


VENDOR APPLICATION

DS 1890 (Rev. 11/2004) (Electronic Version)

Applicant Name					Federal Tax ID or SSN *
Name of Governing Body or Management Organization					
Mailing Address	(Street)	(City)	(State)	(Zip)	(County)
Service Address	(Street)	(City)	(State)	(Zip)	(County)
<i>(If different than mailing address)</i>					
Applicant (owner or executive director)			Telephone number ()		
Type of Service to be Provided			Facility Capacity		
Identification of the type of consultants, subcontractors and community resources to be used by the vendor as part of its service					

CERTIFICATION

I hereby certify to the best of my knowledge and belief, this information is true, correct, and complies with Title 17, Section 54310(a).

Applicant's Signature 	Date
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INSTRUCTIONS

Please read the Department of Developmental Services California Code of Regulations, available from the regional centers, prior to completing this form. Type or print this form. Mail to the regional center serving your area.

Attach applicable information outlined in Title 17, Section 54310(a)(10)

- (A) Any license, credential, registration or permit required for the performance of the service or operation of the program, or proof of application for such document;*
- (B) Any academic degree required for performance or operation of the service;*
- (C) Any waiver from licensure, registration, certification, credential, or permit from the responsible controlling agency;*
- (D) The proposed or existing program design as required in Section 56712 and Section 56762, if applicable, for applicants seeking vendorization as community-based day programs;*
- (E) The proposed or existing staff qualifications and duty statements as required in Sections 56722 and 56724 for applicants seeking vendorization as community-based day programs;*
- (F) The proposed or existing design as required in Section 56780 for applicants seeking vendorization as in-home respite services agencies;*
- (G) The proposed or existing staff qualifications and duty statements as required in Section 56792 for applicants seeking vendorization as in-home respite services agencies;*
- (H) The signed Home and Community-Based Services Provider Agreement with the Department of Health Services, if required.*

* "Except for the Federal Tax ID or Social Security Number, all information provided by you on this form may be released to a member of the public pursuant to the Public Records Act, Section 6250 et seq. of the California Government Code."

HOME AND COMMUNITY BASED-SERVICES PROVIDER AGREEMENT

 Name of Service Provider *(Please type or print)*

 Address

 Telephone

 Vendor Number

 Service Code

CERTIFICATION STATEMENT

The Provider agrees and shall certify under penalty of perjury that all claims for services provided to regional center clients have been provided to the clients by the Provider. The services were, to the best of the Provider's knowledge, provided in accordance with the client's written Individual Program Plan. The Provider shall also certify that all information submitted to the regional center is accurate and complete. The Provider understands that payment of these claims will be from federal and/or state funds, and any falsification or concealment of a material fact may be prosecuted under federal and/or state laws. The Provider agrees to keep for a minimum period of three years from the date of service a printed representation of all records which are necessary to disclose fully the extent of services furnished to the client. The Provider agrees to furnish these records and any information regarding payments claimed for providing the services, on request, within the State of California, to the California Department of Health Services; the Medi-Cal Fraud Unit; California Department of Developmental Services; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services, or their duly authorized representatives. The Provider also agrees that services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

THE PROVIDER AGREES TO INCLUDE WITH EACH CLAIM SUBMITTED TO THE REGIONAL CENTER A CERTIFICATION STATEMENT TO THE ABOVE TERMS AND CONDITIONS WHICH SHALL BE PRINTED ON THE REVERSE SIDE OF EACH PROVIDER OF CARE CLAIM FORM.

I certify that the undersigned will be A PARTICIPATING provider of Medi-Cal home and community-based services upon SUBMISSION OF THIS AGREEMENT TO THE REGIONAL CENTER and satisfaction of all vendorization requirements pursuant to Title 17, California Code of Regulations, and compliance with the requirements for providers of service set out in Welfare and Institutions Code, Division 9, Part 3, and in California Code of Regulations, Title 22.

 Department of Health Services

 Signature of Service Provider

 Date