Application for Pre-Qualification (Form PR003-001)

Applicants are discouraged from submitting information considered confidential and proprietary unless it is deemed essential for the proper evaluation of the Application. If the Application contains information the Applicant considers to be trade secrets; information that is financial; or information that is privileged or confidential; then, the specific pages containing such information shall be clearly marked. It is understood by all parties, the information submitted as part of this Application for Pre-Qualification is not confidential and may be disclosed to the extent authorized by law.

Please complete a response for each item. Any answer of **Not** Applicable requires a detailed explanation/justification attached to this Application.

Applicant Agency Name: _____

Authorized Agency Official (AAO) Name: _____

AAO Title: _____ **Email:** _____

Corporate Address: _____

_____

Applicant Phone Number: _____ **Applicant Website:** _____

Service County: _____

Tax ID Number: _____ **NPI Number:** _____

In order to expedite the Review process, please complete and sign all the items required in this Application for Pre-Qualification including the attestation of accuracy. All items listed below must be submitted as part of this Application. Any items not completed or submitted will be returned without review and determined non-responsive.

- ☐ Application for Pre-Qualification
- ☐ Mandatory Assurances
- ☐ Working Agreement for SSI/SSDI Outreach, Access, and Recovery (SOAR)
- ☐ Certification Regarding Lobbying
- ☐ Civil Rights Compliance Questionnaire
- ☐ Administrative and Fiscal Self Evaluation
- ☐ Agency Operating Budget
- ☐ Certification of Debarment, Suspension, Ineligibility, and Voluntary Exclusion
- ☐ Current Accreditation Certificate ☐ Not Applicable
- ☐ Medicare Acceptance Letter ☐ Not Applicable
- ☐ State License(s) ☐ Not Applicable

☐ Signed and completed Ownership/Controlling Interest Form; ☐ Not Applicable

☐ Proof of Insurance (employment, general, professional, malpractice, property, etc.)

☐ W9 Form

☐ Practitioner Roster (full name; NPI; license; service location; service department) ☐ Not Applicable

☐ Certificate of Status from the Florida Department of State

☐ Articles of Incorporation (N/A for government entities)

☐ Most recent Audit and Management Letter (if applicable) with an unqualified opinion and no findings of material weakness; **Fiscal Year End**: _____

☐ Board of Directors Roster (term, email, affiliation)

☐ Board of Director Meeting Schedule and previous two Meeting Minutes

☐ Agency Bylaws

☐ Letter of Support; (optional)

☐ IRS Form 990

☐ Roster of Other Funders and list of all deficiencies/findings for the previous two (2) year period and status of correction ☐ Not Applicable

☐ Copy of each executed subcontract/**excerpt with services overview** and Memoranda of Understanding related to delivery of client services ☐ Not Applicable

☐ Sliding Fee Scale ☐ Not Applicable

☐ Client Trust Fund procedures ☐ Not Applicable

☐ Quality Assurance / Improvement Plan

☐ Informed Consent Form

☐ Service Plan and related Policy

☐ Treatment Plan and related Policy

☐ Client Record example

☐ Incident Reporting Policy

☐ Grievance and Complaint Policy

☐ Emergency Preparedness Plan/Continuity of Operations Plan

☐ Table of Organization

☐ Resume/Curriculum Vitae for CEO/Executive Director; Clinical Director; Program Director; and Finance Director

☐ Financial Eligibility Screening procedures

☐ Cultural and Linguistic Plan and

☐ Code of Ethics

Applicant Agency Legal Status

☐ Not – For – Profit (include certification of status from the U.S. Internal Revenue Service

☐ Government Organization

☐ For-Profit

Federal Employer Identification Number (FEID):_____

TYPE OF ORGANIZATION (Check all that apply)

☐ Home Health Agency

☐ Hospital

☐ Community Mental Health Center

☐ Skilled Nursing Facility/Nursing Home

☐ Substance Abuse Treatment

☐ Other Inpatient Facility

☐ Other _____

CERTIFICATION AND LICENSURE (Please attach copies to this application)

