**Procedure No.:** I.G.PR.007 **Issue Date:** October 1, 2012

**Subject: Qualifying Providers** **Effective Date:** Upon Release

**Section:** Contracted Services **Approved:**/s/Terrence W. Macy/JD

1. **Purpose**

The purpose of this procedure is to outline the process by which private agencies, organizations and individual practitioners enroll as a new qualified provider or existing qualified provider’s request to add a service. The following services are available: adult companion, adult day health, group day, individualized day support, individualized home supports, personal support, residential habilitation, supported employment, respite care, transportation, clinical behavior support, healthcare coordination, interpreter service, and nutrition.

1. **Applicability**

This procedure applies to the staff of the DDS Operations Center, Waiver Policy Unit, Quality Management, Resource Administration, private provider agencies and individual practitioners.

1. **Definitions**

Assurance Agreement: A standardized agreement signed and initialed by the agency, organization or individual practitioner that assures, as part of the enrollment process, delivery of services and supports that meet specified requirements through demonstration of knowledge and adherence to DDS policy and practices.

Border town: A town just over the Connecticut state line where a provider is seeking to provide a service not available in Connecticut.

Connecticut Administrator: The designated person primarily responsible for the overall management, operation and provision of services in Connecticut for the entity.

Continuous Improvement Plan: A plan developed by the provider that involves stakeholders in a process to assess the strengths and weaknesses of the agency, analyze the causes of any weakness and identifies improvement strategies.

Continuity of Operations Plan (COOP): A plan that describes the priority functions and services of the provider, strategies to maintain critical services based on a number of assumptions, documents many of the resources needed to perform these services and identifies an Incident Management Team capable of addressing disruptions to normal provider operation.

Individual Practitioner: An individual whether incorporated or as a sole proprietorship who provides only Clinical Behavioral Supports or Healthcare Coordination and does not employ others to assist with the clinical or programmatic aspects of the work.

Operations Center: The Central Office unit responsible for the certification and enrollment of qualified providers, participation in the rate setting process, management of the Purchase of Service Contract system of payment and cost reporting for private providers, management of the Fiscal Intermediary contracts, and management of the department’s fiscal spend plan for private services.

Planning and Resource Allocation Team (PRAT)– A regional team chaired by the DDS Planning, Resource Allocation Team (PRAT) Coordinator, and comprised of DDS representatives from Resource Management, Case Management Supervision, Business Office, Family Support, and Regional Administration. This team manages the process whereby DDS identifies available resources, identifies individual Participant needs, assigns priority determination, implements DDS Planning and Resource Allocation policies and procedures, makes recommendations regarding applicants for the HCBS waiver, processes allocation of resources, and makes referrals to available out-of-home residential group living settings and Contractor-based day services.

Principal of the Entity: The designated person primarily responsible for the overall management, operation and provision of services within the entity.

Primary Region: The region designated as the lead region to coordinate administrative activities, if a qualified provider provides supports in two or more regions. Determination may be based on where the greatest numbers of clients are served or location of the provider’s administrative headquarters (negotiable between regions and central office).

Provider Agreement: Each agency upon approval by DDS must enter into a Provider Agreement with the Medicaid agency (DSS). DSS will hold the Provider Agreements and will make payments on behalf of the Medicaid agency (DSS).

Qualified Provider: Agency, organization or individual practitioner that meets the criteria defined below as a prerequisite to providing support services to an individual or group of individuals with intellectual disabilities. Qualified Providers are knowledgeable of the current practices in the field, adhere to the DDS policy and procedures, and follow the requirements and guidelines detailed in the DDS provider Assurance Agreement.

 Quality Management: The Central Office unit responsible for the overall establishment and maintenance of a system to provide monitoring of services to assure compliance with applicable health and welfare standards and evaluate individual outcomes and satisfaction.

Resource Administration: The regional unit responsible for providing oversight and technical assistance to qualified providers of services and supports, and coordinating payments for services to private providers. The Resource Administration unit coordinates with the Regional PRAT on resource allocation management.

Waiver Policy Unit: The Central Office unit responsible for the development of policies and procedures providing notification to participants of service reduction or denial decisions, and the provision of training and technical assistance. This unit participates with DSS in the submission of waiver applications and amendments to CMS, and in the development of required quality monitoring reports to CMS.

