**6.1 IPTP NEW APPLICANT OPEN ENROLLMENT APPLICATION**

# INSTRUCTIONS

### Applicant must read all of the Open Enrollment posted on the 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. DFPS considers a complete answer to be a written response. Responding with “Not Applicable” is only an appropriate response when a question or form does not apply to the Applicant.

### 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 License for the GRO and services for which the Applicant is submitting an Application or a letter from CCR stating that an application for such a License is complete and has been accepted. |

**SECTION II – SERVICE AREA**

A separate Application must be submitted for each License (or letter from CCR stating that an application for such a License is complete and has been accepted) and service type you propose to provide in accordance with the information in this section. If proposing to provide multiple IPTPs, a separate application must be submitted for each facility that you propose to provide IPTP services.

**For In-State Applicants:** Select the appropriate DFPS Region/s for each question.

**APPLICATIONS NOT ACCEPTED** – New applications for IPTPs with all capacity located within a CBC catchment area will not be accepted. For a list of CBC catchments, see the [Community-Based Care page](https://www.dfps.texas.gov/CBC/default.asp) on the DFPS website.

**For Out-of-State Applicants:** Enter the city and state in “Other” for both questions below.

1. **Select the DFPS Region below where your administrative headquarter is located:**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Region: | 1 [ ]  | 2[ ]  | 3[ ]  | 4[ ]  | 5[ ]  | 6[ ]  | 7[ ]  | 8[ ]  | 9[ ]  | 10[ ]  | 11[ ]  |

Other: (City and State)

1. **Please mark the DFPS Region/s where you will be providing services outside of CBC catchment areas.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Region: | 7 | 9 | 10 | 11 |
|  |  |  |  |  |

Other: (City and State)

**SECTION III – INSURANCE**

Review Subsection 1.5.5 of this Open Enrollment, II(G) of Subsection 1.8.1c, and I(G) of 6.3.1 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 IPTP 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. Performance under government contracts and other private party contracts in Texas or any other state for the last five years.

1. Your past experience working with residential child-care services for the last five years.

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

 [ ]  Yes [ ]  No

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

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

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

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

 [ ]  Yes [ ]  No

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

1. Provide the date of the termination and the contract number, and list the factors cited that contributed to DFPS or any other private party or governmental entity taking that action.

1. Describe in detail the actions taken by your Operation to remedy each factor that contributed to that termination.

1. **Have you applied for a contract to provide residential child-care services, and not been awarded a contract by DFPS or any other private party or governmental entity within the last five years?**

 [ ]  Yes [ ]  No

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

1. List the factors that contributed to DFPS or any other private party or governmental entity taking that action; and

1. Describe in detail the actions taken by your Operation to remedy each factor that contributed to that denial.

1. **Provide a list of all current contracts with DFPS or any other private or governmental entity (federal, state or county). 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; and
8. Begin and end date of the contract.

1. **For the contracts listed in question #5 above, briefly describe your compliance with program requirements, and any corrective actions put into place by the contracting agency. Include copies of contract monitoring reports and letters from the contracting entity to the Applicant during the last five years.**

1. Identify the referral sources that make up Applicant’s child population by estimating the percentage (%) for each placement source (for example):

|  |  |
| --- | --- |
| **Referral Source** | **Percentage** |
| DFPS |  |
| Texas Juvenile Justice Department |  |
| Texas Youth Commission |  |
| Out of State |  |
| Other – (List Individually) |  |
| Total | 100% |

Add additional rows to table, if needed, to list “Other” referral sources individually. Total should equal 100%.

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

 [ ]  Yes [ ]  No

 **If yes, specify the following:**

[ ]  Specific Region/City

1. **Does your Operation have experience serving Children with a history of multiple psychiatric hospitalizations?**

[ ]  Yes [ ]  No

**If yes, describe your Operation’s relevant experience providing services similar to the IPTP services being procured under this Open Enrollment.**

**Please also identify the following:**

1. License and licensing-authority under which you provided these services;
2. Compliance with program requirements;
3. Corrective actions required; and
4. Any termination or non-renewal for cause.

