**All certified applicants are invited at their convenience, to apply to become a part of the Department of Children’s Services (DCS) network of providers.**

**The Department of Children’s Services (DCS) shall maintain PCIT in all regions. To become a Parent-Child Interaction Therapy Provider, the treatment provider must be certified to provide PCIT and follow the treatment modality.**

**This competitive process will be evaluated. Potential providers will receive a pass or fail. The Department will have fourteen (14) business days to review any submitted documentations. An award/denial letter will be sent to provider indicating pass or fail.**

|  |  |
| --- | --- |
| **DCS’s Contact:** | **Susan Finney, Program Coordinator of Contracts**  **UBS Tower, 12th Floor, 315 Deaderick Street**  **Nashville, TN. 37243**  **E-mail:** [**EI\_DCS.Contracts@tn.gov**](mailto:EI_DCS.Contracts@tn.gov) |
| **Instructions:** | 1. Complete Face Sheet 2. Communications regarding an application is strictly limited to the DCS contact identified above (via e-mail). 3. All materials submitted through the application become property of the State of Tennessee. By applying, an applicant acknowledges and accepts that the full contents and associated documents submitted will become open to public inspection in accordance with the law of the state of Tennessee. 4. The application will be available for public inspection after an award is effectuated. |

|  |
| --- |
| **Applicant’s Information** |

|  |  |
| --- | --- |
| **Legal Name of Applicant:** |  |
| **Address:** |  |
| **Contact Name:** |  |
| **Phone Number:** |  |
| **E-Mail Address:** |  |
| **Federal Identification Number:** |  |
| **Minority Status:** |  |
| **UEI Numbers:** |  |
| **Place of Incorporation:** |  |
| **Number of years in business:** |  |
| **Region(s) to serve:** |  |
| **Anticipated number of children per region:** |  |

|  |
| --- |
| **Requirements** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Attachments** | **Requirements** | **Pass** | **Fail** |
| **Attachment 1** | Provide a brief Introduction about the Applicant’s agency, signed & dated |  |  |
| **Attachment 2** | Demonstrate how therapist delivering PCIT are certified to provide the treatment modality and continue to meet certification requirements annually. |  |  |
| **Attachment 3** | Demonstrate that the venue where the PCIT service will be provided meets the physical layout and technology requirements to deliver the service to model fidelity. |  |  |
| **Attachment 4** | Demonstrate that you are meeting fidelity monitoring requirements as set by PCIT International. |  |  |
| **Attachment 5** | Provide W-9 |  |  |