1. **Implementation**

Private agencies or individual practitioners seeking to deliver services and supports for the Department of Developmental Services (DDS) must apply to become a Qualified Provider. The three-part process is established to maintain an adequate number of quality providers to meet the needs and supports of the individuals served by DDS. The enrollment process includes a complete review of the enrollment packet including all applicable policies and procedures, a background check of the Principal of the Entity and/or the Connecticut Administrator and an agency interview conducted by the Qualified Provider Committee. Interviews for the individual practitioner will be at the discretion of the Operations Center’s Director and clinical designee.

1. **Minimum Qualifications**

An application will only be processed for the supports and services for which the provider has met the minimum qualifications.

1. Individual Practitioners:
2. Behavioral Support Services:
3. Doctorate and current licensure in psychology (Licensure per CGS Chapter 383), or current certification as a Board Certified Behavioral Analyst (BCBA) or Master’s degree in psychology, special education, social work or a related field.  Proof of Licensure per CGS Chapter 383b (Licensed Clinical Social Worker), or Licensure per CGS Chapter 383a or 383c (Marriage and Family Therapist or Professional Counselor) as applicable.
4. Two years of experience providing behavioral supports to people with developmental disabilities.
5. Healthcare Coordination:
6. A Registered Nurse (RN) licensed in the State of Connecticut with at least two years of nursing experience
7. Relevant experience with people served by DDS or individuals with behavioral health needs.
8. Qualified Provider – The minimum qualifications for providers will be determined by the support category in accordance with the Provider Minimum Qualifications for Support Categories document. (See I.G.PR.007Attachment J: [Provider Minimum Qualifications for Support Categories](http://www.ct.gov/dds/lib/dds/dds_manual/ig/igpr007_attachment_j_provider_minimum_qualifications_for_support_categories.pdf))
9. **Application to Become a Qualified Provider**

A working email is a prerequisite for all qualified providers. The enrollment process, application and required forms that the provider must complete, will be available on the DDS Website. An agency must provide services in Connecticut or an approved bordertown based on the uniqueness of that service and the availability of that service in Connecticut.

A provider must submit to the Operations Center a complete enrollment packet with all components meeting the DDS standards before verification of credentials can occur. The Operations Center reviews the enrollment packet for content and completeness. Any missing or unacceptable items will be detailed in an email to the provider. After two submittals the provider’s application will be deferred in order to process other applications. After three submittals the provider’s application will be denied for any waiver services for a period of six months, after which time an agency can begin a new application process. An enrollment packet that has been inactive for more than six months will be discarded. Components of a complete enrollment packet will include:

