

Qualification by CTBHP to be a Medicaid Provider of Autism Services

The following application process is for individuals and performing providers associated with a clinical group practice to meet the DSS regulations for enrollment as a Medicaid provider for Autism Spectrum Disorder (ASD) services. Individuals qualified through the following process will not be placed on the DDS's provider listing. *Background checks will be completed on all applicants prior to Qualification approval.

All materials are to be faxed (confidential Fax) to Provider Relations 855-750-9862 or emailed to ctbhp@beaconhealthoptions.com.

Individual Providers (includes each practitioner working within a Clinical Group Practice)

- Please provide Social Security Number and Date of Birth on the Fax Cover Letter for Background Check.
- A letter of intent describing the services you intend to provide and experience that reflects the ability to perform those services for person's with ASD.
- A Resume or Curriculum Vita Resume highlighting the individual's professional experience and their qualifications that directly reflect their ability to provide the desired service must be submitted. The resume should be specific to the number of years with direct experience providing services to individuals with Autism Spectrum Disorder. The CV/resume should reflect specific experience in designing, authoring, and implementing behavior support plans.
- University diploma and copy of current professional clinical license or certificate (BCBA).
- Two (2) samples of behavior support plans that include functional assessments. The samples should clearly demonstrate methods for increasing adaptive behaviors and decreasing maladaptive or challenging behaviors. (All documentation must not contain any identifying information of clients).
- If not covered by an agency's liability insurance, applicant must submit a certificate of insurance or certificate of insurability demonstrating professional liability insurance of a minimum of \$500,000 per occurrence and \$1.5 million in aggregate. You are required to provide documentation of such coverage annually and upon request.
- Completed Department of Children & Families Release of Information Form

Additional requirements *will be* requested based on level of experience and/or license.

- Per Policy Transmittal PB 2014-99, if a provider has less than 2 years of full time equivalent work experience in treating individuals with ASD, an interview with designated CT BHP staff will be conducted. Content of interview may include, but is not limited to, discussion of competency to perform holistic functional assessments, collect meaningful data, and recommend proactive and reactive interventions. The interviews also explore professional development in terms of comprehensive training experience and on-the-job supervision.

For questions, please contact CT BHP/Beacon Health Options at 877-552-8247, Options 1, 2, 7 and request to speak with Provider Relations

Additional Information on **CT Medicaid Enrollment**

Gainwell Technologies is the fiscal agent for Medicaid. Please note that Gainwell Technologies requires an on-line enrollment process through their website that is separate and in addition to the CT BHP/Beacon Health Options Qualification. They will not accept paper applications. Their website is www.ctdssmap.com.

A link to Provider Enrollment can be found on the navigation menu (left side of home page) or under the Provider tab on the menu bar at the top of the page.

Note on the online enrollment:

- Have all your information with you (including a copy of your CTBHP/Beacon Health Options Qualification Letter).
- Ensure you have time to complete the entire application (40 minutes or so) as the website does not allow you to save or keep the application in progress.
- Once you complete the on-line portion it will give you a tracking number (ATN) and links to the forms you will need to print, complete, sign and submit to Gainwell. Put your tracking number on these forms so enrollment staff can link them to the online portion you submitted. If you have any questions regarding the application, the number for **Gainwell Technologies** is **1-800-842-8440**.
- You will be provided an AVRS number through Gainwell Technologies in writing. This AVRS number is needed to complete online set up of username and password in order to access the Provider Secure Site

You can also visit the ASD Resource page on the CT BHP website <https://www.ctbhp.com/asd.html> to view the listing of ASD Reimbursement Rates and Codes

Feel free to contact our Provider Relations Department if you have any questions at 1-877-552-8247, Options 1, 2, 7.

We look forward to working with you.

I, _____ do hereby authorize the Department of Children and Families to research <i>Applicant Name</i>						
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 <i>(check one)</i> :						
<input type="checkbox"/> Employment <input type="checkbox"/> Day Care <input type="checkbox"/> Volunteer <input type="checkbox"/> Intern <input type="checkbox"/> Mentor <input type="checkbox"/> Other:						
Name of Agency:				Attention:		
Address: (No. and Street):		Apartment #	City:		State:	Zip:
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 Department. of Children and Families in their search.						
Last Name		First Name:		Middle:	DOB:	SS:
Address: (No. and Street):		Apartment #:	City:	State:	Zip:	Years at current address?: Years Months
Previous Address(es)/List All for the Last Five Years <i>(continue on reverse side of form if necessary)</i>						<input type="checkbox"/> Check if reverse side used
Address: (No. and Street):		Apartment #:	City:	State:	Zip:	Dates From: (Month/Year) Dates To: (Month/Year)
Other Names I have Used – <i>Including Maiden, Previous Marriages(s) (continue on reverse side of form if necessary)</i>						<input type="checkbox"/> Check if reverse side used
Last Name		First Name:		Middle:	DOB:	SS:
Name of Spouses/Other Adults in the Home – <i>Past and Present (continue on reverse side of form if necessary)</i>						<input type="checkbox"/> Check if reverse side used
Last Name		First Name:		Middle:	DOB:	Signature (if still in Home) Date:
Names of ALL Child(ren) – <i>Biological, Stepchildren Including Adult Children In or Out of the Home</i>						<input type="checkbox"/> Check if reverse side used
Last Name		First Name:		Middle:	DOB:	Gender:
Do you have an active DCF investigation at this time? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have an active appeal of a DCF investigation at this time? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Applicant Signature:					Date:	
THIS AUTHORIZATION WILL EXPIRE 180 DAYS AFTER THE DATE OF THE SIGNATURE. FORMS NOT FILLED OUT COMPLETELY AND / OR 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 <i>DCF-CT Careline CPS-BGC USE ONLY - DO NOT WRITE BELOW THIS LINE</i>						
Date:		Central Registry?: <input type="checkbox"/> Yes <input type="checkbox"/> No			Processors Initials:	