



Office of Mental Health

HCBS WAIVER QUALIFICATIONS FORM: SUBCONTRACTOR

A) Identification of applicant:

Agency (business) name: _____

Address: _____

Contact person:

Name: _____ Phone #: () _____

B) Check the service(s) you wish to provide:

Intensive in Home _____

Crisis Response _____

Skill Building _____

Respite _____

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:

**NYS Office of Mental Health
Division of Children and Families, 6th Floor
HCBS Waiver Unit
44 Holland Avenue
Albany, NY 12229
Telephone: (518) 474-8394
Fax: (518) 473-4335
Email: dcfs@omh.ny.gov**