


**VENDOR APPLICATION**

DS 1890 (Rev. 07/2011) (Electronic Version)

Applicant Name					Federal Tax ID or SSN *
Name of Governing Body or Management Organization					
Mailing Address	(Street)	(City)	(State)	(Zip)	(County)
Service Address	(Street)	(City)	(State)	(Zip)	(County)
<i>(If different than mailing address)</i>					
Applicant <i>(owner or executive director)</i>				Telephone number ( )	
Type of Service to be Provided				Facility Capacity	
Identification of the type of consultants, subcontractors and community resources to be used by the vendor as part of its service					

**CERTIFICATION**

I hereby certify to the best of my knowledge and belief, this information is true, correct, and complies with Title 17, Section 54310(a).

Applicant's Signature 	Date
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**INSTRUCTIONS**

*Please read the Department of Developmental Services California Code of Regulations, available from the regional centers, prior to completing this form. Type or print this form. Mail to the regional center serving your area.*

*Attach applicable information outlined in Title 17, Section 54310(a)(10)*

- (A) Any license, credential, registration or permit required for the performance of the service or operation of the program, or proof of application for such document;*
- (B) Any academic degree required for performance or operation of the service;*
- (C) Any waiver from licensure, registration, certification, credential, or permit from the responsible controlling agency;*
- (D) The proposed or existing program design as required in Section 56712 and Section 56762, if applicable, for applicants seeking vendorization as community-based day programs;*
- (E) The proposed or existing staff qualifications and duty statements as required in Sections 56722 and 56724 for applicants seeking vendorization as community-based day programs;*
- (F) The proposed or existing design as required in Section 56780 for applicants seeking vendorization as in-home respite services agencies;*
- (G) The proposed or existing staff qualifications and duty statements as required in Section 56792 for applicants seeking vendorization as in-home respite services agencies;*
- (H) The signed Home and Community-Based Services Provider Agreement with the Department of Health Services, if required.*

\* "Except for the Federal Tax ID or Social Security Number, all information provided by you on this form may be released to a member of the public pursuant to the Public Records Act, Section 6250 et seq. of the California Government Code."

**VENDOR APPLICANT PROFILE**

Federal Tax ID: \_\_\_\_\_  
or SSN: \_\_\_\_\_

**Applicant Name:** (Agency or Individual)

**Name of any governing body or management organization:**

**Type of Service to be provided:**

**Mailing Address:** (Street) (City) (State) (Zip)

**Service Address:** (Street) (City) (State) (Zip)

**Telephone Number**

**Fax Number**

**Emergency Telephone**

**Facility Capacity:**

**Contact Name:**

**Email Address:**

**Languages Spoken by Staff:**

**Type of Consultants, subcontractors and community services to be used (if not listed in service description):**

**Do you accept:** MediCal? Yes No Medicare? Yes No Other insurance? Yes No

**How did you hear about the regional center?**

**Have you / Are you currently vendored with the regional center?** (Please circle) Yes No

If yes, other services for which you are vendored:

**Service/Program:** Vendor # and Service Code Vending Regional Center

**CERTIFICATION:**

I hereby certify to the best of my knowledge and belief, this information is true, correct and complies with Title 17, Section 54310(a).

**Applicant's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_