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 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
- ☐ 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 Assessment: Perpetrator of Domestic Violence

Send completed application to

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

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	☐ Haitian	☐ 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 _____

Milford _____

New Britain _____

New Haven _____

Norwalk _____

Norwich _____

Torrington _____

Waterbury _____

Willimantic _____

Consent Form
Release of Confidential Disciplinary Records

(Must be completed by each licensed behavioral health practitioner providing Assessment Services)

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

PROFESSIONAL REVIEW QUESTIONNAIRE

(Must be completed by each licensed behavioral health practitioner providing Assessments or Assessment Services: Perpetrator of Domestic Violence)

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

Connecticut Credentialed Domestic Violence Professionals
Code of Ethics

(Must be completed by each staff providing Assessment Services: DV)

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.

_____

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

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 each 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 one check 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:

_____

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.

***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

CPS Background Check Processing

***As of August 30th DCF will no longer be accepting CPS background checks via email, mail, or fax. Please see message and links below regarding the new BGC Portal. For credentialing purposes, all providers will need to access this information as you can no longer send to ABH unprocessed background checks for us to send on to the Careline unit for processing. Once you receive the result of the background check from DCF, please forward the response to ABH.**

Please read the notice from the DCF Careline unit below relating to DCF CPS background checks:

To Whom it may concern:

I am reaching out to you regarding some exciting changes that are happening within the background check unit here at the Department of Children and Families. We have implemented a new portal that will allow for easier submission of checks and in many cases a faster return of results for your agency. Our goal is to improve upon our current system and make a more streamlined process for both the applicants and the agency's requesting the checks.

We are asking any agencies that will require more than one individual to submit and access results, set up a shared email as you can only have one email address assigned to each token. Once we receive the shared email or confirmation that there is only one person accessing the portal we will provide you your token code.

*We are requiring that agencies send us copies of the forms they have submitted to the portal to dcf.backgroundcheck@ct.gov. This can be done on a weekly basis and will not delay processing times. When sending us copies please use " Copy of Signed Release of Information" in the subject line.

We have included training materials and videos for your review as we begin this transition. As always please feel free to reach out to the background check unit with any questions or concerns you may have.

Link to Portal: https://portal.dcf.ct.gov/Portal/Main/#dashboard

Regards,

DCF/Background Check Unit
505 Hudson Street
Hartford, CT 06106

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

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

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 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 generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* 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); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

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 for Part II, later.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*