Agency Credentialing Application

Rehabilitative and Support Services

Home and Community Based Services (HCBS)
Money Follows the Person (MFP)/ Mental Health Waiver
WORKING for INTEGRATION, SUPPORT and EMPOWERMENT (WISE)

Agency Name:

Return all requested material to:

Advanced Behavioral Health, Inc.
213 Court Street
Middletown, CT 06457

Attn: Kristie Scott, Program Manager

Please remember to make a copy of all documentation submitted.

The Agency is Applying for Participation to Provide the Following Services:

Check all that apply:

- ☐ Assertive Community Treatment-**RFP awarded agencies only**
- ☐ Community Support Program
- ☐ Peer Support- **Not currently open for credentialing**
- ☐ Recovery Assistant
- ☐ Short Term Crisis Stabilization
- ☐ Supported Employment- **RFP awarded agencies only**
- ☐ Transitional Case Management

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HCBS WISE Credentialing Overview:

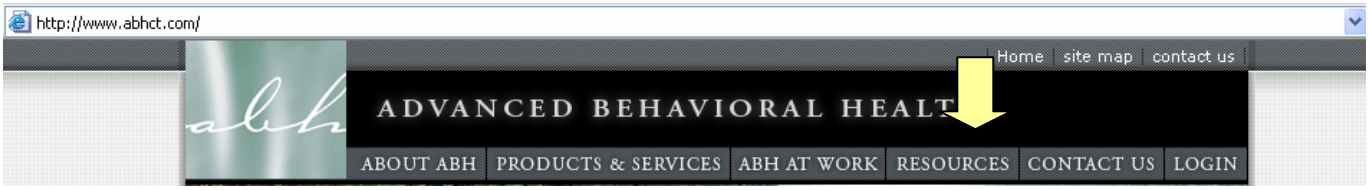
Only providers that have been credentialed and that have an executed provider agreement with Advanced Behavioral Health, Inc. (ABH) will be eligible to provide the following services through the Home and Community Based Services (HCBS) Waiver Program:

Assertive Community Treatment	Short Term Crisis Stabilization
Community Support Program	Support Employment
Peer Supports- Not currently open	Transitional Case Management
Recovery Assistant	

The process:
When ABH receives a complete credentialing application(s) the Provider will be notified within ten days if they have been credentialed to provide services. If items are missing or left blank from the application that Provider will be contacted and the items should be submitted in a timely manner. Credentialing approval will not be granted until the application is complete. Once credentialed the Provider will be added to a Provider Network List and may begin providing services.

Resources:

On the ABH web site – www.abhct.com select the "Resource" tab and then "WISE".



There are additional resource and qualifications on the DMHAS web site at
http://www.ct.gov/dmhas/site/default.asp

SECTION I

GENERAL AGENCY INFORMATION

Agency/Provider Name:			
DBA (if applicable)			
Mailing Address:			
City, State, Zip			
Phone Number ( ) -	Fax Number ( ) -		
Billing Address (if different from above):			
City, State, Zip			
Tax ID Number/EIN:	NPI:	Medicaid Provider ID:	501c3 ID:
What percentage of the organization's fee-for-service business is billed electronically? %			

CONTACT INFORMATION

Chief Executive Officer:	Phone: ( )
E-Mail:	Fax: ( )
Credentialing/Certification Contact:	Phone: ( )
E-Mail:	Fax: ( )
Billing Contact:	Phone: ( )
E-mail:	Fax: ( )

Business Classification

1. Ownership: ☐ Private ☐ Public ☐ State Operated Program

2. Status: ☐ For-Profit ☐ Non- Profit

Prior Credentialing

Has your agency been credentialed for other services by ABH, Inc in the last three years? ☐ Yes ☐ No

SECTION II

The following information/documentation is mandatory to complete the Credentialing process:

1. Copy of Current Agency License (either DPH or DCF)

2. Copy of current Accreditation Certification from either CARF (Commission on Accreditation of Rehabilitative Services) or The Joint Commission.

