



## Fairfax-Falls Church System of Care Comprehensive Services Act FY2016 Provider Application

Thank you for your interest in becoming or continuing as a provider of services for the Fairfax-Falls Church System of Care Comprehensive Services Act program.

The Comprehensive Services Act for At-Risk Youth and Families (CSA) is a Virginia law enacted in 1993 that establishes a single state pool of funds to purchase services for at-risk youth and their families. The state funds, combined with local community funds, are managed by local interagency teams that plan and oversee services to youth. The Community Policy and Management Team (CPMT) is the governing body described in VA Code § 2.2-5205 for administration at the local level.

**Fairfax-Falls Church CSA System of Care** provides intensive, community-based services (both formal and informal) to at-risk children and families identified by Fairfax County Department of Family Services, Fairfax County Juvenile and Domestic Relations District Court, the Fairfax Falls Church Community Services Board, and the Fairfax County, and City of Falls Church Public Schools for residents of Fairfax County and the cities of Fairfax and Falls Church. Under the auspices of the CSA office and in conjunction with the CSA participating public agencies, approved Provider agencies and individuals offer services to children and families eligible for services under the Comprehensive Services Act. Through the Team Based Planning Process, Family Resource Teams, utilizing an individualized family service plan driven by the needs of the child and family, recommends all such services.

### **Mission Statement of the Fairfax-Falls Church CPMT**

The mission of the **Fairfax-Falls Church CPMT** is to provide leadership in the development of new concepts and approaches in the provision of services to children, youth and families of Fairfax County and the cities of Fairfax and Falls Church. The primary focus of the CPMT is to lead the way to effective services to children already at risk of experiencing emotional/behavioral problems--especially those at risk or in need of out-of-home placements--and their families.

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Consideration for award of an Agreement to Purchase Services is contingent upon:

- Submission of this application/certification, with all required attachments;
- Execution of an Agreement to Purchase Services with the Fairfax-Falls Church Community Policy and Management team, and the corresponding Addenda and rate sheets for each offered service.

### **Qualifications for Consideration for Award of an Agreement to Purchase Services:**

- Medicaid Provider enrollment—PREFERRED FOR ALL ELIGIBLE SERVICES.
- Located in the Commonwealth of Virginia, preferably.
- Licensed by the State of Virginia, or the State where services are provided, to provide the offered services—Agencies offering Outpatient Therapy should hold a license to provide Outpatient Mental Health Services.

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|---|---|--|
|  | <p><i>A Fairfax County, Va., publication</i><br/>Department of Administration of Human Services<br/>Contracts and Procurement Management<br/>CSA Contracts Coordinator<br/>703-324-8484</p> | <p>Fairfax-Falls Church Community Policy and Management Team<br/>CSA Contracts<br/>Provider Application -Main<br/>January 2015</p> |
|---|---|--|

- Commitment to the Fairfax-Falls Church CSA System of Care Practice Standards
- Provision of evidence-based practice and interventions.
- Evidence of Trauma Informed practice and cultural/linguistic competence.
- Accreditation by Council on Accreditation (COA), Commission on Accreditation of Rehabilitation Facilities (CARF), or Joint Commission (formerly Joint Commission on Accreditation of Healthcare Organizations. (JCAHO))
- Organization's Outcomes for offered services.

**All Potential or current Providers must submit completed:**

- Provider Application
  - Include a narrative describing the organization, its mission and vision.
  - Include copies of all licenses, certifications and accreditations for the organization.
  - 3 verifiable letters of reference.
  - Annual Report (most recent year)
  - Clinical Staff: names, license type and licensing board. (Use Individual Providers of Outpatient Therapy Application for each licensed clinician.)
- A Provider Proposed Service and Rate Sheet correlating to the resulting APOS and the State Standardized Service Names. Providers are required to include proposed rates and specific service details.
  - Private Day School Services (Addendum A)
  - Residential Schools and Residential Treatment Centers (Addendum B)
  - In-Home Services (Addendum C)
  - Treatment Foster Care(Addendum D)
  - Group Homes & (Addendum E)

**If you are not a Medicaid Enrolled Provider, please provide proof of application or justification for not participating with Virginia Medicaid.**

*The Office of Comprehensive Services is implementing Standard Service Names for services purchased with CSA funding. The names continue to be subject to revisions. Thus, proposed services under the current State Standardized Names are subject to name change.*

Applications may be emailed to [DAHSCSAcontracts@fairfaxcounty.gov](mailto:DAHSCSAcontracts@fairfaxcounty.gov) or mailed to  
CSA Contracts

DAHS Contracts and Procurement Management  
12011 Government Center Pkwy, Suite 738  
Fairfax, VA 22035

Refer all Questions to [DAHSCSAcontracts@fairfaxcounty.gov](mailto:DAHSCSAcontracts@fairfaxcounty.gov) or the CSA Contracts Coordinator at 703-324-8484.

