HOME AND COMMUNITY LIVING ADMINISTRATION (HCLA)

Alternative Living Provider Application

Section 1. Type of Provider

☐ Individual Alternative Living Provider ☐ Agency Alternative Living Provider

Section 2. Application Materials

This section outlines all required documents that must be submitted by the applicant to initiate the process to become an Alternative Living Provider.

- The applicant for the Agency Alternative Living Provider application is the administrator.

Additional documents and training requirements are required for contracting and certification purposes. The applicant must meet the requirements for certification under Chapter 388-829A WAC and Chapter 388-825A WAC prior to being contracted as an Alternative Living provider.

The following must be submitted to the Developmental Disabilities Community Services (DDCS) division to initiate the Alternative Living Provider application process:

☐ Alternative Living Provider Application, DSHS 10-665
☐ A Letter of interest that describes:
  - Your experience supporting people with developmental disabilities.
  - Your teaching and training experience (if applicable).
☐ 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.
☐ Applicant background check confirmation number. (See Section 5 below.)
☐ If a fingerprint check was performed, a copy of the receipt from the fingerprinting appointment.
☐ A copy of the applicant's high school diploma, GED, or an advanced degree.
☐ A copy of the applicant's current automobile insurance coverage for individual alternative living provider applicants.
☐ A copy of the applicant's current driver's license for individual alternative living provider applicants.
☐ A completed and signed W-9.
☐ Copies of the applicant's First Aid, CPR, Bloodborne Pathogens, Safety and Orientation, and Basic Training certificates under WAC 388-829, if obtained and current.
☐ Completed and signed DSHS 27-043 Contractor Intake form.
☐ Completed and signed DSHS 27-094 Medicaid Provider Disclosure Statement (MPDS) form.
☐ Completed and signed DSHS 10-403 Residential Services Providers and County and County-Contracted Providers: Mandatory Reporting of Abuse, Neglect, Exploitation, or Abandonment of a Child or Vulnerable Adult form.
☐ Signed up for email communication and updates through GovDelivery (See GovDelivery Tutorial for more information.)

Section 3. Information About the Applicant

APPLICANT			
BUSINESS STREET ADDRESS	CITY	STATE	ZIP CODE
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	CITY	STATE	ZIP CODE

BUSINESS TELEPHONE NUMBER	CELL PHONE NUMBER	CONFIDENTIAL FAX NUMBER
EMAIL ADDRESS	WEBSITE URL	

Section 4. Business Information

LEGAL NAME OF ENTITY	
UBI NUMBER	EIN NUMBER (IF APPLICABLE)

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 the DDCS division.

   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 the DDCS division.

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 APPLICANT	DATE OF BIRTH	CONFIRMATION NUMBER

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	PRINTED NAME OF APPLICANT

Section 11. 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 Alternative Living Provider are true, complete, and accurate. I understand that DSHS may obtain additional information, verification, and documentation related to my answers or information.

I certify that I am age 21 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 my 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 I give to DSHS may be used by DSHS for this purpose.

I have read Chapter 71A.26 RCW, Chapter 388-829A WAC, Chapter 388-829 WAC , and Chapter 388-825A, and have an understanding of other applicable laws and rules that pertain to my role as an independent contractor.

SIGNATURE	DATE	PRINTED NAME OF APPLICANT

Submitting your Application

Submit the application and supporting documents to your local DDCS division field office. To find the address of a local field office near you, use the DSHS Office Locator tool.

If you have questions about completing this application, contact your local DDCS division field office and ask to be connected with a resource manager.