1. Individual Practitioners of Clinical Behavioral Support or Healthcare Coordination must submit the following:
2. Provider Application
3. Assurance Agreement to deliver services according to criteria specified in the DDS HCBS Waiver Manual and this document; maintain required documentation and follow relevant DDS policies and procedures for all employed providers of this waiver service.
4. Provider Agreement
5. An acknowledgement of Receipt of the DDS False Claims Act Policy and Procedure
6. Confidentiality and HIPAA Assurance Agreement
7. A copy of incorporation papers (as applicable)
8. List any other people with ownership or shares in the corporation (as applicable)
9. A letter of intent describing the services the applicant intends to provide, any special population to be served and geographic areas the applicant intends to serve.
10. Résumé or Curriculum Vita and university diploma. Résumé should highlight the individual’s entire professional experience and the qualifications that directly impact their ability to provide the desired service.
11. A copy of current professional clinical license or certificate (as applicable).
12. Three current letters of reference that clearly identify who the reference is for and the name, phone number and address of the individual supplying the reference. At least one reference should be from a clinician familiar with the applicant’s professional work and that references evidence of positive outcomes for individuals resulting from interventions designed and implemented or overseen by the applicant.
13. 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. Will provide documentation of such coverage annually and upon request.
14. Clinical Behavioral Support Services only: A sample of recent work (two samples of functional analyses or assessments and behavioral support plans including methods for increasing adaptive behaviors and decreasing maladaptive or challenging behaviors).
15. New Agency Qualified Provider
16. Provider Application
17. Signed Assurance Agreement to deliver services according to criteria specified in the DDS HCBS Waiver Manual and this document; maintain required documentation and follow relevant DDS policies and procedures for all employed providers of this waiver service.
18. Provider Agreement
19. An acknowledgement of Receipt of the DSS False Claims Act Policy and Procedure
20. A copy of incorporation papers
21. Mission statement or philosophy of the organization on providing supports to individuals with intellectual disabilities
22. Board composition that includes name, title of position on the board, profession, and length of terms. If the organization is not required to have a Board of Directors, the agency must establish an Advisory Board that should include representation by at least one self-advocate or a parent of a person with intellectual disabilities. A list of members of the Advisory Board must include their title, professional relationship to the organization, and length of terms. An agency that will provide only Clinical Behavioral Supports or Healthcare Coordination will not need to establish an Advisory Board. However, if that agency decides to add services at a later time, the agency must submit their Board composition.
23. A description of the agency/organization’s experience and qualifications that directly impact the ability to provide the desired service or services.
24. Table of organization or current structure including names, titles and programs.
25. Financial audit or evidence of line of credit and source to demonstrate financial stability.
26. Certificate of insurance or certificate of insurability to demonstrate that the organization has or is able to acquire sufficient general liability insurance.
27. For existing organizations, a Strategic Plan must be submitted that demonstrates how DDS supports fit into the existing organization.
28. If this is a new agency, the organization must submit a Business Plan that details the goals of the organization and how they are to be attained. At a minimum, the plan should include a narrative describing the new entity, goals and objectives, a three-year timeline, and a budget based on growth projections.
29. Principal of the Entity’s résumé highlighting the individual’s entire professional experience and the qualifications that directly impact their ability to provide the desired service.
30. Connecticut Administrator’s résumé, if different than the Principal of the Entity, highlighting the individual’s entire professional experience and the qualifications that directly impacts their ability to provide the desired service.
31. If the entity is a partnership or a Limited Liability Corporation (LLC), all the principals must submit their résumé highlighting each individual’s entire professional experience and the qualifications that directly impacts their ability to provide the desired service.
32. Letters of support or references from current or past individuals or entities for which the organization, the Connecticut Administrator, and/or the Principal(s) of the Entity has conducted similar services. There must be three (3) letters each for the organization, the Connecticut Administrator, and/or the principal(s) that clearly identifies who the reference is for and the name, phone number and address of the individual supplying the reference. DDS is required to verify these references.
33. Policy statement and agency procedures must be submitted in accordance with the Supports and Services Policy and Procedure guide.
34. New provider agencies who want to provide the Clinical Behavioral Support or Healthcare Coordination must complete all the requirements for a new qualified provider as specified in the Components of a Complete Enrollment Packet. In addition, the following must also be submitted on the clinician(s) who will provide this service for the agency.
35. Résumé or Curriculum Vita and university diploma.
36. A copy of current professional clinical license or certificate (as applicable).
37. Three current letters of reference and contact information—at least one of which is from a clinician familiar with the applicant’s professional work and which references evidence of positive outcomes for individuals resulting from interventions designed and implemented or overseen by the applicant.
38. Clinical Behavioral Support Only: A sample of recent work (two sample functional analysis or assessment and behavioral support plans including methods for increasing adaptive behaviors and decreasing maladaptive or challenging behaviors).
39. **Review of Policies and Procedures**

An agency’s policies and procedures will be reviewed by the Operations Center and staff with expertise in the area. Providers will be notified via email of procedures that do not meet DDS requirements and require revision. All policies and procedures must be accepted by DDS before the application can continue to be processed.

1. **Background Check and Verification of Credentials**

Each agency must designate an individual who will be the primary person responsible for the overall management, operation and provision of services for the entity in Connecticut. The Operations Center will complete a background check and verify the credentials of the Connecticut Administrator and/or the Principle of the Entity/Connecticut Administrator. The provider may submit a recently completed background check on the Principle of the Entity/Connecticut Administrator to facilitate the qualification process. The Operation Center reserves the rights to request a background check to verify the information. In the case of an individual practitioner, partnership or LLC, the Operations Center will verify the credentials of the individual practitioner, owner(s) or partner(s).

