  Parent Organization: | | | | |
| Federal ID Number – If different from Vendor ID  Applicant:  Parent Organization: | | | Social Security Number - If applying as Individual/Sole Proprietor | |
| Name of Person Authorized to Sign Contract: | Title: | | | Phone Number:    Email: |
| Name of Person Responsible for Billing: | Title: | | | Phone Number:    Email: |
| Type of Applicant – Check appropriate boxes and attach documentation as indicated in File Folder 2 of Appendix B | | | | |
| Are you applying to provide services to DFPS without payment (No-Pay Contract)? Yes No | | | | |
| Governmental Entity  Do you have taxing authority? Yes No | | | | |
| Private Corporation  For Profit  Non-Profit | | State of Incorporation:  Charter Number:  Attach a copy of Certificate of Incorporation | | |
| Limited Liability Company (LLC) Attach a copy of the Articles of Formation | | | | |
| Partnership  Limited  General  Attach a list of names, addresses and Social Security numbers for each partner | | If Partnership – Do you have:  Yes No Partnership Agreement  Yes No Signatory Assignment  If Yes is checked above, attach a copy | | |
| Sole Proprietorship  For Profit  Non-Profit | | If Sole Proprietorship  Provide date of birth: | | |
| Are you a certified Texas HUB?  Yes – Attach a copy of HUB certification form.  No – Select all that apply if you fall into one or both of the categories below:  Minority Owned Business Woman Owned Business | | | | |

### SECTION II- ELIGIBILITY REQUIRMENTS

1. Not be debarred from receiving any federal or state funds at the time of the Contract award?

Yes  No

1. Have you had a contract for residential child-care services or other transitional living services for young adults (similar to what is sought in this Open Enrollment) that was non-renewed or terminated by DFPS or any other private party or governmental entity within the last five years?

Yes  No

If yes:

* 1. Provide the name of the program or entity, date of the non-renewal or termination, the contract number, and list the factors that contributed to DFPS or any other private party or governmental entity taking that action; and

Answer:

* 1. Describe in detail the actions taken by your SIL Program to remedy each factor that contributed to that non-renewal or termination.

Answer:

1. Has a Case Manager (See Sections 1.5.5 and 2.4 of the Open Enrollment) that oversees the Contractor’s SIL Program and Settings. Attach documentation in File Folder 2 of Appendix B showing that Applicant’s Case Manager meets the requirements in Subsections above, which can include resume, education certificate, transcript or diploma, and/or relevant professional licenses.
2. **FOR ECM ONLY - If applying to also provide ECM, has a Case Manager that also meets the requirements for the Trauma Informed Care and Psychotropic Medication Trainings as provided for in Section 1.5.5 (f) of the Open Enrollment. Attach documentation in File Folder 2 of Appendix B showing that these requirements are met.**
3. **Insurance.** Review Sections II (E) in the Open Enrollment’s Section 5.3.1 and I (H) in Open Enrollment’s Section 5.3.2. Indicate in the table below if requirements are met.

|  |
| --- |
| Commercial Crime Insurance or equivalent insurance with 3rd Party endorsement & Employee Dishonesty endorsement: Yes No |
| Commercial General Liability or equivalent insurance: Yes No |
| Contractor must submit insurance coverage documentation for both types listed above with the signed contract. DFPS will not execute a Contract if this documentation is not provided or is found to not meet the insurance requirements. |

**SECTION III- SERVICE AREA AND SETTING TYPES**

Review Open Enrollment’s Sections 1.5 for qualifications and DFPS Regions open for applications, 2.8 for Setting Types and Section III of 5.3.1(C) for Minimum Requirements.

