HILL COUNTRY COMMUNITY MENTAL HEALTH AND MENTAL RETARDATION CENTER D/B/A HILL COUNTRY MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES CENTER

PRIVATE PSYCHIATRIC BED (PPB) SERVICES
OPEN ENROLLMENT APPLICATION

SECTION I. GENERAL:

1. Hill Country Mental Health and Developmental Disabilities Center (HCMHDDC) is seeking Hospitals for the purpose of providing Private Psychiatric Bed (PPB) services and are license as a private psychiatric hospital in accordance with Chapter 577 of the Texas Health and Safety Code and with 26 TAC Chapter 510 *et seq.* (Private Psychiatric Hospitals and Crisis Stabilization Units), or a General or Special Hospital in accordance with Chapter 241 of the Texas Health and Safety Code and with 25 TAC Chapter 133 *et seq.* (Hospital Licensing).

2. Hospital services shall be staffed with medical and nursing professionals who provide 24-hour professional monitoring, supervision and assistance in an environment designed to provide safety and security during acute behavioral health crisis. Staff shall provide intensive interventions designed to relieve acute symptomatology and restore the patient's ability to function in a less restrictive setting.

3. Contingent upon bed availability, the hospital will provide emergency individual psychiatric stabilization services for individuals who present voluntarily or through the civil commitment process from within the HCMHDDC's 19 county catchment area, which includes: Bandera, Blanco, Comal, Edwards, Gillespie, Hays, Kendall, Kerr, Kimble, Kinney, Llano, Mason, Medina, Menard, Real, Schleicher, Sutton, Uvalde, and Val Verde.

4. The funded stay will be for a maximum of seven (7) days unless further bed days are authorized in advance of the seventh (7^{th}) day from the date of the individual's admission to the hospital. Funding beyond seven (7) days will require approval in writing by a person designated by HCMHDDC to provide Utilization Management. Oversight activities with the facility will initiate on the fifth (5th) day of the individual's stay in the hospital. The date of admission is counted at the first (1^{st}) day.

5. The hospital shall have a point of contact for securing a bed. Normally this would be the Admissions Department or Admissions Director.

6. The total rate per day/per bed for each individual patient will be **Seven Hundred and Twenty Dollars ($720.00).** This fee includes transportation cost at discharge if needed. Payment will be made by HCMHDDC Accounts Payable Department.

7. **The term of the PPB agreement between HCMHDDC and the hospital is two (2) years**, and the agreement may be renewed, subject to funding availability. Either party may terminate the agreement without cause by providing sixty (60) days prior notice in

writing to the other party.

SECTION II. HOSPITAL'S OBLIGATIONS:

1. Hospital agrees to maintain and provide HCMHDDC evidence of a current license as a private psychiatric hospital in accordance with Chapter 577 of the Texas Health and Safety Code, and with 25 Texas Administrative Code Chapter 134, concerning Private Psychiatric Hospital and Crisis Stabilization Units, or a General or Special HOSPITAL in accordance with Chapter 241 of the Texas Health and Safety Code, and with 25 Texas Administrative Code Chapter 133, concerning Hospital Licensing.

2. Maintain and provide HCMHDDC evidence of accreditation by The Joint Commission or other accrediting body granted deeming HCMHDDC by the Centers for Medicare and Medicaid Services ("CMS").

3. Provide licensure of accreditation review reports to HCMHDDC upon request.

4. Notify HCMHDDC of any changes in its licensure or accreditation status.

5. Provide HCMHDDC with 24/7 contact information for hospital admission services.

6. Provide24/7 staffing sufficient to provide adequate care for the psychiatric individual.

7. Contact HCMHDDC Utilization Coordinator no later than day five (5) of admission, counting the date of admission as day one (1), to conduct a Utilization Management Review.

8. If the individual becomes stable and is no longer a danger to self or others such as that, voluntary admission or involuntary commitment is no longer necessary.

9. If the individual is discharged against medical advice, HCMHDDC shall be notified immediately.

10. Discharge the individual as directed by the HCMHDDC'S authorized Utilization Manager, or assume all financial obligations for the individual, if providing continued individual psychiatric care past the authorized discharge date. Any disagreements between the PARTIES as to the appropriate discharge date will be mediated between the Medical Directors of the HCMHDDC and the hospital.