1. The following items will be performed:
	1. Criminal Background Check.
	2. Verification of Licenses and certifications.
	3. A check of the CT Sexual Offenders Registry.
	4. A check of the DDS/DCF Abuse and Neglect Registry.
	5. A check the Office of Inspector General Fraud online database and the System for Award Management
	6. Survey other state agencies and regional contacts regarding the quality of supports and if any sanctions or revocations of contracts with this provider or principal have occurred.
2. Agencies or individual practitioners whose credentials have been deemed to be unacceptable will be disqualified from becoming a qualified provider. In addition, Qualified Provider status will be denied if the verification process of the Principal of the Entity, Connecticut Administrator or the individual practitioner has found any of the following:
3. Name is listed on the Office of Inspector General Fraud online database.
4. Name is listed on the System for Award Management online database
5. Name is listed on either the Sexual Offender or the DDS Abuse and Neglect Registry.
6. Falsification of information on the Qualified Provider Application or résumé.
7. A criminal record is identified on the Background Check.
8. In the event that the Principal of the Entity, Connecticut Administrator or the individual practitioner has been convicted of one or more offense, the Operations Center must review the following factors:
9. Applicant’s age at the time the offense was committed.
10. Mitigating factors at the time the offense was committed (substance abuse, self defense, etc.)
11. Number of offenses for which the individual was convicted.
12. Efforts and success at rehabilitation.
13. The amount of time since the offense was committed.
14. The likelihood the offense will be repeated.
15. Individual’s employment related references (history) since committing the offense.
16. The relationship between the job and the offense committed.
17. The training, structure and supervision available on the job.

The Department reserves the right to deny qualified provider status if the Principal of the Entity, Connecticut Administrator or the individual practitioner has a criminal record with offenses generally represented as felonies that include crimes against persons with intellectual disabilities, crimes that hold potential for serious harm to individuals and their families who receive services or supports from the Department. Sanctions, substantiated fraudulent activity, and/or revocations of a contract by the organization, the Principal of the Entity, the Connecticut Administrator or the individual practitioner in his/her current or former employment may be grounds for disqualification depending on the individual circumstances upon which the sanction or revocation occurred.

1. A provider whose credentials are verified as acceptable by the Operations Center will be referred to the Qualified Provider Committee/Operations Center’s clinical designee.
2. **Qualified Provider Interview - Individual Practitioners**

Interviews for the individual practitioner will be at the discretion of the Operations Center’s Director or clinical designee. The Operations Center’s clinical designee will recommend approval/denial of an applicant to the Director of the Operations Center.

1. An individual practitioner will be denied qualified provider status based on any of the following:
2. Failure to demonstrate a thorough understanding of behavioral principles and their application to supporting people with intellectual disabilities or autism.
3. A lack of relevant experience working with people with intellectual disabilities or autism.
4. Any misrepresentation of credentials or experience.

1. The Operations Center will notify the individual practitioner of the results of their application request. Any provider submitting an application may request to meet with the Director of the Operations Center to review the decision. This review is not a formal hearing process.
2. **Qualified Provider Committee – Agency**

After an acceptable review of an agency’s application and verification of credentials, the Qualified Provider Committee will interview the Connecticut Administrator and agency representatives. The Committee will recommend to the Director of the Operations Center the agency approval or denial of an agency’s application. The decision of the Director of the Operations Center will be deemed final. If denied qualified status, providers may submit a new application one year after the official notice of being disqualified.