	Certificate or License Number	Expiration Date
Medicare	_____	_____
Medicaid	_____	_____
State License	_____	_____
JCAHO	_____	_____
CHAP	_____	_____
AAAHC	_____	_____
CARF	_____	_____
ACHC	_____	_____
HFAP/AOA	_____	_____
COA	_____	_____

Restrictions:

Please list any license sanctions or regulatory agency sanctions:

_____

_____

_____

SERVICE LOCATION(S)*: (Please attach list of additional service locations)

Facility Name (Location 1): _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Coordinator: _____ Email: _____

Hours of Operation: :_____ After Hours Contact Number:_____

Population Served: ☐ Infants(0-3) ☐ Preschool(0-5) ☐ Children(6-12) ☐ Adolescents(13-18)

☐ Adults ☐ Geriatrics

Beds: ☐ Adults ☐ Children ☐ Geriatrics ☐ Male ☐ Female

Total Bed Capacity: _____

Outpatient Services (Check all that apply): ☐ Mental Health Psychotherapy ☐ Substance Abuse Psychotherapy ☐ Group Therapy Mental Health ☐ Group Therapy Substance Abuse ☐ Medication Management ☐ Psych Testing ☐ IOP Mental Health ☐ IOP Substance Abuse ☐ PHP Mental Health ☐ PHP Substance Abuse ☐ Other:_____

Inpatient Services (Check all that apply): ☐ Crisis Stabilization Unit Mental Health ☐ Crisis Stabilization Unit Substance Abuse ☐ Addictions Receiving Facility (ARF)/Juvenile Addictions Receiving Facility (JARF) ☐ 23-hour Treatment Observation ☐ Mental Health ☐ Substance Abuse ☐ Detox ☐ Rehabilitation ☐ Residential (Substance Abuse) ☐ Residential (Mental Health) ☐ Residential (Co-Occurring) ☐ Long Term Care ☐ Other:_____

Facility Name (Location 2)**:** _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Coordinator: _____ Email: _____

Hours of Operation:_____ After Hours Contact Number:_____

Population Served: ☐ Infants(0-3) ☐ Preschool(0-5) ☐ Children(6-12) ☐ Adolescents(13-18)

☐ Adults ☐ Geriatrics

Beds: ☐ Adults ☐ Children ☐ Geriatrics ☐ Male ☐ Female

Total Bed Capacity: _____

Outpatient Services (Check all that apply): ☐ Mental Health Psychotherapy ☐ Substance Abuse Psychotherapy ☐ Group Therapy Mental Health ☐ Group Therapy Substance Abuse ☐ Medication Management ☐ Psych Testing ☐ IOP Mental Health ☐ IOP Substance Abuse ☐ PHP Mental Health ☐ PHP Substance Abuse ☐ Other:_____

Inpatient: Services (Check all that apply): ☐ Crisis Stabilization Unit Mental Health ☐ Crisis Stabilization Unit Substance Abuse ☐ Addictions Receiving Facility (ARF)/Juvenile Addictions Receiving Facility (JARF) ☐ 23-hour Treatment Observation ☐ Mental Health ☐ Substance Abuse ☐ Detox ☐ Rehabilitation ☐ Residential (Substance Abuse) ☐ Residential (Mental Health) ☐ Residential (Co-Occurring) ☐ Long Term Care ☐ Other:_____

Facility Name (Location 3)**:**_____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Coordinator: _____ Email: _____

Hours of Operation:_____ After Hours Contact Number:_____

Population Served: ☐ Infants(0-3) ☐ Preschool(0-5) ☐ Children(6-12) ☐ Adolescents(13-18)

☐ Adults ☐ Geriatrics

Beds: ☐ Adults ☐ Children ☐ Geriatrics ☐ Male ☐ Female

Total Bed Capacity: _____

Outpatient Services (Check all that apply): ☐ Mental Health Psychotherapy ☐ Substance Abuse Psychotherapy ☐ Group Therapy Mental Health ☐ Group Therapy Substance Abuse ☐ Medication Management ☐ Psych Testing ☐ IOP Mental Health ☐ IOP Substance Abuse ☐ PHP Mental Health ☐ PHP Substance Abuse ☐ Other:_____

