

# INVITATION TO SUBMIT OFFER TO PROVIDE EXTERNAL SUPPORT COORDINATOR SERVICES

On behalf of the person profiled below, the Division of Services for People with Disabilities,  Central  Eastern  Northern  Western Region, is inviting providers to declare an interest in providing services and supports as described below. Providers wishing to declare an interest must complete Section II of this form and mail or fax the form to:

Fax: ( )- -

**Deadline:**

by 4:30 pm    /    / <div style="display: flex; justify-content: space-around; width: 100%;"> <span>MM</span> <span>DD</span> <span>YY</span> </div>
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name of region contact  
region mailing address  
city, state, zip

## SECTION I    PROFILE OF PERSON SEEKING PROVIDER SERVICES *(Completed by DSPD)*

<b>First Name:</b>	<b>Age:</b>	<b>Gender:</b> <input type="checkbox"/> female <input type="checkbox"/> male
<b>Residence:</b> City:		County:
<b>Guardianship:</b> <input type="checkbox"/> minor w/ parent guardian <input type="checkbox"/> adult w/ guardian <input type="checkbox"/> adult w no guardian <input type="checkbox"/> DCFS		
<b>Type of Disability:</b> <input type="checkbox"/> intellectual disability <input type="checkbox"/> epilepsy/seizure disorder <input type="checkbox"/> cerebral palsy <input type="checkbox"/> autism <input type="checkbox"/> neurological/ brain injury <input type="checkbox"/> other <i>(please specify)</i>		
<b>Type of support requested:</b> <input type="checkbox"/> support coordination		
<b>Type of supports currently received (check all that apply):</b> <input type="checkbox"/> day <input type="checkbox"/> family support/respice <input type="checkbox"/> supervised living <input type="checkbox"/> supported living <input type="checkbox"/> supported employment <input type="checkbox"/> self-directed <input type="checkbox"/> chore/homemaker <input type="checkbox"/> senior day <input type="checkbox"/> housing coordination <input type="checkbox"/> brain injury <input type="checkbox"/> personal assistance <input type="checkbox"/> specialized <input type="checkbox"/> other <i>(please describe):</i>		

**Provider agencies completing a declaration of interest must have a current contract with the Division of Services for People with Disabilities to provide all services described.**

### 1. SECTION II:    PROVIDER DECLARATION OF INTEREST *(To be completed by provider agency)*

<b>Provider Agency Name:</b>		<b>Name of Provider Contact:</b>	
<b>Mailing Address:</b>	<b>City</b>	<b>State</b>	<b>Zip</b>
<b>Daytime Phone Number:</b>	<b>E-mail Address:</b>		
<b>Type of support to be provided:</b> <input type="checkbox"/> support coordination			
<b>Brief Description of Intended Program:</b>			

### SECTION III:    PROVIDER SELECTION *(To be completed by Program Manager)*

<b>Date Declaration was Received:</b>  MM    /    / DD    DD    YY	<b>Follow up and Informed Choice Actions Taken:</b> <input type="checkbox"/> phone contact <input type="checkbox"/> Face to face contact
<b>Provider Selected by Person and/or Guardian?</b> <input type="checkbox"/> yes <input type="checkbox"/> no	<b>Reasons for Selection:</b>