Participating Community Partners – Please list each participating community partner involved in developing this proposal. For agency partners, include both the agency name and the lead individual acting on behalf of that organization. For community partners, who are not affiliated with an agency, list their agency as "Individual." For each participant, include the following: agency name (as applicable), individual name, and a phone number and email for that individual.

Letters of support from each Participating Community Partner should be attached.

AGENCY / PARTICIPANT	INDIVIDUAL NAME	PHONE & EMAIL

^{*}Legal Note: This enrollment form confirms your desire to participate in the Coordinated System of Care.

Coordinated System of Care

Community Application

Please provide the name and contact information for the primary person who will act on behalf of the proposing community in interactions with the State regarding this application.

PRIMARY CONTACT INFORMATION

Primary Contact: It is essential to provide accurate contact information for the applicant's primary contact person. Changes in contact information (name, address, phone and fax numbers) must be updated and provided to the DHH-OBH immediately. The Departments will bear no responsibility for undeliverable correspondence or an inability to make contact based on inaccurate contact information provided by applicants.				
Phone Number:	Email Address:			
Fax Number:	Web Address (if applicable):			
	·			

APPLICATION MUST BE TYPED OR PRINTED LEGIBLY IN BLACK OR BLUE INK USING ARIAL 11 FONT.

Application Checklist:	
Completed List of Participating Community Partners Attached Letters of Support for EACH Community Partner Completed Primary Contact Information Completed Application Checklist Signed Community Acceptance Form Signed WAA Lead Acceptance Form Signed FSO Lead Acceptance Form Ten (10) duplicate copies of entire application packet	

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Community Acceptance of CSoC Requirements and Conditions

We, the undersigned, certify to the following:

We are each committed to carry out the commitments relevant to our agency as described in the attached response to the CSoC RFA. By signing below, we are attesting individually and as a group to the capacity and commitment to work together towards successful CSoC implementation and that all claims submitted in this application are certified to be true, accurate, and complete.

For each signature, please include the following: agency name (as applicable), individual name, and a phone number and email for that individual.

AGENCY / PARTICIPANT	INDIVIDUAL NAME	SIGNATURE

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Proposed WAA Agency Acceptance of WAA Requirements and Conditions

We, the undersigned, in our respective roles as chief executive and board chair of the agency proposed in this application to serve as the WAA in our local CSoC, certify to the following:

We each have read and understand the requirements related to the role of the WAA in Sections 3 and 4 of the CSoC RFA. We attest, individually and as an agency, that our agency is prepared to comply with all of the requirements included in Sections 3 and 4 of the CSoC RFA. We agree to fully implement the wraparound model with all the requirements and conditions listed within the application.

Agency Name:
Agency Address:
Chief Executive Name / Title:
Chief Executive Signature / Date:
Board of Directors Chairman Name / Title:
Board of Directors Chairman Signature / Date:

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Proposed FSO Lead Acceptance of FSO Requirements and Conditions

We, the undersigned, in our respective roles as either (check one):

	(1) (a) chief executive and (b) board chair of the agency proposed in this application to serve as the FSO in our local CSoC OR
	(2) (a) individual leading the work group responsible locally for developing an FSO and (b) individual leading the work group responsible locally for developing the FSO's Local Coordinating Council (LCC) for our local CSoC
cert	ify to the following:
LCC an a all c imp	each have read and understand the requirements related to the role of the FSO and C in Sections 3 and 5 of the CSoC RFA. We attest, individually and, if applicable, as agency, that our agency (if applicable) and community are prepared to comply with of the requirements included in Sections 3 and 5 of the CSoC RFA. We agree to fully lement the FSO and LCC model with all the requirements and conditions listed in the application.
Age	ency Name (if applicable):
Age	ency Address:
Chi	ef Executive OR FSO Lead Name / Title:
Chi	ef Executive / FSO Lead Signature / Date:
Boa	ard of Directors Chairman / LCC Lead Name / Title:
Boa	ard of Directors Chairman / LCC Lead Signature / Date:

^{*}Legal Note: This enrollment form confirms your desire to participate in the Coordinated System of Care.

Please submit all forms to:

United States Postal Service Delivery

LA Department of Health & Hospitals Office of Behavioral Health

Attn: Coordinated System of Care, Unjel Smith

P. O. Box 3868, Bin #9

Baton Rouge, LA 70821

DHL, FedEx, UPS or Hand Delivery

LA Department of Health & Hospitals Office of Behavioral Health

Attn: Coordinated System of Care, Unjel Smith

628 N. 4th Street, 4th Floor

Baton Rouge, LA 70802

If you require a phone number for delivery, you may use (225) 342-2540.

Agencies will be notified by e-mail that their application has been received.

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