Inpatient: Services (Check all that apply): ☐ Crisis Stabilization Unit Mental Health ☐ Crisis Stabilization Unit Substance Abuse ☐ Addictions Receiving Facility (ARF)/Juvenile Addictions Receiving Facility (JARF) ☐ 23-hour Treatment Observation ☐ Mental Health ☐ Substance Abuse ☐ Detox ☐ Rehabilitation ☐ Residential (Substance Abuse) ☐ Residential (Mental Health) ☐ Residential (Co-Occurring) ☐ Long Term Care ☐ Other:_____

CONTACT INFORMATION

Title	Name	Phone Number	Email address
CEO/Executive Director			
Quality Officer			
Program Director			
Data Security Officer			
HIPAA Privacy Officer			
Clinical Director			
Finance Director/CFO			

Name of Electronic Healthcare Record:_____

Applicant Mission Statement (50 words of less):

The following requires no more than one (1) page response:

1. **Describe the Executive Management structure, including key positions and each function. Include how each of these positions will any effort related to a future contract award by BBHC.**

2. **Provide a description of the role the services the Applicant provides in the community and how these services integrate to both the Behavioral Health System of Care and other systems of care. D e s c r i b e any independent or Applicant funded studies, reports, or analysis to support service delivery catchment area and the need for expansion of this service(s) by BBHC. If the Applicant's services are part of a "formally" established continuum of care within a system of care, describe the continuum of care, system of care, its features for enhancing the services, target population served, and the Applicant's roles and responsibilities within this system of care. Applicant's may attach executed agreements formalizing collaboration with other stakeholders within the system of care.**

3. **Describe the Applicant Referral Process (*obtaining* referrals for your services; and how to *make* referrals). Indicate any formal or informal agreements you may have with other entities, or individuals, from whom you receive referrals and who make referrals to you.**

4. **Briefly describe the computer system's hardware and software. Describe your system for capturing and reporting client demographic information, assessment and placement information, services and units of service provided, and outcome data. The description must include a discussion on your ability to comply with the data requirements contained in DCF's PAM 155-2, most current edition, including a determination whether you are able to immediately comply, the amount of time to revise your system in order to comply, and the cost associated with compliance.**

5. **Describe your agency's strategies and tactics employed to educate the community of services provided by your agency and to ensure access to available services.**

6. **Please detail the Applicant's procedures to ensure access to services by persons with disabilities.**

7. **Please detail how the Applicant will promote individual and family living, working, learning, and socializing. Discuss how the Applicant employs person-centered language and the involvement of individuals and families in the planning, development, and implementation and evaluation of all aspects of this service delivery system.**

8. **Please describe the practices utilized by the Applicant to ensure individual and family participation.**

ATTESTATION:

I attest and certify I have answered the above application questions truthfully and that information given in or attached to this application is accurate and completed to the best of my knowledge. I understand as a condition to making this application, any misrepresentations or misstatements in, or omission of any of these answers, whether intentional or not shall constitute grounds for rejection of my request for participation with Broward Behavioral Health Coalition, Inc.

Recipients of BBHC contracted funds must adhere to all applicable state and federal statutes, regulations, and policies, and BBHC policies and requirements. The Applicant is expected to be in compliance with applicable local laws and ordinances.

Anyone who becomes aware of the existence (or apparent existence) of fraud, waste, or abuse related to BBHC contracted funds is required to report this information to the BBHC Chief Executive Officer. This includes embezzlement, misuse, or misappropriation of contract funds, and false statements, whether by organizations or individuals, theft of contracted funds/BBHC property; and, submission of false reports.

BBHC may use administrative remedies when a successful applicant deliberately withholds information; submits fraudulent information; or does not comply with applicable requirements including revocation of award of pre-qualification; financial penalties in accordance with Section 402.73(7), F. S., and Section 65-29.001 F.A.C.; contract termination, with or without cause.

Signature:_____ Date: _____

Printed Name and Title:_____

FOR OFFICE USE ONLY - To be completed by Provider Services Department

- ☐ Site Visit Evaluation Form complete and enclosed (Site Visit Date:_____)
- ☐ Application is complete and signed (Preliminary Review Date:_____)
- ☐ Required documents submitted, current, and signed, if applicable