Qualification by Beacon Health Options to be a Waiver Provider of Autism Services

The following application process is for individuals interested in the Waiver program 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 within 60 days of receipt.

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)
☐ 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.*

☐ 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)
☐ 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 CTBHP 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 CTBHP/Beacon Health Options at 877-552-8247 and request to speak with Provider Relations.

Department of Children and Families
AUTHORIZATION FOR RELEASE OF INFORMATION FOR DCF CPS SEARCH
DCF-3031
12/15 (Rev.)

I, _____ do hereby authorize the Department of Children and Families to research
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:

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 *(continue on reverse side of form if necessary)* ☐ 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 – *Including Maiden, Previous Marriages(s) (continue on reverse side of form if necessary* ☐ Check if reverse side used

Last Name	First Name:	Middle:	DOB:	SS:

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

Last Name	First Name:	Middle:	DOB:	Signature (if still in Home)	Date:

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

Last Name	First Name:	Middle:	DOB:	Gender:

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

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

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

Date:	Central Registry?: ☐ Yes ☐ No	Processors Initials: