**7. TREATMENT FAMILY FOSTER CARE (TFFC) OPEN ENROLLMENT APPLICATION, ATTACHMENTS and**

**REQUIRED FORMS**

# INSTRUCTIONS

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

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

### The Application must be complete for it to be accepted by DFPS, and all questions and forms are required to be answered or submitted. Responding with “Not Applicable” is only an appropriate response when a question or form does not apply to the Applicant. Do not leave any section of the Application blank.

### 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).

1. Applicant will provide the information listed in Service Level Monitor Attachments (See File Folder 4 in Appendix A).

### Applicant will submit all contract application files and documents to: DFPS24HourResidentialApplications@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.

**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 |       |

|  |
| --- |
| Doing Business As Name (DBA) or Parent Organization- Indicate if different from Legal Name above     **Attach** a copy of Assumed Name Certificate If an Applicant has a Parent Organization, **attach** a copy of the agreement between the Applicant and the Parent Organization |
| Mailing Address - If different from Office Address aboveApplicant:      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 box(es) and attach documentation as indicated |
| Are you applying to provide services to DFPS? [ ] 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 Incorporation |
| [ ]  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 AssignmentIf Yes is checked above, **attach** a copy |
| [ ]  Sole Proprietorship [ ] For Profit [ ] Non-Profit | If Sole ProprietorshipProvide 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 |
| **Submit** an HHS CCL License for the CPA and services that Applicant is applying to provide TFFC services.  |

**SECTION II – SERVICE AREA**

DFPS will only accept Applications from HHS CCR Licensed Applicants as a CPA providing treatment services must (see Section 1.6 of the Open Enrollment).

Select the appropriate DFPS Region(s) for each question.

1. **Indicate which DFPS Region your administrative headquarter is located:**

1. **Indicate which DFPS Regions you will be providing TFFC services.**

***\*For Active CBC Catchment Areas -*** *DFPS will not accept applications for RCC CPA Contractors whose entire placement capacity is located solely in a CBC catchment area. If you provide CPA treatment services in part of a CBC area, review Section 1.6.3 of the Open Enrollment before completing this Section of the Application.*

1. **If you are a CPA proposing to provide multiple treatment and/or programmatic services:**
* The identified multiple programmatic services must be listed on your CPA's HHS Child Care License (CCL);
* You must identify the multiple programmatic services on your CCL License that your CPA intends to provide through this Application; and
* Select all the following services that apply to this Application:

[ ]  **Child-Care Services**

**[ ]  Treatment Services for Children with:**

[ ]  Emotional Disorders

[ ]  Intellectual developmental disabilities (ICFIDD)(Mental Retardation)

[ ]  Pervasive Developmental Disorders

[ ]  Primary Medical Needs

**[ ]  Programmatic Services Provided:**

[ ]  Transitional Living Program

[ ]  Assessment Services

[ ]  Intermittent Alternative Care (Respite Child Care)

1. **Requested Service Level Information.** Is your CPA authorized to provide Intense Level of Care Services?

[ ] Yes [ ] No

 **SECTION III – INSURANCE**

Review Section 1.5.4 of this Open Enrollment, Section II (G) of the DFPS Supplemental, Special & Programmatic Conditions for TFFC, and Section I (H) of the DFPS Vendor Uniform Terms and Conditions (see Section 1.7) and indicate in the table below if requirements are met.

|  |
| --- |
| Commercial General Liability or equivalent insurance: [ ] Yes [ ] No  |
| Professional Liability Insurance or equivalent insurance if CPA intends to employ staff to provide professional services: [ ] Yes [ ] No |
| Commercial Crime Insurance or equivalent insurance with 3rd Party endorsement & Employee Dishonesty endorsement: [ ] Yes [ ] No |
| Business Automobile Liability (Owned & Hired Endorsements and Non-owned Auto): [ ] Yes [ ] No |
| **If "No"** is checked for any insurance named above, Contractor must submit insurance coverage documentation 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.**If “Yes”** is checked for any insurance named above, Contractor must submit insurance coverage documentation prior to contract execution. |

**SECTION IV - APPLICANT’S ORGANIZATION**

1. **Describe your organizational history with contracting, including:**
2. Has your organization been contracting with DFPS as a CPA for at least one year?

[ ] Yes [ ] No

1. Your past experience working with residential child-care services for the last five years. Also include information specific to working with children requiring therapeutic and/or treatment services.

