



<p>Are any staff members bilingual? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please specify language(s):</p>
<p>Are you able to provide any foreign language and/or sign language interpreters for non-English speaking/deaf or hard of hearing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Do you have a Provider Agreement in place with any other CDSA(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please list the CDSA(s):</p>
<p>Has a CDSA terminated a Provider Agreement with your agency? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, which CDSA(s) and why:</p>
<p>Have you previously completed a Potential Service Provider Application and the CDSA determined you were not approved to continue with the application process? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, which CDSA(s)?</p> <p>Please explain:</p>
<p>Are you currently completing this application process with another CDSA? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please indicate which CDSA(s):</p>

## PART B

### FOR CBRS PROVIDERS ONLY:

<p>Do the individuals who will provide CBRS currently hold <i>NC Infant Toddler &amp; Family Certification</i>? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please include either:</p> <ul style="list-style-type: none"> <li>• A copy of the Infant, Toddler, and Family Certification Approval Letter (for newly certified individuals)</li> <li>• Their most recent <i>Documentation of Continuing Professional Development</i> form (if not newly certified)</li> </ul>										
<p>If not, please list the degrees held by each individual:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">1. Name: _____</td> <td style="width: 50%;">Degree: _____</td> </tr> <tr> <td>2. Name: _____</td> <td>Degree: _____</td> </tr> <tr> <td>3. Name: _____</td> <td>Degree: _____</td> </tr> <tr> <td>4. Name: _____</td> <td>Degree: _____</td> </tr> <tr> <td>5. Name: _____</td> <td>Degree: _____</td> </tr> </table>	1. Name: _____	Degree: _____	2. Name: _____	Degree: _____	3. Name: _____	Degree: _____	4. Name: _____	Degree: _____	5. Name: _____	Degree: _____
1. Name: _____	Degree: _____									
2. Name: _____	Degree: _____									
3. Name: _____	Degree: _____									
4. Name: _____	Degree: _____									
5. Name: _____	Degree: _____									

## PART C

1. Have any complaints been registered with your licensing board that resulted in action taken against you [if you are a licensed practitioner] or against any of the direct service providers employed by you?  Yes  No

If yes, please explain fully and provide any relevant documentation

2. Has your organization been sued under its professional liability insurance in the past five years?  Yes  No

If yes, please explain fully and provide any relevant documentation

3. Has your organization or any direct service provider ever been sanctioned or excluded by the Division of Medical Assistance (DMA)?  Yes  No

If yes, please explain fully: and provide any relevant documentation:

4. Has your organization ever been prosecuted for fraudulent insurance and/or Medicaid claims, false statements or documents, or misrepresentation or concealment of material fact?  Yes  No

If yes, please explain fully and provide any relevant documentation

**Note:** *Criminal record checks are required for all direct-service providers prior to serving CDSA clients.*

## PART D

1. Describe how you will ensure that services are provided using natural learning environment strategies in the context of families' daily routines and activities, including how families will be involved in the provision of services.

2. Describe your internal quality improvement process.

3. Describe how you demonstrate respect for cultural diversity of children and families.

4. Do you/your staff who will be providing direct services have experience working with infants and toddlers with special needs?  Yes  No

5. How will you ensure continuing, relevant professional development for you/your staff?

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Printed Name of Authorized Representative

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Name of Service Provider Organization

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Signature of Authorized Representative

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Date of Signature

Thank you.

Your application will be reviewed, and you will receive notification of your eligibility to continue with the application process within thirty days.