1. Qualified Provider Committee
2. The Qualified Provider Committee will consist of designated representatives from Resource Administration, the Operations Center, Quality Management Services, Case Management, Waiver Unit, Autism Division, self-advocates and other areas of the Department as needed.
3. A quorum will consist of a minimum of three representatives.
4. The Committee will meet on a quarterly basis depending on the availability of acceptable candidates.
5. The Committee will review the enrollment packet prior to the interview.
6. Interview Process
7. The Committee will interview the Principal of the Entity/ Connecticut Administrator and other representatives of the agency as determined by the provider.
8. The Committee will have a set list of questions developed prior to the interview.
9. One of the Committee members will be charged with the task of documenting the responses provided by the applicant.
10. Committee members will be allowed to ask follow up questions to clarify an applicant’s response.
11. Following the interview, the Qualified Provider Committee will discuss the findings and prepare a recommendation to the Director of the Operations Center.
12. The recommendations shall reflect one of the following:
13. Approval as a qualified provider for all requested services. The agency shall be qualified to provide the full range of supports requested on their application. The agency, the Principal of the Entity and/or the CT Administrator has:
14. the required number of years of experience in the field
15. the required experience of providing quality supports for DD and/or similar services
16. the applicant’s support strategies are in line with the DDS mission statement
17. the supports strategies match the organizational structure and staffing patterns
18. the Business Plan is well thought out and attainable.
19. Approval as a qualified provider for a limited number of services. The supports are limited in scope to allow the organization a means to acquire valuable experience working with individuals with intellectual disabilities and to better understand the many facets of the organizational requirements established by DDS. The Committee may qualify the provider for residential supports, day supports or both. Day supports may be further limited to individualized supports and group day services. Residential supports may be further limited to providing supports only in non-licensed non-twenty-four hour settings. Examples of factors that may limit an organization from providing the requested supports include:
20. The agency, the Principal of the Entity, and/or the Connecticut Administrator have limited experiences in the field or
21. The agency, the Principal of the Entity, and/or the Connecticut Administrator have limited experience managing programs for individuals with intellectual disabilities or
22. There is no history of providing quality supports for individuals with intellectual disabilities with DDS, but the organization, the Principal of the Entity, and/or the Connecticut Administrator have similar experience in other state agencies or in other states with other non-DDS populations or
23. The supports strategies do not match the organizational structure and staffing patterns or
24. The Business Plan is well thought out but is contingent on a number of factors that raise questions if all or part of the plan is unattainable. Or
25. The agency lacks a financial base for operating the target programs.

If the provider has been qualified for fewer services than was requested on their application, the Committee will detail the steps and any specific conditions the provider will need to take to become qualified to provide additional supports. These may include what additional expertise the staff will need, the number of years the organization must maintain qualified provider status while providing supports to individual consumers of the Department, resubmission of the Business Plan addressing the concerns of the Committee, and any other items the Committee may deem necessary.

1. The agency is denied qualified provider status. The Committee disqualifies the organization due to one or more of the following factors:
2. The agency, the Principal of the Entity, and/or the Connecticut Administrator have limited experiences in the field or
3. The agency, the Principal of the Entity, and/or the Connecticut Administrator have limited experience managing programs for individuals with intellectual disabilities or
4. There is no history of providing quality supports for individuals with intellectual disabilities with DDS and the organization, the Principal of the Entity, and/or the Connecticut Administrator do not have similar experience in other state agencies or in other states with other non-DDS populations or
5. The support strategies are not designed to achieve the objectives of the DDS mission statement.
6. The supports strategies do not match the organizational structure and staffing patterns or
7. The Business Plan is contingent on a number of factors that are unattainable or
8. The agency lacks a financial base for operating the target programs.
9. The Operations Center will notify the provider of the results of their application request. Any provider submitting an application may request to meet with the Director of the Operations Center to review the Committee’s decision. This review is not a formal hearing process.
10. The Director of the Operations Center may exempt the interview requirement for agencies that will be providing only Clinical Behavioral Supports, Healthcare Coordination, nutrition or transportation. If an interview is not conducted, the Director of the Operations Center will approve the application based on the recommendation of the clinical designee.
11. **Orientation for Individual Practitioners**

All Individual Practitioners that are qualified will be provided with an orientation packet containing Department and regional information, documentation, billing and other requirements as a qualified provider of a waiver service. Individual practitioners will be encouraged to attend the provider training but attendance is at their own discretion.

1. **Mandatory Orientation for Agency Qualified Providers**

The designated Principal(s) of the Entity/Ct Administrator must attend orientation provided by DDS before the organization can provide supports to individuals served by the Department.

