

## Letter of Intent – Agency Developmental Disabilities

AGENCY: \_\_\_\_\_

**Note: Information must be typed with all fields completed. If a field does not apply, indicate “NA”. Handwritten documents will NOT be accepted.**

Please return the following checklist and applicable documents to:

**Georgia Collaborative Enrollment  
P.O. Box 56324  
Atlanta, GA 30343**

### Letter of Intent Agency Checklist:

- Certificate of Attendance at the most recent Developmental Disabilities Open Enrollment Forum
- Completed Letter of Intent form
- Completed Service Location Addendum(s)
- Copy of a fully executed contract to verify a minimum of one year of same/similar service delivery during the most recent 12 months (Agencies that are not currently providing same or similar services but have provided similar service within previous thirty-six (36) months must submit evidence of service provision as well as full disclosure of reasons for service discontinuation.
- Copy of agency’s most recent business Tax Return or audited financial statement
- Agency Bank Statements – business statements for previous 6 months
- Verification of Tax ID number (*IRS Form 147C or Form CP575A*)
- IRS Exempt Letter (*Non-profit applicants only*)
- IRS Form 990 (*Non-profit applicants only*)
- One Professional Reference Letter
- Copy of “DBA” or trade name Registration (*if applicable*)
- Copy of the Current Georgia Secretary of State registration
- Copy of County/City Business license or permit for each site or documentation from municipality stating a Business license or permit is not required
- Private Home Care (PHC) license (*if applicable*)
- Community Living Arrangement (CLA) Permit (*if applicable*)  
*Note: If agency does not currently have required permit (Community Living Arrangement-CLA), if invited, the agency will have 6 months from the date of the Invitation to Apply to submit the CLA permit.*
- Employment Attestations for (*if applicable*):
  - Clinical Services Supervisor (CSS)
  - Developmental Disabilities Professional (DDP)

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- Director of Developmental Disabilities Services

Current resume of *(if applicable)*:

- Clinical Services Supervisor (CSS)
- Developmental Disabilities Professional (DDP)
- Director of Developmental Disabilities Services

Copy of each individual practitioner's state license/certificate based upon services being requested

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### I. GENERAL INFORMATION

#### A. Georgia Agency Information

Agency Legal Name: \_\_\_\_\_

DBA/Trade Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code (9 Digits): \_\_\_\_\_

Phone #: \_\_\_\_\_ TAX ID#: \_\_\_\_\_

DUNS Number, if applicable: \_\_\_\_\_ Fiscal Year End: \_\_\_\_\_

Mailing Address (if different): \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code (9 Digits): \_\_\_\_\_

#### B. Executive Leadership/Management

Chief Executive Officer: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Clinical Services Supervisor (if applicable): \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Agency Contact: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Developmental Disabilities Services Director (if applicable): \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Developmental Disabilities Professional (DDP) (if applicable): \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Person Completing This Application / Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

#### C. Corporate Information

*Please complete if agency is part of a corporate system:*

Corporate Name: \_\_\_\_\_

Corporate Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code (9 Digits): \_\_\_\_\_

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**AGENCY:** \_\_\_\_\_

Chief Executive Officer: \_\_\_\_\_

Phone (with Area Code): \_\_\_\_\_ Email address: \_\_\_\_\_

Primary Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code (9 Digits): \_\_\_\_\_-\_\_\_\_\_ County: \_\_\_\_\_

### **D. Business Classification**

*Please check only one box for Ownership, one box for Status and one box for business type.*

1. Ownership:            Private            Public             Government Program

2. Status:                For-Profit            Not-for-Profit

3. Business Type:      Authority    College/University    Community Service Board    Corporation

County	County Board of Health	Independent Contractor	Limited Liability Company
Municipality	Non-Profit Organization	Partnership	School Board/School District
Sole Proprietor	State Agency		

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### II. SERVICE LOCATION ADDENDUM

*Complete one page per service location.*

#### A. Service Location:

Site Name: \_\_\_\_\_

Address Line 1: \_\_\_\_\_

Address Line 2: \_\_\_\_\_

City, State, ZIP (9 Digit): \_\_\_\_\_

Phone Number: \_\_\_\_\_

#### B. Billing Address:

*(Please confer with your Billing Dept.)*

Address Line 1: \_\_\_\_\_

Address Line 2: \_\_\_\_\_

City, State, Zip (9 Digit): \_\_\_\_\_

Phone Number: \_\_\_\_\_

#### C. Counties Requested:


#### D. Accessibility:

*This service location is:*

Yes  No - Accessible by Public Transportation     
  Yes  No - Americans with Disabilities Act Compliant

#### E. Healthcare Facility Regulation (HFR) Permits/Licenses:

*This site is licensed by Healthcare Facility Regulation (HFR) as a (include a copy of the license:)*

**Not Applicable**

**Child Caring Institution (CCI)**

Certificate No. \_\_\_\_\_ Effective Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**Child Placing Agency (CPA)**

Certificate No. \_\_\_\_\_ Effective Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**Community Living Arrangement (CLA)**

Permit No. \_\_\_\_\_ Effective Date: \_\_\_\_\_ Capacity: \_\_\_\_\_

**Home Health Agency (HHA)**

Certificate No. \_\_\_\_\_ Effective Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**Personal Care Home (PCH)**

Permit No. \_\_\_\_\_ Effective Date: \_\_\_\_\_ Capacity: \_\_\_\_\_

**Private Home Care (PHC)** *Include copy of HFR letter listing counties approved*

Certificate No. \_\_\_\_\_ Effective Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

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### F. Services Requested Grid

Select the service(s) and applicable waiver being requested.

