REQUEST FOR PROPOSAL

Autism Evaluators

Issued By:

NORTH COUNTRY COMMUNITY MENTAL HEALTH

NORTH COUNTRY
COMMUNITY MENTAL HEALTH

1420 Plaza Drive
Petoskey, MI 49770
www.norcocmh.org

Responses accepted up and through close of business,
October 6, 2025

OVERVIEW

BACKGROUND:

North Country Community Mental Health (NCCMH) operates as a Community Mental Health Authority under the provisions of Act 258 of the Michigan Public Acts of 1974, as amended. "*The purpose of a community mental health services program [is] to provide a comprehensive array of mental health services… including crisis stabilization and response including a 24-hour, 7-day per week, crisis emergency service… and the provision of inpatient or other protective environment for treatment." (MCL 330.1206). NCCMH is a tax-exempt governmental agency.*

NCCMH serves six rural counties in northern Michigan—Antrim, Charlevoix, Cheboygan, Emmet, Kalkaska, and Otsego—covering 3000+ square miles with a population of 152,000, including 36,000 Medicaid beneficiaries.

MISSION, VISION, VALULES OF NORTH COUNTRY COMMUNITY MENTAL HEALTH:

Mission:
Provide collaborative behavioral health services that inspire hope and promote recovery, resilience, and wellness to eligible residents.

Vision:
Hight-quality integrated health care leading to a fulfilled life for all community members.

Values:

- Client Centered – Care is delivered by respecting individual preferences. Every decision will consider the value it adds to the people we serve.

- Respect – We treat everyone-the people we serve, providers, fellow staff members and community partners-with the highest level of respect.

- Integrity – We will consistently do the right thing by maintaining an ethical culture and unified workforce.

- Excellence in Practice – Excellence will be apparent in all that we do. We will provide the highest level of service to promote recovery and quality of life through evidence-based and innovative practices. We produce outcomes that exceed expectations.

PURPOSE OF REQUEST:
North Country Community Mental Health is seeking additional providers for qualified, licensed practitioners to complete autism evaluations for individuals within its six-county service area.

SERVICE DISCRIPTION:
Autism evaluations for individuals with primary or secondary Medicaid are required by MDHHS to allow children with a medical diagnosis of an autism spectrum disorder to access Applied Behavior Analysis as a waiver benefit service. Autism evaluations from qualified practitioners may include the following:

- Autism Diagnostic Observation Schedule
- Autism Diagnostic Interview Revised
- Vineland/ABAS or other adaptive measure
- Cognitive testing as required
- Additional appropriate measures as necessary

These services include provision of evaluation in an office setting for face-to-face evaluations or virtual setting as necessary and appropriate.

Services are to be provided, documented, and reimbursed on per evaluation encounter basis. An evaluation encounter is considered a pre-authorized psychological testing code where face-to-face or virtual evaluation services are provided to the client as pre-authorized.

NCCMH wishes to expand its provider network related to these services in all 6 counties served by NCCMH. The number of clients requesting autism evaluations has continued to increase providing a need for additional evaluators to ensure timeliness of assessment for potential service provision.

Respondents to this request may submit proposals to provide services in any of the 6-county service area.

QUALIFICATIONS:
All those submitting proposals must be able to provide these services in compliance with the Michigan Department of Health and Human Services (MDDHS) Medicaid Provider Manual, all applicable provisions of the Michigan Mental Health Code, Public Act 258 of 1974, as amended MCL 330.1100 et seq, the Michigan Public Health Code, Public Act 368 of 1978, as amended, all applicable Administrative Rules, related Recipient Rights and policies of NCCMH, along with the ability to comply with HIPAA including the Standards of Privacy of Individually Identifiable Health Information (42 C.F.R., Part 2.)

According to MDHHS qualifications, the diagnostic evaluations are performed by a qualified licensed practitioner working within their scope of practice and who is qualified and experienced in diagnosing ASD. A provider's licensure and clinical experience, in accordance with ethical guidelines, determines competency and scope of practice.

Examiners must have the right and capacity to determine when a referral is outside of their scope of practice.

Respondents to this request must be able to provide qualified licensed practitioners as required within the Medicaid manual as the following:

- A physician with a specialty in psychiatry or neurology
- A physician with a subspecialty in developmental pediatrics, developmental behavioral pediatrics, or a related discipline
- A physician with a specialty in pediatrics or other appropriate specialty with training, experience, or expertise in autism spectrum disorders or behavioral health.
- A psychologist with a specialty in clinical child psychology, behavioral and cognitive psychology, or clinical neuropsychology, or other appropriate specialty with training, experience, or expertise in autism spectrum disorders or behavioral health
- A clinical social worker with at least 1 year of experience working within his or her scope of practice who is qualified and experienced in diagnosing autism spectrum disorders
- An advanced practice registered nurse with training, experience, or expertise in autism spectrum disorders or behavioral health
- A physician assistant with training, experience, or expertise in autism spectrum disorders or behavioral health

*Require that a client whose initial diagnosis was performed by a diagnostician with master's level credentials should have their diagnosis and treatment recommendations reviewed by a physician, psychiatric nurse practitioner, or fully credentialed psychologist.

