DEPARTMENT OF CHILDREN AND FAMILIES Organization Credentialing Application to Provide Services

Applicant Check Sheet

Applicants must provide the following:

| Α. | Completed and Signed Original Organization Credentialing Application; |
|----|--|
| В. | Completed DCF Area Office Listing Chart; |
| C. | Copies of all applicable State Licenses; |
| D. | Copies of any applicable Accreditations and/or Certifications; |
| E. | Copy of Current Certificate of General Liability Insurance (for After School Service Providers only); |
| F. | Completed and signed IRS form W-9; |
| G. | Completed After School Provider Program Description (for each After School Service Site); |
| H. | Staff Rosters for each service that the Organization is providing, please check below: After School Services – Clinical Support After School Services – Traditional After School Services for Youth Assessment Assessment: Perpetrator of Domestic Violence Behavior Management Services Case Management Services, specific to youth in the DCF Community Housing Assistance Program (CHAP) Supervised Visitation Support Staff Temporary Care Services Therapeutic Support Staff |
| l. | For After School Provider Site Applicants: |
| | ☐ Is the afterschool licensed by DPH as a Group Day care Home or Child Day Care Center for school age children? ☐ YES ☐ NO ☐ Is your agency currently funded by the CT State Department of Education After School Grant? ☐ YES ☐ NO ☐ Is your agency a 21st Century Community Learning Center Grantee? ☐ YES ☐ NO |
| J. | Copy of Ansell Casey Life Skills End User Certificate (for CHAP Case Management providers only); |
| K. | Copies of Background Checks for all key personnel including the executive director, clinical director, medical director, and contact person, which cannot be dated longer than 6 months prior to application: |
| | CPS Dept. of Public Safety Criminal Conviction Record Check |
| | $\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ $ |
| | Official documentation to support statement regarding history of criminal charges, such as arrest records, court documents, DMV records. |
| L. | The following information must be provided for <u>each</u> employee that will be providing the following service type: |
| | Assessment and/or Behavior Management Services – Current Curriculum Vitae with a minimum of three (3) years clinical work history providing assessments for children |

| | and adolescents indicated by month and year, completed Professional Review Questionnaire, signed Consent Form for Release of Confidential Disciplinary Records, |
|------|--|
| | copy of Current License, Certificate of Malpractice Insurance |
| | Assessment: Perpetrator of Domestic Violence - Current Curriculum Vitae* with a minimum of two (2) years experience involving direct work with victims or batterers including 150 hours facilitating or co-facilitating a batterer intervention group or class or individual work with batterers specific to addressing issues of coercive control, Completion of CT Batterer Intervention Service Provider Curriculum, Ethics Statement, Certificate of Malpractice Insurance |
| | ☐ After School Services Senior Group Leader or Senior Instructor – Completed |
| | and signed Statement of Experience Form, Current Resume*, Proof of Age 20 by copy of current CT motor vehicle license or other government-issued photo identification, copy of current First Aid and CPR certificate from the American Red Cross or American Heart Association. |
| | After School Services Group Leader or Instructor – Completed and signed |
| | Statement of Experience Form, Current Resume*, Proof of Age 18 by copy of current CT motor vehicle license or other government-issued photo identification, copy of current First Aid and CPR certificate from the American Red Cross or American Heart Association. |
| | After School Services Assistant Group Leader – Completed and signed |
| | Statement of Experience Form, Current Resume* or detailed work history, Proof of Age 16 by copy of current CT motor vehicle license or other government-issued photo identification, copy of current First Aid and CPR certificate from the American Red Cross or American Heart Association. |
| | ☐ Case Management specific to youth in CHAP - Statement of Experience Form and |
| | Current Resume*, copy of current motor vehicle license, copy of motor vehicle certificate of insurance. Copy of Department of Motor Vehicles Driving Record Background Check Result. Please note: Dept. of Public Safety Sex Offender Registry* and National Sex Offender Registry* checks will be completed by ABH. |
| | Supervised Visitation, Therapeutic Support Staff and Support Staff - Statement of Experience Form, Current Resume*, copy of current motor vehicle license, copy of motor vehicle certificate of insurance, and copy of current First Aid and CPR certificate from the American Red Cross or American Heart Association. |
| | Temporary Care Services - Statement of Experience Form or Current Resume* and Proof of Age 21 by copy of current motor vehicle license or birth certificate Supervisors for Therapeutic Support Staff, Support Staff & Assessment/DV |
| | Perpetrator - Written documentation of supervisory arrangement, supervisor's current |
| | resume*, and a copy of the master's level degree. Supervisors of CHAP Case Managers - Written documentation of employment status of supervisor, supervisor's current resume* and Statement of Experience Form, |
| | copy of current motor vehicle license, copy of motor vehicle certificate of insurance. Program Administrator or Site Director for After School Services – Completed and signed Statement of Experience Form, Current Resume*, Proof of Age 21 by copy of current CT motor vehicle license or other government-issued photo identification, copy |
| | of current First Aid and CPR certificate from the American Red Cross or American Heart Association. |
| | Signed Provider Agreement for each service (original signature required) http://www.abhct.com/resources DcfCredentialing.asp |
| N. | Signed Confidentiality Statement and Ethics Agreement |
| Resi | umes must include the following: (a) 5 years work history with an explanation of gaps more than 6 |
| | (b) university name, state degree listing and year of graduation (if applicable). |
| | <u>Send Completed Original Applications To:</u> Advanced Behavioral Health |
| | Auvanceu Denaviorai Fleatiti |

