# INTRODUCTION

The Delaware Department of Services for Children, Youth and their Families’ (DSCYF) Division of Prevention and Behavioral Health Services (DPBHS) has established a process for authorizing qualified providers of behavioral health services included in the DPBHS Provider Network. **ALL SERVICE PROVIDERS MUST BE AUTHORIZED BY DPBHS.** Contract execution is a subsequent step once a provider has been qualified which will be covered in other documentation.

PROCESS

To become an authorized provider, the agency must fill out the application attached to this solicitation. The application must be submitted with all required supporting documents as described below.

# AUTHORIZATION

The “Authorized Provider” classification is issued by DPBHS and is a prerequisite for an agency or business that intends to provide children’s behavioral health benefits for individuals who are eligible to receive services from DPBHS. Once authorized, DPBHS sends the agency information to the Delaware Medical Assistance Portal (DMAP) for enrollment as a Fee for Service Medicaid Provider.

DPBHS will authorize/not authorize providers based on the information submitted via the Application for Authorization. Authorized providers receive written notification of their assigned classification (i.e., outpatient services, residential, psychiatric residential treatment facility, etc.) and status by DSCYF within thirty (30) business days of the determination. An applicant may request a review of the outcome of their application for authorized provider status by sending a written request to the DPBHS Director within five business days of receipt of the Division’s notification.

DPBHS will maintain a *Directory of Contracted Service Providers* that lists agencies that are qualified AND contracted to provide children’s behavioral health services to children eligible for DPBHS services. The Directory will be posted on DPBHS’ website. Except for basic contact information, all other information submitted via the application process will remain confidential to the fullest extent of the law.

# General Information

1. Applicants are required to respond to all questions, and submit any ancillary documents with the application as requested. An incomplete application may result in a delay or denial of authorization.
2. DSCYF recognizes the application documentation process can be cumbersome at times. Therefore, if an applicant currently holds a contract with DSCYF’s DPBHS for any service listed in RFP CYF 19-01 **AND** that applicant has previously submitted all required documentation **AND** would like to apply for “Re-Authorization” the applicant can identify those services and attach updated documentation if conditions (e.g. PRTF rate or programming) have changed since the last “Authorization” was approved. **For any service for which this is the applicant’s “Initial” application all requested documentation is required**. **Do not combine Application for Initial service Authorization with Application for service Re-Authorization in the same application.**
3. Completed applications **FOR INITIAL AUTHORIZATION** of a service must be delivered with one (1) original and five (5) copies to the following address as instructed on page #2 of the RFP:

State of Delaware

DSCYF Grants and Contracts Unit

RFP: CYF 19-01

1825 Faulkland Road

Wilmington, DE 19805

1. Completed applications **FOR RE-AUTHORIZATION** of a service(s) must be emailed as follows:

DSCYF\_Contracts@Delaware.gov

1. An Authorized Provider shall report any material changes that could adversely affect the provider’s status within ten days of the material change. Notification must be submitted to DPBHS in writing and signed by the provider/provider’s legal designee.