11. Provide medications and medication-related services provided to individuals served under this Agreement as specified in Title 25 Texas Administrative Code, Chapter 415 C (relating to Use and Maintenance of TDMHMR Drug Formulary).

12. Provide effective, responsive, individualized, and least restrictive treatment.

13. Develop and implement a Comprehensive Treatment Plan and corresponding intervention(s) including a reasonable and appropriate discharge plan that is jointly developed by the HCMHDDC and the hospital, and communication that will facilitate the exchange of information needed to accomplish common Utilization Management activities.

14. Promote recovery, independence, and self-sufficiency.

15. Comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy rules.

16. Ensure comprehensive client/individual rights consistent with regulatory requirements.

17. Provide interdisciplinary, goal-directed, and evidence-based treatment.

18. Utilize a behavior management program.

19. Provide culturally competent treatment.

20. Provide telemedicine in accordance with applicable rules and regulations.

21. Attempt to reduce restraint and seclusion by adopting and implementing the following restraint/seclusion reduction tools:

    a. Using assessment tools to identify risk factors for violence and seclusion and restraint history.
    b. Using a trauma assessment.
    c. Using tools to identify persons with risk factors for death and injury.
    d. Using de-escalating or safety surveys, and
    e. Making environmental changes to include comfort and sensory rooms and other meaningful clinical interventions that assist people in emotional self-management.

22. Comply with the following standards regarding Admission, Continuity of Care and Discharge:

    a. Hospitals must not allow admissions without HCMHDDC approval, which will be provided in writing, generally prior to but within 12 hours.
    b. When the hospital admits an individual, a physician must issue and sign a written order admitting the individual.
    c. The hospital must conduct an intake process as soon as possible, but not later than 24 hours after the individual is admitted.
    d. When the hospital admits an individual, the hospital must promptly notify HCMHDDC's Crisis Worker of the admission and the admission status.
    e. Upon admission of an individual to the hospital, the hospital and HCMHDDC must begin discharge planning for the individual.

f. Discharge planning must involve the hospital treatment team, HCMHDDC's liaison staff or other HCMHDDC designated staff, the designated AUTHORITY Intellectual and Developmental Disabilities (IDD) liaison staff for persons with IDD, the individual, the individual's legally authorized representative (LAR), if any, and any other individual authorized by the individual.

g. Discharge planning must include, at a minimum, the amount of medication that will be provided upon discharge or transfer, and the amount of medication the individual will need after discharge or transfer until the individual is evaluated by a physician and the name of the individual or entity responsible for providing and paying for the medication needed after discharge or transfer, until the individual is evaluated by a physician and development of a transportation plan.

23. Individuals under consideration for referral to the hospital must meet the criteria in the Texas Health and Safety Code Chapters 571-576, as applicable to voluntary admission or the civil commitment process.

24. Hospital shall apply the appropriate use and medical clearance criteria outlined below:

a. Acute and Chronic Medical Condition Criteria: The presence of any of the following represent acute or chronic medical conditions that the hospital does not have the capability to treat, in accordance with the Emergency Medical Treatment & Labor Act (EMTALA) and state law, the hospital will provide evaluation and treatment within its capability to stabilize the person and will arrange for the person to be transferred to a hospital that has the capability to treat the condition:

i. Medical Emergency Indicators including:
   a) Overdose.
   b) Chest pain.
   c) Fluctuating consciousness.
   d) Stab wound, bleeding, or serious injury.
   e) Seizure activity.
   f) Complications from Diabetes.
   g) Injured in assault or fight.
   h) Victim of a sexual assault, or
   i) Resident of a nursing home or assisted living facility.

ii. Acute Medical Conditions, including:
   a) Acute overdose resulting in any vital sign instability in the prior 24 hours.
   b) Acute drug intoxication (blood alcohol level over 0.1).
   c) Unconscious or fluctuating consciousness.
   d) Delirium, including substance induced syndromes.
   e) Uncontrolled seizure activity.
   f) Recent trauma that has not received medical evaluation, including fractures, lacerations, burns, head trauma, and bleeding.
   g) Recent assault or fight that has not received medical evaluation.
   h) Recent sexual assault that has not received medical evaluation.