SERVICES	NOW WAIVER	COMP WAIVER
BEHAVIORAL SUPPORTS SERVICES <ul style="list-style-type: none"> <li>• LEVEL I</li> <li>• LEVEL II</li> </ul>		
ADULT NUTRITION SERVICES		
ADULT OCCUPATIONAL THERAPY (OT)		
ADULT PHYSICAL THERAPY (PT)		
ADULT SPEECH/LANGUAGE THERAPY (SLT)		
COMMUNITY ACCESS – GROUP SERVICES		
COMMUNITY ACCESS – GROUP SERVICES – CO-EMPLOYER		
COMMUNITY ACCESS – INDIVIDUAL SERVICES		
COMMUNITY ACCESS – INDIVIDUAL CO-EMPLOYER		
COMMUNITY LIVING SUPPORT SERVICES (CLS)		
COMMUNITY LIVING SUPPORT SERVICES (CLS) – CO-EMPLOYER		
COMMUNITY RESIDENTIAL ALTERNATIVE SERVICES (CRA) IN A CLA		
ENVIRONMENTAL ACCESSIBILITY ADAPTATION		
NATURAL SUPPORT TRAINING SERVICE		
NURSING SERVICES – REGISTERED NURSE (RN)		
NURSING SERVICES – LICENSED PRACTICAL NURSE (LPN)		
PREVOCATIONAL SERVICES		
RESPIRE SERVICES IN HOME <i>(Requires PHC license and must also apply and be approved for CLS)</i>		
RESPIRE SERVICES OUT OF HOME <i>(Requires a Child Caring Institute, CLA or PCH Permit) Agency must also apply and/or already be approved for CRA services. Cannot be provided at a site approved for CRA</i>		
RESPIRE SERVICES – CO-EMPLOYER		
SPECIALIZED MEDICAL EQUIPMENT		
SPECIALIZED MEDICAL SUPPLIES		
SUPPORTED EMPLOYMENT SERVICES - GROUP		
SUPPORTED EMPLOYMENT SERVICES - GROUP - CO-EMPLOYER		

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SERVICES	NOW WAIVER	COMP WAIVER
SUPPORTED EMPLOYMENT SERVICES – INDIVIDUAL		
SUPPORTED EMPLOYMENT SERVICES – INDIVIDUAL - CO-EMPLOYER		
TRANSPORTATION – ENCOUNTER/TRIP		
TRANSPORTATION – ENCOUNTER/TRIP - CO-EMPLOYER		
TRANSPORTATION – COMMERCIAL CARRIER - MULTI-PASS		
VEHICLE ADAPTATIONS		

**Attestation Statement:**

My signature below indicates that all of the information provided above, and in any attachments to this application document, is complete and correct to the best of my knowledge.

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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### III. PROVIDER PROFILE QUESTIONS

**PLEASE ATTACH A DETAILED EXPLANATION FOR ANY QUESTIONS BELOW THAT WERE ANSWERED “YES”**

Please answer the following questions regarding your organization’s programs:

1. Has the organization, or any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee, had its professional liability or malpractice insurance refused, revoked, declined or accepted on special terms in the past five (5) years?  Yes  No
  
2. Has any government agency suspended, revoked, or taken other action against the organization’s license to practice or to conduct business in the past five years, or taken such an action in the past five years against any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee? (To include Medicaid /Medicare)  Yes  No
  
3. Have any accreditations or memberships in professional organizations been revoked, reduced, denied, or suspended by others or voluntarily given up by the organization, or any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee, in the last five years, or are any actions now under way which may lead to such sanctions?  Yes  No
  
4. Has any Owner, Managing Employee, officer, or shareholder of the organization **ever** been convicted of a crime, excluding minor traffic misdemeanors?  Yes  No
  
5. Has the organization, or any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee, **ever** been previously denied acceptance into, disenrolled from, or withdrawn from GA DBHDD or GA Collaborative ASO network participation?  Yes  No
  
6. Has the organization, or any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee, had any settled claims or judgments relating to sexual misconduct or civil rights violations in the past five years? If **Yes**, enter the total number: \_\_\_\_\_  Yes  No
  
