

Child Development Services/Cumberland County
999 Forest Ave., Portland, ME 04103

Request for Proposal for Contract Providers
Occupational Therapy

1. Name of Individual Proposing to Provide Therapy: _____

2. Address & Phone Number: _____

3. List Credentials (Attach Copies of Licenses/Certifications): _____

4. Describe Years of Experience as a Therapist working with Children Ages Birth- Five:

5. Describe your philosophy in providing Occupational Therapy Services for young children with disabilities: _____

6. Describe the therapy strategies and techniques you typically use when teaching a young child with moderate to severe impairment. _____

7. Describe the kinds of materials and other resources you use in your therapy.

8. CDS/Cumberland requires measurable written goals and objectives prior to beginning service provision to all children. In addition, CDS requires quarterly progress reporting on the goals and objectives. Describe your ability to comply with this requirement. _____

9. Describe your approach to working with the following problems:

Behavioral impairments: _____

Severe language delays: _____

Pervasive Development Disorders: _____

10. CDS/Cumberland requires that you are able to bill insurance companies when necessary. If a child is on Medicaid or has a third party insurance plan that we are allowed to access for payment of Early Intervention Services, you will be required to bill these companies prior to submitting bills to CDS/Cumberland. For your convenience we have listed all of the contact information for applying to become an insurance provider.

If all information is not included the contract will be held up. Please return this completed proposal to CDS/Cumberland as soon as possible. Processing a contract takes 2-4 weeks.

Please include the following information:

1. Resume or Curriculum Vitae
2. Copy of Professional Liability Insurance Coverage
3. License, Certifications and three references
4. Your statement indicating that you are have applied for insurance reimbursement status (If you have already completed this process, provide us with your Medicaid number)

Your signature indicates that you swear that the information enclosed on this form is true and accurate.

Signature: _____ Date: _____