

**DDSD REQUEST FOR APPROVAL FOR BEHAVIORAL SUPPORT CONSULTANTS (BSC'S)  
SUBCONTRACTOR AND EMPLOYEES**

**PROVIDER INFORMATION**

Requesting Agency			Contact Person		
Address					
City	State	Zip	Phone	Fax	
E-mail Address			Date Submitted to DDSD		
Date Submitted to DDSD					

**APPLICANT INFORMATION**

Name					
Address					
City	State	Zip	Phone	SSN (last 4-digits)	
Employee/Subcontractor Start Date					
Do you provide DD/MF Services for any other Agency?			<input type="checkbox"/> Yes <input type="checkbox"/> No    (If "Yes" please list Provider Agency(ies) below)		
Provider Name		Start Date	Provider Name		Start Date

**QUALIFICATIONS/LICENSURE**

**Independent Practice License (check one)**

Psychologist --  LISW--  LPCC-- LPAT--  LMFT--  Issue Date\_\_\_\_\_ Expiration Date\_\_\_\_\_

**Supervisory Level Practice (check one)**

If checking this category, agency must submit a supervision plan according to current DD Waiver Standards and appropriate regulation and licensing board.

LMHC--  LPC--  LMSW--  PA--  Academic Intern--

Master Level Teacher (working prior to 2011)--  Issue Date \_\_\_\_\_ Expiration Date\_\_\_\_\_

**EXPERIENCE**

Check one:    Renewal Request ---    New Request--- (If new, agency must provide resume)

Does proposed BSC have a minimum of 1 year experience caseload history working with individuals with Developmental Disabilities?    YES     NO   
 (If "no", agency must submit a supervision plan according to current DD Waiver Standards & appropriate regulation and licensing board).

**TRAINING REQUIREMENTS**

**New Requests: Submit timeline for completion of each training within the first year of service**

**Renewal Request: If renewal, first year of DDSD approval \_\_\_\_\_**

Submit summary of dates of completion of required trainings per current DD Waiver Standards .  
 (Do not submit certificates of completion unless requested.)

**PROFESSIONAL LIABILITY INSURANCE**

Effective Dates of Current Policy \_\_\_\_\_ to \_\_\_\_\_

\*Submit Certificate of Insurance

Authorized Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

**INFORMATION BELOW IS COMPLETED BY DDSD (FOR OFFICIAL USE ONLY)**

DATE OF REVIEW: _____	<input type="checkbox"/> APPROVED	COMMENTS: _____
DOH SIGNATURE : _____	<input type="checkbox"/> DENIED	_____
APPROVAL DATE: FROM:_____ TO:_____	LICENSEE SEARCH _____	TRANSCRIPT AUDIT_____