

**STATE OF NEW JERSEY  
DEPARTMENT OF HUMAN SERVICES  
DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)**

**APPLICATION FOR REAL LIFE CHOICES SERVICE PROVIDERS  
DDD CONTRACTED AGENCIES**

**BACKGROUND INFORMATION**

1. Date \_\_\_\_\_ Information Completed by \_\_\_\_\_
2. Name of Agency \_\_\_\_\_ Federal ID/Social Security #: \_\_\_\_\_
  - a. Agency Address \_\_\_\_\_
  - b. Billing Address \_\_\_\_\_
  - c. Agency Web Link Yes \_\_\_ No \_\_\_ Web Address \_\_\_\_\_
3. Is your agency a subsidiary of a parent or larger organization? Yes \_\_\_ No \_\_\_
  - a. If yes, name of parent or larger organization \_\_\_\_\_
  - b. Address \_\_\_\_\_
  - c. Telephone # \_\_\_\_\_ Ext. \_\_\_\_\_

**If your agency will render services out of more than one site location, list each site and its corresponding billing address if different than the address indicated above on page 3 of this application.**

4. Agency Type: (check all that apply)  
National \_\_\_ State \_\_\_ Local \_\_\_ For Profit \_\_\_  
Not For Profit \_\_\_ Religious Not for Profit \_\_\_ Limited Liability Corp. \_\_\_
  - a. Executive Director Name \_\_\_\_\_ Telephone # \_\_\_\_\_ Ext. \_\_\_\_\_
  - b. Contact Person Name \_\_\_\_\_ Telephone # \_\_\_\_\_ Ext. \_\_\_\_\_
  - c. Fax # \_\_\_\_\_ E-Mail Address \_\_\_\_\_
  - d. Agency Years of Operation \_\_\_\_\_ Number of Consumers Served Annually \_\_\_\_\_
  - e. Current Services and Supports Offered: \_\_\_\_\_  
\_\_\_\_\_

f. Counties Served: Statewide: Yes \_\_\_ No \_\_\_ If no, check all of the counties where your agency provides services.

Atlantic ___	Bergen ___	Burlington ___
Camden ___	Cape May ___	Cumberland ___
Essex ___	Gloucester ___	Hudson ___
Hunterdon ___	Mercer ___	Middlesex ___
Monmouth ___	Morris ___	Ocean ___
Passaic ___	Salem ___	Somerset ___
Sussex ___	Union ___	Warren ___

**g. Service Locations: (check all that apply)**

\_\_\_ Consumer's Home \_\_\_ Community Location \_\_\_ Agency Site

5. What service(s) does your agency provide through your contract (s) with DDD?

\_\_\_ Individual Supports \_\_\_ Respite \_\_\_ Camp \_\_\_ Hotel Respite \_\_\_ Habilitation  
\_\_\_ Supported Employment \_\_\_ Residential

6. What types of services does your agency wish to qualify to provide to Real Life Choice participants?

\_\_\_ Individual Supports \_\_\_ Respite \_\_\_ Camp \_\_\_ Hotel Respite \_\_\_ Habilitation  
\_\_\_ Supported Employment \_\_\_ Employment Specialist \_\_\_ Transportation  
\_\_\_ Individual/Group Specialized Instruction

7. If you wish to provide a service that you are not currently contracted with DDD to provide, what qualifies you to provide this service? Please outline how services are going to be administered.

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8. Does your agency wish to provide transportation services? \_\_\_ Yes \_\_\_ No

If yes, please answer the following questions:

a. Are you utilizing a vehicle(s) that is not attached to a DDD contracted program?

\_\_\_ Yes \_\_\_ No

b. Does this vehicle(s) have a current New Jersey registration? \_\_\_ Yes \_\_\_ No

c. Does this vehicle(s) have a current New Jersey inspection sticker? \_\_\_ Yes

\_\_\_ No

d. Is this vehicle(s) covered by a current auto insurance policy? \_\_\_ Yes

\_\_\_ No

e. Do all your drivers have a current New Jersey license? \_\_\_ Yes \_\_\_ No

f. If applicable, do your drivers have a current New Jersey CDL license?

\_\_\_ Yes \_\_\_ No (If yes, copy of CDL license is required)

g. Do all your drivers have a driver history abstract completed within the last year? \_\_\_ Yes \_\_\_ No

h. Are all your drivers covered by your auto insurance policy? \_\_\_\_ Yes  
\_\_\_\_ No

**Insurance company name** \_\_\_\_\_  
**Policy #** \_\_\_\_\_

**(Proof of vehicle insurance coverage must be submitted to DDD as part of this application)**

**I certify that all of the information provided in this application is valid and accurate.**

\_\_\_\_\_  
Executive Director Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Any Additional Information you would like to provide (Optional):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PLEASE NOTE: This application is subject to public disclosure under the New Jersey Open Public Records Act.**

PLEASE LIST ALL OFFICES/SITES THROUGHOUT THE STATE THAT YOUR AGENCY WILL RENDER SERVICES

**LOCAL ADDRESS  
AND TELEPHONE NUMBER**

**BILLING ADDRESS  
AND TELEPHONE NUMBER**

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**Additional sheets as needed.**