

**DEPARTMENT OF CHILDREN AND FAMILIES
Individual Credentialing Application to Provide Services**

(For psychologists already credentialed for Court Ordered Psychological Evaluations)

Assessment Services

Applicant Check Sheet

Applicants must provide the following:

- Completed and Signed Original Credentialing Application;
- Completed DCF Area Office Listing Chart;
- Signed Provider Agreement for this service category (original signature required)

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
(For psychologists already credentialed for Court Ordered Psychological Evaluations)

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

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 _____

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 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)