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| *IMPORTANT NOTICE FOR NEW PROVIDERS:*  DPBHS understands the organizational and experiential challenges faced by service providers that are “just getting off the ground.” As a result, new providers may not have all information requested in the application (e.g. survey results, vacancy information, staff turnover, etc.). However, every applicant must complete the following application as thoroughly as possible and attach copies of (1) Required business/facility licenses and/or proof of non-profit status, (2) copy of the certificates of insurance (3) Hire Delaware form, (4) Certifications Form and (5) Assurances Form as listed in Section XII of RFP CYF 19-01. | | | | | | | | |
| *IMPORTANT INSURANCE INFORMATION:*  The contractor must obtain at its own cost and keep in effect during the term of a resulting contract, including all extensions, the insurance specified below with a carrier satisfactory to the State.   1. Workers’ Compensation Insurance under the laws of the State of Delaware and Employer's Liability Insurance with limits of not less than $100,000 each accident, covering all Contractors’ employees engaged in any work hereunder. 2. Comprehensive Liability -Up to one million dollars ($1,000,000) single limit per occurrence including:    1. Bodily Injury Liability -All sums which the company shall become legally obligated to pay as damages sustained by any person other than its employees, caused by occurrence.    2. Property Damage Liability -All sums which the company shall become legally obligated to pay as damages because of damages to or destruction of property, caused by an occurrence.    3. Contractual liability, premises and operations, independent contractors, and product liability. 3. Automotive Liability Insurance that covers all automotive units used for work with limits of not less than $100,000 each person and $300,000 each accident as to bodily injury or death, and $100,000 as to property damage. | | | | | | | | |
| Delaware Division of Prevention and Behavioral Health Services Provider Authorization | | | | | | | | |
| Name of Person/Organization: | | | | | | | | |
| Current Street Address: | | | | | | | | |
| Contact Person: | | | | | Contact’s Phone: | | | |
| Contact’s Email: | | | | | | | | |
| Fax No.: | | Website: | | | | | | |
| ALTERNATE CONTACT INFORMATION | | | | | | | | |
| Name: | | | | | | | | |
| Address: | | | | | | | | |
| Phone: | | | | Email: | | | | |
| BUSINESS TYPE | | | | | | | | |
| Sole/Individual Proprietor: | Yes or No (circle one) | | | | | | |  |
| Business Corporation – For Profit: | Yes or No (circle one) | | | | | | | How long? |
| Business Corporation – Non-Profit: | Yes or No (circle one) | | | | | | | How long? |
| Limited Liability Partnership (LLC) | Yes or No (circle one) | | | | | | | How long? |
| Other (Specify): | Yes or No (circle one) | | | | | | | How long? |
| Tax Status Information | | | | | | | | |
| Federal E. I. Number (Tax ID): | | | Non-Profit Agency?  Yes or No (Circle one)  (If “Yes” include copy of IRS 501c3 letter | | | | | |
| DELAWARE BUSINESS ENTERPRISE AUTHORIZATIONS | | | | | | | | |
| Minority-Owned Business Enterprise | Yes or No (circle one) | | | | | Authorization No.: | | |
| Women-Owned Business Enterprise | Yes or No (circle one) | | | | | Authorization No.: | | |
| If you answered “no” to either of the above, and your business is eligible to be authorized through the Office of Minority and Women Business Enterprises, you are encouraged to apply for said authorization. For more information, visit https://gss.omb.delaware.gov/osd/index.shtml | | | | | | | | |
| TYPE OF SERVICE(S) REQUESTING TO PROVIDE (Circle all that apply) | | | | | | | | |
| 1. Outpatient Services | | | | Initial Application | | | \* Re-Application  (Current Contract) | |
| Mental Health | | | | Yes or No | | | Yes or No | |
| Substance Abuse | | | | Yes or No | | | Yes or No | |
| 1. Intensive In-home Services | | | | Yes or No | | | Yes or No | |
| 1. Parent and Youth Treatment Support Services | | | | Yes or No | | | Yes or No | |
| 1. **Partial Hospital Program (PHP)/Day Hospital** | | | | Yes or No | | | Yes or No | |
| 1. **Inpatient Hospital** | | | | Yes or No | | | Yes or No | |
| 1. **Psychiatric Residential Treatment Facility (PRTF)** | | | | Yes or No | | | Yes or No | |
| 1. **Residential Transition Service** | | | | Yes or No | | | Yes or No | |
| 1. **Transition Support Service (TSS)** | | | | Yes or No | | | Yes or No | |
| 1. **Intellectual and/or Developmental Disability (IDD)** | | | | Yes or No | | | Yes or No | |
| 1. **Crisis Residential Service** | | | | Yes or No | | | Yes or No | |
| 1. **Additional Treatment Support Services** | | | | Yes or No | | | Yes or No | |
| 1. Evidenced-based Practices | | | | Yes or No | | | Yes or No | |
| Family-Based Mental Health Services | | | | Yes or No | | | Yes or No | |
| Multi-Systemic Therapy | | | | Yes or No | | | Yes or No | |
| Functional Family Therapy | | | | Yes or No | | | Yes or No | |
| Dialectical Behavior Therapy | | | | Yes or No | | | Yes or No | |
| 1. Therapeutic Support for Families | | | | Yes or No | | | Yes or No | |
| 1. Can you serve Specialized Populations (see definitions on RFP pages 4-5) | | | | Yes or No | | | Yes or No | |
| 1. Other Service requested in an RFP Addendum | | | | Yes or No | | | Yes or No | |

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| RE-AUTHORIZATION CERTIFICATION  (Check ALL boxes which apply to this Application) |
| \* Check this box to indicate nothing has changed since your agency was last “Authorized” by DSCYF’s DPBHS for any service(s) for which your agency indicated above it seeks “Re-Authorization”. In such instances previously submitted agency documentation will be used for the “Re-Authorization” determination once that submission is confirmed by DSCYF. However, the bidder MUST include documents required by RFP CYF 19-01 |
| \* Check this box to indicate this application is for “Initial” Authorization of indicated service(s) AND/OR to indicate conditions (e.g. PRTF rate or programming) have changed since your agency was last “Authorized” for indicated service(s) AND your agency has attached documentation to support the “Initial” AND/OR “Re-Authorization” of a service(s). Please include all appropriate documentation including documents required by RFP CYF 19-01 |

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| ATTESTATIONS / STATEMENTS | | |
| I have read and agree to the terms as described in the most recent version of the DSCYF Operating Guidelines for Contracted Client Programs/Services, which will be incorporated by reference into any future contract, found on this page in the “Legally Binding Contract Documents Relevant to Executed Contracts” section: <https://kids.delaware.gov/mss/mss_contracts.shtml> | | Initials: |
| I have read and agree to the terms as described in the DSCYF and DPBHS Policies and Procedures: <https://kids.delaware.gov/pbhs/providers.shtml> | | Initials: |
| I have read and agree to the terms as described in the DPBHS Treatment Provider Manual: <https://kids.delaware.gov/pbhs/providers.shtml> | | Initials: |
| SIGNATURES | | |
| I authorize the verification of the information provided on this form and I have retained a copy of this application for my records. | | |
| Signature of Applicant: | Date: | |
| Title (if applicable): | | |

The Authorized Provider Committee requires all applications to include a Narrative Service Description to articulate the proposed service(s) offered, and the target population(s) to be served. If the response includes questionnaires, forms, or other documents, please submit them as an appendix. The responses should be clear and specific, and shall address all areas/subjects requested.