In addition to the above, staff for these services must also complete training in areas of Recipient Rights, Person Centered Planning, CPR/First Aid, Nonviolent Crisis Intervention, as required by NCCMH.

Respondents to this request should also be able to demonstrate through established policies and procedures the ability to provide documentation supporting the delivery of service including an approved autism evaluation to support determination for a medical diagnosis of an autism spectrum disorder according to Medicaid rules, and appropriately bill for services consistent with NCCMH policies.

Respondents to the request should be able to meet all other NCCMH contract requirements. (A copy of the contract can be requested through the Contract Manager, Katie Lorence, klorence@norcocmh.org)

Proposals should be based on actual Medicaid approved cost associated with the provision of this service minus transportation. The submission should be for psychological testing representing one encounter of service, serving one individual per evaluation.

AWARD OF CONTRACT:

The deadline for submission of this proposal is 5:00PM on October 6, 2025. Proposals received after this date and time will not be considered.

A panel consisting of members of NCCMH Clinical Team along with those from the Finance and Administrative Teams will review all responses and select(s) based on quality, expertise, history in providing high quality services, flexibility in meeting changing/future needs, and price. (NCCMH will not be obligated to choose based on the lowest bid.)

NCCMH reserves the right to reject any and all proposals received as a result of the RFP.

NCCMH is not liable for any cost incurred by contractors prior to the issuance of a contract.

Be advised that all information submitted in response to public Request for Proposals may be divulged under the provisions of the Freedom of Information Act (FIOA). Confidential or proprietary information cannot be shielded from disclosure under the FOIA requirements for public bid process.

The contents of the proposal of the successful Bidder may become contractual obligations if a contract continues. Failure of the successful Bidder to accept these obligations may result in cancellation of contract.

NCCMH reserves the right to rebid all or some components of this Request for Proposal (RFP) in the event of significant changes to Medicaid Policy or other future federal, state, or locally applicable laws, regulations or policies.

The Bidder(s) selected through this process will be awarded a contract through September 30,2028, with an option for renewal at NCCMH's discretion, dependent on performance, funding and system need.

ZOOM MEETING:

A meeting to answer potential Respondents questions will be held on September 24, 2025 at 3:00p.m. via zoom. Please pre-register for this meeting by contacting Christine Dillon at cdillon@norcocmh.org. A link will then be sent.

SUBMITTING RESPONSES TO RFP:

Responses to this Request for Proposal must be submitted in an envelope titled and addressed as follows: 2025 NCCMH Autism Evaluators: attention Nancy Rhue, 1420 Plaza Dr., Petoskey, MI 49770, or electronically in PDF format to the following email address, nrhue@norcocmh.org.

BIDDER COVER SHEET

Respondent	Contact Person
Name of Organization: Address: Ex. Director: Telephone: Fax: Website: Federal tax identification #:	Name: Address: Telephone: Email:

Service Description / Service Units	Quote Amount
Psychological Testing Per Encounter: 90791 96136 96130 96131	$_____ /Per Encounter

*Please complete and submit the Provider Application **(Attached)**. In addition to completing the application please submit documentation addressing the following:

- Demonstrate proof of, or the ability to obtain, liability insurance in the amount of $1,000,000.00 per occurrence, and /or aggregate, combined single limit for Personal Injury, Bodily Injury, and Property Damage.
- Describe your organization's experience in providing autism evaluations or like services. (List any accreditations, certifications, licenses, or member affiliations.)
- Submit copies of your organization's policies/procedures regarding evaluator qualifications.
- Describe how your organization ensures that services are delivered by staff trained and mentored consistent with the principles of Trauma Informed Care.
- Provide proof of the ability of, and policies on, performing appropriate background checks for all employees.
- Describe the training and experience of autism evaluators that would be assigned to perform the services listed above.

The Respondent to this request certifies to the best of their knowledge and belief that all information in this response is true and correct and has been duly authorized by their governing body.

