**7 QRTP OPEN ENROLLMENT APPLICATION, ATTACHMENTS and**

**REQUIRED FORMS**

# INSTRUCTIONS

### Applicant must read all of the Open Enrollment posted on the Electronic State Business Daily (ESBD) or Health and Human Services (HHS) Enrollment Sites before completing this Application (see Section 1.3 of the Open Enrollment).

### The Application must be completed and signed in Section VII (Certification) for it to be accepted by the Department of Family and Protective Services (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 QRTP Requirements and Services by Applicant (See File Folder 4 in Appendix A).
2. Applicant will provide the information listed in Quality Assurance Review (See File Folder 5 in Appendix A)

### Applicant will submit all contract application files and documents to the following email address at 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 (if applicable) |  | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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 above  Applicant:    Operation Address - If different from Office Address above  Applicant: | | | | |
| Federal ID Number – If different from Vendor ID  Applicant: | | | 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 | | | | |
| 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 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 | | | | |
| Submita HHSC Licensed General Residential Operations with treatment services the Operation and services for which the Applicant is submitting an Application. Out-of-State Applicants submit license to provide the services sought in this Open Enrollment by their equivalent state licensing authority. | | | | |

**SECTION II – SERVICE AREA**

A separate application must be submitted for each License you propose to provide in accordance with the information in this section. If proposing to provide multiple QRTPs, a separate application must be submitted for each operation that you propose to provide QRTP services (see Sections 1.6 and 1.7).

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

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

Out-of-State: (City and State)

1. **Select the DFPS Region where you will be providing services.**

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

Out-of-State: (City and State)

**SECTION III – INSURANCE**

Review Section II. G. of DFPS Vendor Supplemental, Special and Programmatic Conditions for Qualified Residential Treatment Program (QRTP) 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 Operation 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, Applicant 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, Applicant must submit insurance coverage documentation at the time of 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.
3. 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.
9. **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:

|  |  |
| --- | --- |
| **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 DFPS Region/City

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

Yes No

**If yes, describe your organization’s relevant experience providing services similar to the QRTP 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.**

1. **Does your organization currently operate a program capable of providing the QRTP services described in 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 Qualified Residential Treatment Program?**

Male\_\_\_\_\_\_\_\_\_\_ Female\_\_\_\_\_\_\_\_\_\_

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

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

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

**TARGETED CHARACTERISTICS:**

1. **In accordance with the service 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 |
| 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 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.

**HEALTH CARE and 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 subapplicant, employee or neither of these.**

1. **Identify the name(s) of the individual(s) providing registered or licensed nursing services.**

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 <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 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 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 |  |  |
| LCCA or LCPAA |  |  | Treatment / Clinical Director |  |  |
| Chief Operating Officer |  |  | Other if applicable |  |  |

**Attach current resumes** for the President/CEO, Executive Director, 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 operation, including licensed professional therapists and nursing staff.
2. **What is the annual turnover rate for professional and key management Staff within the last 12 months?**

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

**SECTION V- QRTP REQUIREMENTS**

**Provide in a narrative format how your QRTP will meet the requirements in Sections 2.4.4 - 2.4.9. in the Open Enrollment. This narrative must include:**

1. The trauma-informed research-supported or evidence-based treatment model which is to be utilized.
2. Plan and ability to meet the requirement for having registered or licensed nursing staff and other clinical staff who are available 24 hours a day, seven days a week and on-site during business hours.
3. Plans and processes to facilitate the participation of family members in the child’s treatment program.
4. Plans and processes to facilitate the outreach to the family members of the child, including siblings, including documenting how the outreach is made and maintaining contact information for any known biological family and fictive kinship of the child.
5. Plans and processes to facilitate activities and document into the child’s treatment plan all efforts designed to assist in finding individuals or family members for youth who have no identified family or fictive kin in a supportive role.
6. Plans and processes to document in the Child’s Plan of Service how the family members were integrated into the treatment process, including post-discharge, and how sibling connections are maintained.
7. Plans and processes to perform discharge planning and family-based aftercare support for at least six months post discharge, including logistical limitations that may exist beyond a 50-mile radius of applicant’s operation.

