DEPARTMENT OF CHILDREN AND FAMILIES
Individual Credentialing Application to Provide Services

Supervised Visitation Services

Applicant Check Sheet

Applicants must provide the following:

- ☐ Completed and Signed Original Credentialing Application;
- ☐ Completed DCF Area Office Listing Chart;
- ☐ Completed and Signed Statement of Experience Form;
- ☐ Current resume indicating Bachelors Degree and working experience with children and adolescents indicated by month and year. Resume must include the following: (a) 5 years work history with an explanation of gaps more than 6 months; (b) university name, state degree listing and year of graduation (if applicable).
- ☐ Copy of Current motor vehicle license;
- ☐ Copy of Motor Vehicle Certificate of Insurance (if transporting children);
- ☐ Copy of current First Aid and CPR certificates issued by a nationally recognized accredited organization;
- ☐ Completed and signed IRS form W-9;
- ☐ Copies of Background Checks which cannot be dated longer than 6 months prior to application:
  ____CPS ____Dept. of Public Safety
- ☐ Must submit a color photograph from shoulders up taken against a solid background. Photo must be scanned in jpg format and emailed to badgephoto@abhct.com.
- ☐ Signed Provider Agreement for Supervised Visitation

Scan and submit this form electronically or send by mail to the address below.

Advanced Behavioral Health
Attn: DCF Credentialing Department
Middlesex Corporate Center, 213 Court Street, Middletown, CT 06457
Phone: (860) 638-5309 Fax: (860) 920-4457
Email: DCFCred@abhct.com

DEPARTMENT OF CHILDREN AND FAMILIES
INDIVIDUAL PROVIDER CREDENTIALING APPLICATION

Supervised Visitation Services

I. Individual Provider Information

Provider Name: _____

Name of Supervised Visitation Site:_____

Name of Supervisor including clinical licensure designation:_____

Address (street, suite #, etc.) _____

P.O. Box: _____

City: _____State: _____ Zip: _____

Phone #: (____)_____ Fax #: (____)_____ E-Mail:_____

Tax ID #: _____ Name of Owner of this Tax ID: _____

Social Security Number:_____-_____-_____

Address to which payments are to be sent: ☐ Same as 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. Languages Spoken

☐ Chinese ☐ Croatian ☐ Czech ☐ English ☐ Filipino ☐ French

☐ German ☐ Haitian ☐ Hebrew ☐ Hmong ☐ Italian ☐ Japanese

☐ Korean ☐ Polish ☐ Portuguese ☐ Russian ☐ Serbian ☐ Sign

☐ Slovak ☐ Spanish ☐ Yugoslav ☐ Vietnamese ☐ Other_____

III. Voluntary Information:

Clients and family members often express preferences for a service provider of a particular ethnic background or gender. Your completion of the information below will allow DCF to be more responsive when such a preference is requested. If you volunteer to provide the following information, it will only be used when a client or family member indicates such information is important in selecting service provider. The information collected will not be released to any other party, except in aggregate form.

Ethnic background:

- ☐ African American/Black
- ☐ Asian/Pacific Islander
- ☐ Caucasian/White
- ☐ Native American/Eskimo
- ☐ Puerto Rican
- ☐ Other (not listed above) _____

Gender: ○ Female ◉ Male

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 _____

Norwalk _____

Norwich _____

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 re-credentialing 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 print)

_____ _____

Authorized Signature ***Date***

_____ _____

Name (Please type or print) ***Title (Please type or print)***

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 provider _____

☐ 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 access]

_____

[Print name of person being granted access]

_____

Date

_____

Witness

II. ETHICS AGREEMENT:

I _____ have reviewed the Guide to the Code of Ethics For Current or Potential State Contractors which can be found at:

http://www.ct.gov/ethics/lib/ethics/guides/contractors_guide_09_final.pdf

I agree to comply with those provisions of the Guide that apply to my relationship with DCF and the Judicial Branch.

_____

[Signature of person serving 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

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:
Phone Number: Email:
Address: City: State:

Please describe in detail:

1) In what capacity have you worked with children?

2) What is your interest in providing services to DCF involved children?

3) What is your experience in establishing goals, assessing strengths and challenges and writing progress notes?

Please identify any area(s) that are of particular interest to you:

- ☐ Arts
- ☐ Animals/Pets
- ☐ Agriculture/Horticulture
- ☐ Architecture & Construction
- ☐ Arts, A/V Technology & Communication
- ☐ Coaching
- ☐ Health Science
- ☐ Hospitality & Tourism
- ☐ Human Services
- ☐ Information Technology (IT)
- ☐ Manufacturing
- ☐ Marketing, Sales & Service
- ☐ Music
- ☐ Science, Technology, Engineering & Math (STEM)
- ☐ Transportation, Distribution & Logistics

- ☐ Sports
- ☐ Baseball
- ☐ Basketball
- ☐ Football
- ☐ Volleyball
- ☐ Soccer
- ☐ Wrestling
- ☐ Cheerleading
- ☐ Field Hockey
- ☐ Track & Field
- ☐ Lacrosse
- ☐ Swimming
- ☐ Tennis

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)

Please identify languages spoken other than English:

- ☐ American Sign Language
- ☐ Arabic
- ☐ Armenian
- ☐ Bosnian
- ☐ Creole
- ☐ Croatian
- ☐ Dutch
- ☐ Farsi
- ☐ French
- ☐ German
- ☐ Greek
- ☐ Hebrew
- ☐ Hindi
- ☐ Hungarian
- ☐ Italian
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Mandarin
- ☐ Norwegian
- ☐ Polish
- ☐ Portuguese
- ☐ Russian
- ☐ Serbian
- ☐ Slovak
- ☐ Spanish
- ☐ Swedish
- ☐ Tagalog
- ☐ Vietnamese
- ☐ Yiddish

Preferred Age Group:

- ☐ Child 5-8
- ☐ Child 9-12
- ☐ Child 13-16
- ☐ Child age 17 & above

APPLICANTS PLEASE READ AND SIGN:

I certify under penalty of perjury that all the information provided is true and correct to the best of my knowledge.

