North Carolina Division of Employment and Independence for People with Disabilities
NC Department of Health and Human Services
2801 Mail Service Center
Raleigh, NC 27699-2801

Individual Placement & Support (IPS) - Supported Employment (SE) Renewal Application

Applicant Information

Organization Name: _____ Date: _____

Organization Type: ☐ Profit ☐ Non-Profit

Director Name: _____ Phone: _____ Email: _____

Contact Person: _____ Phone: _____ Email: _____

Billing Address: _____

_____

Local Management Entity (LME) / Managed Care Organization (MCO)

LME/MCO Name: _____ Contact Person: _____

Phone: _____ Email: _____

If your agency is contracted with additional LME/MCO's please include information below:

LME/MCO Name: _____ Contact Person: _____

Phone: _____ Email: _____

LME/MCO Name: _____ Contact Person: _____

Phone: _____ Email: _____

*** Attach documentation showing evidence of current contract to provide IPS SE with each LME/MCO**

Individual Placement and Support Key Criteria

Please list internal and/or external behavioral health providers where behavioral health integration occurs: _____

_____

*** Attach a copy of MOU and/or MOA with any external behavioral providers to this application.**

Please describe your organizations mission and values on employment for individuals with SPMI, SMI, and SUD conditions? _____

_____

What was the date of your last fidelity review for each IPS team within your organization? Provide a copy of the completed fidelity review (s):

_____

_____

Counties where IPS is currently being provided and any plans of expansion.

_____

_____

Please provide a brief explanation of your collaboration and partnership efforts with your EIPD Units.

_____

_____

For the following documentation, please provide an index, label and attach (ONLY IF THERE HAVE BEEN CHANGES)

1. Organizational Information — No Change ☐ See Attached ☐

   A. Provide your agency's mission, vision, and core values.

2. Your organization's policies on the following areas: — No Change ☐ See Attached ☐

   A. Conflict of Interest
   B. Criminal Background Checks
   C. Consumer Complaints
   D. Consumer Satisfaction
   E. Consumer Grievance
   F. ADA Policy
   G. Staff Training
   H. Informed Choice
   I. Accessibility Standard/Physical Accessibility
   J. Health and Safety Standard
   K. Affirmative Action Policy
   L. Fiscal Management Policy
   M. Program Evaluation Standard

3. Please provide sample copies of the following: — No Change ☐ See Attached ☐

   A. Referral and Intake forms
   B. Career profile
   C. Monthly summary or case note used to document service provisions.
   D. New Hire or Job Start Form
   E. Employer contact log
   F. Other forms are used in the delivery of IPS.

4. Supporting documentation: — No Change ☐ See Attached ☐

   A. Documentation that organization is established as a business.
   B. Documentation of non-profit status, if applicable.
   C. A roster of your board of directors, if applicable, including names and addresses.
   D. A copy of your organization chart, if applicable.

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Conflict of Interest Certification

Real or apparent conflicts of interest may occur when an EIPD employee, officer or immediate family member has a financial or other interest in the business relationship involving a provider and that interest might reasonably be expected to influence the outcome of an official action. If it is found that such conflict of interest occurs and is not disclosed and remedied, the provider or potential provider may be barred from performing authorized services with EIPD; and existing authorization and vendor approval may be cancelled. *If a real or apparent conflict of interest exists, attach a separate sheet describing the situation.*

I certify, by signature below, that no real or apparent conflict of interest exists between the applicant organization and EIPD.

Signature: _____

Acknowledgement & Signature

I hereby acknowledge that I have been read the requirements of IPS-SE established by DHHS here, have read and agree to abide by them, and I am making application on behalf of the provider named afore to become an approved contractor with DVRS.

Printed Name: _____

Signature: _____ Date: _____

For EIPD Use Only

Date Received by EIPD: _____

Responsible Unit Manager(s): _____

Assigned CRP Specialist: _____

Vendor Review Date: _____