7. In the past five years, has the organization, or any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee, had any settled claims or judgments relating to any other matter not disclosed in the response to Question 6 above? If **Yes**, enter the total number: \_\_\_\_\_  Yes  No
  
8. Has the organization, or any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee, been a defendant in five (5) or more lawsuits within the **past five (5) years**? If **Yes**, enter the total number: \_\_\_\_\_  Yes  No
  
9. Does the organization hire, continue to employ, or contract with individuals listed on the Office of Inspector General’s List of Excluded Individuals/Entities (to include owners, officers, employees, subcontractors, and others identified in §1128)?  Yes  No
  
10. Has the organization, or any other Provider Entity of which any Owner or Managing Employee is or has been an Owner or Managing Employee, filed for Bankruptcy in the past five years?  Yes  No

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### IV. Employment Attestation: Director of Developmental Disabilities Services

<b>Name</b>			
<b>Phone</b>		<b>Email</b>	
<b>License Number (if applicable)</b>		<b>Expiration Date</b>	
<b>Certificate Number (if applicable)</b>		<b>Expiration Date</b>	
<b>Position</b>	<b>Director of Developmental Disabilities Services</b>		

\_\_\_\_\_  
Signature  
Director of Developmental Disabilities Services

\_\_\_\_\_  
Date

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### V. Employment Attestation: Developmental Disabilities Professional (DDP)

Name			
Phone		Email	
License Number <i>(if applicable)</i>		Expiration Date	
Certificate Number <i>(if applicable)</i>		Expiration Date	
Position	<b>Developmental Disabilities Professional</b>		

\_\_\_\_\_  
Signature  
Developmental Disabilities Professional

\_\_\_\_\_  
Date

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### VI. Employment Attestation: Clinical Services Supervisor (CSS)

Name			
Phone		Email	
License Number <i>(if applicable)</i>		Expiration Date	
Certificate Number <i>(if applicable)</i>		Expiration Date	
Position	<b>Clinical Services Supervisor</b>		

\_\_\_\_\_  
Signature  
Clinical Services Supervisor

\_\_\_\_\_  
Date

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### Developmental Disabilities Services

#### BEHAVIORAL SUPPORTS SERVICES

Submit the following for each person applying for BSS services:

1. Current Resume
2. Evidence of specialized training and education
3. Professional License or Certificate

Position Title	Name	Phone	Email
BSS			
DDP			

**Please note that the DDP for BSS must:**

- Have a minimum of a Master’s degree in psychology, education, social work or a related field, and
- Meet the DDP definition of Behavior Specialist, Behavior Analyst, or Psychologist.

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### **PARTICIPATION STATEMENT:**

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) requires that services be provided according to the service guidelines and that the agency will operate in accordance with applicable standards, rules and regulations and policies.

By signing below, I hereby certify and attest that my staff, agents, contractors, subcontractors, billing agent(s) and I have reviewed and agree to comply with the terms and conditions set forth in the following applicable DBHDD and Department of Community Health (DCH)/ Medicaid Provider manuals:

- [Provider Manual for Community Developmental Disabilities Providers, 02-1201](#)
- [Criminal History Record Check for Contractors, 04-104](#)
- [Rules and Regulations of Department of Behavioral Health and Developmental Disabilities - Client's Rights \(Chapter 290-4-9\)](#)
- Department of Community Health (DCH) Policies and Procedures Manuals, found at the following links:
  - [Part I Policies and Procedures / Billing Manual](#)
  - [Part II– Policies and Procedures for COMPREHENSIVE SUPPORTS WAIVER PROGRAM \(COMP\) and NEW OPTIONS WAIVER PROGRAM \(NOW\)](#)
  - [Part III– Policies and Procedures for COMPREHENSIVE SUPPORTS WAIVER PROGRAM \(COMP\)](#)
  - [Part III– Policies and Procedures for NEW OPTIONS WAIVER PROGRAM \(NOW\)](#)

I understand and acknowledge that the policies and procedures manuals are amended (generally on a quarterly basis) when either Department finds it necessary or appropriate to do so, and that it is my responsibility to check periodically for any revisions pertaining to the delivery of or reimbursement for services rendered to eligible individuals.

I further understand that failure to abide by either Department's (DBHDD or DCH) policies and procedures will result in adverse actions including, but not limited to the denial of claims, monetary recoupment, termination, suspension of payments, and reduction of reimbursement.

I certify and attest that I have reviewed the entire contents of the completed application and that the information provided is accurate and complete. I understand that inaccurate, incomplete or omitted data may lead to sanctions against me.

**Under applicable state and federal laws, I do hereby affirm that I am the authorized agent to complete this document and that the information contained herein this document is complete, true, and correct to the best of my knowledge. I understand that material misrepresentation and/or falsification of any information contained herein shall result in the immediate removal of further consideration for participation.**

\_\_\_\_\_  
Agency Name

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Name (Please Print)

Date (mm/dd/yy): \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Title