

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

**APPLICATION FOR REAL LIFE CHOICES SERVICE PROVIDERS
INDIVIDUAL PROVIDER**

BACKGROUND INFORMATION

1. Date _____ Information Completed by _____
2. Name _____ Social Security #: _____
- a. Address _____
- b. Daytime telephone # _____ Ext. _____
- c. E-mail address: _____ Fax #: _____
3. Where would you be willing to provide services? Statewide: Yes ___ No ___ If no, check all of the counties where you wish to provide services.
- | | | |
|---------------|----------------|----------------|
| Atlantic ___ | Bergen ___ | Burlington ___ |
| Camden ___ | Cape May ___ | Cumberland ___ |
| Essex ___ | Gloucester ___ | Hudson ___ |
| Hunterdon ___ | Mercer ___ | Middlesex ___ |
| Monmouth ___ | Morris ___ | Ocean ___ |
| Passaic ___ | Salem ___ | Somerset ___ |
| Sussex ___ | Union ___ | Warren ___ |

a. Service Locations: (check all that apply)

___ Consumer's Home ___ Community Location ___ Agency Site

4. What type of service(s) do you 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

STANDARDS

5. Are you a Medicaid provider? ___ YES ___ NO If yes, please answer the following questions:
- a. Are you in good standing with this provider? ___ YES ___ NO
If no, why? _____
- b. What is your Medicaid provider contract #? _____
- c. Who is your Medicaid provider contact person? _____
- d. Telephone # of provider contact person _____

6. Are you a Medicare provider? ___ YES ___ NO If yes, please answer the following questions:
- Are you in good standing with this provider? _____ YES _____ NO
If no, why? _____
 - What is your Medicare provider contract #? _____
 - Who is your Medicare provider contact person? _____
 - Telephone # of provider contact person _____
7. Are you a Division of Vocational Rehabilitation Services (DVRS) provider? ___ YES ___ NO If yes, please answer the following questions:
- Are you in good standing with this provider? _____ YES _____ NO
If no, why? _____
 - What is your DVRS provider contract #? _____
 - Who is your DVRS provider contact person? _____
 - Telephone # of provider contact person _____
8. Are you a Division of Youth and Family Services (DYFS) provider? ___ YES ___ NO If yes, please answer the following questions:
- Are you in good standing with this provider? _____ YES _____ NO
If no, why? _____
 - What is your DYFS provider contract #? _____
 - Who is your DYFS provider contact person? _____
 - Telephone # of provider contact person _____
9. Are you a Division of Mental Health Services (DMHS) provider? ___ YES ___ NO If yes, please answer the following questions:
- Are you in good standing with this provider? _____ YES _____ NO
If no, why? _____
 - What is your DMHS provider contract #? _____
 - Who is your DMHS provider contact person? _____
 - Telephone # of provider contact person _____
10. Are you a contracted provider for any other state or county agencies? ___ YES ___ NO If yes, please answer the following questions:
- Are you in good standing with these providers? _____ YES _____ NO
If no, why? _____
 - Please provide agency name(s), contract #'s and contact person and contact person's telephone number.
Agency Name _____ Contract# _____ Contact Person _____
Telephone Number _____

Agency Name _____ Contract# _____ Contact Person _____
Telephone Number _____

17. What type of experience do you have supporting individuals with developmental disabilities? _____

_____ # of Years _____

18. Two Professional References:

1. Name _____ Title _____
Address _____
City _____ State _____ Zip Code _____
Telephone # _____

2. Name _____ Title _____
Address _____
City _____ State _____ Zip Code _____
Telephone # _____

19. Do you wish to provide transportation services? ___ Yes ___ No

If yes, please answer the following questions:

- a. Does your vehicle have a current New Jersey registration? ___ Yes ___ No
- b. Does your vehicle have a current New Jersey inspection sticker? ___ Yes ___ No
- c. Is your vehicle covered by a current auto insurance policy? ___ Yes ___ No
- d. Is the auto insurance policy in your name? ___ Yes ___ No
- e. Do you have a current New Jersey driver's license? ___ Yes ___ No
- f. If applicable, do you have a current New Jersey CDL license? ___ Yes ___ No (If yes, copy of CDL license is required)
- g. Have you had a driver history abstract completed within the last year? ___ 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.

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.