DEPARTMENT OF CHILDREN AND FAMILIES
Organization Credentialing Application to Provide Services

Applicant Check Sheet

Applicants must provide the following:

A. Completed and Signed Organization Credentialing Application;

B. Completed DCF Area Office Listing Chart;

C. Copies of all applicable State Licenses;

D. Copies of any applicable Accreditations and/or Certifications;

E. Completed and signed IRS form W-9;

F. Staff Rosters for each service that the Organization is providing, please check below:

- ☐ After School Services – Clinical Support
- ☐ After School Services – Traditional
- ☐ After School Services for Youth
- ☐ Assessment
- ☐ Assessment: Perpetrator of Domestic Violence
- ☐ Case Management Services, specific to youth in the DCF Community Housing Assistance Program (CHAP)
- ☐ Community Based Life Skills (CBLS) Program
- ☐ General Livery Transportation
- ☐ School Bus Transportation
- ☐ Supervised Visitation
- ☐ Support Staff
- ☐ Temporary Care Services
- ☐ Therapeutic Support Staff

G. For After School Provider Site Applicants:

- ☐ Is the afterschool licensed by CT OEC as a Group Day care Home or Child Day Care Center for school age children? ☐ YES ☐ NO
- ☐ Is your agency currently funded by the CT State Department of Education After School Grant? ☐ YES ☐ NO
- ☐ Is your agency a 21st Century Community Learning Center Grantee? ☐ YES ☐ NO

NOTE: If your agency is licensed by the CT OEC as a Group Day Care Home or Child Day Care Center for after school age children, please complete and submit only the following:

- Complete CT OEC Licensed After School Provider Registration Form
- Provider Agreement #10: After School Services: Traditional
- Completed and Signed W9

All others must complete the credentialing application form and submit the following:

- Completed After School Provider Program Description
- Copy of Current Certificate of General Liability Insurance

H. For CHAP Case Management and CBLS providers only:

- Completion of DCF Provider Learning Inventory of Skills Training (L.I.S.T.)

I. For Transportation Providers only:

- Copy of DOT Livery Permit (For General Livery Providers);
- Copy of Motor Vehicle Certificate of Insurance with the limit of $1.5 million per vehicle coverage;
- Copy of DMV CT Registration Certificate(s).

J. Copies of Background Checks of all staff and all key personnel including the executive director, clinical director, medical director, and contact person, which cannot be dated longer than 6 months prior to application:

__ CPS
__ Dept. of Emergency Services and Public Protection Criminal Conviction Record Check

☐ Written statement concerning any history of criminal charges or child abuse or neglect investigations with an explanation of circumstances.

☐ Official documentation to support statement regarding history of criminal charges, such as arrest records, court documents, DMV records.

K. The following information must be provided for each employee that will be providing the following service type:

☐ **Assessment Services** – Current Curriculum Vitae with a minimum of three (3) years clinical work history providing assessments for children and adolescents indicated by month and year, completed Professional Review Questionnaire, signed Consent Form for Release of Confidential Disciplinary Records, copy of Current License, Certificate of Malpractice Insurance, Mandated Reporter Training Certificate, DCF CPS and DESPP background checks. **Staff Roster must be used as a cover sheet to a staff's application.** **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.**

☐ **Assessment: Perpetrator of Domestic Violence** - Current Curriculum Vitae* with a minimum of two (2) years experience involving direct work with victims or batterers including 150 hours facilitating or co-facilitating a batterer intervention group or class or individual work with batterers specific to addressing issues of coercive control, Completion of CT Batterer Intervention Service Provider Curriculum, Ethics Statement, Certificate of Malpractice Insurance, Mandated Reporter Training Certificate, DCF CPS and DESPP background checks. **Staff Roster must be used as a cover sheet to a staff's application. .** **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.**

☐ **After School Services Senior Group Leader or Senior Instructor –** Completed and signed Statement of Experience Form, Current Resume*, Proof of Age 20 by copy of current CT motor vehicle license or other government-issued photo identification, copy of current First Aid and CPR certificate issued by a nationally recognized accredited organization are required, Mandated Reporter Training Certificate, DCF CPS and DESPP background checks. **Staff Roster must be used as a cover sheet to a staff's application.** **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.**

