# REQUEST FOR PROPOSAL

## Psychologists for Guardianship Evaluations

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 psychological testing and evaluations to assess initial and renewal guardianship needs for individuals within its six-county service area.

**SERVICE DISCRIPTION:**

Provide comprehensive psychological evaluations and reevaluations to assess the current level of Intellectual and Adaptive Functioning and to make recommendations for guardianship covering mental, physical, social, educational, and behavioral status. Guardianship evaluations from qualified practitioners must include but are not limited to guardianship/eligibility assessments consisting of background information, clinical review/mental status examination, intellectual assessment, behavioral assessment, diagnostic formulation, recommendations, and completion of the Michigan Probate Court Report to Accompany the evaluation. Guardianship/eligibility evaluations from qualified practitioners should include the following:

- Wechsler Adult Intelligence Scale
- WRAT 5
- Vineland Adaptive Behavior Scales or other adaptive assessments
- Functional and capacity assessments
- Additional appropriate measures as necessary

These services include provision of evaluation in an office setting for face-to-face evaluations.

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

NCCMH provides guardianship/eligibility evaluations in all 6 counties served by NCCMH. The number of client and court requested evaluations remains consistent. There is a need for additional evaluators to ensure timeliness of evaluations.

Respondents to this request may submit proposals to provide services for 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 1974-6, as amended MCL 330.1600 et seq, the Michigan Public Health Code, Public Act 368 of 1978, as amended, Michigan Court Rules MCR 5.125, MCR 5.140, 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 the Michigan Mental Health Code qualifications, the guardianship/eligibility evaluations are performed by a qualified licensed practitioner working within their scope of practice and who is a qualified and experienced physician or psychologist who, by training or experience, is competent in evaluating individuals with developmental disabilities. 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 Michigan Mental Health Code and the Medicaid manual to complete the following:

- The petition for the appointment of a guardian for an individual who has a developmental disability shall be accompanied by a report that contains all of the following:
  (a) A description of the nature and type of the respondent's developmental disability.
  (b) Current evaluations of the respondent's mental, physical, social, and educational condition, adaptive behavior, and social skills. These evaluations shall take into account the individual's abilities.
  (c) An opinion as to whether guardianship is needed, the type and scope of the guardianship needed, and a specific statement of the reasons for the guardianship.
  (d) A recommendation as to the most appropriate rehabilitation plan and living arrangement for the individual and the reasons for the recommendation.
  (e) The signatures of all individuals who performed the evaluations upon which the report is based. One of the individuals shall be a physician or psychologist who, by training or experience, is competent in evaluating individuals with developmental disabilities.
  (f) A listing of all psychotropic medications, plus all other medications the respondent is receiving on a continuous basis, the dosage of the medications, and a description of the impact upon the respondent's mental, physical and educational conditions, adaptive behavior, and social skills.

- Psychological tests upon which an evaluation of the respondent's mental condition have been based may be performed up to 1 year before the filing of the petition.

- If a report does not accompany the petition, the court shall order appropriate evaluations to be performed by qualified individuals who may be employees of the state, the county, the community mental health services program, or the court. The court may order payment for evaluations of respondents by a public agency that treats or serves the developmentally disabled. State compensation for evaluations paid for by

public mental health agencies shall be determined under sections 302 to 310, and sections 800 to 842. Compensation for an evaluation shall be in an amount that is reasonable and based upon time and expenses. The report shall be prepared and filed with the court not less than 10 days before the hearing.

- A report prepared under this section shall not be made part of the public record of the proceedings but shall be available to the court or an appellate court to which the proceedings may be appealed, to the respondent, the petitioner, their attorneys, and to other individuals the court directs.

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 guardianship/eligibility evaluation to support determination for a medical diagnosis of a developmental disability according to Medicaid rules, and appropriately bill for services consistent with NCCMH policies.

Respondents to this request should have sufficient experience presenting guardianship evaluations either face to face in a court setting, or virtually as directed by the court.

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 10:00a.m. via zoom. Please pre-register for this meeting by contacting Pam Krasinski-Wespiser at pwespiser@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 Psychologists for Guardianship Evaluations: 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:<br><br>Address:<br><br>Ex. Director:<br><br>Telephone:<br><br>Fax:<br><br>Website:<br><br>Federal tax identification #: | Name:<br><br>Address:<br><br>Telephone:<br><br>Email: |

| Service Description / Service Units | Quote Amount |
|---|---|
| Psychological Testing Per Encounter:<br>90791<br>96136<br>96130<br>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 psychological evaluations for guardianship. (List any accreditations, certifications, licenses, or member affiliations.)
- Submit copies of your organization's policies/procedures regarding evaluator qualifications.
- Provide proof of the ability of, and policies on, performing appropriate background checks for all employees.
- Describe the training and experience of licensed practitioners 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)*