1. Indicate below the Setting Type and Region of the physical location where you are applying to provide SIL services and setting(s), and if applicable, indicate the Regions and/or Settings that you are applying to provide ECM. DFPS Regions below are the ones in which DFPS is currently accepting applications. For the other Regions, SIL and ECM will be contracted through Community Based Care (CBC) providers (see Open Enrollment Section 1.5.8).
2. **Apartment Setting**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| SIL | 3A\* | 4 | 5 | 6 | 7 | 8A\* | 9 | 10 | 11 |
| SIL with ECM Services | 3A\* | 4 | 5 | 6 | 7 | 8A\* | 9 | 10 | 11 |
| Apartment Name: | | | | | | | | | |
| Apartment Address: | | | | | | | | | |

1. **College Dorm Setting (ECM is not allowed in this Setting)**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| SIL | 3A\* | 4 | 5 | 6 | 7 | 8A\* | 9 | 10 | 11 |
| College Name: | | | | | | | | | |

1. **Non-College Dorm Setting**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| SIL | 3A\* | 4 | 5 | 6 | 7 | 8A\* | 9 | 10 | 11 |
| SIL with ECM Services | 3A\* | 4 | 5 | 6 | 7 | 8A\* | 9 | 10 | 11 |
| Non-College Dorm Address: | | | | | | | | | |

1. **Shared Housing Setting**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| SIL | 3A\* | 4 | 5 | 6 | 7 | 8A\* | 9 | 10 | 11 |
| SIL with ECM Services | 3A\* | 4 | 5 | 6 | 7 | 8A\* | 9 | 10 | 11 |
| Shared Housing Address: | | | | | | | | | |

1. **Host Home Setting (Only apply for this Setting if you have an active DFPS Residential Child Care Contract that is not in provisional status).**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| SIL | 3A\* | 4 | 5 | 6 | 7 | 8A\* | 9 | 10 | 11 |
| SIL with ECM Services | 3A\* | 4 | 5 | 6 | 7 | 8A\* | 9 | 10 | 11 |
| Host Home Address: | | | | | | | | | |

# Does your Setting’s living and sleeping areas meet the requirements of Open Enrollment and III(C) in Open Enrollment’s Section 5.3.1?

Yes No

1. Attach floor plan for each of the setting(s) for which you are applying to use in your SIL Program and provide the dimensions of it with living and sleeping areas, separate versus shared spaces, privacy, bathroom, kitchen or laundry.

**SECTION IV- SIL PROGRAM REQUIREMENTS**

* + - 1. Provide in a narrative format how your SIL Program will meet the requirements in Section 2.2 in the Open Enrollment. Do not cut and paste from the Open Enrollment. This narrative should also include:

1. How your SIL Program will provide services to young adults;
2. How these SIL services will be coordinated and implemented with CPS Caseworkers and Regional staff, including participating in conference calls and meetings as requested by DFPS (See Open Enrollment’s Section 2.5.1g);
3. Procedures for elevating concerns about young adults to DFPS and maintaining compliance with notification requirements (See Section III in Open Enrollment’s Section 5.3.1); and
4. If you are applying to provide ECM, explanations on how you would meet the heightened needs and requirements for youth in ECM;
5. Other supporting programmatic information.
6. **Transportation must be made available when distance or access to public transportation exceeds one mile for education, training, work, grocery store, laundry facilities, bus or metro stop, library or other community resources. If not available, DFPS may grant a waiver of this requirement upon receipt of Contractor’s plan to provide transportation.**

**SECTION V - CERTIFICATION**

|  |  |
| --- | --- |
| I certify that the information provided in this Application is to the best of my knowledge, complete and accurate, that the named legal entity has authorized me, as its representative, to submit this Application, and that the legal entity complies with all requirements of this Open Enrollment. | |
| Signature of Authorized Representative | Date |
| Name of Authorized Representative (Printed) | Title of Authorized Representative (Printed) |

### APPENDIX A-

### APPLICATION, ATTACHMENTS AND REQUIRED FORMS

**FILE FOLDER 1: Application**

|  |  |  |
| --- | --- | --- |
| ELECTRONIC FILE NAME | DESCRIPTION | Required or If Applicable |
| 01-Application | Application for Enrollment | Required |
| 01.A-DBA | Assumed Name Certificate Attachment | If applicable |
| 01.B-Incorporation | Certificate of Incorporation Attachment | If applicable |
| 01.C-LLC | LLC Articles of Formation Attachment | If applicable |
| 01.D-Partnership | Partnership Agreement Attachment | If applicable |
| 01.E-Partners | Names, addresses and Social Security numbers for each partner | If applicable |
| 01.E-HUB | HUB Certification Form | If applicable |

