North Carolina Division of Vocational Rehabilitation
NC Department of Health and Human Services
2801 Mail Service Center
Raleigh, NC 27699-2801

Community Partnership Renewal Application

Brain Injury Support Services

APPLICANT INFORMATION

Organization Name: _____ Date: _____

_____

Organization Type: ☐ Profit ☐ Non-Profit

Director Name: _____ Phone: _____ Email: _____

Contact Person: _____ Phone: _____ Email: _____

Billing Address: _____

BRAIN INJURY SUPPORT SERVICES

Target Population(s):

Describe your organization's experiences with the target population(s):

LOCATION

Address: _____

VR Unit Office: _____

Phone #: _____

Counties Served: _____

Is this location fully accessible to persons with disabilities? ☐ **YES** ☐ **NO**

***Include details of other locations on a separate sheet.*

FOR THE FOLLOWING; INDICATE IF CHANGES HAVE OCCURRED & ATTACH:

1. Organizational Information — No Change ____ See Attached ____
   - A. Please describe your agency's mission, vision and explain your organization's core values.

2. Competitive Integrated Employment – Required for all services — No Change ____ See Attached ____
   - A. Provide your policy statement on Competitive Integrated Employment including all elements required by WIOA.

3. Extended Services – Required for Supported Employment — No Change ____ See Attached ____
   - A. Please describe how you will customize and fund extended services (long term vocational supports) to comply with the NCDVR/Rehabilitation Services Administration (RSA) Federal Regulations. Include documentation examples of the provision of extended services.

4. Your organization's definition and experience of each of the following terms: — No Change ____ See Attached ____
   - A. Customized Employment
   - B. Job Carving
   - C. Assistive Technology/Rehab Engineering
   - D. Natural Supports

5. Your organization's policies on the following areas: — No Change ____ See Attached ____
   - A. Conflict of Interest
   - B. Criminal Background Checks
   - C. Consumer Complaints
   - D. Consumer Satisfaction
   - E. Consumer Grievance
   - F. ADA Policy
   - G. Staff Training
   - H. Informed Choice
   - I. Accessibility Standard/Physical Accessibility
   - J. Health and Safety Standard
   - K. Affirmative Action Policy
   - L. Fiscal Management Policy
   - M. Program Evaluation Standard

6. Provide job descriptions for direct service staff including minimum qualifications. — No Change ____ See Attached ____

7. Please provide sample copies of the following (if applicable): — No Change ____ See Attached ____
   - A. Intake profile
   - B. Supplemental Evaluation Report
   - C. Community-Based Assessment Report
   - D. CRP Service plans specific to the service for which you are applying
   - E. Task Analysis
   - F. Monthly summary of service provision

9. Describe and illustrate one actual case for each service for which you are applying from referral to successful outcome on the job that best represents the array and quality of services your organization provides. Also, explain how you coordinate or provide on-going support if applying for Supported Employment.

NOTE: Please omit any confidential or identifying information.

No Change ____ See Attached ____

10. Supporting documentation:

No Change ____ See Attached ____

A. A copy of your accreditation certificate, outcome report, and quality improvement plan. If not accredited, attach your plan for accreditation.
B. Any other current and valid licenses, accreditation letters or certifications, if applicable.
C. Your corporate charter, if applicable.
D. Certification of good standing for franchise taxes, if applicable.
E. Documentation of nonprofit status, if applicable.
F. A roster of your board of directors, if applicable, including names and addresses.
G. A copy of your organization chart if applicable.
H. A copy of your current liability insurance for each location where DVRS clients will be served (face sheet only that depicts the limits of your coverage for fire/liability insurance and workers comp).
I. A copy of the current fire inspection certificate awarded by the city, county or state fire marshal to reach location where DVRS clients will be served.
J. A copy of the building inspection or occupancy certificate, if required by city regulation, for each location where DVRS clients will be served.
K. A copy of the wage exemption certificate (WH-228) if you will be paying sub-minimum wages to DVRS clients. This is issued by the U.S. Department of Labor.

Conflict of Interest Certification

Real or apparent conflicts of interest may occur when a DVRS 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 DVRS; 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 DVRS.

Signature: _____

Acknowledgement & Signature

I hereby acknowledge that I have been provided with the DVRS 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 above to become an approved vendor with DVRS.

Printed Name: _____

Signature: _____ Date: _____

For DVRS Use Only

Date Received by DVRS: _____ Responsible Unit Manager(s): _____

Assigned CRP Specialist: _____ Vendor Review Date: _____