

PROVIDER ENROLLMENT/RE-ENROLLMENT APPLICATION

DIVISION OF FAMILY AND CHILDREN SERVICES
COMPREHENSIVE CHILD AND FAMILY ASSESSMENT
FIRST PLACEMENT BEST PLACEMENT

1. Your Name: _____

2. Title/Position: _____

3. Agency: _____

4. Agency Status: For Profit Not-for-Profit

5. Are you applying for re-approval as an individual provider or as an agency?

6. Address (Mailing) _____

7. Address (Location) _____

8. Phone: _____ 9. Fax: _____

10. Email address: _____

11. Web Page Address: _____

12. Yes No Add address to "Approved Assessment Provider" E-mail address book.

13. How long have you been doing assessments? _____

14. How many Comprehensive Assessments have you completed in the past 12 months? _____

15. Do you provide FPBP Wrap-around Services? Yes No

15 (a). If yes, please provide the number of Wrap-around cases served for the calendar year 2002 by the following:

Summer Safety/Summer Enrichment: _____
In-Home Intensive Treatment _____
In-Home Case Management _____
Crisis Intervention (Code 24) _____
Crisis Intervention (Code 47) _____

16. Training:

16 (a). List all individuals who attended "Back to Basics" and "Advanced" training and the dates attended.

16 (b). List all individuals trained in administrating the Child and Adolescent Functional Assessment Scale (CAFAS) by name, dates of training, and name of trainer. Attach copy of verification of certification for each individual listed.

16 (c). List any additional training you or your staff have received that enhances your ability to complete all aspects of the FPBP assessment and wrap-around services program. List by name of training, dates of training, trainer and CEUs attained.

17. Waivers: Has your agency requested any waivers during 2002? Yes No

17 (a). If yes, provide a complete list of all waivers requested, the reasons for each request, the county involved, and whether the waiver was approved (yes or no).

18. List the county DFCS offices you have a signed MOU with: (add additional sheets as necessary)

19. Do you have any plans for expanding your services in Georgia? Yes No

If yes, please list the additional counties or geographic areas you plan to serve:

20. List any special or unique capabilities of your agency. For example, you have staff capability in translating in Spanish, sign language, etc.

21. Are you a Medicaid provider? Yes No. If so, list your provider #
_____ (For interagency use only)

22. Signature: _____ Date: _____

Title: _____

Application **must be** mailed or hand delivered to:

**The Department of Human Resources / DFCS
ATTN: FPBP Statewide Assessment Program
18th Floor
2 Peachtree Street
Atlanta, Georgia 30303**

For questions or assistance, call (404) 675-3459 or email to lbcofield@dhr.state.ga.us. (Applications will not be accepted if they are faxed or emailed.)

ATTACHMENTS (10)

NOTE: The Department of Human Resources, Division of Family and Children Services reserves the right to verify any of the information provided in these attachments with the appropriate credentialing body, licensing board, insurance carrier, or criminal background check system. The Department **will** verify educational and licensure credentials.

The following attachments **must** be included as part of the application:

- (1). Copy of current Business License(s) or other appropriate license or documentation (e.g. Letter of Incorporation).
- (2). Copy of proof of general commercial liability coverage. **You must include with this information a signed release by your agency that gives Department of Human Resources, Division of Family and Children Services (DHR/DFCS) through the Georgia Association of Homes and Services for Children permission to verify with the Insurance Company.**
- (3). Copy of other professional credentials e.g. degrees, resume, etc. for all person(s) who will be completing the assessments/providing services. Provide a list by name, education, and license, for each staff member or subcontractor. **You must include with this information a signed release by each individual that gives Department of Human Resources, Division of Family and Children Services (DHR/DFCS) through the Georgia Association of Homes and Services for Children permission to verify with the specific credentialing body (e.g. university, college, licensing board, etc.) the credentials listed.**
- (4). Copies of all criminal background checks for all staff and all subcontractors and their staffs.
- (5). A signed statement by the director/president/owner indicating that you have verified all individuals that may be transporting children or families have a current valid drivers license and current car insurance. This statement must verify by name all individuals
- (6). A brief statement of your experience in assessing children and families. Included in this statement should be the names, titles, and professional credentials of all supervisory staff and the names of the individuals they are supervising.
- (7). Attach two (2) current references (letters) from individuals or organizations who are familiar with your work. Include their name, address, and phone number.
- (8). **For re-enrollment only.** Copies of **two (2) assessment packages** completed within the past six months. If a particular type of report was not done in the past six months, then submit copies of the two most recently completed. These will be reviewed to insure the Minimum Standards for Child and Family Assessments (Form #65) were followed.

