VMRC

Program Letter of Intent

Date: _____

Program Information:

Program Type:_____

Program Name:_____

Facility Address (if known):_____

City, State, Zip (if known): _____ County (required): _____

Facility Phone (if known): _____

Is facility licensed? ☐ Yes ☐ No ☐ N/A License status: _____

Facility square footage:_____ Licensed Capacity (if applicable): _____

Consumer Information:

Age range:_____ ☐ Males Only ☐ Females Only ☐ Males & Females

☐ Ambulatory ☐ Non-Ambulatory ☐ Functionally Non-Ambulatory

Cognitive Level: ☐ Low ☐ Moderate ☐ High

What level of medical conditions will you serve?

☐ Mild ☐ Moderate ☐ Significant ☐ Severe

Describe medical conditions you will accept: _____

What level of behaviors will you serve? ☐ Mild ☐ Moderate ☐ Significant ☐ Severe

Describe behaviors you will accept: _____

What level of self-care deficits will you serve?

☐ Mild ☐ Moderate ☐ Significant ☐ Severe

Describe self-care deficits you will accept: _____

Owner/Licensee/Director Information:

☐ Mr. ☐ Mrs. ☐ Ms.

Name(s) of Owner(s)/Licensee(s): _____

Owner/Licensee Mailing Address: _____

City, State, Zip: _____ Home phone: _____

Cell phone: _____ FAX #: _____

Social Security #: _____ Email Address: _____

Name of Director: _____

Please discuss the skills and experience you have in serving persons with developmental disabilities—expand on information provided in resume(s): (attach additional pages if needed) _____

Please describe services to be provided: _____

References:

Please provide the names and ***complete*** address of three persons who can give VMRC information on your ability to serve disabled persons. Do not list relatives or any current employee of VMRC. **VMRC reserves the right to contact other resources for information including the Ombudsman Office, Licensing, etc.** If there are multiple individuals jointly opening one program, three references are required for each applicant; you may attach additional sheets if needed. Please make sure it is clear which applicant each reference is for.

1. Name: _____

Company/Agency Name: _____

Address: _____

City/State/Zip: _____ Phone #: _____

2. Name: _____

Company/Agency Name: _____

Address: _____

City/State/Zip: _____ Phone #: _____

3. Name: _____

Company/Agency Name: _____

Address: _____

City/State/Zip: _____ Phone #: _____

May we contact the above references? ☐ Yes ☐ No

Vendor History:

In order to proceed with the vendorization process, all owners/licensees and directors need to be free of Substantial Inadequacies or Corrective Action Plans for six months and free of Sanctions for twelve months.

Has the Owner/Licensee or Director ever been vendored or been employed as Director of a program vendored by VMRC or any other regional center? If yes, for what type of service, which regional center, when, facility #, and under what name? _____

Have any of the vendored services you have identified experienced the following?

Has the vendored service ever been issued any Substantial Inadequacies? ☐ Yes ☐ No ☐ N/A

If yes, what was the issue and date? _____

Has the vendored service ever been on Sanctions? ☐ Yes ☐ No ☐ N/A

If yes, what was the issue and date? _____

Is the vendored service in the process of receiving a Substantial Inadequacy or Sanction? ☐ Yes ☐ No ☐ N/A

Has the vendored service ever received a Corrective Action Plan? ☐ Yes ☐ No ☐ N/A

Has the Owner/Licensee/Director ever been de-vendored by VMRC or any other regional center? ☐ Yes ☐ No ☐ N/A

Has the Owner/Licensee/Director ever been denied a license by CCL, DHS or other licensing agency? ☐ Yes ☐ No ☐ N/A

Has the Owner/Licensee/Director ever been convicted of any crime; e.g., DUI, Medi-Cal fraud, shoplifting, etc. ☐ Yes ☐ No

Please submit the following. You will be notified if you are approved to proceed with the vendorization process.

1. Letter of Intent Form
2. Resume(s) of Qualifications for Owner, Licensee and Director (please provide *detailed* information on your experience with persons with developmental disabilities). VMRC reserves the right to verify work experience provided.

Send to:
Valley Mountain Regional Center
Attn: Robert D. Fernandez, Jr.
P.O. Box 692290
Stockton, CA 95269-2290
(209)955-3620
Email: rfernandez@vmrc.net

By signing, I commit to VMRC to develop the program described above within eighteen (18) months of this date. As per Title 17, I acknowledge that I am not guaranteed referrals or placements. Any alterations in the type of facility to be developed must be requested in writing and approved by VMRC Resource Development staff. I certify that all information on the Letter of Intent Form and Resume(s) is true and accurate.

_____ _____
Owner/Licensee Signature Date

_____ _____
Director Signature Date