***Office of Developmental Programs and Office of Vocational Rehabilitation***

**Provider Transformation Training and Regional Learning Collaborative**

**Application**

*This application is an attachment to ODP Communication 21-045. Applications must be submitted to Laura Cipriani at* *lcipriani@pa.gov* *no later than Friday, July 2, 2021.*

**Organization Name:**

**MPI Number:**

**Name and Title of person submitting application:**

**Phone Number:**        **Email Address:**

**County/Administrative Entity with which your organization is qualified?**

**My organization is interested in (check one):**

[ ]  Transformation Training only

[ ]  Transformation Training and Transformation Regional Learning Collaborative

**BACKGROUND:**

Provide a brief background of your organization and the reason(s) why you are requesting

training and technical assistance:

**APPLICATION:**

1. Does your agency provide Community Participation Support services in a facility setting?

YES [ ]  NO [ ]

1. Does your agency provide Community Participation Support services from one or more service locations that is community-based (non-facility)?

YES [ ]  NO [ ]

1. How many facility sites does your agency operate?

1. How many community-based service locations does your agency have?

1. How many people do you serve in Community Participation Support organization-wide?
2. How many people do you serve in a facility-based setting at least some of the time?

1. In what counties are your facilities located?

1. In what counties do you provide community-based services only?

1. What type of license(s) does your organization hold for Community Participation Support?

[ ]  55 Pa. Code Chapter 2390

[ ]  55 Pa. Code Chapter 2380

[ ]  Other

[ ]  N/A (community-based service locations only)

1. List all public funding sources that your organization receives to provide day, prevocational and/or employment services. (ex. ODP, OLTL, CHC, OVR, etc.)

1. Does your agency hold a U.S. Dept of Labor 14(c) certificate?

YES [ ]  NO [ ]

1. Select the services from the box below which your organization is currently enrolled to provide. For each service that is provided, specify the counties in which your organization is enrolled to provide services and the number of people served for each service.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Enrolled? (Yes/No) | Counties  | Number Served |
| Supported Employment |       |       |       |
| Advanced Supported Employment |       |       |       |
| Small Group Employment |       |       |       |
| Benefits Counseling |       |       |       |

1. On average, what percent of people does your organization serve that transition to competitive integrated employment each year?

1. Describe the methods and activities your organization offers to support the development of job readiness skills for persons that you serve.

1. Describe where your organization is in the process of implementing service model changes that promote competitive integrated employment and how your organization supports Employment First.

1. How will you measure and monitor the impact of your organization’s transformation?
2. Please attach to this application your organization’s most recently filed IRS form 990. (In addition to the 990 you may include your organization’s most recent annual report, but it is not mandatory.)
3. If selected for the Provider Transformation Training, your organization will be required to send a team consisting of two members who hold leadership positions in your agency. If selected for the Transformation Regional Learning Collaborative, your organization will be required to send a team consisting of three members who hold leadership positions in your agency, such as: Executive Director or CEO, Finance Director or CFO, Program Director or COO, or Board Officer, preferably the President.

**By checking this box, you are attesting to your organization’s commitment to do so**. [ ]