Note: Experience in the last five years is considered the most relevant in assessing applications.

1. **Does your Operation currently operate a program capable of providing the Intensive Psychiatric Transition Program services described in Section 2 of this Open Enrollment?**

[ ]  Yes [ ]  No

* 1. **If yes, what is the bed capacity of your current program?**

Male       Female

* 1. **What is the bed capacity that you would dedicate to the Intensive Psychiatric Transition Program?**

Male       Female

1. **Describe how DFPS-referrals under this Open Enrollment will be incorporated into Applicant’s operational capacity:**

1. **How will the IPTP manage admissions and coordinate the transitioning of Children into less restrictive settings?**

1. **Check the appropriate box, if your Operation proposes to serve any of the listed groups of Children.**

|  |  |  |
| --- | --- | --- |
|  [ ]  N/A | [ ]  Children 16 to 17 years of age | [ ]  Young Adults 18 to 22 years of age |

1. **Describe the population to be served through IPTP including age, gender, behavior and mental health disorders**

**TARGETED CHARACTERISTICS**

1. **In accordance with the service levels you are proposing to serve, check the characteristics and behaviors of Children specified for each category 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 |
| 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 Developmental Disabilities (ICFIDD) | [ ] 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.

**BEHAVIORAL HEALTH SERVICES**

1. **Identify the name(s) of the individual(s) providing behavioral health services and state the relationship that this person has with your Organization by indicating if they are a subcontractor, employee or neither of these. All therapists are required to be STAR Health providers.**

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

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

1. **Attach a copy of your Operation'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 Operation'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 <https://www.dfps.texas.gov/Doing_Business/Purchased_Client_Services/Residential_Child_Care_Contracts/documents/24_Hour_RCC_Requirements.pdf>.

1. **Attach a copy of your Operation's professional organizational chart that clearly depicts lines of authority.**
2. **Attach a copy of your Operation'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 and/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 with fiscal components** | **Experience with programmatic components** |
| President/CEO |  |        |        |
| Executive Director |  |        |        |
| Administrator |  |        |        |
| Chief Operating Officer |  |        |        |
| Comptroller/CFO |  |       |       |
| Program Director |  |       |       |
| Treatment/ Clinical Director |  |       |       |
| 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 Operation 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?**

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.**
2. **Attach the following additional financial documents:**
	1. Bank statements for the most recent 3 months
	2. Projected 12-month budget
	3. Balance sheet (statement of financial position)
	4. Income statement

**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, REQUIRED FORMS and SERVICE LEVEL MONITOR ATTACHEMENTS**

**FILE FOLDER 1: Application**

|  |  |  |  |
| --- | --- | --- | --- |
| **Document****Location** | **Electronic File Name** | **Document** | **Is Document Required Yes/No** |
| Current Document | 01-Application | Application for Enrollment | Yes |
| Applicant Provides | 01.A-DBA | Assumed Name Certificate | Yes, if applicable. |
| Applicant Provides | 01.B-Incorporation | Certificate of Incorporation | Yes, if applicable. |
| Applicant Provides | 01.C-LLC | LLC Articles of Formation | Yes, if applicable. |
| Applicant Provides | 01.D-Partnership  | Partnership Agreement | Yes, if applicable. |
| Applicant Provides | 01.E-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 | 01-License | HHS License or CCR acceptance letter | Yes |
| Applicant Provides | 02.A-Board | Board of Directors | Yes, if applicable. |
| Applicant Provides | 02.B-Key Position | Person in Key Position | Yes |
| Applicant Provides | 02.C-Org Chart | Professional Organizational Chart | Yes |
| Applicant Provides | 02.D-Staffing Plan | Professional Staffing Plan | Yes |
| Applicant Provides | 02.E-Resume/ Professional Licenses | Resumes and Professional Licenses for Key Management Staff (Label applicable additional resumes accordingly, e.g. 02.F, 02.G, etc.) | Yes |
| Applicant Provides | 02.F-Resume/ Professional Licenses | Yes, if applicable. |
| Applicant Provides | 02.G-Resume/ Professional Licenses | Yes, if applicable. |

