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)	**Limited License Provider**
☐ Supported Employment (license required)	☐ Day Supports
☐ Supportive Home Care	☐ Residential Supports
☐ Children's Integrated Community Supports	**Assistive Services**
☐ Wellness Monitoring	☐ Home Modifications
☐ Targeted Case Management (license required)	☐ Vehicle Modifications
	☐ 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?	No
a. 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 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)?	No
a. If yes, please explain:	

See website for full information on the affiliation process:

[I Want to Provide Services | Sedgwick County, Kansas]