DSHS WASHINGTON STATE Department of Social and Health Services

DEVELOPMENTAL DISABILITIES COMMUNITY SERVICES (DDCS)

DDCS Overnight Respite Services Provider Application

Section 1. Information about Proposed Overnight Planned Respite Location

ADMINISTRATOR NAME

PHYSICAL LOCATION ADDRESS | CITY | STATE | ZIP CODE | COUNTY

MAILING ADDRESS (IF DIFFERENT FROM ABOVE) | CITY | STATE | ZIP CODE

BUSINESS TELEPHONE NUMBER (INCLUDE AREA CODE) | CELL PHONE NUMBER (INCLUDE AREA CODE)

EMAIL ADDRESS

Section 2. Home Information

Does the applicant own this home? ☐ Yes ☐ No

If no, has the applicant notified the landlord of their intent to offer OPRS to DDCS clients in this home?
☐ Yes ☐ No

If yes, list the date the landlord was notified:

LANDLORD'S NAME (IF APPLICABLE) | TELEPHONE NUMBER (INCLUDE AREA CODE)

Section 3. Application Materials

This section outlines all required documents that must be submitted to initiate the process to become an Overnight Respite Provider.

Additional documents and training requirements are required for contracting and certification purposes.

The applicant must meet the requirements for certification under WAC 388-829R prior to being contracted as an Overnight Planned Respite Provider.

The following must be submitted to DDCS to initiate the Overnight Planned Respite Services Provider application process:

- ☐ DDCS Overnight Planned Respite Services Provider Application, DSHS 15-607.
- ☐ A letter of interest that describes:
  - Your experience supporting people with developmental disabilities;
  - Your teaching and training experience.
- ☐ A copy of the Washington State business license issued to you by the Department of Revenue. A Unified Business Identifier (UBI) is issued with your business license and is required to complete the application process. Business licensing information is located on the Department of Revenue's website.
- ☐ Background check confirmation code(s). (See Section 6 below.)
- ☐ If a fingerprint check was performed, a copy of the receipt(s) from the fingerprinting appointment.
- ☐ A copy of your current automobile insurance coverage.
- ☐ Copies of any First Aid, CPR, Bloodborne Pathogens, Safety and Orientation, and Basic Training certificates under WAC 388-829 if obtained and current.
- ☐ Signed up for GovDelivery (not required, but highly recommended). (See GovDelivery Tutorial for more information.

Section 4. Business License Number

BUSINESS LICENSE NUMBER

Section 5. Background Check Information

For best results use Google Chrome browser.

1. Complete a DSHS online Background Check Central Unit (BCCU) Online Application Form located at https://fortress.wa.gov/dshs/bcs/ and **submit the confirmation number and date of birth** with the application packet to DDCS.
   - You may use the Background Check Requirements for Applicant's brochure to assist you.
2. Complete fingerprinting after you receive your Washington State Name / Date of Birth Background Check Results and submit a copy of the receipt from the fingerprinting appointment to DDCS.

Fingerprinting: All new applicants must have a fingerprint-based background check. If the applicant passes the state background check, the applicant will receive instructions for scheduling a fingerprinting appointment. (See DDA Policy 5.01 Background Check Authorizations for more information.)

NAME OF PERSON	DATE OF BIRTH	CONFIRMATION NUMBER

SIGNATURE	DATE	PRINTED NAME OF APPLICANT

Section 6. Current Employee of the State of Washington

Are you a current employee of the State of Washington? ☐ Yes ☐ No

If "Yes," what agency do you work for?

For DSHS employees, a completed DSHS 03-023, Notification of Outside Employment form will be required before services can be authorized.

Section 7. Consent to Release and Use Confidential Information

The applicant **must sign** this section.

I consent to the release and use of confidential information about me within the Department of Social and Health Services (DSHS) for purposes of contracting and certification. I grant permission to DSHS and any agency, division, office, or law enforcement agencies to use my confidential information and disclose it to each other as appropriate. DSHS may define some or all of such information as public information and also disclose this information to third parties when such information is not exempt from such disclosure by state or federal law. Information may be shared verbally, electronically, by mail, or by hand delivery.

I am aware that DSHS is required to respond to requests for disclosure of information from the public. DSHS may only withhold information if a specific disclosure exemption exists. (RCW 42.56, Chapter 388-01 WAC)

Completion of this form allows the use and sharing of confidential information within DSHS, and with the individual applicant or agency, for application processing purposes. DSHS may disclose and receive confidential information from outside agencies, divisions, offices and the police.

This consent is valid for as long as I am the person named in this application. A copy of this form is valid for my permission to release and use this information.

SIGNATURE	DATE	NAME OF INDIVIDUAL (PLEASE PRINT)
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Section 8. Applicant Certification

I certify, under the penalty of perjury under the laws of the State of Washington and by my signature, that the information provided in this application and all additional documents and forms required for contracting as an Overnight Planned Respite Provider are true, complete, and accurate. I understand that DSHS may obtain additional information, verification and/or documentation related to my answers or information.

I certify that I am age 18 or older.

Copies of all documents needed to verify the items in this application are attached. Original documents will be readily available to DSHS upon request.

I understand that failure to accurately answer or fully complete the questions on this application may result in denial of the application, contract, or both.

I understand and agree that the information I give to DSHS will be used to verify the information in this application. Any information given to DSHS may be used by DSHS for this purpose.

I have read Chapter 71A.26 RCW, Chapter 388-829R WAC, and Chapter 388-829 WAC, and have and understanding of other applicable laws and rules that pertain to my role as an independent contractor.

SIGNATURE OF OVERNIGHT PLANNED REPISTE PROVIDER APPLICANT DATE	PRINTED NAME OF APPLICANT

Submitting Your Application

Submit your application and supporting documents to the Conditional and short-Term Services Program Manager at ARSC@dshs.wa.gov.

If you have questions about completing this application, contact Rae Graham, Conditional and Short-Term Services Program Manager at Rae.Graham@dshs.wa.gov.