

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

**Case Management**  
**Specific to youth in the Community Housing Assistance Program**

***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 in a Human Services field or at least seven (7) years work experience in the field of human services;
  - Copy of Current Motor Vehicle license;
  - Copy of Motor Vehicle Certificate of Insurance;
  - Copies of any applicable Accreditations and/or Certification i.e. Ansell Casey Life Skills End User Certificate;
  - 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;
  - 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 Criminal Conviction Record Check
    - \_\_\_\_ Department of Motor vehicles Driving Record
    - \_\_\_\_ Dept. of Public Safety Sex Offender Registry\* \_\_\_\_ National Sex Offender Registry\*
- \*These checks will be completed by ABH.
- 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**

**Case Management  
Specific to youth in the Community Housing Assistance Program**

**I. Individual Provider Information**

Provider Name: \_\_\_\_\_

Name of Supervisor: \_\_\_\_\_

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**

- |                                  |                                   |                                     |                                     |                                      |                                   |
|----------------------------------|-----------------------------------|-------------------------------------|-------------------------------------|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Croatian | <input type="checkbox"/> Czech      | <input type="checkbox"/> English    | <input type="checkbox"/> Filipino    | <input type="checkbox"/> French   |
| <input type="checkbox"/> German  | <input type="checkbox"/> Haitian  | <input type="checkbox"/> Hebrew     | <input type="checkbox"/> Hmong      | <input type="checkbox"/> Italian     | <input type="checkbox"/> Japanese |
| <input type="checkbox"/> Korean  | <input type="checkbox"/> Polish   | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Russian    | <input type="checkbox"/> Serbian     | <input type="checkbox"/> Sign     |
| <input type="checkbox"/> Slovak  | <input type="checkbox"/> Spanish  | <input type="checkbox"/> Yugoslav   | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Other _____ |                                   |

**III. Voluntary Information:**

Clients and family members often express preferences for 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 \_\_\_\_\_

New Britain \_\_\_\_\_

New Haven (Metro) \_\_\_\_\_

New Haven (Greater) \_\_\_\_\_

Norwalk \_\_\_\_\_

Norwich \_\_\_\_\_

Stamford \_\_\_\_\_

Torrington \_\_\_\_\_

Waterbury \_\_\_\_\_

Willimantic \_\_\_\_\_

## Department of Children and Families

### STATEMENT OF EXPERIENCE

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

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

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Are you a Parent?     Yes     No    How many children do you have? \_\_\_\_\_

What are their ages? \_\_\_\_\_

**Check all that apply to your WORKING experience with children (not to include biological):**

I have provided babysitting or childcare:	Years of Experience	Occasional Babysitting	Routine Scheduled Childcare
<input type="checkbox"/> Child age 0-2	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Child age 3-5	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Child age 6-12	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Child age 13-16	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Child age 17 and above	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Child who needs special health care or treatment: (Please specify)	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other (Please specify):	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

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
<input type="checkbox"/> Youth Group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Church Group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Big Brothers or Big Sisters Program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Youth Sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> School Aide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Red Cross or Other Public Health Institution	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> YMCA Activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Reading or Storytelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other (Please specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____

**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:** \_\_\_\_\_

## **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 voided 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***

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

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

## Department of Motor Vehicle Driving Record Check Procedure

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 Street, 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 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



**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

(print applicant name)

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.

I understand that this information will be used solely to determine my suitability for (check one):

- employment
- day care
- foster care
- adoption
- volunteer
- Intern
- mentor

Advanced Behavioral Health, ATTN: DCF Credentialing Dept. 213 Court St., Middletown CT 06457

by: \_\_\_\_\_  
(Agency name / address/ city / state / zip code)

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.

For DCF Use

**PLEASE PRINT CLEARLY IN INK**

NAME \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First Middle

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

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

ADDRESS \_\_\_\_\_  check if reverse side used  
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 MARRIAGE(s):  
Last First Middle  
Last First Middle

check if reverse side used

NAMES OF SPOUSES/other ADULTS IN THE HOME: \_\_\_\_\_  
Past and present  
Last First Middle DOB  
Social Security Number (SSN) \* Signature / Date \*(if still in the home)

check if reverse side used

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

check if reverse side used

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\*\*\*\*\*

Mail To: DCF Hotline Background Searches

revised 06/06

505 Hudson St, Hartford, CT 06106

**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.

<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:

- 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 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,