



Vendor Agency: _____

Service Provider Name: _____
(vendor to be added into system)

Date of Birth: / /

Address: _____

- Add New Provider ()
- Modify Provider ()
- Inactivate Provider ()

Vendor Agency Supervisor: _____ Phone: _____ Email: _____

(Person who will receive email alert)

Any areas the vendor is unwilling or unable to travel to: _____

Availability:

- () Weekdays - AM () Weekends - AM
- () Weekdays - PM () Weekends - PM
- HS/GED () AA () BA/BS () Masters Degree () MD or JD ()

Credentials (check highest level completed):

Professional Licenses: _____

DCW Trng. Completion Date: _____ Prof. Trng. Completion Date: _____

Gender (check one): Male () Female () Transgender ()

Race/Ethnicity:

Caucasian () Black/African American () Hispanic/Latino () Asian/Pacific Islander () Multi-racial () Other () _____

Language Spoken (other than English):

American Sign language () Vietnamese () Spanish () Other () _____

Special Interests (Check all that apply):

Arts () Computer Technology () Sports () Music () Other ()

Areas of Clinical Experience

ADHD () Adoption Issues () Anger Management () Anxiety Disorder () AODA - Teens/Adolescents ()

Autism () Bonding Assessment () Cognitive Disabilities () Mood Disorders ()

Domestic Violence Disorder () Domestic Violence Victim () EMDR () Gambling () Gang Issues ()

Grief Issues () Immigration/Refugee Issues () LGBTQ () ODD/Conduct Disorder () Personality Disorder ()

Play Therapy () Reactive Attachment Disorder () Separation Issues (FC/OHC issues) ()

Sexual Abuse - Offender () Sexual Abuse - Victim () Schizophrenia/Other Psychotic Disorders () Trauma ()

Experience in WRAP or related fields 1-6 Months () 7-12 Months () 1-2 Years () 2 + Years () 4 + Years ()

List related field(s) of experience: _____

Code/Title (check all that apply)

- 4653 Respite Services - Hourly ()
- 4654 Respite Services - Daily ()
- 4655 Family Support ()
- 4656 Skill Building ()
- 4657 Intensive In-Home Hourly ()
- 4659 Crisis Response - Hourly ()
- 5000 Outpatient Diagnostic Assessment ()
- 5050 Psychiatric Reviews/Medication Checks ()
- 5100 Individual Therapy ()
- 5101 Individual Risk Reduction Counseling ()

Code/Title (check all that apply)

- 5110 Family Mental Health Therapy ()
- 5120 Group Behavioral Health Therapy ()
- 5130 Art Therapies ()
- 5135 Mediation ()
- 5160 In Home Comm. Behavioral Services ()
- 5180 Functional Assessments ()
- 5203 DCW-Crisis Respite ()
- 5204 DCW - Teacher Aide ()
- 5205 DCW - Parent Aide ()
- 5206 DCW Mentoring ()
- 5207 DCW Recreation ()

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- 5208 DCW Supported Work Environment ()
- 5209 Groups: Mentoring or Skillbuilding
- 5240 Behavioral Management Services()
- 5300 Crisis Foster Home Beds ()
- 5301 Crisis Residential Beds ()
- 5340 Residential Treatment Center ()
- 5341 Residential Diagnostic Services ()
- 5400 Group Home Care ()
- 5523 Tutoring ()
- 5526 Life Coach ()

- 5530 Community Supervision ()
- 5531 Rise and Shine ()
- 5535 Group Recreation ()
- 5537 Community Interpreter ()
- 5538 Professional Translation ()
- 5570 Vendor Transportation ()
- 9002 Transportation Services - Hourly ()
- 9013 Legal ()
- 9014 Translation ()

Is the provider an agency supervisor (can reassign provider from "staff"?) and view all notes. () Yes () No
 Does the provider have the ability to change agency information (address & telephone number)? () Yes () No

APPROVAL OF PROVIDER CHANGE REQUEST

The above request can not be processed until this section is complete.

Supervisor Signature

Supervisor Name (Print)

Date

Title

Date of OMH Fingerprinting _____

Date fingerprinting results received _____

Date SCR Submitted _____

Date SCR Clearance Received _____

I understand that this worker cannot work 1:1 (unsupervised) with a client until the results of all clearances (SCR and OMH) are received.

Supervisor Signature

Date

VERIFICATION OF PROVIDER CHANGE REQUEST

I verify that the above-described provider has been added/changed/inactivated in CareManager according to the above instructions.

CCNY Signature

CCNY Name (Print)

Date

Provider Login name assignment: _____

Password: _____

Family First Entry Date: _____

Comments:

Vendor supervisor (or HR representative) has verified the vendor (employee) is not included on an exclusion list in the following locations:
(these exclusion lists document if a provider is banned from working in any program that receives Medicaid funds)

www.epls.gov

Date of verification: _____

www.omig.ny.gov/data/content/view/72/52/

Date of verification: _____

www.oig.hhs.gov/fraud/exclusions.asp

Date of verification: _____

By signing and submitting this form as agency administrator/designee, you are affirming that the information provided on this form is accurate at the time of submission

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