

DEPARTMENT OF CHILDREN AND FAMILIES
Individual Credentialing Application to Provide Services

Assessment Services

Applicant Check Sheet

Applicants must provide the following:

- Completed and Signed Original Credentialing Application;
- Completed DCF Area Office Listing Chart;
- 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 and Signed Professional Review Questionnaire;
- Signed Consent Form for Release of Confidential Disciplinary Records;
- Copy of Current License;
- Copy of Current Malpractice Insurance with coverage limits of \$1 million per occurrence and \$3 million aggregate;
- 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
- Signed Provider Agreement for this service category (original signature required)
http://www.abhct.com/resources_DcfCredentialing.asp

Send Completed Applications To:

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

**DEPARTMENT OF CHILDREN AND FAMILIES
INDIVIDUAL PROVIDER CREDENTIALING APPLICATION**

Assessment Services

I. Evaluator Information

Evaluator Name: _____

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. Licensure

State License Registration Number: _____ Expiration Date: _____

Are there any conditions that have been placed on the above Licensure? NO YES

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

III. Malpractice Insurance Coverage

Current Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Policy Number: _____

Effective Date of Coverage: _____ Exp. Date: _____

Date that coverage with this carrier first began: _____

Limits of Coverage: Per Occurrence \$ _____M Aggregate \$ _____M

***** PLEASE PROVIDE A COPY OF YOUR CURRENT MALPRACTICE INSURANCE *****

IV. Languages Spoken

- Chinese Croatian Czech English Filipino French
 German Hatian Hebrew Hmong Italian Japanese
 Korean Polish Portuguese Russian Serbian Sign
 Slovak Spanish Yugoslav Vietnamese Other _____

V. Special Expertise

Evaluation Expertise:

- Learning disabilities Cognitive impairment Alcohol/drug abuse
 Young children Adolescents Autism spectrum disorders
 Other _____ Other _____ Other _____

VI. Voluntary Information:

Clients and family members often express preferences for an evaluator 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 an evaluator. 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 _____

New Britain _____

New Haven (Metro) _____

New Haven (Greater) _____

Norwalk _____

Norwich _____

Stamford _____

Torrington _____

Waterbury _____

Willimantic _____

PROFESSIONAL REVIEW QUESTIONNAIRE

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 jurisdiction ever been refused, limited, suspended, revoked or voluntarily 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 substances ever been limited, suspended, revoked or voluntarily relinquished?			
4. Have your privileges in any hospital ever been suspended, diminished, revoked, or not renewed involuntarily or voluntarily?			
5. Have you ever been reprimanded by, or had your membership refused, suspended, or revoked by any professional organization?			
6. Have you ever been named as a party in a malpractice action?			
7. Have any claims ever been made against you for professional negligence or malpractice?			
8. Have you ever been convicted of a crime other than a minor traffic offense?			
9. Are you currently using illegal drugs?			
10. Do you have any physical, mental, or addictive problems that may interfere with your ability to carry out the duties and responsibilities of your profession?			
11. Have you ever been denied professional liability insurance, or has your policy ever been revoked, canceled, or voluntarily relinquished under a threat of cancellation?			
12. Have you ever been the subject of investigation by any peer review committee?			
13. Are you able to perform all of the services being requested in this application according to accepted standards of professional performance and without posing a direct threat to clients or others?			
14. Are you, your partner(s), or any member of your family involved with, employed by, or part of an investigation with the Department of Children and Families (DCF)?			

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

Consent Form

Release of Confidential Disciplinary Records

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.

Please list any documents that the Department is not authorized to release:

Signature

Date

Printed or Typed Name

Date of Birth

Address

Connecticut License Number

Expiration Date

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 Public Safety
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;
3. Mail the completed form along with a check for \$50.00 to the following address:

State Police Bureau of Identification
1111 Country Club Road
Middletown, CT. 06457



**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 record by Name/Date of Birth search
() Conn. Only record by Fingerprint supported search

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 each subject requested.
2. If a fingerprinted background is required submit a Fingerprint card along with this form.
3. Enclose a \$50. dollar Check or Money Order payable to: " *D P S* "
4. If you are requesting more than one name please submit one check for the total dollar amount of all subjects requested.
5. Mail Request with Check or Money Order to: Department of Public Safety
Bureau of Identification
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:

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 PUBLIC SAFETY. THE DEPARTMENT OF PUBLIC SAFETY 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 ASSUME 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 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

**Request for Taxpayer
Identification Number and Certification**

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

Print or type
see specific instructions on page 2

Name (as shown on your income tax return)	
Business name, if different from above	
Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ <input type="checkbox"/> Exempt payee <input type="checkbox"/> Other (see instructions) ▶	
Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
City, state, and ZIP code	
List account number(s) here (optional)	

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number : : :
OR
Employer identification number : :

Part II Certification

Under penalties of perjury, I certify that:

- 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
- I am a U.S. citizen 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 failed 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

Signature of 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).
- 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 businesses. 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,