

**HCBS WAIVER QUALIFICATIONS FORM: SUBCONTRACTOR**

**A) Identification of applicant:**

**Agency (business) name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Contact person:**

**Name:** \_\_\_\_\_ **Phone #:** (    ) \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Check the service(s) you wish to provide:**

Intensive In-Home \_\_\_\_\_

Crisis Response \_\_\_\_\_

Skill Building \_\_\_\_\_

Respite \_\_\_\_\_

Family Support \_\_\_\_\_

Youth Peer Advocate \_\_\_\_\_

Pre-Vocational \_\_\_\_\_

Supported Employment \_\_\_\_\_

**B) List all CURRENT licenses, contracts, approved programs, and certifications (include Medicaid numbers where appropriate):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**If none are current, list those operative in the past:**

\_\_\_\_\_  
\_\_\_\_\_

**C) Describe other agency affiliations demonstrating agency effectiveness in interagency cooperative ventures:**

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**D) Describe agency's ability to serve S.E.D. children:**

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**NOTE: For first time applicants, a detailed narrative describing the agency must be additionally completed and attached. Please include mission, history, and populations served.**

I certify that the summary information submitted is accurate and true to the best of my knowledge.

Signature of Authorized Agency Representative \_\_\_\_\_

Date: \_\_\_\_\_

Print Name and Title \_\_\_\_\_

**NOTE: The LGU must send this form along with a written recommendation to:**

**NYS Office of Mental Health  
Division of Children and Families, 6<sup>th</sup> Floor  
HCBS Waiver Unit  
44 Holland Avenue  
Albany, NY 12229  
Telephone: (518) 474-8394  
Fax: (518) 473-4335  
Email: [dcfs@omh.ny.gov](mailto:dcfs@omh.ny.gov)**