1. **Have you had a contract for residential child-care services that was non-renewed or terminated by any private party or governmental entity within the last five years?**

 [ ]  Yes [ ]  No

**If yes, please answer the following:**

* 1. Provide the name of the entity that you contracted with, contract service type, date of the non-renewal/termination, and list the factors that contributed to that action; and

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

1. **Provide a list of all current contracts held by your organization. List must at a minimum include if applicable:**
2. Type of Contract (Private, federal, state or county);
3. Contract number;
4. Contact person at the contract entity;
5. Contact phone number;
6. Type of service;
7. Dollar value of the contract;
8. Begin and end date of the contract;
9. Any corrective actions put into place by the contracting agency; and
10. Copies of contract monitoring reports during the last five years.

1. **Does your CPA place geographical limitations on accepting admissions?**

 [ ]  Yes [ ]  No

 **If yes, specify the following:**

[ ]  Specific Region/City

**TARGETED CHARACTERISTICS**

**Check the characteristics and behaviors of children you propose to serve specified for each category found in the table below.**

|  | **Does Applicant currently serve Children with this characteristic?**  | **If DFPS needed to place a Child with this characteristic, would the Child be accepted?** | **If answer in second column is ‘No’, and the Child later exhibited this characteristic, would the Child be discharged?** |
| --- | --- | --- | --- |
| **Characteristic** |
| Actively Exhibiting Psychotic Behavior | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| ADD / ADHD | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Anxiety Disorder | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Assaultive Behaviors or Homicidal | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Criminal acts – an act that violates the law | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Cruelty to Animals | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Danger to Self  | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Danger to Others  | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Depression | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Developmental Disorders | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| DSM-IV Axis I & II Diagnosis | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Eating Disorder | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Emotional Abuse | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Emotional Disorders | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Enuresis/Encopresis | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Fire Setting | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Fire Setting History | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Gang Activity / Affiliation | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Gender Identity Issues/ Sexual Orientation | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Victims of Human Trafficking  | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Impulse Control Disorder | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Learning Disorder | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Maladaptive Behaviors | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Medically Fragile | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Intellectual Disabilities | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Oppositional Defiant | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Pervasive Developmental Disorder | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Physically Abused | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Physically Neglected  | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Pregnant | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Primary Medical Needs | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Probation/Parole/TYC/JPC | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Requires Hospitalization | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Runaway History | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Sexual Abuse History | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Sexually Inappropriate / Sexualized Behaviors | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Sexual Perpetrator History  | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Special Needs\* | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Substance Abuse / Use | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Substance Abuse or Dependence with the need for medical detoxification | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Suicidal | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Suicidal Gestures | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Suicidal Ideation | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Verbal Aggression – threaten, bully or other coercing, including threats of physical harm | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |
| Other: (Specify)       | [ ] Yes [ ] No | [ ] Yes [ ] No | [ ] Yes [ ] No |

\***Special Needs -** means a Child with medical, mental, emotional, behavioral or educational needs that could require extra on-going attention.

**CHILDREN’S RECORDS**

1. **Identify where Children’s current and archived records will be maintained and backed up.**

**ORGANIZATIONAL STRUCTURE OF PROFESSIONAL, KEY MANAGEMENT, DIRECT CARE STAFF, AND FOSTER PARENTS**

1. **Attach a copy of your CPA's Board of Directors including:**
2. Full names;
3. Titles;
4. Addresses;
5. Email addresses; and
6. Phone numbers.
7. **Attach a copy of your CPA's Person(s) in a Key Position including:**
8. Full names;
9. Titles, if applicable;
10. Addresses;
11. Email addresses; and
12. Phone numbers.

See definition of Person in a Key Position in the Requirements at <http://www.dfps.state.tx.us/Doing_Business/Purchased_Client_Services/Residential_Child_Care_Contracts/documents/24_Hour_RCC_Requirements.pdf>.

1. **Attach a copy of your CPA's professional organizational chart that clearly depicts lines of authority.**
2. **Attach a copy of your CPA's professional staffing plan, which must contain:**
3. Minimum qualifications for the position; and
4. The primary roles of that position.