**SECTION VI- SERVICES BY APPLICANT**

Provide in a bulleted format how your QRTP Program will meet the service requirements in Section 2.5. of the Open Enrollment.

This narrative must include information that clearly explains all information in sections 2.5.1 - 2.5.11. Any application that does not clearly address each of these areas may be deemed incomplete.

**SECTION VII – 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. I have attached a Corporate Board of Directors Resolution or similar document authorizing me to enter into contracts on behalf of this legal entity.  By signing this Application, I certify that the Texas address shown on the Application is the Applicant's address, which qualifies the Applicant as a Texas Resident Bidder as defined in Texas Administrative Code, Title 34, Part 1, Chapter 20. | |
| Signature of Authorized Representative | Date |
| Name of Authorized Representative (Printed) | Title of Authorized Representative (Printed) |

**APPENDIX A - APPLICATION, ATTACHMENTS, REQUIRED FORMS AND UTILIZATION REVIEW ATTACHEMENTS**

**FILE FOLDER 1: Application**

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

**FILE FOLDER 2: Attachments**

|  |  |  |
| --- | --- | --- |
| **ELECTRONIC FILE NAME** | **Document** | **Is Document Required Yes/No** |
| License | HHS CCL | Yes |
| Accreditation | Documentation of Current Accreditation | Yes |
| Board | Board of Directors | Yes, if applicable. |
| Key Position | Person in Key Position | Yes |
| Org Chart | Professional Organizational Chart | Yes |
| Staffing Plan | Professional Staffing Plan | Yes |
| Resume/ Professional Licenses | Resumes and Professional Licenses for Key Management Staff  (Label applicable additional resumes, using the individuals initials) | Yes |
| Resume/ Professional Licenses | Yes, if applicable. |
| Resume/ Professional Licenses | Yes, if applicable. |
| 12 Month Budget | 12 Month Budget | Yes |
| Bank Statements | 3 Consecutive Months of most current Bank Statements | Yes |
| Terms and Conditions of all Loans | Loan Agreement for any Loans obtained by the Applicant | Yes, if applicable. |
| Rental Property Agreement | Rental Property Contract or Lease Agreement | Yes, if applicable. |

**FILE FOLDER 3: Required Forms**

|  |  |  |
| --- | --- | --- |
| **ELECTRONIC FILE NAME** | **Document** | **Is Document Required Yes/No** |
| [Form 2031](https://www.dfps.state.tx.us/Doing_Business/forms.asp) | Signature Authority Designation | Yes |
| [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 Applicants and Subapplicants | Yes |
| [Form 2970c](https://www.dfps.state.tx.us/Doing_Business/forms.asp) | Executive Director | Yes, if applicable. |
| [Form 2970c](https://www.dfps.state.tx.us/Doing_Business/forms.asp) | Chief Executive Officer | Yes, if applicable. |
| [Form 2970c](https://www.dfps.state.tx.us/Doing_Business/forms.asp) | Comptroller | Yes, if applicable. |
| [Form 2970c](https://www.dfps.state.tx.us/Doing_Business/forms.asp) | Chief Financial Officer | Yes, if applicable. |
| [Form 2971c](https://www.dfps.state.tx.us/Doing_Business/forms.asp) | Request for Criminal History and DFPS History Check | Yes |
| [Form 2971c](https://www.dfps.state.tx.us/Doing_Business/forms.asp) | Executive Director | Yes, if applicable. |
| [Form 2971c](https://www.dfps.state.tx.us/Doing_Business/forms.asp) | Chief Executive Officer | Yes, if applicable. |
| [Form 2971c](https://www.dfps.state.tx.us/Doing_Business/forms.asp) | Comptroller | Yes, if applicable. |
| [Form 2971c](https://www.dfps.state.tx.us/Doing_Business/forms.asp) | Chief Financial Officer | Yes, if applicable. |
| [Form AP-152](https://www.dfps.state.tx.us/Doing_Business/forms.asp) | Application for Texas Identification Number | Yes |
| [Form 9007RCC](https://www.dfps.state.tx.us/Doing_Business/forms.asp) | Internal Control Structure Questionnaire (ICSQ) for Residential Child Care | Yes |
| Attachment I-2(b) | If yes, submit most current financial statement; or  If no, submit current financial position | Yes |
| Attachment I-3 | If yes, submit most recent tax return | Yes, if applicable. |
| Attachment I-4 | If yes, submit current Audit and  Management letter (Only applicable to operations that have conducted annual audits) | Yes, if applicable. |
| Attachment I-9A | If yes, submit copy of IRS Audit Report; and Related IRS correspondence | Yes, if applicable. |
| Attachment I-9D | Description of IRS discrepancies or liens impacting operation’s financial position | Yes, if applicable. |
| Attachment II-10 | If yes, submit a description of discrepancies and/or unresolved issues with the State Auditor’s Office (SAO) | Yes, if applicable. |
| Attachment II-11 | Submit procedures describing your process for safeguarding and securing confidential information | Yes |
| [Form 9025a](https://www.dfps.state.tx.us/Doing_Business/forms.asp) | Related Party (Building & Transportation - Leases/Rental Worksheet) | Yes |

