Kansas Department for Aging and Disability Services

LICENSE APPLICATION

COMMUNITY SERVICE PROVIDER (K.A.R. 30-63-10 et.seq)

☐ Day Services
☐ Residential

☐ New Application ☐ Renewal Application ☐ Supplement to Application

[1] I/DD Service Provider (Legal Name)				**[3] Federal ID Number/EIN**	
[2] Agency Mailing Address	**City**	**State**	**Zip**	**[4] Requested Effective Start Date**	
		KS			**Submit application at least 60 days before start date**
[5] Director/Administrator/CEO/President		**[6] Phone Number**		**[9]Principal Affiliating CDDO** *primary service area*	
		(___)____- _____			
[7] Email Address/Agency Web Address *(if applicable)*		**[8] Fax Number**		**[10]Other Affiliating CDDO** *additional service area*	
		(___)____- _____			

[11] Board Chair *(if applicable)*	**[12]Mailing Address**	**[13]Phone Number**	**[14]Fax Number**
		(___)____- _____	(___)____- _____

[15] Location(s) where services will be provided *(List all physical locations, phone numbers, and capacity to serve* add additional pages, if needed)*

Physical Address	**Phone Number**	**Capacity to Serve**
	(___)____- _____	
Physical Address	**Phone Number**	**Capacity to Serve**
	(___)____- _____	
Physical Address	**Phone Number**	**Capacity to Serve**
	(___)____- _____	

CERTIFICATIONS

1. I agree to abide by all laws, **KMAP provider requirements,** regulations, training materials, policies and procedures governing the provision of community services for people with developmental disabilities including the HCBS I/DD Waiver.
2. I agree to fully cooperate with and be responsive to requests from and service reviews by the Kansas Department for Aging and Disability Services (KDADS) or its agents, and/or any CDDO in whose area community services are provided.
3. I understand that after notice and an opportunity to correct the deficiencies, the license status can be negatively affected, up to and including revocation of the license.
4. I certify that the licensee has and will maintain all licenses, certificates, and inspections of all local, county, state, and federal authorities, and that all wage and hour protections are in place under the FLSA. [e.g. Minimum wage payments, withholding taxes, occupational and health safety, zoning, fire safety inspections] .
5. I certify that services provided under this license will only be provided by employees of the licensee and that no person will be served in a location without such location having first been inspected and approved by local, county, state, and federal authorities, including KDADS.
6. I certify that the information provided above is true, full, and complete to the best of my knowledge, information, and belief. I further certify that I will supplement this application to KDADS within seven days if any of the information changes, including but not limited to the addition of a location(s).

AUTHORIZATION

AS AN AUTHORIZED AGENT OF APPLICANT, I HAVE READ THE LAWS AND REGULATIONS GOVERNING THE OPERATION OF A COMMUNITY SERVICE PROVIDER. APPLICANT, IF GRANTED A LICENSE, WILL COMPLY AND COOPERATE WITH KDADS AND WILL BE RESPONSIVE TO ITS REQUESTS. APPLICANT WILL MAINTAIN CURRENT INFORMATION ON THIS APPLICATION, AND ANY ATTACHMENTS, AND WILL NOTIFY KDADS AND SUPPLEMENT THIS APPLICATION IF ANY INFORMATION CHANGES.

Signature		**Title**		**Date**	

Send Applications to: KDADS Survey, Certification, & Credentialing
ATTN: Quality Assurance/Program Manager
612 S. Kansas Ave Topeka
Topeka, Kansas 66603

Website: www.kdads.ks.gov
Phone: 785-296-4737
Fax: 785-296-0256
Email: HCBS-KS@kdads.ks.gov

Internal Use Only

QA Recommend? ☐Y ☐N **Date** _____		**CDDO Affiliation** ☐Y ☐N **Date** _____
I certify that I completed the following tasks: Name _____ **Signature** _____ **Date** _____		