APPLICANT SIGNATURE: Date:

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC SAFETY
DIVISION OF STATE POLICE
BUREAU OF IDENTIFICATION

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

Check Type of Background Search Requested:

( ) Conn. Only search by Name/Date of Birth-$36 (will only provide existence of a record and not actual record)
(X) Conn. Only Criminal Conviction History Record Search-$75.00 (Name/DOB Search will provide a copy only if a record exists)
( ) Conn. Only Criminal Conviction History Record searched by Fingerprint-$75.00*
*Fingerprinting completed at a Connecticut State Police location - $15.00

Name of Requester: ADVANCED BEHAVIORAL HEALTH, INC. **Date:**_____

Requesters Address: ATTN: DCF Credentialing Department 213 Court St.,

City: Middletown **State:** CT **Zip:** 06457 **Phone Number:** 860.638.5309

1. **Print full name and date of birth, maiden or alias names for <u>each</u> subject requested.**
2. **If a fingerprinted criminal history record check is required submit a Fingerprint card along with this form.**
3. **Enclose a Check or Money Order for the applicable amount made payable to: "Treasurer-State of CT"**
4. **If you are requesting more than one name please submit <u>one check</u> for the total dollar amount of all subjects requested. A separate form will be required for each search requested.**
5. **Mail Request with Check or Money Order to:** **DESPP-SPBI**
   1111 Country Club Road
   Middletown, CT 06457-2389

_____/___/_____
Subject's Last Name **First** **(Middle)** **Date of Birth**

List any alias or maiden names and dates of births used:

_____

<u>The result of this search is based on name and date of birth or fingerprint card submission and contains State of Connecticut criminal conviction history record information ONLY. Please be advised that the criminal history record information may change daily due to erasures, corrections, pardons or other modifications to individual criminal history record information, the Department of Emergency Services and Public Protection (DESPP) cannot guarantee the accuracy of the information except with respect to the date the information is disclosed or obtained. DESPP and the State of Connecticut are not responsible for any errors or omissions resulting from subsequent dissemination of this data. The subject and/or requester assumes all liability in the use of data obtained from this database.</u>

***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 Equal Opportunity Employer

DPS-0846-C (Rev. 11/14/17)
Form Available @ www.ct.gov/despp

Connecticut Department of Children and Families
AUTHORIZATION FOR RELEASE OF INFORMATION FOR DCF CPS SEARCH
DCF-3031
10/18 (Rev.)

I, *(Applicant Name)*: _____
do hereby authorize the Department of Children and Families to research its records to determine whether or not I am on the *me* central registry of persons responsible for child abuse and neglect
I understand that this information may be used to determine my suitability solely for *(check one)*:

☐ Employment ☐ Day Care ☐ Volunteer ☐ Intern ☐ Mentor
☐ Other:

(This area for DCF Use only)
Date Processed:
Central Registry: ☐ YES ☐ NO
Processor's Initials:

Name of Agency *(requesting background check)*:	Attention:		
Advanced Behavioral Health - DCF Credentialing Department	SARAH TKACS		
Address: (No. and Street):	City:	State:	Zip:
213 Court St.,	Middletown	CT	06457

I release the Department of Children and Families from any liability for any damages I may incur which may result from the release / use of this information.
I submit my following information to assist the Department of Children and Families in their search.

Applicant Last Name	Applicant First Name:	Middle:	DOB:	SS:

Applicant Address: (No. and Street):	Apartment #:	City:	State:	Zip:	Years at current address?" Years	Months

List All Previous Applicant Address(es) for the Last Five Years ☐ *Check if an additional sheet is necessary, and attached*

Address: (No. and Street):	Apartment #:	City:	State:	Zip:	Dates From: Month	Dates From: Year	Dates To: Month	Dates To: Year

Other Names I have Used – *Including Maiden, Previous Marriages(s)* ☐ *Check if an additional sheet is necessary and attached*

Last Name	First Name:	Middle:	DOB:	SS:

Name of Spouses/Other Adults in the Home – *Past and Present* ☐ *Check if an additional sheet is necessary and attached*

Last Name	First Name:	Middle:	DOB:	Signature (if still in the home)	Date:

Names of ALL Child(ren) – *Biological, Stepchildren, Including Adult Children In or Out of the Home* ☐ *Check if an additional sheet is necessary and attached*

Last Name	First Name:	Middle:	DOB:	Gender:
				Select One or Enter your own
				Select One or Enter your own
				Select One or Enter your own
				Select One or Enter your own

Do you have an active DCF investigation at this time? ☐ Yes ☐ No Do you have an active appeal of a DCF investigation at this time? ☐ Yes ☐ No

Applicant Signature:	Date:

This authorization will expire 180 days after the date of the signature. Forms not filled out completely and / or clearly will be returned. Do not leave any blank spaces. Please specify with "N/A" if not applicable. **DCF Conducts a Search of the CT Registry ONLY** The Accuracy of this Search is Limited to the Information Provided by the Applicant to DCF.

How To Submit: *Email:* DCF.BackgroundCheck@ct.gov | *Fax:* 860-560-7071 | *Mail:* DCF-Background Check Unit, 505 Hudson Street, Hartford, CT 06106

Please be advised that due to the large volume of forms received, we are unable to provide confirmation of receipt or status updates during the background check process. If, after 4 weeks, you do not receive the results of any form(s) you sent in or if you have any questions, please contact the BGC Unit.