**FILE FOLDER 3: Required Forms**

To complete the below, see definition of Principal in the Requirements at <https://www.dfps.texas.gov/Doing_Business/Purchased_Client_Services/Residential_Child_Care_Contracts/documents/24_Hour_RCC_Requirements.pdf>

| **Document****Location** | **Electronic File Name** | **Document** | **Is Document Required Yes/No** |
| --- | --- | --- | --- |
| Package 3 Form I | 01-[Form 2031](https://www.dfps.texas.gov/Application/Forms/showFile.aspx?Name=2031.docx) | Signature Authority Designation | Yes |
| Package 3 Form II | 02-[Form 2970c](https://www.dfps.texas.gov/Application/Forms/showFile.aspx?NAME=F-500-2970c.pdf) | Disclosure and Consent to Release of Information Regarding Criminal or Abuse/Neglect History For Applicants, Employees or Volunteers of DFPS Contractors and Subcontractors – Must be completed for all Principals, in addition to all 4 of the positions below, as applicable | Yes |
| Package 3 Form II | 02.A-2970c | Executive Director | Yes, if applicable. |
| Package 3 Form II | 02.B-2970c | Chief Executive Officer | Yes, if applicable. |
| Package 3 Form II | 02.C-2970c | Comptroller  | Yes, if applicable. |
| Package 3 Form II | 02.D-2970c | Chief Financial Officer | Yes, if applicable. |
| Package 3 Form III | 03-[Form 2971c](https://www.dfps.texas.gov/Application/Forms/showFile.aspx?NAME=F-500-2971c.pdf) | Request for Background Check for Purchased Client Services – Must be completed for all Principals, in addition to all 4 of the positions below, as applicable | Yes |
| Package 3 Form III | 03.A-2971c | Executive Director | Yes, if applicable. |
| Package 3 Form III | 03.B-2971c | Chief Executive Officer | Yes, if applicable. |
| Package 3 Form III | 03.C-2971c | Comptroller  | Yes, if applicable. |
| Package 3 Form III | 03.D-2971c | Chief Financial Officer | Yes, if applicable. |
| Package 4 Form IV | 04-[Form AP-152](https://fmx.cpa.texas.gov/fm/pubs/payment/payee_setup/?s=forms_payee_maint&p=app_tin) | Application for Texas Identification Number | Yes |
| Package 4 Form V | 05-[Form 9007RCC](https://www.dfps.texas.gov/Application/Forms/showFile.aspx?Name=9007RCC.docx) | Internal Control Structure Questionnaire (ICSQ) for Residential Child Care | Yes |
| Applicant Provides | 05.A-Attachment I-2 | If yes, submit most current financial statement; or If no, submit current financial position | Yes |
| Applicant Provides | 05.B-Attachment I-2C | If yes, submit most recent tax return | Yes, if applicable. |
| Applicant Provides | 05.C-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 | 05.D-Attachment I-7A | If yes, submit copy of IRS Audit Report; and Related IRS correspondence  | Yes, if applicable. |
| Applicant Provides | 05.E-Attachment I-7D | Description of IRS discrepancies or liens impacting operation’s financial position | Yes, if applicable. |
| Applicant Provides | 05.F-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 | 05.G-Attachment I-9 | If yes, submit procedures describing your process for safeguarding and securing confidential information | Yes, if applicable. |
| Package 5 Form VI | 06-[Form 9025a.doc](https://www.dfps.texas.gov/Application/Forms/showFile.aspx?Name=9025a.pdf) | 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.