**PROFESSIONAL AND KEY MANAGEMENT STAFF**

1. **What is the level of experience (in months or years) with fiscal and/or programmatic components of federal or state programs? If some positions are not applicable, indicate as such.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Position | Name | Experience | Position | Name | Experience |
| President/CEO |  |        | Comptroller/CFO |  |        |
| Executive Director |  |        | Program Director |  |        |
| Administrator |  |        | Treatment / Clinical Director |  |        |
| Chief Operating Officer |  |        | LCCA or LCPAA |  |        |

1. **Attach current resumes and Professional Licenses for the President/CEO, Executive Director, Administrator, Chief Operating Officer, Comptroller/CFO, Program Director, Clinical Director, and Licensed Child-Care Administrator for the CPA for which you are submitting an Application.**
	1. Attach copies of licenses of any professional licensed employee of the organization, including licensed professional therapists.
2. **What is the annual turnover rate for professional and key management Staff within the last 12 months?**

**Direct Care Staff and Foster Parents**

1. **In what region(s) does your CPA plan to develop new TFFC homes?**

1. **An Applicant must submit Form 9077RCC Internal Control Structure Questionnaire (ICSQ) and all applicable attachments (Appendix A File Folder 3) to confirm accounting systems and procedures in in place that support fiscal responsibility.**

**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 and accept them without alteration. |
| Signature of Authorized Representative | Date      |
| Name of Authorized Representative (Printed)      | Title of Authorized Representative (Printed)      |

**APPENDIX A - APPLICATION, ATTACHMENTS, REQUIRED FORMS and SERVICE LEVEL MONITOR ATTACHEMENTS**

**FILE FOLDER 1: Application**

|  |  |  |  |
| --- | --- | --- | --- |
| **Document****Location** | **ELECTRONIC FILE NAME** | **Document** | **Is Document Required Yes/No** |
| Package 2 Form B | Application | Application for Enrollment | Yes |
| Applicant Provides | DBA | Assumed Name Certificate | Yes, if applicable. |
| Applicant Provides | Incorporation | Certificate of Incorporation | Yes, if applicable. |
| Applicant Provides | LLC | LLC Articles of Formation | Yes, if applicable. |
| Applicant Provides | Partnership  | Partnership Agreement | Yes, if applicable. |
| Applicant Provides | Insurance | Insurance Documents | Yes, if currently insured. Insurance is not required at the time of application. |

**FILE FOLDER 2: Attachments**

|  |  |  |  |
| --- | --- | --- | --- |
| **Document Location** | **ELECTRONIC FILE NAME** | **Document** | **Is Document Required Yes/No** |
| Applicant Provides | License | HHS CCL  | Yes |
| Applicant Provides | Board | Board of Directors | Yes, if applicable. |
| Applicant Provides | Key Position | Person in Key Position | Yes |
| Applicant Provides | Org Chart | Professional Organizational Chart | Yes |
| Applicant Provides | Staffing Plan | Professional Staffing Plan | Yes |
| Applicant Provides | Resume/ Professional Licenses/Work History | Resumes, Professional Licenses Work History with any other Residential Provider for Key Management Staff(Label applicable additional resumes accordingly, e.g. 02.F, 02.G, etc.) | Yes |
| Applicant Provides | Bank Statements | 3 Consecutive Months of most current Bank Statements | Yes |
| Applicant Provides | Terms and Conditions of all Loans | Loan Agreement for any Loans obtained by the Applicant | Yes, if applicable. |
| Applicant Provides | Rental Property Agreement | Rental Property Contract or Lease Agreement | Yes, if applicable. |

