1199 S. Belt Line Road, Suite
100
Coppell, Texas 75019
phone 972-906-2813
fax 972-906-2834
www.TexasSDC.org

Dear Provider:

Thank you for your interest in providing services to clients of the Texas Self-Directed Care (TXSDC) program. As you may know, this is a pilot program of the Texas Department of State Health Services in which adults with serious mental illnesses more directly control the funds spent on their recovery.

Your services have been identified as ones that may be useful to program participants in pursuing their recovery goals, and we would like to invite you to become an enrolled provider in this program. In order to enroll, we ask that you complete the attached application. By enrolling in TXSDC, you may reach additional clients who are motivated to use your service as they have more choice in providers. Provider information is published in a Directory which is distributed to all program participants and their program representatives, and available online at www.TexasSDC.org. In addition, enrolled providers are guaranteed payment within 90 days for authorized services rendered.

For more information about TXSDC, please visit our website at www.TexasSDC.org or contact me at 972-906-2813 or Walter.Norris@TexasSDC.org .

Thank you for your interest in this important pilot program, and I look forward to hearing from you.

Sincerely,

Walter Norris
TXSDC Program Director

NOTE: We recommend that you send the application by certified mail or by email with return receipt requested. Please return this form and any attachments to:

Walter Norris
1199 S. Belt Line Rd. suite 100
Coppell, TX 75019
972-906-2813
Walter.Norris@TexasSDC.org

or

Luis Moreno
1199 S. Belt Line Rd. suite 100
Coppell, TX 75019
214-244-5332
Luis.Moreno@TexasSDC.org

A. Information for Provider Directory and Enrollment

1. Your name or organization name as you would like it to appear in the TXSDC Provider Directory:

2. Brief description (blurb) of your mission statement, goals, experience or credentials as you would like it to appear in the TXSDC Provider Directory:

3. Days and hours of service or emergency availability:

4. Location of services (address and phone):

5. Contact person name and phone number, website, email, and fax:

6. Languages spoken:

7. Description of specific service(s) provided and fees:

Service	Brief description	Cost	Unit

B. TXSDC Participation Agreement

1. The Provider agrees to bill only for the services performed within the specialty or specialties designated in item A7, above. The services or goods must have been actually provided to eligible TXSDC participants by the Provider prior to submitting the claim.

2. Provider agrees to accept TXSDC participants as new patients/clients without regard to race, religion, gender, color, national origin, age or physical or mental health status, or on any other basis deemed unlawful under federal, state or local law.

3. Provider agrees to maintain strict confidentiality concerning TXSDC participants served.

4. TXSDC will pay Provider only for services pre-authorized in the participant's Individual Recovery Plan and Budget. TXSDC will not pay Provider for any unauthorized services.

5. Provider shall accept payment from TXSDC as payment in full and shall not bill TXSDC participants under any circumstances.

6. Provider agrees to submit claims to TXSDC in the form of written invoices that include the participant's name and address, the Provider's name and address, the date services were rendered, the fees for services rendered and a description of services rendered. Invoices must be submitted to TXSDC by the 15th day of the month following the month of service.

7. TXSDC agrees to remit payment to Provider for authorized services within ninety (90) days of receipt of a properly completed invoice.

8. Provider agrees to refund any moneys received in error or in excess of the amount to which the Provider is entitled from the TXSDC program within 90 days of receipt.

9. The Provider agrees to comply with local, state, and federal laws, as well as rules, regulations, and statements of policy applicable to the TXSDC program.

10. The parties agree that this is a voluntary agreement between TXSDC and the Provider in which the Provider agrees to furnish services or goods to TXSDC participants. Provided that all requirements for enrollment have been met, this agreement shall remain in effect for no more than two (2) years from the effective date of the Provider's eligibility, or until termination of the pilot program.

11. This agreement may be terminated by either party at will with 30 days notice in writing. Said notice shall be delivered by certified mail, return receipt requested, or in person with proof of delivery.

12. This Agreement may be terminated immediately by TXSDC if TXSDC determines, in its sole discretion, that the health, safety or welfare of TXSDC participants may be jeopardized by the continuation of this Agreement.

C. Recovery

TXSDC Provider Network members shall promote individual recovery as defined by the participant to the fullest extent.

Recovery: In its simplest form recovery can be defined as improving, mending, healing and renewal. A more practical definition is told better by individuals who have participated in recovery from mental illnesses such as the following:

"Broadly defined, recovery is the ability to live well irrespective of an individual's experience of mental illness. It means that people are able to minimize or eradicate the distressing symptoms associated with mental illnesses, to make personal decisions about lifestyle and future direction, to find personal meaning in activities of daily living, in relationships, and in spiritual expression….It is about rekindling hope and realizing dreams. It means achieving personal outcomes."

Recovery is about developing individual's strengths and assets and giving individual's the room, support and confidence to do so in the process.

D. Information Required for Claims Processing (adapted single case agreement)

1. Please attach a completed IRS W-9 form:

2. **Clinical Mental Health providers only, please also provide copies of the following documents:**

- NPI number from CMS (we must have NPI# on file to process claims) not necessary unless licensed
- Current State License for both the facility and the practitioner – only to mh proc
- Current malpractice insurance face sheet reflecting limits of 1million/1 million for non-MDs and 1 million for MDs
- Current DEA for medication management purposes
- JCAHO or CAR accreditation (facilities only)

3. Please sign and date below:

______________________________ ________________________

Provider Signature Date