

**NEW JERSEY DEPARTMENT OF HUMAN SERVICES  
DIVISION OF DEVELOPMENTAL DISABILITIES  
REAL LIFE CHOICES  
PROVIDER AGREEMENT**

Name of Provider
Federal ID #:

**PROVIDER AGREES TO:**

1. Participate as a provider in Division of Developmental Disabilities Real Life Choices;
2. Maintain status as a qualified provider of services to Real Life Choices consumers by keeping all licenses, certifications, accreditations and other credentials in good standing;
3. Notify the Division of Developmental Disabilities of permanent loss, temporary suspension, or probationary status of all qualifying credentials, i.e. licenses, certifications, accreditations;
4. Notify the Division of Developmental Disabilities of changes in the name, address, telephone and contact person for the agency.
5. Ensure that all support staff meet at least the minimum requirements for employment and receive training as mandated by the Division of Developmental Disabilities or other licensing, certifying or accreditation agencies by which the agency is regulated;
6. Provide services and supports as specified in the Plans of Care of Real Life Choices participants;
7. Follow the instructions of the fiscal intermediary agency for submission of invoices and time sheets for services rendered;
8. Comply with the reimbursement schedule for services as set by the Division of Developmental Disabilities.
9. Authorize the Family Support Center of New Jersey to list agency as a DDD Qualified Provider on the Iris Real Life Choices website. (Information will be sent directly to you by the Family Support Center)
10. Certify all information in the application is valid and have read the instructions regarding how to submit the requested information/documentation.

Failure to continue to meet any of the above conditions shall be cause for termination of the provider agreement.

The provider also agrees that either the provider or the Division of Developmental Disabilities may terminate this agreement by giving the other party 30 days written notice.

Name of Responsible Individual (Print)	
Title	Telephone #
Signature	Date

Instructions: Mail completed Provider Agreement to:  
**Division of Developmental Disabilities**  
**P.O. Box 726**  
**Trenton, New Jersey 08625**  
**Attention: Nydia Gutierrez**  
**Telephone: (609) 987- 0858 Fax: (609) 987- 2070**