**FILE FOLDER 3: Required Forms**

| **Document****Location** | **ELECTRONIC FILE NAME** | **Document** | **Is Document Required Yes/No** |
| --- | --- | --- | --- |
| Package 6 Form I | [Form 2031](https://www.dfps.state.tx.us/Doing_Business/forms.asp) | Signature Authority Designation | Yes |
| Package 7 Form J | [Form 2970c](https://www.dfps.state.tx.us/Doing_Business/forms.asp) | Disclosure and Consent to Release of Information Regarding Criminal or Abuse/Neglect History For Applicants, Employees or Volunteers of DFPS Contractors and Subcontractors | Yes |
| Package 7 Form J | 2970c - A | Executive Director | Yes, if applicable. |
| Package 7 Form J | 2970c - B | Chief Executive Officer | Yes, if applicable. |
| Package 7 Form J | 2970c - C | Comptroller  | Yes, if applicable. |
| Package 7 Form J | 2970c - D | Chief Financial Officer | Yes, if applicable. |
| Package 8 Form K | [Form 2971c](https://www.dfps.state.tx.us/Doing_Business/forms.asp) | Request for Criminal History and DFPS History Check | Yes |
| Package 8 Form K | 2971c - A | Executive Director | Yes, if applicable. |
| Package 8 Form K | 2971c - B | Chief Executive Officer | Yes, if applicable. |
| Package 8 Form K | 2971c - C | Comptroller  | Yes, if applicable. |
| Package 8 Form K | 2971c - D | Chief Financial Officer | Yes, if applicable. |
| Package 9 Form L | [Form AP-152](https://www.dfps.state.tx.us/Doing_Business/forms.asp) | Application for Texas Identification Number | Yes |
| Package 10 Form M | [Form 9007RCC](https://www.dfps.state.tx.us/Doing_Business/forms.asp) | Internal Control Structure Questionnaire (ICSQ) for Residential Child Care | Yes |
| Applicant Provides | Attachment I-2 | If yes, submit most current financial statement; or If no, submit current financial position | Yes |
| Applicant Provides | Attachment I-2C | If yes, submit most recent tax return | Yes, if applicable. |
| Applicant Provides | Attachment I-3 | If yes, submit current Audit and Management letter (Only applicable to operations that have conducted annual audits) | Yes, if applicable. |
| Applicant Provides | Attachment I-7A | If yes, submit copy of IRS Audit Report; and Related IRS correspondence  | Yes, if applicable. |
| Applicant Provides | Attachment I-7D | Description of IRS discrepancies or liens impacting operation’s financial position | Yes, if applicable. |
| Applicant Provides | Attachment I-8 | If yes, submit a description of discrepancies and/or unresolved issues with the State Auditor’s Office (SAO) | Yes, if applicable. |
| Applicant Provides | Attachment I-9 | If yes, submit procedures describing your process for safeguarding and securing confidential information | Yes, if applicable. |
| Applicant Provides | Attachment III-14 | Explain why foster family rates for all four (4) years are not included | Yes, if applicable. |
| Applicant Provides | Attachment III-15 | Descriptions of Applicant’s processes for ensuring financial disbursement to foster families are made within ten (10) days of receipt of DFPS funds  | Yes, if applicable. |
| Applicant Provides | Attachment III-17 | If yes, submit a description of how your organization pays for Intermittent Alternative Care | Yes, if applicable. |
| Package 11 Form N | [Form 9025a.doc](https://www.dfps.state.tx.us/Doing_Business/forms.asp) | Related Party (Building & Transportation - Leases/Rental Worksheet) | Yes |

**FILE FOLDER 4: Service Level Monitor Attachments**

The following information needs to be organized in File Folder 4 as provided below.

|  |  |  |  |
| --- | --- | --- | --- |
| **Document Location** | **ELECTRONIC FILE NAME** | **Document** | **Is Document Required Yes/No** |
| Applicant Provides | License | HHS License  | Yes |
| Applicant Provides | Model and Philosophy | Program Model and Philosophy | Yes |
| Applicant Provides | Policies and Procedures | Complete Set of Program Policies and Procedures | Yes |
| Applicant Provides | Substance Abuse | Substance Abuse Policy and Procedure | Yes |
| Applicant Provides | Program Components | Description of All Program Components Including Behavioral and Therapeutic Interventions | Yes |
| Applicant Provides | Children’s Orientation | Children’s 1. Rules, Rewards, Consequences and/or
2. Orientation Manual/Handbook
 | Yes |
| Applicant Provides | Daily Schedules | Example of Daily Schedules for 1. School Year,
2. Summer and
3. Weekends
 | Yes |
| Applicant Provides | Recreation Schedule | Example of Recreation Schedule | Yes |
| Applicant Provides | Therapeutic Value | Description of Recreational Program, including its therapeutic value | Yes |
| Applicant Provides | School Relationship | Written description of the relationship with the school system | Yes |
| Applicant Provides | Observation | Plan to Provide 1. Direct, Continuous Observation of a Child Who May Be at Risk for Harming Self or Others, and
2. Awake Night Staff Based on the Child’s Needs
 | Yes |
| Applicant Provides | Professional Staffing Plan | Professional Staffing Plan to Include 1. Responsibility for Developing Diagnostic Assessments and
2. Treatment Plans
 | Yes |
| Applicant Provides | Training Schedule | Training Schedule for Foster Parents to Complete Annual Training Requirements | Yes |
| Applicant Provides | Medical, Dental and Therapy Services | Contracts, Agreements or Plans for Professionals Providing 1. Medical,
2. Dental and
3. Therapy Services
 | Yes |
| Applicant Provides | Psychotropic Medication | Contracts, Agreements, or Plans for Professionals to Provide 1. Psychotropic Medication Training and
2. Medication Monitoring, and
3. On-Call/Emergency Services
 | Yes |
| Applicant Provides | Child’s Record | Sample of 1. 72-Hour Treatment Plan,
2. Diagnostic Assessment,
3. Treatment Plan or Plan of Service;
4. Individual, Group and/or family Therapy notes;
5. Progress Reports;
6. School reports;
7. Medication Monitoring reports;
8. Serious Incidents reports,
9. Case Management Notes, daily logs or Documentation by Foster Parents
 | Yes |