# FAIRFAX-FALLS CHURCH System of Care Comprehensive Services Act FY2016 Provider Application

\* To complete the application, fill in the blanks with the requested information. Attach additional sheets if needed. Attach all requested supplemental documents.

|   |     |       |                  |         |    |
|---|-----|-------|------------------|---------|----|
| Provider Name:  |     |       |                  |         |    |
| Business Address:   |     |       |                  |         |    |
| City:   |     | State |                  | Zip     |    |
| Phone Number:   |     |       |                  | Fax No. |    |
| EIN:  |     |       |                  |         |    |
| Mailing Address (if different from above)                                   |     |       |                  |         |    |
| City:   |     | State |                  | Zip     |    |
| Agency Director:  |     |       |                  | Title   |    |
| E-mail:   |     |       |                  | Phone   |    |
| Primary Billing Contact:  |     |       |                  | Title   |    |
| E-mail:   |     |       |                  | Phone   |    |
| Current Fairfax-Falls Church CSA Provider:                                  | Yes | No    | Nonprofit Agency | Yes     | No |
| If your company is a subsidiary of another company, complete the following: |     |       |                  |         |    |
| Parent Company:   |     |       |                  | Phone   |    |
| Business Address:   |     |       |                  |         |    |
| City:   |     |       |                  | State   |    |
| EIN:  |     |       |                  |         |    |
| CEO   |     |       |                  | Phone   |    |

|   |  |
|---|--|
| <b>Provider Application Provider Name:</b>  |  |
| <b>Provider Narrative:</b><br>(provide a brief description of the organization, including mission and the history of the organization.) |  |

**Licensure and Accreditation**

Licensure: List each license issued by the State (do not include individual clinician licenses)

|                 |  |                 |                        |
|-----------------|--|-----------------|------------------------|
| Type of License |  | Issuing Entity: |                        |
| Date of issue   |  | Expiration Date | Attach copy of License |
| Type of License |  | Issuing Entity: |                        |
| Date of issue   |  | Expiration Date | Attach copy of License |
| Type of License |  | Issuing Entity: |                        |
| Date of issue   |  | Expiration Date | Attach copy of License |

Accreditation: List each certification and/or accreditation held by the organization

|                                      |  |                 |                              |
|--------------------------------------|--|-----------------|------------------------------|
| Type of Accreditation/certification: |  | Issuing Entity: |                              |
| Date of issue                        |  | Expiration Date | Attach copy of certification |
| Type of Accreditation/certification: |  | Issuing Entity: |                              |
| Date of issue                        |  | Expiration Date | Attach copy of certification |
| Type of Accreditation/certification: |  | Issuing Entity: |                              |
| Date of issue                        |  | Expiration Date | Attach copy of certification |

|   |  |  |  |                |            |
|---|--|--|--|----------------|------------|
| <b>Provider Application Provider Name:</b>  |  |  |  |                |            |
| <b>Medicaid Enrollment</b>  |  |  |  |                |            |
| <b>Virginia Medicaid (Magellan) Provider Number:</b>  |  |  |  |                |            |
| <b>Medicaid Eligible Services Offered:</b>  |  | <input type="checkbox"/> Treatment Foster Care <input type="checkbox"/> Residential Treatment Services, Level A, B or C<br><input type="checkbox"/> Outpatient Services <input type="checkbox"/> Intensive In Home Services<br><input type="checkbox"/> Mental Health Support Services <input type="checkbox"/> Behavior Therapy/Modification Services |  |                |            |
| <b>Liability Insurance Provider</b><br>(Provide verification)   |  |  |  |                |            |
| <b>Private Insurance Accepted:</b><br>(List Third Party Payers)                                       |  |  |  |                |            |
| <b>Facility/Group Home Names and Locations</b>  |  |  |  |                |            |
| <i>If applicable, include information regarding all facilities at which services may be provided.</i> |  |  |  |                |            |
| <b>Facility Name:</b>   |  |  |  |                |            |
| <b>Facility Address:</b>  |  |  |  |                |            |
| <b>City:</b>  |  |  |  | <b>State</b>   | <b>Zip</b> |
| <b>Phone Number:</b>  |  |  |  | <b>Fax No.</b> |            |
| <b>Mailing Address (if different from above)</b>  |  |  |  |                |            |
| <b>City:</b>  |  |  |  | <b>State</b>   | <b>Zip</b> |
| <b>Facility/Program Director:</b>   |  |  |  | <b>Title</b>   |            |
| <b>E-mail:</b>  |  |  |  | <b>phone</b>   |            |
| <b>Primary Billing Contact:</b>   |  |  |  | <b>Title</b>   |            |

|  |  |         |  |     |  |
|--|--|---------|--|-----|--|
| <b>Provider Application Provider Name:</b>   |  |         |  |     |  |
| <b>Facility/Group Home Name and Location</b> |  |         |  |     |  |
| Facility Name:                               |  |         |  |     |  |
| Facility Address:                            |  |         |  |     |  |
| City:  |  | State   |  | Zip |  |
| Phone Number:                                |  | Fax No. |  |     |  |
| Mailing Address (if different from above)    |  |         |  |     |  |
| City:  |  | State   |  | Zip |  |
| Facility/Program Director:                   |  | Title   |  |     |  |
| E-mail:                                      |  | Phone   |  |     |  |
| Primary Billing Contact:                     |  | Title   |  |     |  |
| E-mail:                                      |  | Phone   |  |     |  |

All of the information in this application is accurate and truthful. This application is submitted with the intent to enter into an Agreement for the Purchase of Services as a Provider of Services.

\_\_\_\_\_  
Signature of Authorized Representative

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

\_\_\_\_\_