Attn: DCF Credentialing Department
Middlesex Corporate Center, 213 Court Street, Middletown, CT 06457
Phone: (860) 638-5309 Fax: (860) 638-5302

months;

DEPARTMENT OF CHILDREN AND FAMILIES ORGANIZATION CREDENTIALING APPLICATION

I. PRIMARY LOCATION Organization Name: ______ Address (street, suite #, etc.) City: _____ State: _____ Zip: ____ Tax ID #: _____ Name of Owner of this Tax ID: _____ Address to which payments are to be sent: Same as Facility Named Above Phone # / Fax # / E-Mail Address for Billing Purposes Same as Above If different address or contact information: Address (street, suite #, etc.) City: _____ State: ____ Zip: ____ Phone # (____) Fax #: (___) E-Mail: II. SERVICES PROVIDED AND STAFF ROSTER ☐ After School Services – Clinical ☐ Behavior Management Services ☐ After School Services – Clinical ☐ After School Services – Traditional ☐ CHAP Case Management ☐ After School Services – Youth ☐ Supervised Visitation ☐ Support Staff ☐ Assessments □Assessment: Perpetrator of Domestic ☐ Temporary Care Services Violence ☐ Therapeutic Support Staff

Please attach a Staff Roster for each service selected above that the organization provides. Include Name, Languages spoken, and if applicable Professional License Type and License Number. See Staff Roster attached to this application.

Service type(s) provided at this location: Address (street, suite #, etc.) PO Box: City: State: Zip: Phone # () Fax #: () E-Mail: Service type(s) provided at this location: Address (street, suite #, etc.) PO Box: _____ City: ______ State: _____ Zip: _____ Please attach any additional locations on a separate sheet of paper. IV. KEY FACILITY PERSONNEL Executive Director: Telephone #/Ext. Medical Director: ______ Telephone #/Ext. _____ Telephone #/Ext. Clinical Director: Telephone #/Ext. Contact Person: V. LICENSURE / CERTIFICATION / REGISTRATION **JCAHO** Certificate # _____ Exp. Date_____ COA Certificate # Exp. Date CARF Certificate # _____ Exp. Date_____ ADAD Certificate # _____ Exp. Date____ State License Certificate # Exp. Date Other Other Other Are there any conditions that have been placed on the above Licensure / Certification / Registration? NO YES

If your answer is Yes, please provide a detailed explanation on a separate sheet of paper and attach to this application.

III. ADDITIONAL SERVICE LOCATIONS

DCF Organization Application rev. August2007 01-28-0/04-01-09/03-28-11

VI. PROFESSIONAL LIABILITY INSURANCE COVERAGE

| Current Company: | | | | |
|---------------------------------------|---|------------------|-----------------|----------------|
| Address: | | | | |
| | State: | | Zip: | |
| Effective Date of Co | verage: | E | xp. Date: | |
| Retroactive Coverage | ge To: | Incident \$ | M Aggregate | ; \$M |
| Type of Policy: | Claims Made | Occurrence | Self-Ins | ured Trust |
| - | any Trust or other prof ability in any medical m | • | • | ein the YES |
| Are all clinical perso | onnel covered by this p | olicy? | NO | YES |
| *** PLEASE P | ROVIDE A COPY OF YOU | R CURRENT MALPRA | CTICE INSURANCE | *** |
| | | | | |
| | VII. GENERAL LIABI | LITY INSURANCE | COVERAGE | |
| | | | | |
| Current Company: | | | | |
| | | | | |
| · · · · · · · · · · · · · · · · · · · | State: | | Zip: | |
| Effective Date of Co | overage: | Exp. Da | ate: | |
| Incident \$ | Aggregate | e \$M | | |
| Type of Policy: C | laims Made | Occurrence | Self Insured T | rust |
| | | | | |

