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| SEAL31.TIF | **FACILITY BASED RESPITE APPLICATION**State Form 56582 (9-18)  | FAMILY AND SOCIAL SERVICES ADMINISTRATIONDIVISION OF MENTAL HEALTH AND ADDICTION (DMHA)YOUTH HOME AND COMMUNITY-BASED WRAPAROUND SERVICES (HCBS)402 W. Washington Street, Room W353Indianapolis, In 46204-2739Telephone: (317) 232-7800 |

**SECTION A: Agency Applying as a Facility Based Respite Services Provider**

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| *Submit a copy of at least one of the following:* |
| [ ]  Emergency shelters licensed under 465 IAC 2-10[ ]  Special needs foster homes licensed under IC 31-27-4[ ]  Therapeutic foster homes licensed under IC 31-27-4[ ]  Child Care Centers licensed under IC 12-17.2-4[ ]  Child Care Homes, licensed under IC 12-17.2-5-1[ ]  School Age Child Care Project licensed under IC 12-17-12 [ ]  Medicaid approved PRTF under 405 IAC 5-20-3.1 and licensed under 465 IAC2-11-1 as private secure residential facility [ ]  Child caring institutions licensed under IC 31-27-3 |

**SECTION B: Facility Physical Address - *Must match license(s) submitted in Section A.***

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| Name of Facility      |
| Street Address      |
| City, State, ZIP      |

**SECTION C: Facility Contact *(Primary contact to appear on the picklist.)***

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| Primary Contact Name or Role      |
| Primary Contact Telephone Number      |
| Primary Contact E-mail      |
| Alternate Contact Name or Role      |
| Alternate Contact Telephone Number      |
| Alternate Contact E-mail      |

**SECTION D: Specialty Comment**

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| Facility based respite providers should consider using the specialty comment section (up to 256 characters) to indicate any specific admission criteria (e.g. girls only), as well as alternative contact information, as only the primary contact will appear on the pick list. Comments are subject to review and approval by DMHA.  |
| Specialty Comment:       |

**SECTION E: Counties for the Pick List**

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| *Please list the counties from which you are willing to accept referrals. If willing to accept referrals from all counties, please check the box below.* |
| Counties      |
| [ ]  All Counties |

**SECTION F: Signature / Attestation**

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| *To acknowledge understanding, read and initial the assurances below prior to signing this application.* |
| 1. I assure that, if approved, I will maintain compliance with all applicable state and federal statutes, policy, regulations, and licensure requirements for the approved DMHA Youth HCBS Program(s). Initial: \_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
| 1. I assure that, if approved, I will provide only those HCBS for which the individual has been approved; services which have been authorized by the State of Indiana in the Plan of Care; and in accordance with the Provider Agreement. Initial: \_\_\_\_\_\_\_\_\_\_\_\_\_\_
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| 1. I assure that the information stated in the Rendering Provider Application Form is correct and complete to the best of my knowledge. I am aware that, should an investigation at any time indicate that the information has been falsified, I may be considered for sanctions up to and including termination from the program. I hereby authorize the Indiana Family and Social Services Administration to make any necessary verifications of the information provided herein, and further authorize and request each educational institution, medical/license board or organization to provide all information that may be required in connection with my application for participation in this Indiana Medicaid HCBS Program. Initial: \_\_\_\_\_\_\_\_\_\_\_\_\_\_
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| Signature | Date *(month, day, year)*      |
| Print Name      |
| Title      |
| Agency Name      |