



**Babies Can't Wait
District 3-1
Contract Application**

Dear Provider,
Thank you for your interest in becoming a BCW provider. Please fill out the following information and send back with the needed information. You will be contracted on an as needed basis.

I. GENERAL INFORMATION

Agency/Business/Individual Name:

Federal ID# Social Security#:

Address:

Director/Administrator:

Contact Person:

Phone:

E-mail: (required)

II. SERVICES

Please indicate which Early Intervention Services you will provide. **Attach copies of all licenses and/or Certifications, to include Resumes of all providers.**

| <u>Services</u> | <u>License/Certification</u> |
|---|------------------------------|
| <input type="checkbox"/> Assistive Technology | _____ |
| <input type="checkbox"/> Audiological Services | _____ |
| <input type="checkbox"/> Family Training/Counseling | _____ |
| <input type="checkbox"/> Health Services | _____ |
| <input type="checkbox"/> Translation Services | _____ |
| <input type="checkbox"/> Occupational Therapy | _____ |
| <input type="checkbox"/> Physical Therapy | _____ |
| <input type="checkbox"/> Service Coordination | _____ |
| <input type="checkbox"/> Special Instruction | _____ |
| <input type="checkbox"/> Speech/Language Services | _____ |
| <input type="checkbox"/> Evaluations | _____ |

III. OTHER CREDENTIALS NEEDED

You or your Agency will be required to submit the below documentation 45 days prior to the effective date of your contract.

- Proof of Liability Insurance
- Background Investigation (conducted within the past year)
- Medicaid Number or Confirmation number when submitting request for a Medicaid number via the internet
- Copy of State of GA Therapist License

IV. DISTRICT TRAINING & TEAMING

All providers must be able to attend team meetings in the morning hours. District 3-1 reserves the right to suspend or void any Service Provision or Service Coordination contract for failure to attend the training session.

Cobb-Douglas BCW program will be training and developing primary service provider teams. I understand that I/my agency is willing to participate in this service model, and be trained

_____. (must sign)

Areas of service are listed below; **please circle** the areas you would like to serve:

(You must be able to serve the entire area)

Kennesaw-Acworth

East Cobb

South Cobb

Marietta

Douglasville

How many children would you like on your caseload: _____

V. CONTRACT PROCESSING

1. Receipt of your Contract Application and Provider Information Sheet
2. Date stamp all documentation by BCW Office.
3. Agencies will be contacted for contracted services by date stamp order for services indicated on Contract Application.

Thank you for your interest.

Sincerely,

Yolanda Farmer

Office Manager

Children with Special Needs