*** PLEASE PROVIDE A COPY OF YOUR CURRENT CERTIFICATE OF LIABILITY INSURANCE ***

VIII. HISTORY OF SANCTIONS, MALPRACTICE CLAIMS, ADVERSE EVENTS

Malpractice Claim History 1. Has the Organization been named in any malpractice action? Yes No Yes No 2. Has the Organization had or currently have pending, any legal actions? 3. Has the Organization had professional liability insurance refused, revoked, declined or accepted on special terms? ☐Yes ☐No 4. Has any government agency investigated, suspended, revoked or taken other action against the Organization's license to conduct business? (Include Medicaid/Medicare) Yes No 5. Have any memberships in professional organizations been revoked, reduced, denied, or suspended by others or voluntarily given up by the Organization, or are any actions now under way, which may lead to such sanctions? ☐Yes ☐No 6. Has any license, certification, or accreditation been revoked, denied or suspended by others or voluntarily given up by the Organization, or are any actions now under way, which may lead to such sanctions? ☐Yes ☐No 7. Have any owners, officers or shareholders of the Organization been convicted of a crime, excluding misdemeanors? ☐Yes ☐No 8. Has the Organization been assessed a penalty, conviction, suspension, or other Sanction; or is the Organization currently under investigation by Medicare or Medicaid Programs? ☐Yes ☐No 9. Has the Organization ever been a defendant in any lawsuit with regard to the practice of mental health or substance abuse treatment where there has been an award or payment of \$50,000.00 (fifty thousand dollars) or more? ☐Yes ☐No 10. Has any claim or suit for alleged malpractice been brought against the facility/ program, or are you aware of any circumstances that might lead to such a claim or suit against the facility/program? ☐Yes ☐No Number of claims (check one) \square 0 \square 1 \square 2 ☐ More If you answered yes to any questions 1-10 above, please attach a description of the occurrence (citing dates and other relevant information). My signature certifies that I have answered all questions accurately, completely and to the best of my ability. I understand that any misrepresentation or false statement can result in my being withdrawn from the DCF list of providers as well as possible recourse through the Connecticut Department of Public Health. Signature Date **Printed Name** Date of Birth

DCF Area Office Listing Chart

Please indicate which DCF Area Offices you would like to receive referrals from (check all that apply).

| Bridgeport | |
|----------------------|--|
| Danbury | |
| Hartford | |
| Manchester/Rockville | |
| Meriden | |
| Middletown | |
| Milford | |
| New Britain | |
| New Haven (Metro) | |
| Norwalk | |
| Norwich | |
| Stamford | |
| Torrington | |
| Waterbury | |
| Willimantic | |

CERTIFICATION AND AUTHORIZATION

DCF has contracted with Advanced Behavioral Health, Inc. (ABH®) as the credentialing vendor for the DCF Credentialing Program. ABH will assist DCF in facilitating the provider application process. For purposes of making this application to become a participating DCF provider, the Applicant certifies that all information provided to DCF or ABH is true and correct to the best of the Applicant's knowledge and belief. The Applicant agrees to notify DCF or ABH promptly if there are any material changes in the information provided, whether prior to or after acceptance as a DCF provider. The Applicant understands and agrees that if DCF or ABH determines that this application contains any significant misstatements, misrepresentations or omissions, DCF's acceptance of this application for participation and any subsequent participating provider agreement which DCF enters into with the Applicant may be void at DCF's sole discretion.

The Applicant hereby authorizes the release to DCF or ABH of any information held by any person, entity or governmental agency which DCF or ABH determines may have relevant information for purposes of evaluating this original application or any recredentialing information. The Applicant agrees to hold any such person, entity or governmental agency providing information to DCF or ABH harmless from any liability for providing such information.

The Applicant hereby further authorizes DCF or ABH to release any and all information related in any way to the Applicant's professional practice to any person, entity or governmental agency which: (a) provides DCF or ABH with an authorization signed by the Organization; or (b) has a legal right to know under any state or federal law. The Applicant agrees to hold DCF and ABH harmless from any liability for providing such information as specified herein.

The Applicant understands and agrees that the certifications, authorizations, and other provisions contained herein shall remain in force for as long as this application is pending and, if accepted for participation, for as long as the Applicant's provider agreement with DCF remains in force.

The Applicant further understands and agrees that (a) the Applicant has the burden of producing all information required or requested by DCF or ABH in connection with this application; and (b) DCF or ABH is under no obligation to complete the processing of this application until such information is provided by the Applicant.

| Name of Applicant (Please type or prin | nt) |
|--|------------------------------|
| Authorized Signature | Date Date |
| Name (Please type or print) | Title (Please type or print) |

| DCF Credentialing | SERVICE TYPE (Please Check) |
|--|--|
| Staff Roster (Please complete a separate roster for each service.) | ☐ After School: Clinical Support☐ After School: Traditional☐ After School: Youth |
| Organization Name: | ☐ Assessments ☐ Assessments: DV ☐ Behavior Management ☐ CHAP Case management |
| *Supervisor's Name and Designation: | ☐ Supervised Visitation ☐ Support Staff ☐ Temporary Care ☐ Therapeutic Support Staff |

| NAME | LANGUAGE(S) SPOKEN | PROFESSIONAL LICENSE TYPE | LICENSE NUMBER |
|------|-----------------------|------------------------------|----------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

* For Supervised Visitation Services:

Credentialing Criteria: Supervisor must be a licensed behavioral health practitioner: Licensed Professional Counselor; Licensed Clinical Social Worker (CGS, Chapter 383b); Licensed Marriage and Family Therapist (CGS, Chapter 383 a); Licensed Alcohol and Drug Counselor (CGS, Chapter 376b); Licensed Psychologist (CGS, Chapter 383a); Licensed and Board Certified/Board Eligible (BC/BE) Psychiatrist.

