

3. Type of application:

Initial Enrollment

Reapplication/Re-enrollment

The applicant (check one) () is () is not a current DDS
 Service provider
 The applicant (check one) () is () is not a current CT
 Medicaid provider

For initial enrollment or reapplication/re-enrollment, use **X** to indicate services the provider agency will provide under each program. Use **X** to specify which region(s) or locations where service will be provided.

Provide Service	Service	North Region	South Region	West Region	Specific Towns (if not region wide)
	Adult Companion Services				
	Adult Day Health				
	Group Day Services				
	Health Care Coordination (in-home supports for non family setting)				
	Individualized Day Support				
	Personal Support				
	Supported Employment				
	Assisted Living:				
	Level 1				
	Level 2				
	Level 3				
	Level 4				
	Core Services				
	Individualized Home Supports (Formerly Supported Living & IS Hab)				
	Live In Care Giver				
	Residential Habilitation:				
	CTH				
	CLA				
	Respite Care				
	Interpreter Service				
	Nutrition				
	Independent Support Broker (formerly FICS)				
	Clinical Behavioral Support Services				
	Vehicle Modifications				
	Transportation				
	Specialized Medical Equipment & Supplies				
	Personal Emergency Response System (PERS)				

Note: All supports are expected to be provided within the State of Connecticut. Applications for services provided outside of the State of Connecticut are limited to locations within close proximity to the state borders or unique supports presently unavailable in the state. Prior approval by the Department of Developmental Services is required.

Beginning Date Medicaid Services will be provided: ____/____/____

4. Provider Agency Acknowledgement

I understand that the provider agency is responsible for submitting to DDS verification and documentation of its qualifications to render the Waiver Services indicated on this application

Signature of Authorized Agent for Provider Agency	Typed or Printed Name and Title of Authorized Agent
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Date: _____

Instructions:

- 1) A completed "Department of Development Services Application for Provider Participation" form with attachments should be submitted to:

Peter Mason
Contracts Manager
Department of Developmental Services
460 Capitol Avenue
Hartford, Connecticut 06106

- 2) Attachments:

Signed Assurance Agreement
Policy & Procedure Documentation
Licenses and qualifications of all consultants

- 3) The DDS will notify the Qualified Provider applicant in writing within 60 days if the application is complete and identify what information is missing or incomplete. The applicant will be given a time frame to provide the missing information.
- 4) The DDS will notify a Qualified Provider applicant in writing whether the application has been accepted within 60 days of the receipt of a complete application.