1. The Department will offer Provider orientation based on a standardized training curriculum to be presented by staff from one of the DDS regions on a rotating basis at least once every three months.
2. The training will include applicable DDS policies, procedures and directives, and presentations on the following: Case Management Services, Placement and Resource Allocation Team, Self Determination, Individual Budgets, Resource Administration, Quality Service Reviews, Quality Improvement, Health Services, Clinical Services, Abuse and Neglect, process for Request for Proposals (RFP), and regional contact information.
3. The provider is encouraged to have additional agency staff participate in this orientation.
4. The regions will maintain a list of providers who attend the training. The list will be sent to the Operations Center.
5. When training is deemed mandatory for an agency’s personnel, they must be present for the entire training.
6. **Notification of Qualified Provider Status**
	* + 1. Individual Practitioner Notification

The Operations Center will send the official notification of qualified services to the individual practitioner and will add them to the qualified provider list. Upon receipt of the official notice, the individual practitioner will be able to begin to provide supports to individuals of the Department for services for which they have been qualified.

* + - 1. Agency Notification

Afterconfirmationhas been received that the designated CT Administrator/ Principal of the Entity has attended the mandatory orientation, the Operations Center will send the official notification of qualified services to the agency and will add the organization to the qualified provider list. Upon receipt of the official notice, the provider will be able to begin to provide supports to individuals of the Department for only those services for which the organization has been qualified.

1. **Amendment to Services**
2. Qualified Providers requesting to amend their services must submit an “Application to Amend Services for Qualified Providers” form to the Operations Center. Qualified Providers must be in good standing with DDS, meet the minimum qualifications of the requested support category and may be required to submit additional policies and procedures based on the new service.
3. Qualified Providers may add Clinical Behavioral Support and Healthcare Coordination if they are in good standing with DDS and meet the qualifications of the services by submission to the Operations Center of the following:
4. Application to Amend Services for Qualified Providers
5. Letter of Intent describing the services the applicant intends to provide, a description of the participants(s) to be supported, the geographic areas applicant intends to serve and a description of the initial training the clinician will receive on DDS policies and procedures.
6. A procedure on clinical oversight and ongoing educational training.
7. The following documents for each clinician who will provide Clinical Behavioral Support or Healthcare Coordination for the agency:
8. Résumé or Curriculum Vita and university diploma
9. A copy of current professional clinical license or certificate (as applicable)
10. Three current letters of reference and contact information—at least one of which is from a clinician familiar with the applicant’s professional work and that references evidence of positive outcomes for individuals resulting from interventions designed and implemented or overseen by the applicant.
11. Clinical Behavioral Support Services Only: A sample of recent work (two sample functional analysis or assessment and behavioral support plans including methods for increasing adaptive behaviors and decreasing maladaptive or challenging behaviors)
12. Existing qualified provider agencies already providing Clinical Behavioral Support and Healthcare Coordination must submit the following to add new clinicians:
13. A procedure on clinical oversight and ongoing educational training. (if not previously sent).
14. The following documents must be submitted for each clinician who will provide Clinical Behavioral Support or Healthcare Coordination for the agency:
15. Résumé or Curriculum Vita and university diploma
16. A copy of current professional clinical license or certificate (as applicable)
17. Three current letters of reference and contact information—at least one of which is from a clinician familiar with the applicant’s professional work and that references evidence of positive outcomes for individuals resulting from interventions designed and implemented or overseen by the applicant.
18. Clinical Behavioral Support Only: A sample of recent work (two sample functional analysis or assessment and behavioral support plans including methods for increasing adaptive behaviors and decreasing maladaptive or challenging behaviors).
19. **Change of Principal of the Entity**

All qualified providers are required to notify the Operations Center of a change in the Principal of the Entity or the Connecticut Administrator. Prior to the new persons’ employment, the provider must submit a Criminal Background Verification Certificate for a Change in Principal of the Entity, Connecticut Administrator, Partnership or LLC along with a signed Assurance Agreement to the Operations Center. The Operations Center will complete a criminal background check with the Connecticut State Police. The provider may submit a recently completed background check on the Principle of the Entity/Connecticut Administrator to facilitate the qualification process. The Operation Center reserves the rights to request a background check to verify the information. The provider will be informed of any recorded convictions that have not been previously reported to DDS by the agency. A Principal of the Entity/CT Administrator whose criminal background has been deemed to be unacceptable (as described in IV. 2) would be cause to disqualify the agency from providing services should the entity employ the individual. If the new staff is the designated Administrator for Connecticut, then the individual must attend the Provider Orientation within 30 days from the date of hire or until the next mandatory Orientation is offered. Failure to attend this orientation within the stated timeframe may result in the suspension of providing supports to new referrals.