* For Therapeutic Support Staff, Support Staff & Assessment/DV Perpetrator:

Credentialing Criteria: All certified individuals providing this service must be supervised by a master's prepared clinician with experience in child and adolescent behavioral health. Assigned supervisor will be verified through collection of: written documentation of supervisory arrangement, supervisor's current resume, and a copy of the master's level degree.

* For CHAP Case Management:

Credentialing Criteria: All providers shall have an identified Program Manager who must meet the requirements outlined in paragraph 1 of the provider agreement and also have at least one year of supervisory experience. The CHAP Program Manager shall be an employee of the Provider, not a subcontractor, intern or volunteer. Assigned CHAP Program Manager will be verified through collection of: Written documentation of employment status of supervisor, supervisor's current resume and Statement of Experience Form, copy of current motor vehicle license, copy of motor vehicle certificate of insurance.

* For Program Administrator or Site Director of After School Services:

Credentialing Criteria: Individual must be a minimum of 21 years of age, as verified by a valid CT motor vehicle license or other government-issued photo identification. Must possess a Bachelor's Degree in a field related to Human Services (social work, sociology, counseling, child welfare, psychology, marriage and family therapy, education, public administration/public health, child care management, child development, family studies or other human services degree), and must have a minimum of 2 (two) years experience in after school programming as evidenced by a current resume with gaps no greater than 6 months. A completed Statement of Experience Form along with a current CPR and First Aid certificate from the American Red Cross or American Heart Association is also required.

Department of Children and Families

STATEMENT OF EXPERIENCE

(Must be completed by each applicant providing
TEMPORARY CARE, SUPERVISED VISITATION, CHAP CASE MGMT, THERAPEUTIC SUPPORT STAFF, SUPPORT STAFF and
AFTER SCHOOL Services)

| Name: | | | |
|---|--|---------------------------|-----------------------------------|
| Date of Birth: | | | |
| Address: | _ City: | State: | |
| Are you a Parent? □ Yes □ No How many chi | ildren do you have? | | |
| What are their ages? | | | |
| Check all that apply to your WORKING experience | e with children (not | to include biol | ogical): |
| I have provided babysitting or childcare: | Years of Experience | Occasional Babysitting | Routine Scheduled Childcare |
| □ Child age 0-2 | P 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 | | |
| □ Child age 3-5 | | | |
| □ Child age 6-12 | | | |
| □ Child age 13-16 | | | |
| □ Child age 17 and above | | | |
| □ Child who needs special health care or treatment: (Please specify) | | | |
| □ Other (Please specify): | | Ц | Ш |
| | | | |
| I have acted as a volunteer in the community with children and youth including: | Child age 1-5 | Child age 6-12 | Child age 13 and above |
| □ Youth Group | | | |
| □ Church Group | | | |
| □ Big Brothers or Big Sisters Program | | | |
| □ Youth Sports | | | |
| □ School Aide | | | |
| □ Red Cross or Other Public Health Institution | | | |
| □ YMCA Activities | | | |
| □ Reading or Storytelling | | | |
| □ Other (Please specify): | | | |
| APPLICANTS PLEASE READ AND SIGN: I certify under penalty of perjury that all the information provided is true and or | • | - | |
| APPLICANT SIGNATURE: | DA1 | E: | |

PROFESSIONAL REVIEW QUESTIONNAIRE

(Must be completed by each licensed behavioral health practitioner providing Assessments, Behavior Management, or Assessment Services: Perpetrator of Domestic Violence)

Please answer the following questions by placing a check mark in the appropriate category. If you answer "yes" to any of the questions please provide a detailed explanation on a separate sheet of paper (EXCEPTION: Question #13).