i) Blood pressure greater than 160/110.
j) Pulse less than 50, or any symptomatic bradycardia, in the prior 24 hours.
k) Pulse greater than 120 in the prior 24 hours.
l) Temperature above 101oF.
m) White Blood count (WBC) greater than 15,000.
n) Hemoglobin (HGB) is less than 10.
o) Hematocrit (HCT) less than 30.
p) Any abnormal electrolytes.
q) Creatinine phosphokinase (CPK) greater than 1500 or CPK greater than 1000 with elevated temperature and muscular rigidity.
r) Serum glucose below 70 or over 400 during the prior 48 hours.
s) Acute O2 saturation below 90%.
t) Chest Pain.
u) Shortness of breath.
v) Unstable arrhythmia.
w) Pulmonary edema.
x) Acute congestive heart failure.
y) Acute respiratory distress syndrome.
z) Acute asthma.
aa) Acute cardiovascular accident.
bb) Acute CNS trauma.
cc) Gastrointestinal (GI) bleeding during the prior 48 hours.
dd) Requires indwelling tubing (for example, a nasogastric tube).
ee) Post-op instability, demonstrated as any instability in vital signs or laboratory values in the prior 48 hours, or
ff) Open wounds and/or wounds requiring sterile equipment to manage.

iii. Chronic Medical Conditions, including individuals who:

a) Require specialized cancer care, including radiation or chemotherapy.
b) Require medical care from a nursing home prior to admission.
c) Require care for decubiti, Stage 3-4.
d) Require blood or blood product transfusions.
e) Require continuous oxygen, oximetry, or support equipment (CPCPs, BiPAPs, O2 concentrators).
f) Are being treated for active tuberculosis (TB).
g) Require isolation for infection control.
h) Require on-going intravenous (IV) therapy.
i) Have a subclavian line, arterial line, or require hyperalimentation or total parenteral nutrition (TPN).
j) Require suctioning.
k) Require peritoneal or hemodialysis treatments.
l) Require complex care of sterile equipment for managing the care of wounds.
m) Require tracheotomy care and have a chronic condition that causes non-ambulation to an extent to preclude the engagement in treatment programming.
n) Are considered a high-risk pregnancy.

o) Have a multiparous pregnancy, or
p) Are pregnant and at 38-weeks' gestation or later.

25. To comply with the applicable state and federal laws and regulations related to the provisions of individual mental health services, including the Texas Health and Safety Code Chapters 573 and 574, relating to the civil commitment process, Emergency Medical Treatment and Labor Act of 1986, Texas Health, and Safety Code Chapters 241, 571, 575, 576, and 577, and Title 25 Texas Administrative Code:

    a. Chapter 133 (relating to hospital licensing).
    b. Chapter 134 (relating to Private Psychiatric HOSPITAL and Crisis Stabilization Units).
    c. Chapter 404, Subchapter E (relating to Rights of Persons Receiving Mental Health Services).
    d. Chapter 405, Subchapter E (relating to Electroconvulsive Therapy).
    e. Chapter 411, Subchapter J (relating to Standards of Care and Treatment in Psychiatric Hospital).
    f. Chapter 414, Subchapter I (relating to Consent to Treatment with Psychoactive Medication – Mental Health Services), and
    g. Chapter 415, Subchapter F (relating to Interventions in Mental Health Programs).

SECTION III: HCMHDDC'S OBLIGATIONS:

1. HCMHDDC will ensure it has medical clearance for everyone as deemed necessary by the hospital prior to transporting that individual to the hospital.

2. To pay the hospital **Seven Hundred and Twenty Dollars ($720.00) per bed/day,** for each person admitted to the hospital under the provisions of the PPB agreement for no more than seven (7) days as authorized by HCMHDDC. This fee includes transportation at discharge, if needed. Additional days over seven (7), may be authorized in writing by a person designated by HCMHDDC to provide Utilization Management.

3. Will provide hospital prior to or within 12 hours after admission, a funding letter for everyone for which HCMHDDC gave prior verbal authorization.