Complete package for re- application must include:

- | | |
|---|--|
| <input type="checkbox"/> Infant/Toddler Screening/Ass Rpt | <input type="checkbox"/> Ages 4 - 18 Assessment Report |
| <input type="checkbox"/> Family Assessment Report | <input type="checkbox"/> Adolescent Assessment (Ages 14-18) Report |
| <input type="checkbox"/> Educational Assessment Report | <input type="checkbox"/> Medical/Dental Assessment Report |

Note: If any of the six (6) reports above are not provided in the re-application, a specific reason for not including that report must be stated. For example, if no referrals for adolescent assessments were received, then this reason should be stated.

(9). List the members of your staff and their specific roles and responsibilities in the provision of both assessment and wrap-around services. Include an organizational chart reflecting the individuals listed.

(10). **For re-enrollment only.** For agencies doing wrap-around services, copies of two different Wrap-Around Services Documentation reports (Ref: Section XIII, G. page 117 of the Bluebook).

Note:

1. Applications should be bound and tabbed in accordance with the enrollment/re-enrollment application numbers and attachments. The application should include a cover letter and table of contents.

Once approved, providers are responsible for keeping their enrollment package current by providing to the Department of Human Resources / DFCS, ATTN: FPBP Statewide Assessment Program, 18th Floor, 2 Peachtree Street, Atlanta, Georgia 30303, Atlanta GA 30303 updated information on staffing, credentials, licensure, and insurance coverage as changes occur.

Application and all attachments **must be** mailed or hand delivered to:

**The Department of Human Resources / DFCS
ATTN: FPBP Statewide Assessment Program
18th Floor
2 Peachtree Street
Atlanta, Georgia 30303**

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ENROLLMENT/RE-ENROLLMENT APPLICATION INSTRUCTIONS

DIVISION OF FAMILY AND CHILDREN SERVICES **COMPREHENSIVE CHILD AND FAMILY ASSESSMENT** ***FIRST PLACEMENT BEST PLACEMENT***

1. Provide your full name.
2. Provide the title of the person on line 1. or the position. For example, Executive Director, or Clinical Director, or Case Manager
3. Provide the name of the organization that you are applying to be approved under. Provide the legal name and/or the name doing business as. For example, "Comprehensive Family and Health Services" doing business as "New Horizons" If applying as an Individual, list the full name of the individual, including his/her title. For example, Dr. Joe Smith, Ph.D., Clinical Psychologist.
4. Check the appropriate box regarding your organization status.
5. Check the appropriate box as indicated.
6. Provide your official mailing address.
7. Provide your organization location address if different from your mailing address. Otherwise enter "SAME"
8. Business telephone number.
9. Business fax number.
10. Business or other e-mail address where you wish to receive e-mail on any aspect of the application process. This e-mail address may be incorporated into an overall e-mail address book of approved providers. The purpose will be to disseminate information pertinent to providers doing assessments. Types of information that might be provided are training topics and dates, alerts to changes in standards, application and re-application information, and any other information of interest to all approved private providers.
11. List your web page address, if applicable.
12. Check the appropriate box. It is ***strongly recommended*** that you provide an e-mail address and keep it current. This is the preferred method of communication with all providers and will ensure you of getting critical information in a timely manner.
13. List the number of *months* you have been doing assessments.
14. **For re-enrollment only.** Completed comprehensive assessments should equal the numbers of invoices you have submitted and received payment.
15. **For re-enrollment only.** Check the appropriate box.
 - 15 (a) Indicate the number of cases for each type of service listed.
16. Training
 - 16 (a) Include with the list copies of attendance certificates for all individuals listed, if available.

- 16 (b) CAFAS Training - must include a copy of verification of certification for each individual listed.
- 16 (c) Include any information on additional training that may be applicable.
17. **For re-enrollment only.** Waivers. Check appropriate box.
- 17 (a) Provide a complete list as indicated.
18. **For re-enrollment only.** List only those Georgia counties your provide assessment services to through a Memorandum of Understanding (MOU).
19. Do you have any plans for expanding your services? If yes, please explain and list additional areas.
20. List any unique capabilities of your agency, including other types of services or programs you provide.
21. Only answer yes to this question if you have a Medicaid provider number.
22. The Executive Director, President or equivalent must sign and date the re-application upon completion. If the application is from an individual as opposed to an organization, then the individual is responsible for signing the re-application. Please include the title and date signed.

Please mail the re-application form and all other accompanying information to:

**The Department of Human Resources / DFCS
ATTN: FPBP Statewide Assessment Program
18th Floor
2 Peachtree Street
Atlanta, Georgia 30303**

Note: The State Provider Review Committee reserves the right to check and verify the credentials, degrees, and/or licensing information on any employee included as part of the application.