1. A valid HHS License or CCR acceptance letter.
2. Complete setof program policies and procedures, model and philosophy. Submitted policies and procedures must include:
	1. A substance abuse policy that indicates the Applicant will ensure substance abuse services will be provided for the Child, if needed. Substance abuse services can include referrals to outpatient/inpatient programs in the community, or substance abuse services provided through the Applicant's IPTP; and
	2. 24-Hour Continuous Supervision policy that indicates the Applicant will ensure compliance with Section 1115 of the Requirements relating to GROs who are serving seven or more children. The policy must include a floor plan of the facility.
	3. [HHS Form 2960-Attachment C](https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/forms/2960/2960-AttachmentC.pdf) – General Residential Operations – Additional Operation Plan completed for all Applicant operations licensed on or after December 1, 2019. This plan documents the operational, community engagement, and educational plan.

Submit all of your IPTP/GRO’s Policies and Procedures.

1. Description of all program components to include behavioral and therapeutic interventions.
2. Children’s rules, rewards, consequences and/or orientation manual/handbook.
3. Example of daily schedules for school year, summer and weekends.
4. Example of recreation schedule.
5. Description of recreational program including its therapeutic value.
6. Written description of the relationship with the school system or a written agreement between the Applicant and the school district.

Information needed includes an outline of the Applicant's responsibilities including procedures for resolving conflicts occurring during school activities.

1. Written plan to provide direct, continuous observation of a Child who may be at risk for harming self or others and to provide awake night staff if indicated based on the needs of the Child.
2. Professional staffing plan to include responsibility for developing diagnostic assessments and treatment plans.
3. Training schedule for Direct Care Staff to complete annual training requirements.
4. Contracts, agreements or plans for professionals providing medical, dental and therapy services.
5. Contracts, agreements or plans for professionals to provide psychotropic medication training and medication monitoring and on-call/emergency services.
6. Example of a Child’s Record to include a sample of:
7. 72-Hour Treatment Plan;
8. Diagnostic Assessment;
9. Treatment plan or plan of service;
10. Individual, group and/or family therapy notes;
11. Progress reports and school reports;
12. Medication monitoring reports;
13. Serious incidents reports;
14. Case management notes; and
15. Daily logs or documentation by Direct Care Staff.

|  |  |  |  |
| --- | --- | --- | --- |
| **Document Location** | **Electronic File Name** | **Document** | **Is Document Required Yes/No** |
| Applicant Provides | 01-License | HHS License or acceptance letter | Yes |
| Applicant Provides | 02-Model and Philosophy | Program Model and Philosophy | Yes |
| Applicant Provides | 02.A-Policies and Procedures | Complete Set of Program Policies and Procedures | Yes |
| Applicant Provides | 02.B-Substance Abuse | Substance Abuse Policy and Procedure | Yes |
| Applicant Provides | 03-Program Components | Description of All Program Components Including Behavioral and Therapeutic Interventions | Yes |
| Applicant Provides | 04-Children’s Orientation | Children’s 1. Rules, Rewards, Consequences and/or
2. Orientation Manual/Handbook
 | Yes |
| Applicant Provides | 05-Daily Schedules | Example of Daily Schedules for 1. School Year,
2. Summer and
3. Weekends
 | Yes |
| Applicant Provides | 06-Recreation Schedule | Example of Recreation Schedule | Yes |
| Applicant Provides | 07-Therapeutic Value | Description of Recreational Program, including its therapeutic value | Yes |
| Applicant Provides | 08-School Relationship | Written description of the relationship with the school system | Yes |
| Applicant Provides | 09-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 | 10-Professional Staffing Plan | Professional Staffing Plan to Include 1. Responsibility for Developing Diagnostic Assessments and
2. Treatment Plans
 | Yes |
| Applicant Provides | 11-Training Schedule | Training Schedule for Direct Care Staff to Complete Annual Training Requirements | Yes |
| Applicant Provides | 12-Medical, Dental and Therapy Services | Contracts, Agreements or Plans for Professionals Providing 1. Medical,
2. Dental and
3. Therapy Services
 | Yes |
| Applicant Provides | 13-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 | 14-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 and School reports;
6. Medication Monitoring reports;
7. Serious Incidents reports,
8. Case Management Notes;
9. Daily logs or Documentation by Direct Care Staff.
 | Yes |