North Carolina Division of Vocational Rehabilitation
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)

Organization Name: _____ Date: _____

Director Name: _____ Phone: _____ Email: _____

Contact Person: _____ Phone: _____ Email: _____

*** Attach a copy of your allocation letter to this application.**

Behavioral Health Integration

Please identify where individuals receive Behavioral Health: _____

_____

Describe your organization's experience with the target population(s): _____

_____

VR Unit Office: _____

Counties Served: _____

_____

_____

*** Attach a copy of your MOU to this application.**

Continued on page 2

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

1. Organizational Information

   A. Please describe your agency's mission, vision and explain your organization's core values.

2. Follow Along Supports

   A. Please describe how you will customize follow along supports to comply with Fidelity Model of IPS SE and the North Carolina state service definition.

   https://files.nc.gov/ncdhhs/State-Funded%20IPS%20for%20AMH-ASA%201.7.19%20FINAL%20for%20Posting.pdf

3. Your organization's definition and experience of each of the following terms:

   A. IPS SE, to include job development, job supports, and follow along supports.
   B. Assistive Technology/Rehab Engineering
   C. Natural Supports

4. Your organization's policies on the following areas:

   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

5. Provide job descriptions for direct service staff including minimum qualifications according to the state service definition.

   https://files.nc.gov/ncdhhs/State-Funded%20IPS%20for%20AMH-ASA%201.7.19%20FINAL%20for%20Posting.pdf

6. Please provide sample copies of the following (if applicable):

   A. Intake profile
   B. Career profile
   C. Personal Care Plan
   D. Monthly summary of service provision
   E. Follow Along Support services documentation

7. Describe and illustrate one actual case for each service for which you are applying from referral to successful outcome on the job that best represents the array and quality of services your organization provides. Also, explain how you coordinate or provide follow along supports. *NOTE: Please omit any confidential or identifying information.*

8. Supporting documentation:

   A. A copy of your license to practice behavioral health issued though DMHDDSAS.
   B. Your corporate charter, if applicable.
   C. Certification of good standing for franchise taxes, if applicable.
   D. Documentation of non-profit status, if applicable.
   E. A roster of your board of directors, if applicable, including names and addresses.
   F. A copy of your organization chart, if applicable.

Continued on page 3

Conflict of Interest Certification

Real or apparent conflicts of interest may occur when a DVRS 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 DVRS; 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 DVRS.

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 DVRS Use Only

Date Received by DVRS: _____

Responsible Unit Manager(s): _____

Assigned CRP Specialist: _____

Vendor Review Date: _____