Authorized Representative

Signature:_____ Date:_____

Name and Title (Print):_____

Reset Form

NORTH COUNTRY COMMUNITY MENTAL HEALTH

NORTH COUNTRY COMMUNITY MENTAL HEALTH AUTHORITY

CONTRACT PROVIDER APPLICATION

1) PROVIDER IDENTIFICATION/INFORMATION

Contracted Provider Name:

D/B/A's (if none, write none):

Federal Tax ID/SSN:

Provider website/URL:

Provider Legal Entity Type - Check one of the following:

- ◯ Sole Proprietors and partnerships: Individual providers including practitioners who file taxes on the 1040 series of tax forms
- ◯ For-profit corporations: Those companies that typically file a tax form 1120 with the IRS.
- ◯ Governmental units: Includes transportation authorities, intermediate school districts, public universities and community colleges.
- ◯ Non-Profit organizations or corporations: Typically, those organizations that have 501(c)3 status and report on the IRS 990 form.

2) SERVICES PROVIDED

Check all general categories of services that you are qualified to provide, regardless of whether or not those services are included in your NCCMH contract:

- ☐ Licensed Residential
- ☐ Personal Residential Home
- ☐ Professional Services (Therapy, Doctor, etc.)
- ☐ Other:
- ☐ Respite/Respite Camp
- ☐ Day Programs
- ☐ InPatient Hospital

National Provider Identifier (NPI) #, if applicable:

Medicaid ID #, if applicable:

Are you registered in CHAMPS: ◯ YES ◯ NO **Are you accepting New Enrollees?** ◯ YES ◯ NO

Cultural Competency is required training for our staff: ◯ YES ◯ NO

Do you have Linguistic Capabilities: ◯ YES ◯ NO

Specify any secondary language capabilities:

ADA Compliance: Are all of your Office/Facility, Retail outlets, Exam Rooms, Equipment able to accommodate persons with disabilities? ◯ YES ◯ NO

Method of Personal Intervention: We ◯ DO ◯ DO NOT **train on and solely use the CPI Method.**

We (also or alternatively) use the following methods of personal intervention:

Note: If you do not SOLELY utilize the CPI form of intervention in facilities where NCCMH clients are placed, you are required to request written approval from NCCMH Behavior Treatment Committee on the use of other forms of Non-Violent Crisis Intervention other than CPI. Alternative methods must be approved by written contract addendum. Please contact the NCCMH Contract Manager at providerrelations@norcocmh.org for information.

3) CONTACT INFORMATION

Corporate/Legal Address:

Physical Address:

City: State: Zip:

Mailing Address:

City: State: Zip:

Authorized Person to sign & modify contracts:

Contract Signee:
Title:
Phone:
Cell:
Fax:
Email:

Primary Contact for Client Placement:

Business Name:
Primary Contact:
Address:
City: State: Zip:
Phone:
Fax:
Cell:
Email:

Primary Contact for Finance:

Business Name:
Primary Contact:
Address:
City: State: Zip:
Phone:
Fax:
Cell:
Email:

PLEASE ATTACH ADDITIONAL INFORMATION AS NEEDED FOR EACH SPECIFIC MAIN LOCATION/CONTACT.

PLEASE ATTACH LISTING OF HOMES, LICENSES AND CONTACT INFORMATION FOR EACH LICENSED/SPECIALIZED OR OTHER HOME TYPE.

4) ACCREDITATION, LICENSES

Are you licensed or accredited? ◯ Yes ◯ No If yes, list below:

Accreditation/License Entity Name: _____ Expiration: _____

Accreditation/License Entity Name: _____ Expiration: _____

Accreditation/License Entity Name: _____ Expiration: _____

If no, do you have plans to become accredited? ◯ YES ◯ NO

PLEASE ATTACH COPY OF ACCREDITATION OR LICENSES.

5) ATTESTATION

I fully understand that any misstatements in, or omissions from, this application may constitute cause for disqualification or termination of provider participation with North Country Community Mental Health Authority. All information submitted in this application is true to the best of my knowledge and belief.

I verify that all professional staff and other health services staff who deliver direct services to our consumers are current and in good-standing with their respective training, licensing and/or certifying board or agency. I also verify that those employees who do not yet have their required training, license and/or certification, have a plan and are working to obtain the appropriate license and/or certification. I also verify relevant legal background checks as well as educational credentials were verified or completed prior to hire and rechecked on any frequency required by Medicaid or by contract with North Country Community Mental Health Authority.

I understand that any contractual relationship with North Country Community Mental Health Authority may be subject to termination if I fail to comply with any of the regulations or policies specified in the contract or by Medicaid regulation.

DECLARING THAT THE STATEMENTS MADE IN THIS APPLICATION ARE TRUE, I HEREBY MAKE APPLICATION AND REQUEST TO BECOME OR REMAIN A PART OF THE NCCMH PROVIDER NETWORK:

_____ _____

Name of Contractor's Authorized Representative Title

_____ _____

Signature of Authorized Representative Date

(INK OR CERTIFIED DIGITAL SIGNATURE REQUIRED)