☐ **After School Services Group Leader or Instructor –** Completed and signed Statement of Experience Form, Current Resume*, Proof of Age 18 by copy of current CT motor vehicle license or other government-issued photo identification, copy of current First Aid and CPR certificate issued by a nationally recognized accredited organization are required, Mandated Reporter Training Certificate, DCF CPS and DESPP background checks. **Staff Roster must be used as a cover sheet to a staff's application.** **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.**

☐ **After School Services Assistant Group Leader –** Completed and signed Statement of Experience Form, Current Resume* or detailed work history, Proof of Age 16 by copy of current CT motor vehicle license or other government-issued photo identification, copy of current First Aid and CPR certificate issued by a nationally recognized accredited organization are required, Mandated Reporter Training Certificate, DCF CPS and DESPP background checks. **Staff Roster must be used as a cover sheet to a staff's application.** **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.**

☐ **Case Management specific to youth in CHAP -** Statement of Experience Form and Current Resume*, copy of current motor vehicle license, copy of motor vehicle certificate of insurance. Copy of Department of Motor Vehicles Driving Record Background Check Result, Mandated Reporter Training Certificate, DCF CPS and DESPP background checks. **Staff Roster must be used as a cover sheet to a staff's application. .** **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.**
Please note: Dept. of Public Safety Sex Offender Registry* and National Sex Offender Registry* checks will be completed by ABH.

☐ **Community Based Life Skills (CBLS) -** Current Resume*, copy of current motor vehicle license, copy of motor vehicle certificate of insurance, copy of current First Aid and CPR certificate issued by a nationally recognized accredited organization are required, Mandated Reporter Training Certificate, DCF CPS and DESPP background checks. **Staff Roster must be used as a cover sheet to a staff's application.** **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.**
Please note: Dept. of Public Safety Sex Offender Registry* and National Sex Offender Registry* checks will be completed by ABH.

☐ **Supervised Visitation -** Statement of Experience Form, Current Resume*, copy of current motor vehicle license, copy of motor vehicle certificate of insurance, and copy of current First Aid and CPR certificate issued by a nationally recognized accredited organization are required, Mandated Reporter Training Certificate, DCF CPS and DESPP background checks. **Staff Roster must be used as a cover sheet to a staff's application. .** **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.**

☐ **Temporary Care, Therapeutic Support Staff and Support Staff -** Statement of Experience Form, Current Resume*, 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, Mandated Reporter Training Certificate, DCF CPS and DESPP background checks. **Staff Roster must be used as a cover sheet to a staff's application. .** **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.**

☐ **General Livery and School Transportation Services –** Copy of current CT motor vehicle license with either S,V,A,F or P endorsement, copy of motor vehicle certificate of insurance, copy of current First Aid and CPR certificate issued by a nationally recognized accredited organization are required, Mandated Reporter Training Certificate, DCF CPS and DESPP background checks. **Staff Roster must be used as a cover sheet to a staff's application. .** **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.**

SPECIAL REQUIREMENT: It is the responsibility of the organization to assure all drivers are meeting all Department of Motor Vehicles statutes and regulations Chapter 246 Motor Vehicle: C.G.S § 14-100 regarding Seat Safety Belts and Child Restraint Systems.

☐ **Supervisors for Supervised Visitation -** Written documentation of supervisory arrangement, supervisor's current resume*, and a copy of DPH license.

☐ **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.

☐ **Supervisors of Therapeutic Support Staff, Support Staff, Assessment/DV Perpetrator Community Based Life Skills (CBLS) Educator -** Written documentation of supervisory arrangement, supervisor's current resume*, and a copy of the master's level degree.

☐ **Program Administrator or Site Director for After School Services –** Completed and signed Statement of Experience Form, Current Resume*, Proof of Age 21 by copy of current CT motor vehicle license or other government-issued photo identification, copy of current First Aid and CPR certificate issued by a nationally recognized accredited organization are required.

L. Signed Provider Agreement for each service
http://www.abhct.com/resources_DcfCredentialing.asp

M. Signed Confidentiality Statement and Ethics Agreement

* Resumes 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).