**FILE FOLDER 2: Attachments**

|  |  |  |
| --- | --- | --- |
| ELECTRONIC FILE NAME | DESCRIPTION | Required or If Applicable |
| 02-Case Manager Resume | Case Manager Resume | Required |
| 02.A-Case Manager Education | Transcript, Diploma or Certificate | Required |
| 02.B ECM Case Manager Training | Training Certificates | ECM Required |
| 02.C-Case Manager Licenses | Professional Licenses | If Applicable |
| 02.D-Insurance | Insurance Certificate | Required |
| 02.E-Floor Plan | Submit Floor Plan for Each Setting (See #3 in Section III) | Required |
| 02.F-Access to Resources | Provide Names and Locations of Resources in Section IV (1) (f) | Required |
| 02.G-Access to Community Resources | Provide Names and Locations of Community Resources in Section IV (1) (f)#. Provide any existing or established relationships. | Required |
| 02.H-Access Plan | If any are not available in Section IV (1) (f) within in one mile, provide plan for transportation or access | If applicable |
| 02.I-SIL Program | SIL Program Requirements (See Section IV) | Required |
| 02.J ECM Services | SIL Program Requirements (See Section IV) | ECM Required |
| 02K-SIL Fiscal | Documentation of reserve funds or a line of credit that demonstrates a minimum of $25,000 | Required |

**FILE FOLDER 3: Required Forms**

|  |  |  |  |
| --- | --- | --- | --- |
| Form Number | NAME | PURPOSE | Document Location |
| 2031 | Signature Authority Designation | Designation of contract signature authority | [2031.doc](http://www.dfps.state.tx.us/Doing_Business/forms.asp) |
| 2970c | Disclosure and Consent to Release of Information Regarding Criminal or Abuse/Neglect History For Applicants, Employees or Volunteers of DFPS Contractors and Subcontractors | Disclosure and release for Executive Director, CEO, Comptroller and CFO, if applicable | [F-500-2970c.pdf](http://intranet.dfps.state.tx.us/Application/Forms/showFile.aspx?Name=F-500-2970c.pdf) |
| 2971c | Request for Criminal History and DFPS History Check | Criminal history and DFPS check for Executive Director, CEO, Comptroller and CFO, if applicable | [F-500-2971c.pdf](http://intranet.dfps.state.tx.us/Application/Forms/showFile.aspx?Name=F-500-2971c.pdf) |
| AP-152 | Print off copy of FMX Application for Texas Identification Number [If currently a Contractor with DFPS and a Texas Identification Number (TIN/Vendor ID #) is already set up, log in and update.] | Application for identification number | [Texas Comptroller of Public Accounts FMX System](http://www.dfps.state.tx.us/Application/Forms/showFile.aspx?Name=AP-152.pdf) |
| 9007RCC | Internal Control Structure Questionnaire (RCC) | Contractor's disclosure of internal controls. Instructions included. | [9007RCC.doc](http://www.dfps.state.tx.us/Doing_Business/forms.asp) |
| 9025a | Related Party (Building & Transportation) Leases/Rental Worksheet | Allowable cost determination to related party | [9025a.doc](http://www.dfps.state.tx.us/Doing_Business/forms.asp) |

### APPENDIX B-

**ADDENDUM TO THE SIL OPEN ENROLLMENT APPLICATION TO PROVIDE ECM SERVICES**

1. Legal Name of Entity applying to add ECM Services:

Name of person coordinating addition of ECM Services:

Phone number:

Email address:

Name of case manager:

1. Has any information from SECTION I APPLICANT INFORMATION for the Entity changed since SIL application was received? If yes, provide an explanation of these changes.
2. To fulfill SECTION II- ELIGIBILITY REQUIRMENTS #4, submit current training certificates for Trauma Informed Care and Psychotropic Medication.
3. Are there any currently operating SIL locations and settings that the Entity operates where you will NOT be adding ECM? If so, state locations and settings where you will NOT be adding ECM.
4. To fulfill SECTION IV- SIL PROGRAM REQUIREMENTS #1(d), provide a narrative of how you will meet the heightened needs and requirements for youth in ECM, specifically addressing items included in:

* 1.4.5(d)
* 2.4.3
* 2.5.2.