

**DEPARTMENT OF CHILDREN AND FAMILIES**  
**Individual Credentialing Application to Provide Services**  
**Assessment Services: Perpetrator of Domestic Violence**

***Applicant Check Sheet***

**Applicants must provide the following:**

- Completed and Signed Original Credentialing Application;
- Completed DCF Area Office Listing Chart;
- Current Curriculum Vitae with the required years of experience in the field of domestic violence as stated in the Provider Agreement for Assessment Services: Perpetrator of Domestic Violence;
- Completed Professional Review Questionnaire;
- Documentation: Completed CT Batterer Intervention Service Provider Curriculum;
- Signed Professional Conduct and Ethics Statement;
- 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;
- If applicant is an intern, copy of documentation related to supervisor's information including but not limited to supervisor's current resume, supervisory arrangement, copy of current license and copy of current malpractice insurance must be included in this application. **Supervisor must provide documentation that he/she has met all the requirements of Sec. C 1&2 of the Provider Agreement for Assessment Services: Perpetrator of Domestic Violence;**
- 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](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: Perpetrator of Domestic Violence**

**I. Evaluator Information**

Evaluator Name: \_\_\_\_\_

Name of Supervisor: (if applicant is an intern) \_\_\_\_\_

**Supervisor must provide documentation that he/she has met all the requirements of Sec. C 1&2 of the Provider Agreement for Assessment Services: Perpetrator of Domestic Violence.**

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. 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

## **Connecticut Credentialed Domestic Violence Professionals Code of Ethics**

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 \_\_\_\_\_

## **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.

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***Name of Applicant (Please type or print)***

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***Authorized Signature***

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***Date***

---

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

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

**Department of Public Safety  
Criminal Conviction Record Check Procedure**

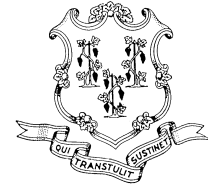
The procedural steps for an individual criminal conviction record check are as follows:

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



**AUTHORIZATION FOR RELEASE OF INFORMATION FOR DCF CPS SEARCH**



I, \_\_\_\_\_ do hereby authorize the Department of Children and Families to research  
(Type Applicant Name)

**For DCF Use**

their records for any and all information concerning charges, findings, dispositions, etc. relating to child abuse or neglect in which I / my family have been named, and to release it to the agency listed below.

**Advanced Behavioral Health, 213 Court Street, Middletown, CT 06457.**  
**Attn. DCF Credentialing Department -S. Tkacs** (Agency Name / Address / City / State / Zip Code)

I understand that this information will determine my suitability solely for: (check one)  
 Employment  Day Care  Volunteer  Intern  Mentor  Other

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 Dept. of Children and Families in their search.

**PLEASE TYPE OR PRINT LEGIBLY/LEAVE NO BLANK SPACES**

NAME \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First Middle Month Day Year

ADDRESS \_\_\_\_\_ Social Security Number (SSN) \_\_\_\_/\_\_\_\_/\_\_\_\_  
Street [No P.O. Boxes] Apt# City  
State Zip Code How long at current address? \_\_\_\_\_ YRS \_\_\_\_\_ MOS

PREVIOUS ADDRESS(S)/LIST ALL FOR THE LAST FIVE YEARS (continue on reverse side of form if necessary)  Check if reverse side used

ADDRESS \_\_\_\_\_  
Street [No P.O. Boxes] Apt# City  
State Zip Code From \_\_\_\_\_ Until \_\_\_\_\_ (Mo/Yr)

ADDRESS \_\_\_\_\_  
Street [No P.O. Boxes] Apt# City  
State Zip Code From \_\_\_\_\_ Until \_\_\_\_\_ (Mo/Yr)

OTHER NAMES I HAVE USED: \_\_\_\_\_  
Including MAIDEN, PREVIOUS Last First Middle  
MARRIAGE(s): \_\_\_\_\_  
Last First Middle

Check if reverse side used  
NAME OF SPOUSES/other NAME OF SPOUSES/other  
ADULTS IN THE HOME: \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
Past and present Last First Middle Month Day Year  
Social Security Number (SSN) \*Signature/Date \*(if still in the home)

Check if reverse side used  
Last First Middle DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
Social Security Number (SSN) \*Signature/Date \*(if still in the home)

NAME of ALL CHILD(REN) NAME of ALL CHILD(REN)  
Biological, Stepchildren Biological, Stepchildren  
Including adult children Including adult children  
in or out of the home in or out of the home  
Last First Middle sex DOB \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First Middle sex DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Check if reverse side used  
Last First Middle sex DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

DATE: \_\_\_\_\_ APPLICANT SIGNATURE: \_\_\_\_\_

**THIS AUTHORIZATION WILL EXPIRE 180 DAYS AFTER THE DATE OF THE SIGNATURE**

**FORMS NOT FILLED OUT COMPLETELY AND PRINTED CLEARLY WILL BE RETURNED\*\*\*\*\*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.

Mail To: DCF Hotline Background Searches; 505 Hudson Street; 5th Floor; Hartford, CT 06106

revised 05/09

**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:

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
2. 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. 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.

<b>Sign Here</b>	Signature of U.S. person ▶	Date ▶
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**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:

1. 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
3. 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,