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
ORGANIZATION CREDENTIALING APPLICATION

I. PRIMARY LOCATION

Organization Name: _____

Address (street, suite #, etc.) _____

PO Box: _____

City: _____ State: _____ Zip: _____

Phone # (____) _____ Fax #: (____) _____ E-Mail: _____

Tax ID #: _____ Name of Owner of this Tax ID: _____

Address to which payments are to be sent: ☐ Same as Facility Named 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. SERVICES PROVIDED AND STAFF ROSTER

☐ After School Clinical Support - Child
☐ After School Clinical Support - Youth
☐ After School Services – Traditional
☐ After School Services – Youth
☐ Assessments
☐ Assessment: Perpetrator of Domestic Violence
☐ CHAP Case Management
☐ Community Based Life Skills (CBLS)
☐ General Livery Transportation
☐ School Transportation
☐ Supervised Visitation
☐ Support Staff
☐ Temporary Care Services
☐ Therapeutic Support Staff

Please attach a Staff Roster for each service selected above that the organization provides. See Staff Roster attached to this application.

III. ADDITIONAL SERVICE LOCATIONS

Service type(s) provided at this location: _____

Address (street, suite #, etc.) _____

PO Box: _____

City: _____ State: _____ Zip: _____

Phone # ( ) _____ Fax #: ( ) _____ E-Mail: _____

Service type(s) provided at this location: _____

Address (street, suite #, etc.) _____

PO Box: _____

City: _____ State: _____ Zip: _____

Phone # ( ) _____ Fax #: ( ) _____ E-Mail: _____

Please attach any additional locations on a separate sheet of paper.

IV. KEY FACILITY PERSONNEL

Executive Director: _____ Telephone #/Ext. _____

Medical Director: _____ Telephone #/Ext. _____

Clinical Director: _____ Telephone #/Ext. _____

Contact Person: _____ Telephone #/Ext. _____

V. LICENSURE / CERTIFICATION / REGISTRATION

☐ JCAHO Certificate # _____ Exp. Date _____

☐ COA Certificate # _____ Exp. Date _____

☐ CARF Certificate # _____ Exp. Date _____

☐ DOT Permit # _____ Exp. Date _____

☐ State License Certificate # _____ Exp. Date _____

☐ Other _____

☐ Other _____

☐ Other _____

Are there any conditions that have been placed on the above Licensure / Certification / Registration? ☐ NO ☐ YES

If your answer is Yes, please provide a detailed explanation on a separate sheet of paper and attach to this application.

VI. PROFESSIONAL LIABILITY INSURANCE COVERAGE

Current Company:

Address: _____

City: _____ State: _____ Zip: _____

Effective Date of Coverage: _____ Exp. Date: _____

Retroactive Coverage To: _____ Incident $_____M Aggregate $_____M

Type of Policy: ☐ Claims Made ☐ Occurrence ☐ Self-Insured Trust

Are you covered by any Trust or other professional liability arrangement wherein the government limits liability in any medical malpractice action? ☐ NO ☐ YES

Are all clinical personnel covered by this policy? ☐ NO ☐ YES

***** PLEASE PROVIDE A COPY OF YOUR CURRENT MALPRACTICE INSURANCE *****

VII. GENERAL LIABILITY INSURANCE COVERAGE

Current Company:

