APPLICATION FOR APPROVAL TO BECOME A CASE MANAGEMENT PROVIDER OF BDDS SERVICES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

State Form 53869 (R / 11-10)

FAMILY AND SOCIAL SERVICES ADMINISTRATION / DIVISION OF DISABILITY AND REHABILITATIVE SERVICES
BUREAU OF DEVELOPMENTAL DISABILITIES SERVICES (BDDS)

PART 1: GENERAL INFORMATION

Date of Application ***(month, day, year)***: ______________________________

Legal Name of Entity: ______________________________

FID or EIN or SSN: ______________________________

List any "Doing Business As" (DBA) names:

Sole Proprietorships using an assumed business name (DBA) **must** submit proof of registration in the office of the County Recorder of each county in which a place of business is located. Corporations, LLC's and Partnerships using an assumed business name (DBA) **must** submit: • Verification from the Secretary of State of Indiana, **and** • Proof of registration in the office of the County Recorder of each county in which a place of business is located, **and** • Verification of tax identification number from the IRS.	

Type of Entity: *(Check only one)*

- ☐ Corporation (for profit)
- ☐ Corporation(not-for-profit)
- ☐ Limited Liability Company
- ☐ Partnership
- ☐ Individual/Sole Proprietorship

Main Office Address

Street Address *(PO Box not allowed)*: ______________________________

City: ____________________ State: __________ ZIP code: ____________

Telephone Number: ____________ E-Mail Address: ____________ Fax number: ____________

On a separate attachment, list the above information for all service locations

Contact Information

Title	Name	Telephone number	E-mail address

Applicants should refer to 460 IAC 6 and applicable BDDS/BQIS policy and guidance for qualifications/requirements for case management providers of services for individuals with intellectual and developmental disabilities.

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PART 2: SERVICE FUNDING STREAMS

- All appropriate parts of the application must be submitted.
- All required supporting documentation must be submitted.

Applicant **must** submit Part 1 AND Part 2 of the application to be considered.

The following documents must be completed along with the application:

1. **W-9**

Statements of Compliance and Application Signature

If you agree to comply with each statement, place your initials beside each statement. If you do not agree to comply with any of the statements, the application will not be accepted.

_______1. Applicant assures that, if approved, the provider entity complies and will maintain compliance with all applicable state and federal statutes and regulations and licensure requirements of the approved Service(s), including all applicable provisions of the federal Americans with Disabilities Act as set forth in 460 IAC 6-10-3.

_______2. Applicant assures that, if approved, the provider entity complies and will maintain compliance with 460 IAC 6, including documentation requirements for all providers and those related to the specific services the provider delivers.

_______3. Applicant assures that, if approved, the provider will provide services as identified in the Individualized Support Plan (ISP) to an individual, as set forth in 460 IAC 6-6-2 (5) and reflected within the individual's approved Cost Comparison Budget (CCB) and/or approved State Line Item Budget.

_______4. Applicant understands that by signing below, the provider acknowledges and fully understands that the application/proposal and all the provider's supporting documentation may be subject to public inspection under the Indiana Access to Public Records Act (IC 5-14-3)

Signature ______________________________

Printed name ______________________________

Job Title ____________________ **Date** ***(month, day, year)*** ____________________

Receipt of an unsigned/undated application will be denied.

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