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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 | | | | | | | | | | | | | | | | | | |  | |
| 1. Provide an annual audit. | | | | | | | | | | | | | | | | | | |  | |
| 1. Billing shall be supported with documentation required by the CDDO | | | | | | | | | | | | | | | | | | |  | |
| 1. Maintain driving record checks for all employees who transport clients | | | | | | | | | | | | | | | | | | |  | |
| 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 | | | | | |