YES

NO

N/A

| 1. | Has your license to practice your profession in any ju | risdiction | | |
|------|--|----------------------|------------|--------|
| | ever been refused, limited, suspended, revoked or vo | luntarily | | |
| | relinquished? | | | |
| 2. | Has any action(s) ever been taken against you by the | Licensing | | |
| | Board of any state? | · · | | |
| 3. | Has your DEA registration to prescribe controlled sub | stances ever | | |
| _ | been limited, suspended, revoked or voluntarily relind | | | |
| 4. | Have your privileges in any hospital ever been suspe | | | |
| | diminished, revoked, or not renewed involuntarily or v | | | |
| 5. | Have you ever been reprimanded by, or had your me | | | |
| ٥. | refused, suspended, or revoked by any professional of | | | |
| 6. | Have you ever been named as a party in a malpraction | | | |
| | Have any claims ever been made against you for pro | | | |
| /. | negligence or malpractice? | iessionai | | |
| 8. | Have you ever been convicted of a crime other than a | minor troffic | | |
| Ο. | offense? | מ וווווטו נומוווט | | |
| 0 | | | | |
| | Are you currently using illegal drugs? | ma that may | + | |
| 10. | Do you have any physical, mental, or addictive proble | | | |
| | interfere with your ability to carry out the duties and re | esponsibilities | | |
| 4.4 | of your profession? | | | |
| 11. | Have you ever been denied professional liability insu | | | |
| | your policy ever been revoked, canceled, or voluntari | ly | | |
| | relinquished under a threat of cancellation? | | | |
| 12. | Have you ever been the subject of investigation by an | ny peer | | |
| | review committee? | | | |
| 13. | Are you able to perform all of the services being requ | | | |
| | application according to accepted standards of profes | | | |
| | performance and without posing a direct threat to clie | nts or | | |
| | others? | | | |
| 14. | Are you, your partner(s), or any member of your fami | | | |
| | with, employed by, or part of an investigation with the | Department | | |
| | of Children and Families (DCF)? | | | |
| | | | | |
| | signature certifies that I have answered all questions | | | |
| | ity. I understand that any misrepresentation or false s | | | |
| | DCF list of providers as well as possible recourse thro | ough the Connecticut | Department | of Pul |
| Hea | ılth. | | | |
| | | | | |
| | | | | |
| Sig | nature | Date | | |
| | | | | |
| | | | | |
| Prir | ited Name | Date of Birth | | |
| | | | | |

Consent Form Release of Confidential Disciplinary Records (Must be completed by each licensed behavioral health practitioner providing

Assessment and/or Behavior Management Services)

I hereby give my consent and authorization for the Department of Public Health, Division of Medical Quality Assurance, to confirm the existence of any pending complaints and to release any records of disciplinary actions to the Department of Children and Families or Advanced Behavioral Health.

| <u>Please list any documents that the D</u> | <u>repartment is not authorized to release:</u> |
|---|---|
| | |
| | |
| | |
| | |
| Signature | Date |
| | |
| Printed or Typed Name | Date of Birth |
| | |
| Address | |
| | |
| Connecticut License Number | Expiration Date |

Connecticut Credentialed Domestic Violence Professionals Code of Ethics

(Must be completed by each staff providing Assessment Services: DV)

Connecticut credentialed domestic violence professionals agree to:

- 1. Be committed to the safety and welfare of survivors of domestic violence and their children including: avoiding interventions or actions that increase the risk to survivors or their children; considering the safety of survivors and their children in decisions related to working with batterers and remaining focused on the prevention of new incidents of abuse and on addressing the impact of prior violence.
- 2. Strive to contribute to the self determination of all survivors by informing them of program limitations, potential dangers and risks, program content and available community resources, supports and services.
- 3. Strive to help create personal, professional and spiritual environments where power is shared and not misused or abused, so that the empowerment process is more likely to occur.
- 4. Be committed to continuing education and maintaining a knowledge base and skill set consistent with issues and techniques central to working with perpetrators of and/or family members experiencing domestic violence.
- 5. Ensure that all clients are provided with a clear description of services including reasonable fees that are fair and commensurate with the services performed and with consideration of the client's ability to pay.
- 6. Comply with agency, state and federal laws and regulations regarding confidentiality and duty to notify in cases of suspected child abuse and neglect, abuse of the elderly and disabled persons and sexual exploitation by therapists.
- 7. Strive to provide services in a culturally responsive and competent manner evidenced by equity and parity in access to services, and in consideration of traditions and beliefs regardless of race, ethnicity, language, gender, sexual orientation, economic status and/or disability.
- 8. Strive to recognize and address their own values and biases in order to provide high quality service, without prejudice to all clients.
- 9. Maintain accurate and appropriate records of their interactions with clients in a manner that safeguards the confidentiality of the survivor of domestic violence and, when not covered by a release of information, the confidentiality of the perpetrator of domestic violence. A separate record related to partner contact will be maintained.

| Name | Date |
|--------|------|
| | |
| Agency | |

Department of Motor Vehicle Driving Record Check Procedure

(Must be completed by each staff providing CHAP Case Management Services)

The procedural steps for an individual criminal conviction record check are as follows:

- 1. Inquiries must be made on a DMV Copy Records Request (form J-23), available at any full service DMV location or by electronic request from http://www.dmvct.state.ct.us/J23FORM.HTM:
- 2. When completing form J-23:
 - Check the box requesting Driving History.
 - Fill in section 1.
 - Complete the "requester" section at bottom of the form. You must also include your telephone number.
 - For "Requester's Address", please fill in:
 C/O Attn: DCF Credentialing Dept, 213 Court St. Middletown, CT 06457
- 3. Inquiries must be sent with:
 - Payment by check made payable to "DMV" in the amount of \$20 for each request.
 - Copies of two forms of identification from the requestor. (One form must be photo identification and the other form needs to also identify the requestor.)
- 4. Mail completed form and documents to:

Department of Motor Vehicles Copy Records Unit 60 State Street Wethersfield, CT 06161

In approximately one to two weeks you will receive a certified copy of your driving history.