Address: _____

City: _____ State: _____ Zip: _____

Effective Date of Coverage: _____ Exp. Date: _____

Incident $_____ Aggregate $_____M

Type of Policy: ☐ Claims Made ☐ Occurrence ☐ Self Insured Trust

***** PLEASE PROVIDE A COPY OF YOUR CURRENT CERTIFICATE OF LIABILITY INSURANCE *****

VIII. HISTORY OF SANCTIONS, MALPRACTICE CLAIMS, ADVERSE EVENTS

Malpractice Claim History

1. Has the Organization been named in any malpractice action? ☐Yes ☐No
2. Has the Organization had or currently have pending, any legal actions? ☐Yes ☐No
3. Has the Organization had professional liability insurance refused, revoked, declined or accepted on special terms? ☐Yes ☐No
4. Has any government agency investigated, suspended, revoked or taken other action against the Organization's license to conduct business? (Include Medicaid/Medicare) ☐Yes ☐No
5. Have any memberships in professional organizations been revoked, reduced, denied, or suspended by others or voluntarily given up by the Organization, or are any actions now under way, which may lead to such sanctions? ☐Yes ☐No
6. Has any license, certification, or accreditation been revoked, denied or suspended by others or voluntarily given up by the Organization, or are any actions now under way, which may lead to such sanctions? ☐Yes ☐No
7. Have any owners, officers or shareholders of the Organization been convicted of a crime, excluding misdemeanors? ☐Yes ☐No
8. Has the Organization been assessed a penalty, conviction, suspension, or other Sanction; or is the Organization currently under investigation by Medicare or Medicaid Programs? ☐Yes ☐No
9. Has the Organization ever been a defendant in any lawsuit with regard to the practice of mental health or substance abuse treatment where there has been an award or payment of $50,000.00 (fifty thousand dollars) or more? ☐Yes ☐No
10. Has any claim or suit for alleged malpractice been brought against the facility/ program, or are you aware of any circumstances that might lead to such a claim or suit against the facility/program? ☐Yes ☐No

Number of claims (check one)
☐ 0 ☐ 1 ☐ 2 ☐ More

If you answered yes to any questions 1-10 above, please attach a description of the occurrence (citing dates and other relevant information).

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

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

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

DCF Credentialing

Staff Roster

Organization Name:

***Supervisor's Name and Designation:**

SERVICE TYPE (Please Check)

- ☐ After School: Clinical Support
- ☐ After School: Traditional
- ☐ After School: Youth
- ☐ Assessments
- ☐ Assessments: DV
- ☐ CHAP Case management
- ☐ Community Based Life Skills (CBLS)
- ☐ Supervised Visitation
- ☐ Support Staff
- ☐ Temporary Care
- ☐ Therapeutic Support Staff
- ☐ Transportation: General Livery
- ☐ Transportation: School

Please complete a separate roster for each service.

LAST NAME	FIRST NAME	BACHELOR'S DEGREE (if applicable)	DATE GRADUATED	LANGUAGE(S) SPOKEN OTHER THAN ENGLISH

* For Supervised Visitation Services:

Credentialing Criteria: Supervisor must be a licensed behavioral health practitioner: Licensed Professional Counselor; Licensed Clinical Social Worker (CGS, Chapter 383b); Licensed Marriage and Family Therapist (CGS, Chapter 383 a); Licensed Alcohol and Drug Counselor (CGS, Chapter 376b); Licensed Psychologist (CGS, Chapter 383a); Licensed and Board Certified/Board Eligible (BC/BE) Psychiatrist.

* For Therapeutic Support Staff, Support Staff & Assessment/DV Perpetrator:

Credentialing Criteria: All certified individuals providing this service must be supervised by a master's prepared clinician with experience in child and adolescent behavioral health. Assigned supervisor will be verified through collection of: written documentation of supervisory arrangement, supervisor's current resume, and a copy of the master's level degree.

* For CHAP Case Management:

Credentialing Criteria: All providers shall have an identified Program Manager who must meet the requirements outlined in paragraph 1 of the provider agreement and also have at least one year of supervisory experience. The CHAP Program Manager shall be an employee of the Provider, not a subcontractor, intern or volunteer. Assigned CHAP Program Manager will be verified through collection of: 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.

* For Program Administrator or Site Director of After School Services:

Credentialing Criteria: Individual must be a minimum of 21 years of age, as verified by a valid CT motor vehicle license or other government-issued photo identification. Must possess a Bachelor's Degree in a field related to Human Services (social work, sociology, counseling, child welfare, psychology, marriage and family therapy, education, public administration/public health, child care management, child development, family studies or other human services degree), and must have a minimum of 2 (two) years experience in after school programming as evidenced by a current resume with gaps no greater than 6 months. A completed Statement of Experience Form along with a current CPR and First Aid certificate from the American Red Cross or American Heart Association is also required.

* For Community Based Life Skills (CBLS) Services:

Credentialing Criteria: Individuals providing supervision must be, at a minimum, a master's prepared clinician with experience in child and adolescent behavioral health. Written documentation of supervisory arrangements, supervisor's current resume, and a copy of supervisor's masters level degree is required.

Individuals who do not meet the above criteria, but who have at least seven (7) years of experience in the field of Human Services will be considered on a case-by-case basis. The Department will review the applicant's experience, education and training, other qualifications and the current resume.

