

#01059 Community Rehabilitation Program Renewal Vendor Application

Applicant Information

Organization Name:				Date:	
Organization Type:	Profit	Non-Profit	Public		
Director Name:	Phone:		Email:		
Contact Person:	Phone:		Email:		
Billing Address:					

Community Rehabilitation Program Services

Please mark each service you offer:

- Supported Employment Services
- Work Adjustment Services
- Project SEARCH® Services

* For approved CRP vendors who wish to add or continue Project SEARCH®, please complete the entire application including the Project SEARCH® addendum

Target Population(s):

Is each location fully accessible to persons with disabilities? Yes No

Address:	
EIPD Unit	
Office(s):	

For the following documentation, please provide an index, label and attach:

1 Organizational Information & Supporting Documentation:

No Change	Changes Attached and Labeled	
<input type="checkbox"/>	<input type="checkbox"/>	A. Criminal Background Check policy
<input type="checkbox"/>	<input type="checkbox"/>	B. Accreditation certificate, outcome report, and quality improvement plan (If not yet accredited, attached your plan for accreditation)
<input type="checkbox"/>	<input type="checkbox"/>	C. Any other current and valid licenses, accreditation letters or certifications if applicable.
<input type="checkbox"/>	<input type="checkbox"/>	D. Your corporate charter, if applicable.

<input type="checkbox"/>	<input type="checkbox"/>	E.	Copy of your Board of Director roster including names and addresses, if applicable
<input type="checkbox"/>	<input type="checkbox"/>	F.	A roster of your Board of Directors if applicable, including names and addresses.
<input type="checkbox"/>	<input type="checkbox"/>	G.	A copy of the current fire inspection certificate awarded by the city, county or state fire marshal to reach location where EIPD clients will be served.
<input type="checkbox"/>	<input type="checkbox"/>	H.	Job descriptions for direct service staff including minimum qualifications.
MUST BE ATTACHED			I. Current liability insurance for each location where EIPD clients will be served (face sheet only that depicts the limits of your coverage for fire/liability insurance and workers' compensation).

2 Please indicate if there has been a substantial change in your organization's policies on the following areas in the previous 3 years:

No Change	Changes Attached and Labeled	
<input type="checkbox"/>	<input type="checkbox"/>	A. Conflict of Interest
<input type="checkbox"/>	<input type="checkbox"/>	B. Consumer Complaints
<input type="checkbox"/>	<input type="checkbox"/>	C. Consumer Satisfaction
<input type="checkbox"/>	<input type="checkbox"/>	D. Consumer Grievance
<input type="checkbox"/>	<input type="checkbox"/>	E. ADA Policy
<input type="checkbox"/>	<input type="checkbox"/>	F. Staff Training
<input type="checkbox"/>	<input type="checkbox"/>	G. Informed Choice
<input type="checkbox"/>	<input type="checkbox"/>	H. Accessibility Standard/Physical Accessibility
<input type="checkbox"/>	<input type="checkbox"/>	I. Health and Safety Standard
<input type="checkbox"/>	<input type="checkbox"/>	J. Affirmative Action Policy
<input type="checkbox"/>	<input type="checkbox"/>	K. Fiscal Management Policy
<input type="checkbox"/>	<input type="checkbox"/>	L. Program Evaluation Standards

3 Competitive Integrated Employment is required for all services. To satisfy the definition of competitive integrated employment, the Workforce Innovations Opportunity Act requires that the employment must satisfy the following 3 major components: competitive earnings (Section 7(5)(A) of the Act and §361.5(c)(9)(i) of the final regulations), integrated location (§361.5(c)(9)(ii) and §361.5(c)(32)(ii)), opportunities for advancement §361.5(c)(9)(iii) as defined by the Workforce Innovations Opportunity Act.

Attach a copy of your Competitive Integrated Employment policy or describe below.

4

Extended Services – Required for Supported Employment

A. Who is your funding source for Long -Term Vocational Services?

[Blank line for funding source]

B.

Describe how you fund Long-Term Vocational Services for individuals who are not eligible for funding or if you do not have a contract with the LME/MCO.

[Five blank lines for describing funding methods]

Conflict of Interest Certification

Real or apparent conflicts of interest may occur when a EIPD employee, officer or immediate family member has a financial or other interest in the business relationship involving a provider and that interest might reasonably be expected to influence the outcome of an official action. If it is found that such conflict of interest occurs and is not disclosed and remedied, the provider or potential provider may be barred from performing authorized services with EIPD; and existing authorization and vendor approval may be cancelled. If a real or apparent conflict of interest exists, attach a separate sheet describing the situation.

I certify, by signature below, that no real or apparent conflict of interest exists between the applicant organization and EIPD.

Signature:

[Blank line for signature]

Acknowledgement & Signature

I hereby acknowledge that I have been provided with the EIPD Standards for Providers of Community Rehabilitation Programs, have read and agree to abide by them, and I am making application on behalf of the provider named afore to become an approved vendor with EIPD.

Printed Name:

[Blank line for printed name]

Signature:

[Blank line for signature]

Date:

[Blank line for date]

For EIPD Use Only

Date Received by EIPD:

[Blank line for date received]

Responsible Unit Manager(s):

[Blank line for manager name]

Assigned CRP Specialist:

[Blank line for specialist name]

Vendor Review Date:

[Blank line for review date]

Approved Counties:

[Blank line for approved counties]

CRP Vendor Application Addendum for Project SEARCH™ Services

Complete this addendum if you would like to continue Project SEARCH® services.

To demonstrate compliance with the Project SEARCH® model fidelity, list the members of your Project SEARCH® collaborative team.

EIPD Unit Office: _____
Host Business (must be confirmed): _____
Education Agency: _____
Long-term Support Funding Agency (LME/MCO): _____

Any Other Partners?	Name	Function
	_____	_____
	_____	_____
	_____	_____

To assure model fidelity, Project SEARCH® must be conducted under a license issued by Cincinnati Children’s Hospital Medical Center. Please list the Project SEARCH® license holder:

License Holder: _____

Acknowledgement & Signature

I hereby acknowledge that my organization meets the eligibility requirements for Project SEARCH® services and wish to continue as an EIPD provider of Project SEARCH® training and placement services.

Printed Name:	_____	
Signature:	_____	Date: _____

For EIPD Use Only

Date Received by EIPD: _____ Vendor Review Date: _____

Program Specialist for Business Engagement: _____

Regional CRP Specialist: _____