4. Obtain a Detention or Commitment Order for the hospital.

5. The crisis worker or designee will follow up with the hospital's social worker by the third (3rd) day of admission, counting the date of admission as day one (1), to provide Continuity of Care.

6. HCMHDDC Utilization Coordinator or a designee authorized to perform the UM function, will conduct a Utilization Management Review with hospital's social worker no later than day five (5) of admission, counting the date of admission as day one (1).

7. HCMHDDC will provide the hospital with 24/7 contact information for continuity of care

services provided by HCMHDDC.

8. If HCMHDDC determines that the safety and well-being of individuals served by the hospital is in jeopardy, HCMHDDC will arrange to transfer the individual to another hospital that meets requirements, and hospital will assist with the process.

EXHIBIT A

PSYCHIATRIC EMERGENCY FLOW CHART BETWEEN BOTH PARTIES

Psychiatric Emergency Flow Chart

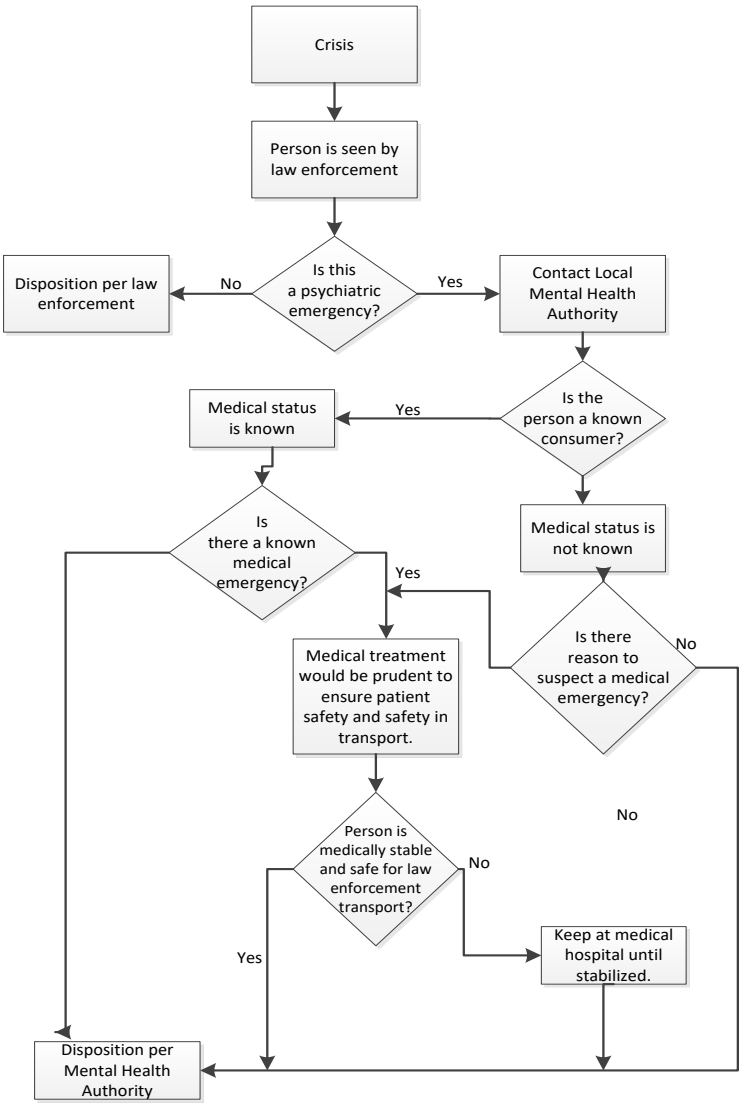
The Peace Officer may use the following indicators to determine if a medical emergency exists:

- Overdose
- Acute intoxication with alcohol or drugs
- Chest pain
- Fluctuating consciousness
- Stab wound, bleeding, or serious injury
- Seizure activity
- Complications from Diabetes
- Injured in assault or flight
- Victim of a sexual assault
- Person is a resident of a nursing home or assisted living facility. Note: With the elderly, sometimes medical problems can cause symptoms that look like mental illness, but are not. It's important to rule out medical problems as the cause.

