FAMILY VOICES NETWORK VENDOR AGENCY APPLICATION

1. APPLICANT INFORMATION

Vendor Agency Name:		
Applicant Name:		Phone:
Vendor Agency Address:		
City:	State:	ZIP Code:

2A. SERVICES YOU WISH TO PROVIDE IN THE FAMILY VOICES NETWORK: NON CLINICAL

Respite Services		Teacher Aide		Skill Builder: Daily Living Skills	
Family Support		Parent Skill Builder		Skill Builder: Social Skills	
Crisis Response Hourly		Recreation		Skill Builder: Career/Educational Skills	
In Home Community Behavioral Health Services		Supported Work		Behavioral Management Services	
Crisis Respite		Groups: Skill Building		Juvenile Justice Stabilization Support	
Parent Skills Training Group		Community Supervision		Community Interpreter	
Tutoring		Rise and Shine		Professional Translation	
Transportation Services- Hourly		Group Recreation		Mediation*	

2A. For Each Non Clinical Code you wish to provide please include a list of staff who can provide that code, as well as any internal programs that would fit into any of the service codes.

2B. SERVICES YOU WISH TO PROVIDE IN THE FAMILY VOICES NETWORK: CLINICAL

Outpatient Diagnostic Assessment		Group Behavioral Therapy		Individual Risk Reduction Counseling	
Psychiatric Reviews/ Medication Check		Art Therapies		Functional Assessment	
Family Mental Health Therapy		Play Therapy		Juvenile Justice Stabilization Support Mental Health Screening	

2B. For Each Clinical Code you wish to provide please include a list of staff who can provide that code including their license #, expiration date of their license and the clinical supervisor who will be signing off their clinical services.

3A. LIST ALL CURRENT LICENSES, CONTRACTS, APPROVED PROGRAMS, AND CERTIFICATIONS (INCLUDE MEDICAID NUMBERS WHEN APPROPRIATE):

3B. LIST ALL PAST LICENSES, CONTRACTS, APPROVED PROGRAMS, AND CERTIFICATIONS:

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3C.ATTACH A STATEMENT DESCRIBING OTHER AGENCY AFFILIATIONS DEMONSTRATING EFFECTIVENESS IN INTERAGENCY COOPERATIVE VENTURES:	
4. ATTACH A STATEMENT DETAILING THE AGENCY'S ABILITY TO SERVE ERIE COUNTY'S SYSTEM OF CARE CHILDREN/YOUTH:	
5. ATTACH A DETAILED NARRATIVE DESCRIBING THE AGENCY, INCLUDING THE FOLLOWING ITEMS FOR SECTION 5.	
Please attach a separate document labeled section 5 with each section and subsection, i.e. 5a, 5b, etc.	
A. Agency Mission and vision	
B. History of the Agency	
C. Populations currently served by the Agency	
D. Agency Governing Body/ Board of Directors	
E. Agency Organizational Chart	
F. Agency Policies and Procedures that must include the following:	
F.1 Supervision Policy Clinical and Non Clinical, As Applicable	F.2 Corporate Compliance Policy
F.3 HIPAA Policy	F.4 Cultural and Linguistic Competency Policy
F.5 Risk Management Policies	F.6 Quality Assurance and Quality Improvement Policies
F.7 New Hire Policies	F.8 Proof of Ability to Provide SCR & NYS Justice Center Background Checks
G. Agency Proof of Insurance Coverage	
H. Any additional information you would like to include	
6. LETTER OF RECOMMENDATION FROM CURRENT MEMBER OF FAMILY VOICES NETWORK.	
Please attach a separate document with the recommendation labeled for section 6.	
PLEASE MAIL YOUR APPLICATION TO AMANDA ZWIRECKI C/O CCNY, INC. 567 EXCHAGE ST. SUITE 201 BUFFALO, NEW YORK 14210	

Mediation is not a clinical code but it does require a specific set of credentials, please see the FVN Vendor Code Manual for requirements.

I certify that the summary information submitted is accurate and true to the best of my knowledge.

Signature of Authorized Agency Representative

Date

Print Name and Title