HCBS WAIVER QUALIFICATIONS FORM: ICC PROVIDER

A) Identification of applicant:

Agency (business) name:_____

Address:_____

_____

_____

Contact person:
Name:_____ **Phone #: ( )**_____

B) Check the service(s) you wish to provide in addition to Intensive Care Coordination (ICC):

Intensive In Home	☐	Crisis Response	☐
Skill Building	☐	Respite Hourly	☐
Respite Overnight	☐	Family Support	☐

C) List all CURRENT licenses, contracts, approved programs, and certifications (include Medicaid numbers where appropriate):

_____

_____

_____

_____

If none are current, list those operative in the past:

_____

_____

D) Describe other agency affiliations demonstrating agency effectiveness in interagency cooperative ventures:

_____

_____

E) Describe agency's ability to serve S.E.D. children:

NOTE: For first time applicants, a detailed narrative describing the agency must be additionally completed and attached. Please include mission, history and populations served.

I certify that the summary information submitted is accurate and true to the best of my knowledge.

Signature of Authorized Agency Representative_____ Date:_____

Print Name and Title_____

NOTE: The LGU must send this form along with a written recommendation to:
Gary Hook, HCBS Waiver Coordinator
OMH Division of Children and Families, 6th Floor
44 Holland Avenue
Albany, NY 12229