**An inpatient facility or a mental health facility is not statutorily authorized to require a peace officer to transport a person in custody under Chapter 573, Health and Safety Code, to a medical facility for a medical evaluation prior to taking that person to the mental health facility.

The opinion of law enforcement as to whether a medical emergency exists is final in the screening conducted with the Local Mental Health Authority.

See Attorney General Opinion No. GA-0753, dated December 28, 2009, regarding whether a peace officer who has taken a person into custody under Chapter 573 of the Health and Safety Code may be required to transport that individual to a medical facility for evaluation prior to taking that person to a mental health facility.



APPLICATION AND INSTRUCTIONS
See Attachment

PRIVATE PSYCHIATRIC BED (PPB) SERVICES

OPEN ENROLLMENT APPLICATION

Application Instructions: Please be sure to answer every question. If the question does not apply to your organization, simply and clearly document "N/A." Hill Country Mental Health and Developmental Disabilities Center reserves the right to not evaluate incomplete enrollment applications. False statements by any applicant may disqualify the application.

Applications must be sent to: Hill Country Mental Health and Developmental Disabilities Center
Contracts Department
819 Water Street, Suite 300
Kerrville, Texas 78028

-Applications may also be emailed to: purchasing@hillcountry.org
-Applications may not be faxed.

Questions regarding this application should be directed to Michael Beltran, michael8740@hillcountry.org, 830-792-7504, and purchasing@hillcountry.org.

Business Demographics

Legal Name: _____ Tax ID# _____

DBA: _____

Address: _____

_____
City State Zip Code

Business Phone: _____ Fax #: _____

Contact Person: _____ Title: _____ Phone: _____

Email: _____

Indicate if you provide any of the following:

1. TTY/TTD (Hearing Impaired Services/Capabilities ___Yes ___No
2. American Sign Language ___Yes ___No
3. Handicap Accessible ___Yes ___No
4. Public Transportation Access ___Yes ___No
5. Bilingual Services ___Yes ___No

Services

A. Will the Hospital have qualified staff available to administer medications or to supervise individuals in the self-administration of medication? _____
B. How many individuals can the Hospital serve? _____
C. How long do people currently wait to get into the Hospital's services? _____
D. Detail the specific population the Hospital would serve. Include ages and level of severity and concurrent diagnoses: _____
_____
_____
E. Are there any restrictions on who the Hospital will serve? _____
If yes, please explain: _____
F. Describe the Hospital's experience in providing emergency individual psychiatric stabilization services for individuals who present voluntarily or through the civil commitment process over the last five 5) years: _____
_____
_____
G. Describe the Hospital's ability to work with persons who are hearing impaired, persons who have limited language skills, and persons who speak a language other than English:
_____
_____
_____
H. Describe the Hospital's experience in working with persons with physical impairments and adaptive equipment: _____

Financial

A. Is the Hospital incorporated as "Profit," "Not-for-Profit," or "Other?" _____ If "Other," please explain: _____
B. Does the Hospital have sufficient reserves or lines of credit to operate during the period between billing and receiving reimbursement from third party payors? _____
If not, please explain: _____
_____
_____

C. Has the Hospital declared any type of bankruptcy in the prior seven (7) years? _____
_____
_____

D. Is the Hospital currently under investigation, or has a license or accreditation revoked by any state/federal/local authority or licensure agency, within the last five (5) years? _____
_____
_____

E. Has the Hospital had any judgements or settlements against it within the last ten (10) years? _____ If yes, please explain: _____
_____
_____

F. Has the Hospital been placed on "Vendor Hold" by any agency or government entity in the past three (3) years? _____ If yes, please explain: _____
_____
_____

G. Is the Hospital currently held in abeyance or barred from the award of a federal or state contract? _____ If yes, has this occurred in the last five (5) years? _____
_____
_____

Risk Assessment

A. Does anyone working for the Hospital providing direct care or in management have any felony convictions? _____ If yes, please explain: _____
_____
_____

B. Has the Hospital or its employees had any validated client abuse, client neglect, or rights violations claims in the last three (3) years? _____ If yes, please explain in detail: _____
_____
_____

C. Does the Hospital currently have any malpractice claims pending or closed during the past five (5) years? _____ If yes, please supply the following information:
    1. Letter from your attorney explaining the facts of the case.
    2. Copies of the complaint and judgement.
    3. Name of malpractice carrier that handled the claim and firm representing the carrier.

