Sedgwick County Developmental Disability Organization
Provider Application

Agency Name:

Address Information

Primary Location (Where your business is physically located)

Street:

City: State: Zip:

Mailing Address (Where you want to receive correspondence)

Street:

City: State: Zip:

Billing Address (Where you want billings to be sent)

Street:

City: State: Zip:

Business Phone:

Business Fax:

Business E-Mail:

After hours emergency name and number:

(Indicate the name of a staff member and the number where they can be reached after hours should an emergency situation occur and someone at your organization must be notified.)

Profit Status: (check one) ☐ NOT FOR PROFIT ☐ FOR PROFIT

Federal Tax Number:

Contract Signer:

(The individual with your organization who is authorized to enter into contractual agreements.)

Phone: E-Mail:

SERVICES

Check the service(s) which you are providing or intend to provide over the next contract year.

Agency Directed Services	**Financial Management Services**
❑ Assistive Services	❑ Overnight Respite
❑ Day Supports	❑ Personal Assistant Services
❑ Medical Alert Rental	❑ Sleep Cycle Support
❑ Overnight Respite	❑ Specialized Medical Care
❑ Residential Supports	
❑ Sleep Cycle Support	
❑ Specialized Medical Care	
❑ Supported Employment	**Limited License Provider**
❑ Supportive Home Care	❑ Day Supports
❑ Wellness Monitoring	❑ Residential Supports
❑ Targeted Case Management ❑ Ages 0 – 13 ❑ Ages 14 – 18 ❑ Ages 18 and Over	

KEY STAFF MEMBERS (Please list names of staff members in the following positions or indicate N/A if this does not apply to your organizational structure)

Agency Director:

Agency Director's Title:

Phone: E-Mail:

DD Services/Program Director:

DD Services/Program Director's Title:

Phone: E-Mail:

Financial Director:

Phone: E-Mail:

Contact Person for ANE Reports:

Phone: E-Mail:

Admissions Representative:

Phone: E-Mail:

Complete this section if you provide Targeted Case Management	
QA Team Leader:	
Phone:	E-Mail:
Behavior Management Committee Chair:	
Phone:	E-Mail:
BASIS Representative:	
Phone:	E-Mail:

GENERAL INFORMATION

1. Do you do business with any other Sedgwick County Department? No

If yes, which department?

2. Has the agency ever been denied a contract by Sedgwick County? No

a. If yes, what type of contract was denied?

b. If yes, what date was the contract denied?

c. If yes, what department denied the contract?

3. Has the agency ever been denied a provider agreement by Medicaid? No

If yes, please explain:

4. Has the agency ever been banned from providing Medicaid services? No

If yes, please explain:

5. How many full time equivalent (FTE) direct care staff are employed to provide services to people funded under the CDDO/CSP contract?

***Please attach a certificate of insurance verifying general liability coverage ($500,000 or more), auto insurance (if you will be transporting clients in the minimum amount of $500,000), and workers compensation coverage.**