AP-2204 REV.71513

LICENSE APPLICATION

Targeted Case Management for IDD (K.A.R. 30-63-10)

☐ New Application
☐ Renewal Application
Renewal Date _____

[1] DD Targeted Case Management Service Provider (Legal Name)				[3] Federal ID Number/EIN	
[2] 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		**[8] Fax Number**		**[10]Other Affiliating CDDO** *additional service area*	
		(___) ___ - ____			
[11] Physical Address *Office*				**[12]Phone Number**	**[13]Web Address**
[11] Board Member *(if applicable)*	**[12]Mailing Address**			**[13]Phone Number**	**[14]Fax Number**
				(___) ___ - ____	(___) ___ - ____

CERTIFICATIONS

1. This agency and all case managers, working through this agency, have read and hereby agree to comply with the most current "Rules of Conduct for Case Managers Serving People with Developmental Disabilities."
2. This agency and all case managers agree to abide by all laws, regulations, KMAP manual, training materials, policies and procedures governing the provision of community services and/or Targeted Case Management services (If applicable) for people with developmental disabilities.
3. I hereby agree to 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 I provide Targeted Case Management services. And agree to maintain being in good standing with the CDDO affiliate agreements in areas I serve.
4. I hereby certify that the information provided above is true, full and complete to the best of my knowledge, information and belief.
5. I understand that – after notice and an opportunity to correct the deficiencies – my license status can be negatively affected, up to and including revocation of the license.
6. I certify that this agency has and will maintain all license, certificates, 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]

AUTHORIZATION

AS AN AUTHORIZED AGENT OR APPLICANT, I HAVE READ THE LAWS AND REGULATIONS GOVERNING THE INTELLECTUAL/DEVELOPMENTAL DISABILITIES (I/DD) TARGETED CASE MANAGER 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 THEIS APPLICATION, AND ANY ATTACHMENTS, AND WILL NOTIFY KDADS AND SUPPLEMENT THIS APPLICATION IF ANY INFORMATION CHANGES.

Signature		**Title**		**Date**	

Send Applications to: KDADS Community Services and Programs
ATTN: Quality Assurance
503 S. Kansas Ave
Topeka, Kansas 66612

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

Internal Use Only

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