

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

APPLICATION FOR CERTIFICATION TO PROVIDE LIMITED SERVICES  
TO A PERSON UNDER THE SELF-ADMINISTERED SERVICES  
COMMUNITY SERVICES WAIVER

Name of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Name of Person Applicant Desires to Support: \_\_\_\_\_

Service(s) Applicant Desires to Provide (*Circle All that Apply*):

**RP1 (Q-D); RP6 (D); RP7 (Q-D); RP8 (Q-D);**

**Knowledge Requirements for Certification:**

- Employment Agreement Date: \_\_\_\_\_
- Department of Human Services  
Provider Code of Conduct Date: \_\_\_\_\_
- Division of Services for People  
with Disabilities' Code of Conduct Date: \_\_\_\_\_
- Emergency Contact Information Date: \_\_\_\_\_
- Person's Support Book Date: \_\_\_\_\_
- Service Specific Training  
(determine by Person/Family) Date: \_\_\_\_\_
- Incident Reporting Date: \_\_\_\_\_
- Behavior Management  
(if applicable) Date: \_\_\_\_\_

**SIGNATURES:**

**I represent that I have read and am familiar with the above-identified materials and that I have been oriented to and/or trained on all of the materials**  
**by: \_\_\_\_\_ on the dates indicated. I**  
**further represent that I both understand and will comply with the requirements identified**

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**in the materials in providing services to the Person and that I am capable of providing appropriate services to the Person.**

\_\_\_\_\_  
*Signature of Applicant*

\_\_\_\_\_  
*Date (mm/dd/yyyy)*

**I, \_\_\_\_\_ represent that I am the Person, the Person's Representative, or the Person's Designated Administrator of Supports, and that I am familiar with both the above-identified materials and the supports required by the Person. I further represent that I provided orientation and/or training to the Applicant on all of the above required materials on the dates indicated above. I further represent that based on the training and orientation provided to the Applicant, I am satisfied that the Applicant has the knowledge, understanding and ability to provide appropriate services to the Person.**

\_\_\_\_\_  
*Signature of Person, Representative or Designated Administrator*

\_\_\_\_\_  
*Date (mm/dd/yyyy)*

**AWARD OF CERTIFICATION TO PROVIDE LIMITED SERVICES  
TO A PERSON WITH INTELLECTUAL DISABILITY OR RELATED CONDITION  
RECEIVING SELF-ADMINISTERED SERVICES**

Based on the forgoing representations of the Applicant and the Person, Person's Representative, or Person's Designated Administrator of Supports, the Applicant has met the minimum requirements necessary for Certification to Provide Limited Services to the Person receiving Self-Administered Services. The Division, therefore, awards the Applicant certification to provide the following services to: \_\_\_\_\_

*Name of Person*

*(Circle All that Apply):*

**RP1 (Q-D); RP6 (D); RP7 (Q-D); RP8 (Q-D);**

\_\_\_\_\_  
*Signature of Person's Support Coordinator*

\_\_\_\_\_  
*Date (mm/dd/yyyy)*