

**Renewal Application for Title 404 NAC Certification**

**Identifying Information**

1. **Full Name of entity requesting renewal of certification:**

*(business name – legal name of the individual or business to whom the certification should be issued)*

2. **Legal Name of entity requesting renewal of certification (if different from above):**

*(government, corporation, partnership, limited liability company, or other type)*

**Federal Employer ID #:**

*(required if not an individual)*

3. **Business Address:**

**(Street Address)**

**(City)**

**(State)**

**(Zip code)**

4. **Preferred mailing address for receipt of official notices from the Department (if different from above):**

**(Mailing Address)**

**(City)**

**(State)**

**(Zip code)**

5. **Name of Director:**

6. **Mailing Address of Director:**

**(Mailing Address  
code)**

**(City)**

**(State)**

**(Zip  
code)**

7. **Telephone Number:**

**FAX Number:**

8. **Email Address:**

## Ownership Information

**1. Ownership type (check one):**

- Individual/Sole Proprietorship
- Partnership
- Corporation
- Government
- Limited Liability Company
- Other (Please Specify)

**2. Name of owner(s) of the entity:**

**3. Mailing Address of owner(s):**

(Mailing Address) (City) (State) (Zip code)

**4. List of names and addresses of all persons in control of the entity. The list must include all individual owners (if different from above), partners, limited liability company members, members of board of directors owning or managing operations, and any other persons with financial interest or investments in the agency. In the case of publicly held corporations, only those stockholders who own 5% or more of the company's stock must be listed:**

*(Attach additional page(s), if necessary.)*

**5. Governing authority members:**

*(Attach additional page(s), if necessary.)*

**a.) Will any of these persons provide direct support services (either regularly or by emergency)?**

- Yes  No

**b.) If the answer to (a) is "Yes", is/are the person(s) certified or licensed as a member of their profession in Nebraska?**

- Yes  No

If the answer to (b) is “Yes”, please submit a copy of the current license or certification with this application or specify your profession and send your license or certification number. License information can be found at: [http://dhhs.ne.gov/publichealth/Pages/lis\\_lisindex.aspx](http://dhhs.ne.gov/publichealth/Pages/lis_lisindex.aspx)

6. Profit status (*check one*):

- Non-Profit    Profit

7. Foreign Corporation (*check one*):

- Yes    No

If the applicant is a foreign corporation, attach a copy of the registration as a foreign corporation filed with the Nebraska Secretary of State.

*Please note that Title 404 NAC 3-001.01A states that the Department will not pay family members to provide DD services. Family member means the parent (biological, step or adoptive), spouse, or child of the individual in services or a person of the same relation by marriage. Guardians may not receive payment to provide services to their ward in accordance with Nebraska’s approved 1915(c) Home and Community Based Services Medicaid Waivers.*

**Program Description for Provision of Services**

1. Attach a copy of the applicant’s organizational chart identifying authority over the agency and the organization of management positions.

2. Service options to be renewed (as outlined in 404 NAC 4-001). Check all that apply:

- Individual Support Options - Supported Day (see 404 NAC 5)
- Individual Support Options - Supported Living (see 404 NAC 5)
- Provider Operated - Residential Services (see 404 NAC 6)
- Provider Operated - Day Services (see 404 NAC 6)
- Licensed Center for Persons with Developmental Disabilities (CDD) (See 175 NAC 3)
- Respite Services (see 404 NAC 8)

3. Address (including street and city) and telephone number of each location for service delivery for day and residential services as specified in 404 NAC 6, if applicable, including type of service to be provided at each location and planned capacity at each location.

Physical mailing address of setting(s) (including street and city) Capacity	Phone	Type of Service

(Attach additional page(s) if necessary.)

4. A paper copy (and electronic copy if available) of current policies and procedures, as specified in 404 NAC 4-003.04. *The provider must establish written policies which demonstrate compliance with the “Core Requirements” specified in 404 NAC 4, 5, 6, 8, and 10, as applicable to the services the intended to be provided. These policies should be tabulated or marked to identify the location or specific link to the regulatory requirements.*

5. List of all existing sub-contractors and proposed sub-contracts that will provide services under this application, if any.

*(Attach additional page(s) if necessary.)*

I, the undersigned, attest that there is no criminal history or listing on the Department’s registries or the Nebraska State Patrol Sex Offender Registry for anyone in management level positions, including owners, directors, and managers. I also understand that the Department will not certify a provider whose administrative staff or management have been convicted of any of the crimes listed in 404 NAC 4-004.03F, as specified in 404 NAC 4-002.09A #15.

I, the undersigned, attest that all assurances given in this application are to be considered accurate for the certification period unless changes are submitted in writing, as specified in 404 NAC 4-002.09A #14.

I, the undersigned, attest that I have read the rules and regulations issued by the Nebraska Department of Health and Human Services and will comply with them should a certification be issued.

Signature of the Director of the provider

Date

Signature of governing authority chairperson (if applicable)

Date

*Failure to disclose requested information on the application, or providing incomplete or incorrect information on the application, may result in the denial of a certification, as specified in 404 NAC 4-002.09A1*

Please mail the completed renewal application to:

Administrative Assistant

[DHHS.DDCBSOI@nebraska.gov](mailto:DHHS.DDCBSOI@nebraska.gov)

DHHS –Division of Developmental Disabilities

P.O. Box 98947

Lincoln, NE 68509-8947

-or- Email the completed form to:

**For Office Use Only**

Date of receipt of Application:

Is application information complete:

Yes  No

*Comments*

Receipt of appropriately tagged and indexed policies and procedures (paper or electronic copy):

Yes  No

*Date*

*Comments*

Assigned for review to:

*DD Surveyor/Consultant*

*Date*

**Division of Developmental Disabilities Determination:**

**Certification Issued:**

Yes  No

*Date*

**Terms of Certification Issued:**

One-Year  Two-Year

*Comments*