Department of Emergency Services & Public Protection Criminal Conviction Record Check Procedure

The procedural steps for an individual criminal conviction record check are as follows:

- 1. Print full name and date of birth of each subject requested;
- 2. List any alias or maiden names and dates of births used by each subject;
- Make checks or money order payable to: Treasurer State of CT
- Mail the completed form along with a check for \$50.00 to the following address:

DESPP-SPBI 1111 Country Club Road Middletown, CT. 06457



STATE OF CONNECTICUT DEPARTMENT OF EMERGENCY SERVICES & PUBLIC PROTECTION DIVISION OF STATE POLICE BUREAU OF IDENTIFICATION



STATE OF CONNECTICUT CRIMINAL HISTORY RECORD REQUEST FORM (PLEASE TYPE OR PRINT CLEARLY)

| Name of Requester:_ | Advanced Beha | vioral F | lealth, l | nc. | | Date: | | |
|--|---|---------------------|-------------------------|--|---|---|--|---------|
| Requesters Address: | ATTN: DCF C | redent | tialing C | Departme | nt, 213 Court | St., | | |
| City:Middlelown | State:_ | CT | _Zip:_ | 06457 | _Phone | Number:_ | (860) 638-5309 | |
| | | | | | | | | |
| | date of birth | , mai | den d | or alias | names f | or <u>each</u> s | ubject | |
| requested. | | | | 5.4 | | 20 | 50 | is form |
| requested. If a fingerprinted ba | ckground is | requ | ired s | submit | a Finger | print card | along with th | |
| requested. If a fingerprinted ba Enclose a \$50. dolla | ckground is ir Check or i g more than | requ None | ired s | submit ler pay | a Finger able to: | print card | l along with th | "" |
| requested. If a fingerprinted ba Enclose a \$50. dolla If you are requesting amount of all subject | ckground is ir Check or N g more than its requeste | requ Mone one | ired s y Ord name | submit ler pay please | a Finger able to: submit | print card " <i>Treasur</i> one chec | l along with th | "" |
| requested. If a fingerprinted ba Enclose a \$50. dolla If you are requesting amount of all subject | ckground is ir Check or N g more than its requeste | requ Mone one | ired s y Ord name | submit ler pay please to: DE 111 | a Finger able to: submit SPP-SPE | print card " <i>Treasur</i> one chec | l along with the rer-State of C7 k for the total | "" |
| . If a fingerprinted ba . Enclose a \$50. dolla . If you are requesting | ckground is ir Check or N g more than its requeste | requ Mone one | ired s y Ord name | submit ler pay please to: DE 111 | a Finger able to: submit SPP-SPE | print card " <i>Treasur</i> one chec Bl ry Club R | l along with the rer-State of C7 k for the total | "" |

The result of this search is based on name and date of birth or fingerprint card submission and contains State of Connecticut criminal history record information ONLY. Please be advised that the information you are provided is only current as of the date the data is extracted from the computerized criminal history record system of the Department of Emergency Services and Public Protection (despp). DESPP and the state of connecticut are not responsible for any errors or ommissions resulting from subsequent dissemination of this data. The subject and/or requester assumes all liability in the use of data obtained from this database.

"A COPY OR FACSIMILE OF THIS FORM CAN BE USED.

Phone: (860) 685-8480 Fax: (860) 685-8361 1111 Country Club Road Middletown, CT 06457-2389 An Affirmative Action/Equal Opportunity Employer

Department of Children and Families

CT. Abuse and Neglect Central Registry Background Check Procedure

The procedural steps for an individual background check of the Connecticut Abuse and Neglect Central Registry are as follows:

1. The individual requesting a background check completes the "AUTHORIZATION FOR RELEASE OF INFORMATION FOR DCF CPS SEARCH" form.

Please Note:

- All information requested in the form must be provided in a clear and legible manner.
- 2. Once completed, the form is submitted to:

Department of Children and Families
Hotline Background Searches
505 Hudson Street
Hartford, CT, 06106

- 3. The Department of Children and Families (DCF) conducts a search of the Central Registry data base.
- 4. DCF provides a written response sent to the employer identified on the AUTHORIZATION form. The response summarizes the results of the Central Registry search as Pass or Fail.

