

# SEDGWICK COUNTY DEVELOPMENTAL DISABILITY ORGANIZATION PROVIDER APPLICATION

**Agency Name:** \_\_\_\_\_

**Number of Years in business:** \_\_\_\_\_

**Current License(s):** \_\_\_\_\_

**Prior License(s):** \_\_\_\_\_

## **Address Information**

**Primary Location** (where your business is physically located)

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Mailing Address** (location where you want to receive correspondence)

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Billing Address** (location where you want billing/accounts payable information sent)

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Business Phone: \_\_\_\_\_

Business Fax: \_\_\_\_\_

Business Email: \_\_\_\_\_

After hours emergency

name & phone: \_\_\_\_\_

(Indicate the name of a staff member and the phone number where they can be reached should an emergency occur and someone at your agency must be notified)

**Agency Type:**      Non-Profit: ☐ For-Profit: ☐

**Federal Tax Number:** \_\_\_\_\_

**Contract Signer**

(The individual authorized to enter into contracts for your agency)

Name: \_\_\_\_\_

Email: \_\_\_\_\_

Phone: \_\_\_\_\_

**Services**

Agency-Directed Services		Self-Directed Services	
	Day Supports (license required)		Financial Management Services
	Medical Alert Rental		Personal Care Services
	Overnight Respite (license required)		Enhanced Care Services
	Residential Supports		Overnight Respite
	Shared Living (license required)		Specialized Medical Services (home health license required)
	Enhanced Care Services		
	Specialized Medical Services (home health license required)		
			<b>Limited License Provider</b>
	Supported Employment (license required)		Day Supports
			Residential Supports
	Supportive Home Care		
	Children's Integrated Community Supports		<b>Assistive Services</b>
			Home Modifications
	Wellness Monitoring		Vehicle Modifications
	Targeted Case Management (license required)		Specialized Medical Equipment and Supplies

**Key Staff Members** (Please list names & contact information for staff members in the following positions or indicate N/A if this does not apply to your organizational structure)

Agency Director: \_\_\_\_\_

Agency Director Title: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

IDD Services/Program  
Manager: \_\_\_\_\_IDD Services/Program  
Manager Title: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Finance Director: \_\_\_\_\_

Finance Director Title: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Quality Assurance

Contact: \_\_\_\_\_

Quality Assurance Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Admissions Director: \_\_\_\_\_

Admissions Director

Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**General Information**

1. Do you do business with any other Sedgwick County Department?	
a. If yes, which department?	

2. Has the agency ever been denied a contract by Sedgwick County?	
a. If yes, what type of contract was denied?	
b. If yes, what date was the contract denied?	
c. If yes, what County Department denied the contract?	

3. Has your agency or any employees been excluded from participating in a Federally funded health care program (i.e. excluded through OIG)?	
a. If yes, please explain:	

**See website for full information on the affiliation process:**

**[I Want to Provide Services | Sedgwick County, Kansas](#)**