**FILE FOLDER 4: QRTP Requirements and Services by Applicant**

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

|  |  |  |
| --- | --- | --- |
| Application Section V | QRTP Requirements | Yes |
| Application Section VI | Applicant Services | Yes |

**FILE FOLDER 5: Quality Assurance Review**

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

1. A valid HHS License and Documentation of Current Accreditation in compliance with Section 2.3.11. in the Open Enrollment.
2. Complete setof program policies and procedures, model and philosophy. Submitted policies and procedures must include:
   1. 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 Operation; and
   2. 24-Hour Continuous Supervision policy that indicates the Applicant will ensure compliance with Section 1115 of the 24-Hour Requirements relating to GROs who are serving seven or more children. The policy must include a floor plan of the operation.
   3. Notifications Related to the Child policy that indicates the Applicant will ensure compliance with Section 1420 of the 24-Hour Requirements relating to GROs.
   4. [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.
3. Description of all program components to include behavioral and therapeutic interventions.
4. Children’s rules, rewards, consequences and/or orientation manual or handbook.
5. Example of daily schedules for school year, summer and weekends.
6. Example of recreation schedule.
7. Description of recreational program including its therapeutic value.
8. 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; school reports;
12. Medication monitoring reports;
13. Serious incidents reports;
14. Case management notes; and
15. Daily logs or documentation by Direct Care Staff.

|  |  |  |
| --- | --- | --- |
| **ELECTRONIC FILE NAME** | **Document** | **Is Document Required Yes/No** |
| License | HHS License or acceptance letter | Yes |
| Accreditation | Current Accreditation | Yes |
| Model and Philosophy | Program Model and Philosophy | Yes |
| Policies and Procedures | Complete Set of Program Policies and Procedures | Yes |
| Substance Abuse | Substance Abuse Policy and Procedure | Yes |
| 24-Hour Continuous Supervision | 24-Hour Continuous Supervision Policy and Procedure | Yes |
| Notifications Related to the Child | Notifications Related to the Child Policy and Procedure | Yes |
| [HHS Form 2960 Attachment C](https://hhs.texas.gov/laws-regulations/forms/2000-2999/form-2960-application-a-license-operate-a-residential-child-care-facility) | General Residential Operations – Additional Operation Plan | Yes |
| Program Components | Description of All Program Components Including Behavioral and Therapeutic Interventions | Yes |
| Children’s Orientation | Children’s   1. Rules, Rewards, Consequences and/or 2. Orientation Manual/Handbook | Yes |
| Daily Schedules | Example of Daily Schedules for   1. School Year, 2. Summer and 3. Weekends | Yes |
| Recreation Schedule | Example of Recreation Schedule | Yes |
| Therapeutic Value | Description of Recreational Program, including its therapeutic value | Yes |
| School Relationship | Written description of the relationship with the school system | Yes |
| 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 |
| Professional Staffing Plan | Professional Staffing Plan to Include   1. Responsibility for Developing Diagnostic Assessments and 2. Treatment Plans | Yes |
| Training Schedule | Training Schedule for Direct Care Staff to Complete Annual Training Requirements | Yes |
| Medical, Dental and Therapy Services | Contracts, Agreements or Plans for Professionals Providing   1. Medical, 2. Dental and 3. Therapy Services | Yes |
| 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 |
| 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 Direct Care Staff | Yes |