

State of Kansas
DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES
LICENSE APPLICATION

AP-2204 REV.2/07

**PROVIDERS OF CASE MANAGEMENT FOR PEOPLE WITH DEVELOPMENTAL
DISABILITIES, AS DEFINED IN K.A.R. 30-63-10**

[1] DD Targeted Case Management Service Provider		[2] MAILING ADDRESS (STREET, CITY, STATE, ZIP)	
[3] FEDERAL ID NUMBER:		[4] REQUESTED EFFECTIVE START DATE:	
[5] DIRECTOR'S/ADMINISTRATOR'S NAME	[7] PHONE NUMBER ()	[11] A. PRINCIPAL AFFILIATING CDDO	
[6] E-MAIL ADDRESS:	[8] FAX NUMBER ()	[11] B. OTHER AFFILIATING CDDOS	
[10] LICENSE REQUESTED 1. REGULAR COMMUNITY SERVICE PROVIDER 2. LIMITED LICENSE COMMUNITY SERVICE PROVIDER**			
[12] BOARD CHAIRPERSON'S NAME (IF APPLICABLE)	[13] PHONE NUMBER ()	[14] ADDRESS (STREET, CITY, STATE, ZIP)	
<p style="text-align: center;">[15] PROCEDURAL REQUIREMENTS:</p> <ol style="list-style-type: none"> 1. All services required to be licensed under K.A.R. 30-63-10 et.seq. must be licensed to receive state and federal reimbursement for services rendered. Each individual case manager (if applicable) must meet qualification requirements, and accomplish required training/assessments to provide case management services. 2. A license application must be submitted for: <ol style="list-style-type: none"> a) Annual renewal of existing services b) Initial application to provide community services 3. Applicants first seeking to become a licensed DD Targeted Case Management Service Provider may be issued a temporary provisional license, subject to further review before a final decision is made, based on apparent ability to achieve compliance with regulations communicated in the applicant's policies and procedures and through an interview with SRS staff. Provisional temporary status will continue until SRS has had adequate time to assess actual compliance with the regulations. 4. Names of persons receiving services, and the addresses where those services take place, will be made available to SRS by the applicant upon request. 5. To ensure completion of the licensing process by the requested effective date, the license application must be submitted at least 60 (SIXTY) days PRIOR to beginning to start services. <p style="text-align: center;">[16] CERTIFICATIONS:</p> <ol style="list-style-type: none"> 1. This agency and all case managers have read and hereby agree to comply with the "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, training materials, policies and procedures governing the provision of community services and/or 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 State Department of Social and Rehabilitation Services or its agents, and/or any CDDO in whose area I provide community services and/or case management services. 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 effected, 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] <p style="text-align: center;">[17] AUTHORIZATION</p> <p>AS AN AUTHORIZED PERSON OF THE DD Targeted Case Management Service Provider, I HAVE READ THE LAWS AND REGULATIONS GOVERNING THE OPERATION OF THIS COMMUNITY SERVICE PROVIDER AND IT IS MY INTENTION TO COMPLY INSOFAR AS POSSIBLE AND TO COOPERATE WITH AND BE RESPONSIVE TO REQUESTS FROM THE STATE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES. THE DD Targeted Case Management Service Provider AGREES TO MAINTAIN CURRENT INFORMATION ON THIS APPLICATION AND ANY ATTACHMENTS. AND TO NOTIFY SRS/HCP/CSS IMMEDIATELY SHOULD ANY INFORMATION CONTAINED ON THIS APPLICATION (NEW OR RENEWAL) CHANGE.</p>			
[18] SIGNATURE OF AUTHORIZED PERSON	[19] TITLE	[20] DATE	

Community Service Provider License Application Instructions

Please Note - The instructions contained on this page are applicable to FORM AP-2204 Revised 2/07

Each block on the license application form is identified by a number [] in each block. Each number on the application corresponds to a specific instruction on this form.

- [1] **DD TCM SERVICE PROVIDER** - Specific name of the organization that is seeking this license
3. Legal Name of the Entity
 4. With the exception of court orders, sale of, take over of, merger of, the licensed community service provider, the legal name on the license certificate will not be changed for the sake of convenience during the course of this license
 5. HCP/CSS must be notified in writing of all changes to facts presented on this license application that are material to the continued operation of this community service provider.
- [2] **Mailing address:**
6. Street (box)
 7. City
 8. State
 9. Zip
- [3] **Federal Identification number**
- [4] **Requested Effective Start Date** - If a new application, the application must be submitted at least 60 days prior to anticipated start date.
- [5] **Name of Director / Administrator / CEO / President**
- [6] **E-mail address**
- [7] **phone number**
- [8] **fax number**
- [9] **NOT APPLICABLE FOR DD TCM SERVICE PROVIDER**
- [10] **NOT APPLICABLE FOR DD TCM SERVICE PROVIDER**
- [11] A. **IDENTIFY THE PRINCIPAL CDDO WITH WHOM YOU ARE AFFILIATED OR WISH TO BE AFFILIATED. THE PRINCIPAL CDDO AREA IS WHERE ADMINISTRATIVE FUNCTIONS OCCUR AND/OR WHERE THE MAJORITY OF SERVICES ARE PROVIDED.**
- B. **LIST ADDITIONAL AFFILIATING CDDO AREAS**

NOTE - DD TCM SERVICE PROVIDERS ARE NOT REQUIRED TO SUBMIT A LICENSE APPLICATION FOR EACH CDDO AREA IN WHICH THEY WILL BE PROVIDING SERVICES (AS LONG AS THEY OPERATE UNDER THE SAME DIRECTOR AND POLICIES).

- [12] **Board Chairperson's name**
- [13] **Phone number** of Board Chairperson
- [14] **Address** (Street, City, State, Zip) of the Board Chairperson
- [15] **PROCEDURAL REQUIREMENTS** - a list of requirements
- [16] **CERTIFICATIONS** - a list of certifications that the authorized agency staff person is assuring the State of Kansas that this DD TCM Service Provider will be in compliance with at all times.
- [17] **AUTHORIZATION** - A written statement that the provider has read all applicable laws, rules, regulations, and policies regarding the performance of their responsibilities as a Licensed DD TCM Service Provider, and that the person signing the application is authorized to do so.
- [18] **SIGNATURE** of authorized person
- [19] **TITLE** - The given title of the person who is authorized by position, board resolution, or ownership
- [20] **DATE** - date that the application is signed and submitted to SRS/HCP/CSS

All Community Service Provider License applications should be mailed to:
Division of Health Care Policy/Community Supports and Services
Docking State Office Building
915 SW Harrison 10th floor
Topeka, Kansas 66612