## Community Rehabilitation Program Renewal Application

# Department of Health and Human Services

Division of Vocational Rehabilitation Services (DVRS)



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| Applicant Information | | | | | | | | | | |
| Organization Name: |  | | | | | | | Date: | |  |
|  | | | | | | | | | | |
| Organization Type: | Profit | | Non-Profit |  | | | | | | |
|  | | | | | | | | | | |
| Director: |  | | | | | | | | | |
|  | | | | | | | | | | |
| Contact Person: |  | | | | | | | |  | |
|  | | | | | | | | | | |
| Billing Address: |  | | | | | | | | | |
|  |  | | | |  | |  | | | |
| Phone: | (     ) | | | | Director’s E-mail: |  | | | | |
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| Community Rehabilitation Program Services | | | | | | | | | | |
| Please mark each service you propose to offer and note the location(s) where it will be available. | | | | | | | | | | |
| Supported Employment Services | | | | | | | | | | |
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| Project Search Services | | \*For **existing approved** CRP vendors who wish to add Project Search, please skip to pg 4 & complete addendum. | | | | | | | | |
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| Work Adjustment Services | |  | | | | | | | | |
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| Target Population(s):      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| **Is DVRS currently funding these services?**  **How many years how you been funded by DVRS to provide these services?**  **Are you currently in good standing with DVRS?**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
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| Is each location fully accessible to persons with disabilities?  Yes  No | |
| Address: |  |
| Phone: |  |
| Contact Person’s E-mail: |  |
| Counties Served: |  |
| VR Unit Office: |  |
| Contact Person: |  |

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| For the following documentation, please provide an index, label and attach:   1. Organizational Information and Supporting Documentation    1. A copy of your criminal background check policy.    2. A copy of your accreditation certificate, outcome report, and quality improvement plan. If not accredited attached your plan for accreditation.    3. Any other current and valid licenses, accreditation letters or certifications, if applicable.    4. Your corporate charter, if applicable.    5. Certification of good standing for franchise taxes, if applicable.    6. Documentation of nonprofit status, if applicable.    7. A roster of your board of directors, if applicable, including names and addresses.    8. A copy of your organization chart if applicable.    9. 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).    10. 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.    11. A copy of the building inspection or occupancy certificate, if required by city regulation, for each location where DVRS clients will be served.    12. 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. 2. Extended Services – Required for Supported Employment    1. 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. 3. Your organization’s policies on the following areas if they have substantially changed in previous 5 years 4. Conflict of Interest 5. Consumer Complaints 6. Consumer Satisfaction 7. Grievance 8. ADA Policy 9. Staff Training 10. Informed Choice 11. Accessibility Standard/ Physical Accessibility 12. Health and Safety Standard 13. Affirmative Action Policy 14. Fiscal Management Policy 15. Program Evaluation Standard 16. How do you plan to address integration at the job site? 17. Insert a statement about competitive integrated employment? |

**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:

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| CRP Vendor Application Addendum for Project Search Services | | | | |
| Complete this addendum and submit to the NCDVR Program Specialist for Transition Services if you would like to conduct Project Search services. | | | | |
| To demonstrate compliance with the Project Search model fidelity, list the members of your Project Search collaborative team. | | | | |
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| Instructor/Education Agency | |  | | |
| Vocational Rehabilitation Unit Office | |  | | |
| Long-term Support Funding Agency (LME/MCO) | |  | | |
| Host Business (must be confirmed) | |  | | |
|  |  | |  | |
| Any other partners? | Name | | Function | |
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To assure model fidelity, Project Search must be conducted under a license issued by Cincinnati Children’s Hospital Medical Center. Please select one of the following options regarding licensing:

|  |  |
| --- | --- |
|  | My organization pursued licensing independently and I am the Project Search license holder. |
|  | My organization is a member of a team whose license was funded by a grant awarded by the NC Council on Developmental Disabilities. The following team member agency is pursuing licensing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | My organization is a member of a team whose license was funded by some other entity. The following team member agency is in receipt of a license: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Acknowledgement & Signature**

I hereby acknowledge that my organization meets the eligibility requirements for Project Search services and wish to be considered as an NCDVR provider of Project Search training and placement services.

Printed name:

Signature: Date:

**For DVRS Use Only**

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| --- | --- |
| Date Received by DVRS: | Vendor Review Date: |
| Program Specialist for Transition Services: | Regional CRP Specialist: |