Financial Management Services
Provider Services
P.O. Box 479, East Windsor CT. 06088-0479
Phone: (860) 627-9500 Fax: (860) 627-0230
Toll-Free: 1-877-722-8833

ABI WAIVER PROVIDER AGREEMENT FOR AGENCY EMPLOYEES

1. All of the statements and information contained in my Agency employee Application Supplement are true and correct.

2. I acknowledge that I can perform all the standards and duties for the services for which I am applying as stated in the provider manual.

3. I will immediately notify the Department **and** the Fiscal Intermediary - Allied Community Resources - if any information provided by me on this application changes.

4. I will maintain current standing with respect to any license and/or certification requirement established by the Department for my ABI provider type and service specialty.

5. I will immediately notify the Department **and** Allied Community Resources if such licenses and/or certifications expire, are revoked, suspended or otherwise terminated for any reason.

6. I will provide (**EXCEPT while the participant is in a hospital/skilled nursing facility**), all services in accordance with the terms of the ABI Waiver participant's service plan.

7. I acknowledge that I may be suspended or terminated from the provider directory if I am found by the Department to have engaged in fraudulent or abusive activities.

8. I agree to not use or disclose protected health information (PHI) other than as permitted or as required by law and to use appropriate safeguards to prevent improper use or disclosure of PHI.

9. I acknowledge that I am 18 years of age or older and eligible to provide services for the agency by which I am employed.

10. I understand that if I provide a service for which I have not gained approval, I will not be paid under the Waiver.

11. I understand that I **MAY NOT** provide services both privately and as an agency employee to the same ABI Waiver participant as this creates a conflict of interest and is strictly against program rules.

12. I understand that this is a State and Federal Government program. Altering timesheets, hours worked, or reporting of false hours is considered fraud. I know I will be subject to prosecution for fraud to the fullest extent of the law. I may be subject to prosecution on both a State and Federal level should I commit this crime.

13. I understand that this program does not provide Worker's Compensation coverage. This is the responsibility of the agency.

14. I understand that **I am not employed by Allied Community Resources**.

15. I understand that if I have previously worked for any other agencies, I must have left that agency in good standing and that Allied Community Resources may contact said agency and obtain any and all employment records.

16. I understand that I may not work with a participant on the ABI Medicaid Waiver Program if I am a relative of his/her conservator, if applicable

17. **I HAVE READ AND ACCEPT THE TERMS OF THE PROVIDER AGREEMENT AS STATED ABOVE**.

_____

Provider Name (please print)

_____

Provider Signature

_____

Agency Name

_____

Date Signed

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ABI Waiver Program - PROVIDER APPLICATION – Cognitive Behavioral Service

Complete this application in detail and include experience specifically related to cognitive/behavioral programming to people with a brain injury, delivered in community settings. Please note that applications not completed and approved within 90 days from the date they are initially received by Allied Community Resources (ACR) will be considered invalid and the applicant will be required to complete a new application and submit it to ACR for review. Please complete this form carefully and include a copy of your license, credentials or resume depicting your qualifications for Cognitive Behavioral services under the A.B.I. Waiver program.

Name: _____ Phone: _____
Address: _____ Cell: _____
City: _____ State: _____ Zip Code: _____
Email address: _____ Social Security Number: _____
Date-of-Birth*: _____ *(*required for criminal history background check of private providers)*

If Agency Employee, Name of Agency: _____
Do you speak languages other than English? ☐ YES* ☐ NO
*Please list: _____

Education:
Name of College: _____ Year of graduation: _____
Type of Degree: ☐ Bachelors ☐ Masters ☐ Doctorate
In what concentration is your degree? _____

Qualifications:
The State of Connecticut Department of Social Services has specific criteria that must be met in order for you to be considered as a provider of **Cognitive Behavioral** services. Professional licensure is required in any of the following fields: Psychologist, Neuropsychologist, Educational Psychologist or Speech, Occupational or Physical Therapist. Three years of experience working with individuals in a community setting is required as well as successful completion of the ABI Basic Informational Session.

Check here if a copy of your credentials is included. ☐

Have you ever completed an Allied Community Resources sponsored Informational Session on Acquired Brain Injury?
☐ YES ☐ NO If yes, Date: _____

Please include your resume with this application which should reflect experience in the development of a structured cognitive/behavioral intervention plan, which has as its primary focus the teaching of socially appropriate behaviors and the elimination of maladaptive behaviors through the development and implementation of cognitive compensatory strategies. You may use the back side of this page to provide specific examples. Check here if back of page was used. ☐

By signing and dating below, I understand that a Criminal History Background check will be performed on private providers as part of the application process. I attest that all of the information outlined on my application is a true and accurate depiction of my qualifications.

_____

Provider Name (Please Print) Provider Signature Date Signed

Name: Date:

ABI Waiver Program

ABI Program Services – Cognitive Behavioral Services Description:

Individual interventions designed to increase an individual's cognitive and behavioral capabilities and to further the individual's adjustment to successful community engagement including:

- Comprehensive assessment of cognitive strengths and liabilities, quality of adjustment and behavioral functioning
- Development and implementation of cognitive and behavioral strategies
- Development of a structured cognitive/behavioral intervention plan
- Ongoing or periodic consultation with the waiver participant, support system and providers concerning cognitive and behavioral strategies and interventions specified in the cognitive/ behavioral intervention plan
- Ongoing or periodic assistance with training of the waiver participant, support system and providers concerning cognitive behavior strategies and interventions
- Periodic reassessment and revision as needed, of the cognitive/behavioral intervention plan.

This service is performed within the context of the individual's person-centered team, in concert with the case manager. Cognitive/behavioral programs may be provided in the individual's home or in the community in order to reinforce the training in a real-life situation.

The service will be delivered utilizing two procedure codes, one for in person face to face visits that include the participant, providers and/or supporters. A quarterly, in person meeting with the waiver participant is required for this service.

The second procedure code is for non-face-to-face service that includes development of the cognitive behavioral plan and phone or other types of interactions with participants, providers or supporters.

Provider Qualifications:

Agency: CARF certification in Brain Injury, or JCAHO, or Accreditation for Behavioral Health Care; Employ individual who meet qualifications below.

Individual: Professional licensed as any of the following with at least three years of experience in cognitive/behavioral programming for people with a brain injury, delivered in community settings:

- Behavior Analysts
- Psychologists
- Neuropsychologists
- Occupational therapists
- Educational Psychologists
- Speech therapists
- Physical therapists

Training requirement (if not proven as part of educational record):

Attend the **ABI Basic Information Session** and pass the associated quiz with a grade of 80 or higher.

- Provider will have completed an approved training program(s) concerning acquired brain injury and person-centered planning, given by a state agency, the fiduciary, community providers, Brain Injury

Alliance of CT, or an Independent Living Center prior to providing services to a ABI Waiver Program participant.

Form **W-9**
(Rev. August 2013)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

Print or type See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

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

☐ Other (see instructions) ▶

Exemptions (see instructions):
Exempt payee code (if any) _____
Exemption from FATCA reporting code (if any) _____

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

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
			–		–				

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 on page 3.

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

General Instructions

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

Future developments. The IRS has created a page on IRS.gov for information about Form W-9, at *www.irs.gov/w9*. Information about any future developments affecting Form W-9 (such as legislation enacted after we release it) will be posted on that page.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, payments made to you in settlement of payment card and third party network transactions, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct.

Note. If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.