

EARLY INTERVENTION DAY TREATMENT

NEW TEMPORARY RENEW

APPLICANT INFORMATION

ORGANIZATION NAME: _____

PHYSICAL ADDRESS: _____
Street City County State Zip Code

MAILING ADDRESS: _____
(if different) *Street City County State Zip Code*

E-MAIL ADDRESS: _____

PHONE NUMBER: _____

TAXPAYER ID # (TIN): _____

OPERATOR INFORMATION

DIRECTOR NAME: _____

OWNERSHIP TYPE: SOLE-PROPRIETORSHIP PARTNERSHIP CORPORATION

PRIVATE NON-PROFIT OTHER (specify): _____

The applicant affirms receipt of the *DDS Certification, Investigation, and Monitoring for Center-Based Community Services (CBCS)* standards and agrees to comply with these standards, as indicated by the signature below:

Signature of Authorized Representative Date

EARLY INTERVENTION DAY TREATMENT

NEW OR TEMPORARY APPLICANT

1. Current copy of Child Care Center license(s)
2. Articles of Incorporation
3. Completed W-9
4. Name, address, and percentage of ownership for all owners with more than 5% of ownership interest
5. If applicable, list of Board of Directors including names of officers and mailing address

RENEWING APPLICANT

1. Current copy of Child Care Center license(s)
2. Current copy of EIDT license
3. Articles of Incorporation
4. Completed W-9
5. Name, address, and percentage of ownership for all owners with more than 5% of ownership interest
6. If applicable, list of Board of Directors including names of officers and mailing address

If seeking “deemed status,” attach current copy of Accreditation

*Additional information may be requested and required upon review of application(s) for licensure.