If Pass, the AUTHORIZATION is returned stamped as "no record found".

If Fail, the circumstances of the initial Report of Suspected Abuse and Neglect and the date of the substantiation of abuse or neglect are provided.

DCF may be contacted for additional information including a copy of the DCF investigation that resulted in a substantiation of abuse and/or neglect.

5. So that ABH may receive the results to process the application, please enclose a stamped envelope addressed to:

Advanced Behavioral Health, Inc.
Attn: DCF Credentialing Department
213 Court Street
Middletown, CT 06457



Authorization for Release of Information for DCF CPS Search



| I, | do hereby authorize the Department of Children and Families to research (Type Applicant Name) | | | | | | | | | |
|--|--|--|-------------------------------------|--|------------------------|---------------------|------------------------------------|--|----------------|--|
| their records for an I/my family may h suitability solely fo | y and all informatic been named | nation con | lease it to the as | gency listed below | w. I under | stand th | at this inform | ation will de | termine my | |
| By: Agency Name / Address/City / State / Zip Code | Attention: Agency: Address: City: | Agency: ATTN: DCF Credentialing Dept S. Tkacs Address: 213 Court St. Middletown CT 06457 | | | | | | Zip Code: | | |
| I release the Depar release / use of this | tment of Childs information. | en and Far I submit m | milies from any y following info | liability for any ormation to assist | tamages I the Dept. | may inc of Child | ur which may Iren and Fami | result from lies in their | the search. | |
| | PLEAS | E TYPE | OR PRINT L | EGIBLY / LE | AVE NO | BLAN | K SPACES | Contractor Contractor | | |
| Name: | | | | | | | Date of Birth: | | | |
| Last Address: | Last | | | First Mid | | | Social Security #: | | | |
| Name of Street Contract of Stree | P.O. Boxes) | | | | Apartme | nt No. | How Long at Current Address: | Yrs. | Mos. | |
| City | | T Etc. | APPLICATION OF THE PARTY OF | State | Zip Code | | | Charl if ear | erse side used | |
| Previous Addressee | Street | e Last Pive | Apt.# | City/Town | rarm-y-neco | State | Zip Code | The second secon | To Month/Yr. | |
| | No P.O. Boxes) | | | | | | | Month/Yr. | TO MINISTER | |
| 25.07.22.27.29.20.27 | | | | Stronger to a Charles Andre | | | | hook of some | se side used | |
| Other Names I have | Last | ng Maiden, | erevious marria | First | | () religion (2.15) | | Middle | se side data | |
| | | | | | | | | | | |
| Name of Spouses/O | ther Adults in t | he Home - | Past and Present | | | 7176 | | | se side used | |
| Last | F | rst | Middle | D.O.B. Month/Day/Year | Social Sec | eurity# | | Signature/Dat f Still in the Hor | | |
| | | | | | | | | | | |
| Names of ALL Chi | d(ren) – Biologi | ical, Stepch | ildren Including | Adult Children In | or Out of t | he Home | . 00 | heck if reve | rse side used | |
| Last | | | First | Middle | | Sex | D.O.B. Month/Day/Year | | | |
| | | | | | | | | | | |
| | | | | | | 200 | | | 2000 NO | |
| Date: | | Ap | plicant Signatu | ire: | | | | 1 | | |
| ****DCF C | FORM | S NOT FILL | ED OUT COMPLE | E 180 DAYS AFTER TELY AND PRINTER COURSEY of this Search | CLEARLY | WILL BE | RETURNED | the Applicant to | DCF | |
| | | _ | * | es – 505 Hudson | | | | | 1415 | |
| DCF-CT HOTLINE | | | | | | | | ŧ | | |
| DATE OF THUILDE | LA S-DUC USE (| | ECOPE FOUN | | | | coor's Initiale | | | |

Form W-9 (Rev. October 2007) Department of the Treasury

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

| 9.2 | Name (as shown on your income tax return) | | | |
|--|---|------------------------|---------------------|---|
| on page | Business name, if different from above | | | |
| Print or type Specific Instructions | Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership ☐ Umited liability company. Enter the tax classification (D-disregarded entity, C-corporation, P-pi ☐ Other (see instructions) ▶ | ortnorship) ► | ☐ Exempt payee | |
| Print Ic Inst | Address (number, street, and apt. or sulle no.) | Requester's name and a | ddress (optional) | |
| Specif | City, state, and ZIP code | | | |
| 8 | List account number(s) here (optional) | | | |
| Par | Taxpayer Identification Number (TIN) | | | |
| backu allen, | your TIN in the appropriate box. The TIN provided must match the name given on Line 1 p withholding. For individuals, this is your social security number (SSN). However, for a resole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entity imployer identification number (EIN). If you do not have a number, see How to get a TIN o | esident ties, it is | nty number | |
| - | If the account is in more than one name, see the chart on page 4 for guidelines on whos | | entification number | |
| | er to enter. | | | |
| Part | Certification | · · · | ' | Т |