ASSURANCES DOCUMENT

Applicant assures the following:

1. That all attachments to the Application as distributed by HILL COUNTRY MHDD CENTER Authority have been received.
2. The Applicant does not discriminate in its services or employment practices based on race, color, religion, sex, national origin, ethnicity, disability, veteran status, or age.
3. All cost and pricing information is reflected in the Application response document or attachments.
4. Applicant accepts the terms, conditions, criteria, and requirements set forth in the Application.
5. Applicant accepts the HILL COUNTRY MHDD CENTER Authority's right to cancel the Application at any time prior to contract award.
6. Unless otherwise required by law, the information in the application submitted by the Applicant has not been knowingly disclosed by the Applicant to any other Applicant prior to the notice of intent to award.
7. No claim will be made for payment to cover costs incurred in the preparation of the submission of the application or any other associated costs.
8. The individual signing this document and the contract is authorized to legally bind the Applicant.
9. The address submitted by the Applicant to be used for all notices sent by the Local Authority is current and correct.

_____	_____	_____
Signature Authority for the Applicant	*Title of the Applicant*	*Date*

HILL COUNTRY COMMUNITY MENTAL HEALTH AND MENTAL RETARDATION CENTER D/B/A HILL COUNTRY MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES CENTER

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j) Pulse less than 50, or any symptomatic bradycardia, in the prior 24 hours.
k) Pulse greater than 120 in the prior 24 hours.
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m) White Blood count (WBC) greater than 15,000.
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    e. Chapter 411, Subchapter J (relating to Standards of Care and Treatment in Psychiatric Hospital).
    f. Chapter 414, Subchapter I (relating to Consent to Treatment with Psychoactive Medication – Mental Health Services), and
    g. Chapter 415, Subchapter F (relating to Interventions in Mental Health Programs).

SECTION III: HCMHDDC'S OBLIGATIONS:

1. HCMHDDC will ensure it has medical clearance for everyone as deemed necessary by the hospital prior to transporting that individual to the hospital.

2. To pay the hospital **Seven Hundred and Twenty Dollars ($720.00) per bed/day,** for each person admitted to the hospital under the provisions of the PPB agreement for no more than seven (7) days as authorized by HCMHDDC. This fee includes transportation at discharge, if needed. Additional days over seven (7), may be authorized in writing by a person designated by HCMHDDC to provide Utilization Management.

3. Will provide hospital prior to or within 12 hours after admission, a funding letter for everyone for which HCMHDDC gave prior verbal authorization.

4. Obtain a Detention or Commitment Order for the hospital.

5. The crisis worker or designee will follow up with the hospital's social worker by the third (3rd) day of admission, counting the date of admission as day one (1), to provide Continuity of Care.

6. HCMHDDC Utilization Coordinator or a designee authorized to perform the UM function, will conduct a Utilization Management Review with hospital's social worker no later than day five (5) of admission, counting the date of admission as day one (1).

7. HCMHDDC will provide the hospital with 24/7 contact information for continuity of care

services provided by HCMHDDC.

8. If HCMHDDC determines that the safety and well-being of individuals served by the hospital is in jeopardy, HCMHDDC will arrange to transfer the individual to another hospital that meets requirements, and hospital will assist with the process.