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: Email:
Address: 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:

- ☐ Arts
- ☐ Animals/Pets
- ☐ Agriculture/Horticulture
- ☐ Architecture & Construction
- ☐ Arts, A/V Technology & Communication
- ☐ Coaching
- ☐ Health Science
- ☐ Hospitality & Tourism
- ☐ Human Services
- ☐ Information Technology (IT)
- ☐ Manufacturing
- ☐ Marketing, Sales & Service
- ☐ Music
- ☐ Science, Technology, Engineering & Math (STEM)
- ☐ Transportation, Distribution & Logistics

- ☐ Sports
- ☐ Baseball
- ☐ Basketball
- ☐ Football
- ☐ Volleyball
- ☐ Soccer
- ☐ Wrestling
- ☐ Cheerleading
- ☐ Field Hockey
- ☐ Track & Field
- ☐ Lacrosse
- ☐ Swimming
- ☐ Tennis

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)

Please identify languages spoken other than English:

- ☐ American Sign Language
- ☐ Arabic
- ☐ Armenian
- ☐ Bosnian
- ☐ Creole
- ☐ Croatian
- ☐ Dutch
- ☐ Farsi
- ☐ French
- ☐ German
- ☐ Greek
- ☐ Hebrew
- ☐ Hindi
- ☐ Hungarian
- ☐ Italian
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Mandarin
- ☐ Norwegian
- ☐ Polish
- ☐ Portuguese
- ☐ Russian
- ☐ Serbian
- ☐ Slovak
- ☐ Spanish
- ☐ Swedish
- ☐ Tagalog
- ☐ Vietnamese
- ☐ 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:

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

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

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_____

Authorization for Release of Information for DCF CPS Search

DCF-3031
12/15 (Revised)

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

its records to determine whether or not I am on the central registry of persons responsible for child abuse and neglect I understand that this information may be used to determine my suitability solely for *(check one)*: ☐ **Employment** ☐ **Day Care** ☐ **Volunteer** ☐ **Intern** ☐ **Mentor** ☐ **Other**

By: Agency Name / Address/City / State / Zip Code

Attention: SARAH TKACS
Agency: DCF Credentialing Department
Address: Advanced Behavioral Health
City: 213 Court St., Middletown **State:** CT **Zip Code:** 06457

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

Address: _____ Social Security #: _____
Street (No P.O. Boxes) Apartment No.

How Long at Current Address: _____ Yrs. _____ Mos.

_____
City State Zip Code

Previous Address(es)/List All for the Last Five Years *(continue on reverse side of form if necessary)* ☐ Check if reverse side used

Street (No P.O. Boxes)	Apt. #	City/Town	State	Zip Code	Dates From (Month/Yr.)	Dates To (Month/Yr.)

Other Names I have Used – *Including Maiden, Previous Marriages(s)* ☐ Check if reverse side used

Last	First	Middle

Name of Spouses/Other Adults in the Home – *Past and Present* ☐ Check if reverse side used

Last	First	Middle	D.O.B. Month/Day/Year	Signature/Date (If Still in the Home)

Names of ALL Child(ren) – *Biological, Stepchildren Including Adult Children In or Out of the Home* ☐ Check if reverse side used

Last	First	Middle	Gender	D.O.B. (Month/Day/Year)

Do you have an active DCF investigation at this time? ◯ Yes ◯ No
Do you have an active appeal of a DCF investigation at this time? ◯ Yes ◯ No

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. DO NOT LEAVE ANY BLANK SPACES. PLEASE SPECIFY WITH N/A IF NOT APPLICABLE.

******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 Careline Background Searches – 505 Hudson Street – 5th Floor – Hartford, CT 06106 or FAX: 860-560-7071

DCF-CT Careline CPS-BGC USE ONLY DO NOT WRITE BELOW THIS LINE

DATE: _____ Central Registry: YES ___ NO ___ Processor's Initials:_____

Department of Emergency Services & Public Protection
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. Make checks or money order payable to: Treasurer – State of CT

4. Mail the completed form along with a check for $75.00* to the following address:

DESPP-SPBI
1111 Country Club Road
Middletown, CT. 06457

* Effective December 1, 2017 the fee for the state Criminal History Checks will rise to $75.

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