

VENDOR APPLICATION

DS 1890 (Rev. 2/2001)

Applicant Name

Federal Tax ID or SSN

Name of any Governing Body or Management Organization

Mailing Address

(Street)

(City)

(State)

(zip)

(County)

Service Address

(Street)

(City)

(State)

(zip)

(County)

(if different than
mailing address)

Applicant (owner or executive director)

Telephone number

Type of Service to be Provided

Facility Capacity

Identification of the type of consultants, subcontractors and community resources to be used by the vendor as part of its service

CERTIFICATION

I hereby certify to the best of my knowledge and belief, this information is true, correct, and complies with Title 17, Section 54310(a).

Applicants Signature

Date

INSTRUCTIONS

Please read the Department of Developmental Services California Code of Regulations, available from the regional centers, prior to completing this form. Type or print this form. Mail to the regional center serving your area.

Attach applicable information outlined in Title 17, Section 54310(a)(10)

- (A) Any license, credential, registration or permit required for the performance of the service or operation of the program, or proof of application for such document;
- (B) Any academic degree required for performance or operation of the service;
- (C) Any waiver from licensure, registration, certification, credential, or permit from the responsible controlling agency;
- (D) The proposed or existing program design as required in Section 56712 and Section 56762, if applicable, for applicants seeking vendorization as community-based day programs;
- (E) The proposed or existing staff qualifications and duty statements as required in sections 56722 and 56724 for applicants seeking vendorization as community-based day programs;
- (F) The proposed or existing design as required in Section 5678.9 for applicants seeking vendorization as in-home respite services agencies;
- (G) The proposed or existing staff qualifications and duty statements as required in Section 56792 for applicants seeking vendorization as in-home respite services agencies.
- (H) The signed Medi-Cal Program Provider Agreement, Claim Certification, with the Department of Health Services, if required.