EXHIBIT A

PSYCHIATRIC EMERGENCY FLOW CHART BETWEEN BOTH PARTIES

Psychiatric Emergency Flow Chart

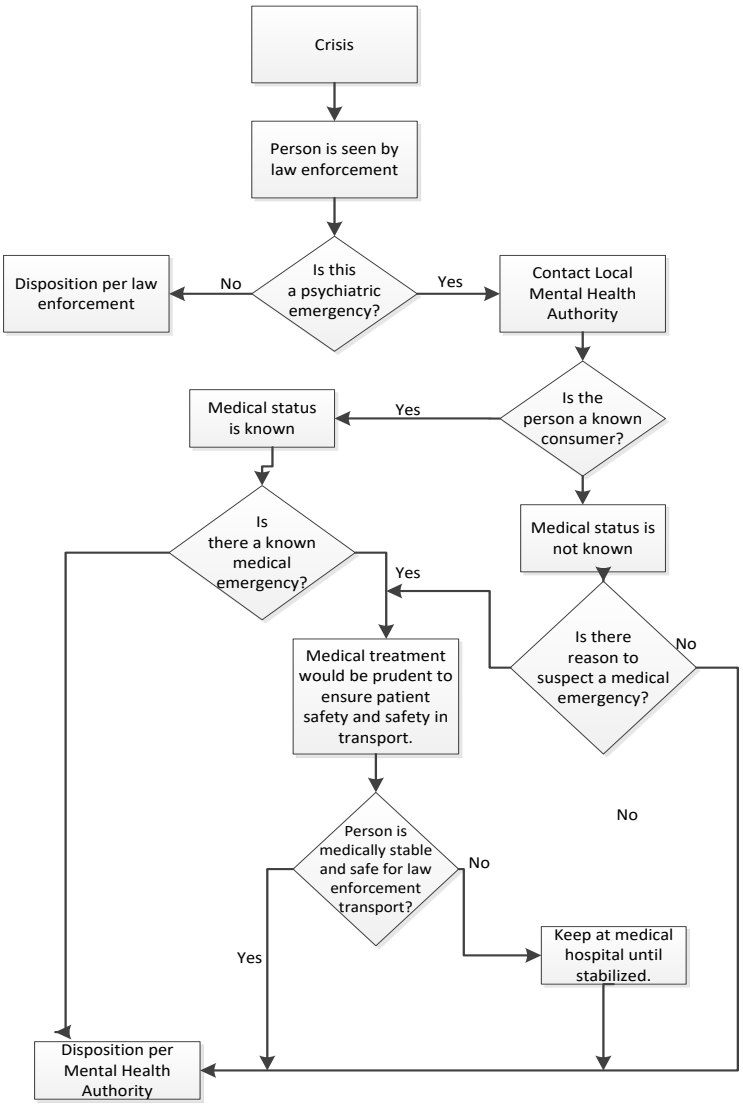
The Peace Officer may use the following indicators to determine if a medical emergency exists:

- Overdose
- Acute intoxication with alcohol or drugs
- Chest pain
- Fluctuating consciousness
- Stab wound, bleeding, or serious injury
- Seizure activity
- Complications from Diabetes
- Injured in assault or flight
- Victim of a sexual assault
- Person is a resident of a nursing home or assisted living facility. Note: With the elderly, sometimes medical problems can cause symptoms that look like mental illness, but are not. It's important to rule out medical problems as the cause.

**An inpatient facility or a mental health facility is not statutorily authorized to require a peace officer to transport a person in custody under Chapter 573, Health and Safety Code, to a medical facility for a medical evaluation prior to taking that person to the mental health facility.

The opinion of law enforcement as to whether a medical emergency exists is final in the screening conducted with the Local Mental Health Authority.

See Attorney General Opinion No. GA-0753, dated December 28, 2009, regarding whether a peace officer who has taken a person into custody under Chapter 573 of the Health and Safety Code may be required to transport that individual to a medical facility for evaluation prior to taking that person to a mental health facility.



APPLICATION AND INSTRUCTIONS
See Attachment

PRIVATE PSYCHIATRIC BED (PPB) SERVICES

OPEN ENROLLMENT APPLICATION

Application Instructions: Please be sure to answer every question. If the question does not apply to your organization, simply and clearly document "N/A." Hill Country Mental Health and Developmental Disabilities Center reserves the right to not evaluate incomplete enrollment applications. False statements by any applicant may disqualify the application.

Applications must be sent to: Hill Country Mental Health and Developmental Disabilities Center
Contracts Department
819 Water Street, Suite 300
Kerrville, Texas 78028

-Applications may also be emailed to: purchasing@hillcountry.org
-Applications may not be faxed.

Questions regarding this application should be directed to Michael Beltran, michael8740@hillcountry.org, 830-792-7504, and purchasing@hillcountry.org.