In case of a partnership or LLC, any change in the ownership or partners must be reported to the Operations Center. The Operations Center may require the reconstructed LLC or partnership to reapply as a provider. The provider must submit a Criminal Background Verification Certificate for a Change in Principal of the Entity, Connecticut Administrator, Partnership or LLC along with a new Assurance Agreement to the Operations Center for any new owner(s) or partner(s). The Operations Center will verify the criminal background check with the Connecticut State Police. The provider will be informed of any recorded convictions that have not been previously reported to DDS by the agency. An owner or partner whose criminal background has been deemed to be unacceptable would be cause to disqualify the organization from providing services should the entity proceed with the change. If the new owner(s) or partner(s) is the designated administrator for Connecticut, then the individual must attend the Provider Orientation within 30 days from the day he/she is designated or until the next mandatory Orientation is offered. Failure to attend this orientation within the stated timeframe may result in the suspension of providing supports to new referrals.

1. **Maintaining Qualification Status**
	* 1. It is the responsibility of all qualified providers to submit updated agreements and documentation of credential maintenance (i.e., license renewal) to DDS in a timely manner.
		2. Notify DDS of any changes to the provider’s email address.
		3. Notify DDS of any changes to the name of the corporation.
		4. Qualified providers that provide Behavioral Supports or Healthcare Coordination must notify DDS when a clinician fails to meet the licensing or certification requirements and/or the clinician leaves the employ of the provider. Failure to comply with this requirement may result in the removal from the list of approved providers of services. Under no circumstances can a provider bill a Fiscal Intermediary or DDS for Behavioral Supports or Healthcare Coordination performed by an unqualified, unlicensed and/or non-certified clinician.

**E. References:**

None

**F. Attachments:**

I.G.PR.007Attachment A: [Application for Qualified Providers](http://www.ct.gov/dds/lib/dds/dds_manual/ig/igpr007_attachment_a_application_for_qualified_providers.doc)

I.G.PR.007Attachment B: [Agency Assurance Agreement](http://www.ct.gov/dds/lib/dds/dds_manual/ig/igpr007_attachment_b_agency_assurance_agreement.doc)

I.G.PR.007Attachment C: [Clinical Behavioral Support Services-Individual Practitioner Assurance Agreement](http://www.ct.gov/dds/lib/dds/dds_manual/ig/igpr007_attachment_c_clinical_behavioral_support_services_assurance_agreement.doc)

I.G.PR.007Attachment D: [Healthcare Coordination–Individual Practitioner Assurance Agreement](http://www.ct.gov/dds/lib/dds/dds_manual/ig/igpr007_attachment_d_healthcare_coordination_assurance_agreement.doc)

I.G.PR.007Attachment E: [Confidentiality and HIPAA Assurance Agreement](http://www.ct.gov/dds/lib/dds/dds_manual/ig/igpr007_attachment_e_confidentiality_and_hipaa_assurance_agreement.doc)

I.G.PR.007Attachment F: [DSS Provider Agreement](http://www.ct.gov/dds/lib/dds/dds_manual/ig/igpr007_attachment_f_dss_provider_agreement.doc)

I.G.PR.007Attachment G: [Acknowledgement of Receipt of DDS False Claims Act Policy and Procedure](http://www.ct.gov/dds/lib/dds/dds_manual/ig/igpr007_attachment_g_acknowledgement_of_receipt_of_dds_false_claims_act_p_p.doc)

I.G.PR.007Attachment H: [Criminal Background Verification Certificate for a Change in Principal of the Entity, Connecticut Administrator, Partnership or LLC](http://www.ct.gov/dds/lib/dds/dds_manual/ig/igpr007_attachment_h_criminal_background_verification_certificate.doc)

I.G.PR.007Attachment I: [Supports and Services Policy and Procedure Guide](http://www.ct.gov/dds/lib/dds/dds_manual/ig/igpr007_attachment_i_supports_and_services_policy_and_procedure_guide.doc)

I.G.PR.007Attachment J: [Provider Minimum Qualifications for Support Categories](http://www.ct.gov/dds/lib/dds/dds_manual/ig/igpr007_attachment_j_provider_minimum_qualifications_for_support_categories.pdf)