Complete all of the sections below. If a section is not applicable to your application, enter “N/A.”

**Mission State and Philosophy of Service:**

What are the mission, history, and philosophy that underlie the agency’s delivery of services?

Please describe the following:

**Description of Service(s):**

1. Describe the services offered, including criteria for admission, continued stay and discharge;
2. Basis for recommended scope and intensity of service(s) to be provided;
3. Proposed service delivery options (locations and times), service capacity and geographic accessibility;
4. Service implementation plan which may include the need to transition clients from current services to proposed services (if appropriate);
5. Detailed description(s) of the treatment approach (or approaches) to be used to meet the needs of the population(s) to be served with details, including at a minimum:
   1. Evidence-based practice(s) (EBP) and innovative approaches to be used, and the specific needs targeted in approach;
   2. Expected treatment outcomes for each service including median length, frequency, and intensity of service elements. DPBHS seeks highly individualized services with variable service lengths, in contrast to traditional services that are program-based and scheduled in a predictable, standard manner. DPBHS is seeking increased flexibility and adaptability on the part of service providers as opposed to that in conventional treatment models;
   3. Identification of a specific process and assessment tool(s) used for determining necessary treatment for individual child and family needs and for progress toward achieving treatment goals;
   4. Psychiatric services and medication prescribing practices;
   5. Detailed description of the transition planning and discharge process that is child-centered and youth-guided with family, school, and community engagement, including coordination/collaboration with community-based resources;
   6. Description of efforts to increase continuity of care and avoid disruptions, as well as to reduce the need for out of home or hospital services;
   7. Description of crisis planning and services;
   8. Definition of reportable events and the process of handling the incidents; and
   9. Definition of cultural competency and description of the efforts to implement and maintain a culturally diverse staff and a culturally acceptant environment.
   10. Identify your ability to serve “Special Populations” as defined on RFP pages 4-5
6. Proposed exclusion criteria for admission or participation in services for the population(s) and the criteria used to justify the exclusion; and
7. If appropriate, summarize:
8. Most recent Consumer/Family Satisfaction Survey;
9. Most recent Staff Satisfaction Survey; and
10. The rates regarding staff vacancies and staff training compliance.
11. Submit as enclosures:
12. Three letters of reference;
13. One sample of a treatment plan; and
14. A copy of the agency’s quality improvement/strategic plan.
15. **Certificate of Insurance** from your insurance company for Commercial Liability **and** Professional Liability Insurance.
16. Copies of **all licenses and certifications** required by the jurisdictional authority where services are provided

**Health and Safety:**

1. List any national or other accreditation(s) and certification(s).
2. List and explain any programs or services that the agency offers that are under any probationary or other problematic statuses.
3. List the current licensing authorizations the agency hold in the state(s) in which you are incorporated
4. List and explain any suspension or revocation of service licenses or authorizations.
5. List and explain any current or pending litigation.
6. Submit as enclosure:
7. One copy of the agency Emergency Operation Plan (EOP); and

**Policies, Procedures, and Quality Assurance:**

1. Describe the agency’s quality assurance system
2. Submit as enclosures:
3. One copy of Rights Policy;
4. One copy of Abuse/Neglect Policy;
5. One copy of Risk/Incident Management Policy;
6. One copy of Grievance/Appeals Process; and
7. One copy of Training Policy.

**Business Practices:**

1. Describe the agency’s governing body
2. Submit a copy of the agency’s organizational chart
3. Submit a copy of the agency’s Operational Plan
4. Describe the agency’s internal auditing system, including auditing schedules
5. What is the agency’s current “Authorized Medicaid Provider” status?
6. Describe the agency’s ability to initiate and deliver DPBHS’ service(s) on an ongoing basis
7. Describe the agency’s pre-employment screening criteria and process.

**NOTE: THE STATE OF DELAWARE RESERVES THE RIGHT TO CONTACT ANY APPLICANT TO DISCUSS OR REQUEST ADDITIONAL INFORMATION REGARDING ANY ASPECT OF THIS APPLICATION.**

**ACQUISITION OF AUTHORIZED PROVIDER STATUS DOES NOT GUARANTEE THAT AN AUTHORIZED PROVIDER WILL BE SELECTED TO PROVIDE SERVICES AND AWARDED A CONTRACT.**