

DEPARTMENT OF CHILDREN AND FAMILIES
Individual Credentialing Application to Provide Services

Support Staff

Applicant Check Sheet

Applicants must provide the following:

- Completed and Signed Credentialing Application;
- Completed DCF Area Office Listing Chart;
- Current resume indicating at least three years (36 months) of paid work experience consistent with age and need of the child or youth. Resume must include the following: (a) 5 years work history with an explanation of gaps more than 6 months; (b) university name, state degree listing and year of graduation (if applicable);
- Copy of diploma from highest education attained (if applicable);
- Completed and Signed Statement of Experience Form;
- Copy of Current Motor Vehicle license;
- Copy of Motor Vehicle Certificate of Insurance with a state minimum of 50,000/\$100,000 coverage;
- Copy of current First Aid and CPR Certificate issued by a nationally recognized accredited organization;
- Copy of written documentation of supervisory arrangement, supervisor's current resume, and a copy of the master's level degree to be included with this application;
- 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 [Support Staff](#)

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**

Support Staff Services

I. Individual Provider Information

Provider Name: _____

Name of Supervisor including masters level designation: _____

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 _____
- Milford _____
- New Britain _____
- New Haven _____
- Norwalk _____
- Norwich _____
- 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)

Department of Children and Families
STATEMENT OF EXPERIENCE

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

Name:

Phone Number:

Address:

Email:

City:

State:

Please describe in detail:

1) In what capacity have you worked with children?

2) What is your interest in providing services to DCF involved children?

3) What is your experience in establishing goals, assessing strengths and challenges and writing progress notes?

Please identify any area(s) that are of particular interest to you:

- | | |
|---|---|
| <input type="checkbox"/> Arts | <input type="checkbox"/> Human Services |
| <input type="checkbox"/> Animals/Pets | <input type="checkbox"/> Information Technology (IT) |
| <input type="checkbox"/> Agriculture/Horticulture | <input type="checkbox"/> Manufacturing |
| <input type="checkbox"/> Architecture & Construction | <input type="checkbox"/> Marketing, Sales & Service |
| <input type="checkbox"/> Arts, A/V Technology & Communication | <input type="checkbox"/> Music |
| <input type="checkbox"/> Coaching | <input type="checkbox"/> Science, Technology, Engineering & Math (STEM) |
| <input type="checkbox"/> Health Science | <input type="checkbox"/> Transportation, Distribution & Logistics |
| <input type="checkbox"/> Hospitality & Tourism | |
|
 | |
| <input type="checkbox"/> Sports | <input type="checkbox"/> Wrestling |
| <input type="checkbox"/> Baseball | <input type="checkbox"/> Cheerleading |
| <input type="checkbox"/> Basketball | <input type="checkbox"/> Field Hockey |
| <input type="checkbox"/> Football | <input type="checkbox"/> Track & Field |
| <input type="checkbox"/> Volleyball | <input type="checkbox"/> Lacrosse |
| <input type="checkbox"/> Soccer | <input type="checkbox"/> Swimming |
| | <input type="checkbox"/> Tennis |

Department of Children and Families
STATEMENT OF EXPERIENCE

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TEMPORARY CARE, SUPERVISED VISITATION, CHAP CASE MGMT, THERAPEUTIC SUPPORT STAFF, SUPPORT STAFF and AFTER
SCHOOL Services)*

Please identify languages spoken other than English:

- | | | |
|---|------------------------------------|-------------------------------------|
| <input type="checkbox"/> American Sign Language | <input type="checkbox"/> Greek | <input type="checkbox"/> Polish |
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Hebrew | <input type="checkbox"/> Portuguese |
| <input type="checkbox"/> Armenian | <input type="checkbox"/> Hindi | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Bosnian | <input type="checkbox"/> Hungarian | <input type="checkbox"/> Serbian |
| <input type="checkbox"/> Creole | <input type="checkbox"/> Italian | <input type="checkbox"/> Slovak |
| <input type="checkbox"/> Croatian | <input type="checkbox"/> Japanese | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Dutch | <input type="checkbox"/> Korean | <input type="checkbox"/> Swedish |
| <input type="checkbox"/> Farsi | <input type="checkbox"/> Laotian | <input type="checkbox"/> Tagalog |
| <input type="checkbox"/> French | <input type="checkbox"/> Mandarin | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> German | <input type="checkbox"/> Norwegian | <input type="checkbox"/> Yiddish |

Preferred Age Group:

- Child 5-8
 Child 9-12
 Child 13-16
 Child age 17 & above

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:



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

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

Request for Taxpayer Identification Number and Certification

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

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

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.		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) _____ <i>(Applies to accounts maintained outside the U.S.)</i>	
	<input type="checkbox"/> Individual/sole proprietor or single-member LLC	<input type="checkbox"/> C Corporation		<input type="checkbox"/> S Corporation
	<input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____	<input type="checkbox"/> Partnership		
	<input type="checkbox"/> Trust/estate			
	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:

- 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); and
- 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 ▶
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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.