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**Affiliate Application**

**Instructions**: Please complete the entire application. If you need additional space, please use the back of the application. If you have any questions, please contact the CDDO at (620)431-7796.

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| Name of Agency Requesting Affiliation: |       |
| Address: |       |
| City: |       | State: |       | Zip Code: |       |
| Telephone: |       |
| Fax: |       |
| Cell: |       |
| E-Mail Address: |       |
| Website: |       |
| Name of Executive Director/President: |       |
| Corporate Status: | For Profit | [ ]  | Not for Profit | [ ]  |
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| Mission Statement: |       |
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| What is your experience working with people with disabilities? |
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| Are you willing to serve all persons regardless of the severity of each person’s disability? |       |
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| What services are you planning to provide in each of the four counties in the CDDO catchment area? |
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| What is the maximum number of persons you are able to serve? |       |
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| Are you willing to abide by state regulations 30-63-1 thru 30-63-3 and 30-64-1 and 30-64-33? |
|       |
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| Please initial the following regulations thus indicating that you understand the requirement. |
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| 1. Background checks will be completed on all employees
 |       |
| 1. Reports, documentation, data will be furnished as requested by the CDDO
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| 1. Provide an annual audit.
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| 1. Billing shall be supported with documentation required by the CDDO
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| 1. Maintain driving record checks for all employees who transport clients
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| 1. There is a need for nursing oversight
 |       |
| 1. Staff will meet minimum training requirements
 |       |
| 1. Filing all state and federal reports; ex. Employment tax, social security, workman’s Comp, etc.
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| Documents Required: |
| 1. Business Plan
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| I, the undersigned, acknowledge that if my agency is approved as an affiliate of the Tri-Valley CDDO, that I will comply with all of the requirements as dictated in the contract agreement and agree to abide by state and federal regulations governing developmental disabilities services. |
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|       |  |       |
| Authorized Representative |  | Date |