Under penalties of perjury, I certify that:

- 1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
- I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
- 3. I am a U.S. cittzen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have fated to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here U.S. person ▶ Date ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

- Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
 - 2. Certify that you are not subject to backup withholding, or
- Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

. The U.S. owner of a disregarded entity and not the entity,



DEPARTMENT OF CHILDREN AND FAMILIES

CONFIDENTIALITY STATEMENT AND ETHICS AGREEMENT

Note: For Organizations: Each employee who will have access to clients or client records will sign the confidentiality agreement. It is to be kept by the agency so that DCF and or the Judicial Branch can verify if needed. The Ethics Agreement is to be signed by the Executive Director of the agency and returned to ABH®. Solo Providers are to complete both forms and submit to ABH®.

| I. CONFIDENTIALITY STATEMENT: |
|--|
| I,, understand that I am being granted access to confidential information that is the property of the adult client or the parent or legal guardian of the minor client which may include the State of Connecticut Department of Children and Families ("DCF") and/or the Connecticut Judicial Branch. I am a/an: |
| € consultant |
| € employee of the following DCF or Judicial Branch service provide |
| €other authorized user |

By signing this document, I understand and agree as follows:

- 1. In the course of providing services to and/or performing my duties I may have access to hard copy and/or electronic confidential DCF, Judicial Branch or family case information. "Confidential information" includes, but is not limited to, client names, client contact information, juvenile court history, documents received from third parties regarding clients' cases, and all details of clients' cases whether received in oral, documentary or electronic form.
- 2. I will not solicit confidential information from any source beyond what is necessary to perform my duties.

- 3. I will not discuss confidential information in any setting or forum except when performing tasks directly related to my duties.
- 4. I will not discuss confidential information with any person who is not employed by the referring agency, unless specifically authorized to do so for purposes of performing my duties.
- 5. I will only discuss confidential information with authorized persons in an area where privacy can be ensured. For example, confidential information will not be discussed in public or semipublic areas including hallways, waiting rooms, elevators and restaurants.
- 6. I will not distribute confidential information in any written or documentary or electronic format to anyone unless specifically authorized to do so, as appropriate, for purposes of performing my duties. This specifically includes, but is not limited to, use of DCF, family case information, or Judicial Branch information in a research project or written publication.
- 7. If I recognize the name of an adult or child client with whom I have a personal or business relationship not connected with my duties, I will immediately notify the referral agent and will not read additional information or access the case further without written approval.
- 8. I will not remove any confidential information, either physically or electronically, from workspace operated by the Department of Children and Families, the Judicial Branch, or any provider, unless expressly authorized in writing.
- 9. I will return all confidential information in my possession upon the completion of my duties, and I will not keep any copies of any information, in any format, to which I have gained access.
- 10. I understand that Connecticut General Statutes §17a-28 addresses the confidentiality of DCF case records and states, in part:
 - "...The information contained in reports and any information relative to child abuse, wherever located, shall be confidential..."
 - "...Any violation of this section...shall be punishable by a fine of not

more than one thousand dollars or imprisonment for not more than one year."

- 11. I understand that I may be subject to the above-cited criminal penalty if I illegally disclose confidential information.
- 12. I understand that I may also be subject to a civil lawsuit if I illegally disclose confidential information.
- 13. I understand that if I am sued for a willful or negligent breach of confidentiality, DCF or Judicial Branch shall not be responsible for any costs or damages associated with said suit.
- 14. For DCF and CSSD families, I understand that my access privileges to confidential information will expire twelve (12) months from the date I sign this Agreement unless an authorized DCF Manager requests that my access privileges be renewed for another twelve (12) months. If my access is renewed, the provisions of this Agreement will remain in full force and effect even if I am not asked to sign a new Confidentiality Agreement.
- 15. I understand that even after my access privileges expire, and even after I am no longer providing services, the provisions of this Confidentiality Agreement remain in full force and effect indefinitely, including my potential civil and criminal liability for breach of confidentiality.

| [Signature of person being granted acces | | | |
|---|--|--|--|
| Print name of person being granted access | | | |
| Date | | | |
| Witness | | | |



II. ETHICS AGREEMENT:

| I | have reviewed the <u>Guide to the Code of Ethics</u> |
|--------------------------|---|
| For Current or Potential | tate Contractors which can be found at: |
| http://www.ct.gov/eth | cs/lib/ethics/guides/contractors_guide_09_final.pdf |
| | those provisions of the Guide that apply to my and the Judicial Branch. |
| [Signature of person | erving as a DCF or Judicial Branch vendor or contractor] |
| Print name of person | serving as a DCF or Judicial Branch vendor or contractor |
| Date | |
| Witness | |