Business Demographics

Legal Name: _____ Tax ID# _____

DBA: _____

Address: _____

_____
City State Zip Code

Business Phone: _____ Fax #: _____

Contact Person: _____ Title: _____ Phone: _____

Email: _____

Indicate if you provide any of the following:

1. TTY/TTD (Hearing Impaired Services/Capabilities ___Yes ___No
2. American Sign Language ___Yes ___No
3. Handicap Accessible ___Yes ___No
4. Public Transportation Access ___Yes ___No
5. Bilingual Services ___Yes ___No

Services

A. Will the Hospital have qualified staff available to administer medications or to supervise individuals in the self-administration of medication? _____
B. How many individuals can the Hospital serve? _____
C. How long do people currently wait to get into the Hospital's services? _____
D. Detail the specific population the Hospital would serve. Include ages and level of severity and concurrent diagnoses: _____
_____
_____
E. Are there any restrictions on who the Hospital will serve? _____
If yes, please explain: _____
F. Describe the Hospital's experience in providing emergency individual psychiatric stabilization services for individuals who present voluntarily or through the civil commitment process over the last five 5) years: _____
_____
_____
G. Describe the Hospital's ability to work with persons who are hearing impaired, persons who have limited language skills, and persons who speak a language other than English:
_____
_____
_____
H. Describe the Hospital's experience in working with persons with physical impairments and adaptive equipment: _____

Financial

A. Is the Hospital incorporated as "Profit," "Not-for-Profit," or "Other?" _____ If "Other," please explain: _____
B. Does the Hospital have sufficient reserves or lines of credit to operate during the period between billing and receiving reimbursement from third party payors? _____
If not, please explain: _____
_____
_____

C. Has the Hospital declared any type of bankruptcy in the prior seven (7) years? _____
_____
_____

D. Is the Hospital currently under investigation, or has a license or accreditation revoked by any state/federal/local authority or licensure agency, within the last five (5) years? _____
_____
_____

E. Has the Hospital had any judgements or settlements against it within the last ten (10) years? _____ If yes, please explain: _____
_____
_____

F. Has the Hospital been placed on "Vendor Hold" by any agency or government entity in the past three (3) years? _____ If yes, please explain: _____
_____
_____

G. Is the Hospital currently held in abeyance or barred from the award of a federal or state contract? _____ If yes, has this occurred in the last five (5) years? _____
_____
_____

Risk Assessment

A. Does anyone working for the Hospital providing direct care or in management have any felony convictions? _____ If yes, please explain: _____
_____
_____

B. Has the Hospital or its employees had any validated client abuse, client neglect, or rights violations claims in the last three (3) years? _____ If yes, please explain in detail: _____
_____
_____

C. Does the Hospital currently have any malpractice claims pending or closed during the past five (5) years? _____ If yes, please supply the following information:
    1. Letter from your attorney explaining the facts of the case.
    2. Copies of the complaint and judgement.
    3. Name of malpractice carrier that handled the claim and firm representing the carrier.

ASSURANCES DOCUMENT

Applicant assures the following:

1. That all attachments to the Application as distributed by HILL COUNTRY MHDD CENTER Authority have been received.
2. The Applicant does not discriminate in its services or employment practices based on race, color, religion, sex, national origin, ethnicity, disability, veteran status, or age.
3. All cost and pricing information is reflected in the Application response document or attachments.
4. Applicant accepts the terms, conditions, criteria, and requirements set forth in the Application.
5. Applicant accepts the HILL COUNTRY MHDD CENTER Authority's right to cancel the Application at any time prior to contract award.
6. Unless otherwise required by law, the information in the application submitted by the Applicant has not been knowingly disclosed by the Applicant to any other Applicant prior to the notice of intent to award.
7. No claim will be made for payment to cover costs incurred in the preparation of the submission of the application or any other associated costs.
8. The individual signing this document and the contract is authorized to legally bind the Applicant.
9. The address submitted by the Applicant to be used for all notices sent by the Local Authority is current and correct.

_____	_____	_____
Signature Authority for the Applicant	*Title of the Applicant*	*Date*