HIGH FIDELITY WRAPAROUND 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 HFW VENDOR NETWORK: NON-CLINICAL

4653 Respite Services		5207 Recreation		5523 Tutoring	
4655 Family Support		5208 Supported Work		5529 Parent Skills Training - Group	
4659 Crisis Response		5209 Groups: Skill Building		5530 Community Supervision	
5135 Mediation*		5211 Skill Builder: Daily Living Skills		5531 Rise & Shine	
5160 In-Home Community Behavioral Services		5212 Skill Builder: Social Skills		5535 Group Recreation	
5203 Crisis Respite		5213 Skill Builder: Career/Educational Skills		5537 Community Interpreter	
5204 Teacher Aide		5240 Behavioral Management Services		5538 Professional Translation	
5205 Parent Skill Builder		5510 Juvenile Justice Stabilization Support Service		5570 Transportation Services	

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

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 HFW VENDOR NETWORK: CLINICAL

5000 Outpatient Diagnostic Assessment		5110 Family Mental Health Therapy		5180 Functional Assessments	
5050 Psychiatric Reviews/Medication Check		5120 Group Behavioral Health Therapy		5512 Juvenile Justice Stabilization Mental Health Screening	
5100 Individual Therapy		5130 Art Therapies			
5101 Individual Risk Reduction Counseling		5131 Play Therapy			

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 on 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 (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. Agency Proof of Status to do Business in NYS (i.e. Certificate of Status, Certificate of Incorporation, LLC Certificate, 501(c)(3) Certificate, etc.)	
I. Any additional information you would like to include	
6. LETTER OF RECOMMENDATION FROM CURRENT MEMBER OF THE HFW CSOC IN ERIE COUNTY + TWO LETTERS OF RECOMMENDATION FROM PROFESSIONAL REFERENCES	
Please attach separate documents with the letters of recommendation labeled section 6.	
PLEASE MAIL YOUR APPLICATION TO ALANA EATON C/O CCNY, INC. 567 EXCHANGE STREET, SUITE 201, BUFFALO NY 14210	

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

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Signature of Authorized Agency Representative Date

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Print Name and Title