3. For agencies providing Recovery Assistant services only , if the agency is not JOINT or CARF accredited, please provide verification of one of the following accreditations or certifications: Medicare certification, CHAP (Community Health Accreditation Program) or ACHC (Accreditation Commission for Health Care)

4. Copy of any other nationally recognized Accreditations

5. Copy of Insurance Cover page for Malpractice/ Professional Liability and General Liability
    i. Limit coverage's must be at least $1,000,000 per occurrence/$3,000,000 in the annual aggregate
    ii. All addresses for all sites/locations covered by the policy

6. Signed DSS Performing Provider Agreement- Each agency must complete, even if currently enrolled through DSS

7. Signed ABH Service Agreement

History of Agency Sanctions, Malpractice Claims and/or Adverse Events

Please complete this section in its entirety. If a question does not apply to your facility, you may check Not Applicable (N/A). ***In the last five years:***	Yes	No	N/A
Has the agency's state license/certification ever been revoked, suspended, or limited?	☐	☐	**X**
Is there action pending to revoke, suspend or limit the agency's license/certification?	☐	☐	**X**
Has the agency ever had its Joint Commission accreditation revoked, suspended, or limited?	☐	☐	☐
Is there action pending to revoke, suspend, or limit the agency's Joint Commission accreditation?	☐	☐	☐
Has the agency ever had its CARF accreditation revoked, suspended, or limited?	☐	☐	☐
Is there action pending to revoke, suspend, or limit the agency's CARF accreditation?	☐	☐	☐
Has the agency ever had any OTHER (i.e. COA,CHAP, ACHC, AOA, etc.) certification/accreditation revoked, suspended or limited?	☐	☐	☐
Is there action pending to revoke, suspend, or limit the agency's OTHER (i.e. COA, AOA, etc) certification/accreditation?	☐	☐	☐
Has the agency ever had any sanctions imposed by Medicare and/or Medicaid?	☐	☐	**X**
Has the agency ever been denied professional liability insurance or has its insurance ever been canceled, suspended, otherwise limited or denied renewal?	☐	☐	**X**
Has the agency ever been a defendant in any lawsuit regarding the practice of mental health or substance abuse treatment where there has been an award or payment of $50,000 or more?	☐	☐	**X**
Has the agency had any malpractice claims regarding the practice of mental health or substance abuse treatment where there has been an award or payment of $50,000 or more?	☐	☐	**X**

Note: If you have answered yes to any of the above questions, please complete the form on the next page by providing the current status and details. Please include the following: description of incident, including correspondence with state licensing boards, and/or a detailed description of any litigation, including settlements, court awards, etc. Please feel free to include a personal summary of the events. However, your application cannot be processed without the necessary official documentation.

Completed and signed by:_____ **Date:** _____
(All signatures must be original)

Agency Malpractice Claims/Suit History

(copy and complete this form for each additional claim/suit)
This form is only completed if you answered "yes" to any item listed on page 6 of this application

Name of Claimant:_____

Date of Alleged Incident:_____**Date Lawsuit Filed**:_____

Name of Court and Case Number:

Court:_____

Case Number:_____

Provide, in detail, the nature of the allegation of wrongdoing/negligence: (attach separate page, if necessary)

_____
_____
_____

Status of Case:

- ☐ Pending before Malpractice Panel
- ☐ Pending in Court
- ☐ Closed without Payment
- ☐ Pre-trial Settlement (include dollar amount):
- ☐ Verdict for Defendant
- ☐ Verdict for Plaintiff:

What was/is the agency's status:

- ☐ Sole defendant
- ☐ Co-defendant
- ☐ Other (please describe):

Name and phone number of Insurance Carrier:_____

Name and Phone Number of Defense Attorney:_____

Name and Phone Number of Plaintiff's Attorney:_____

Provide name and phone numbers of others that could furnish additional information regarding the claim/suit:

_____

Name:_____

Signature:_____ (All signatures must be original)

Date:_____

SECTION III

Chief Clinical Officer Information: Pages 8 and 9 are to be completed by the Chief Clinical Officer, who must be a licensed clinician; for the agency.

Demographic Information:

Last Name:	First Name:	MI

Social Security Number: (For identification purposes only)

			-			-				

Date of Birth:

Month	Day	Year

Is Chief Clinical Officer for the agency ☐ Employed by Agency or ☐ Under Contract with Agency

Primary Practice Office Address **State of Primary Practice**: _____ _____

Street	City/Town	State	Zip Code

Office Telephone Number:

Fax Number:

E-mail Address:_____

Licensure/Certification

Indicate the discipline under which you are LICENSED and/or CERTIFIED at the highest level to practice independently:

Complete the following license information for ALL states in which you are currently licensed.

State	License Type (e.g., Psychologist, etc.)	License #	Expiration Date (Month/Day/Year)

Please attach a current copy of all licenses.

Indicate current applicable Certifications

Certification Type	Certification #	Expiration Date (Month/Day/Year)
Drug Enforcement Agency (DEA) Certificate (MD, APRN)		

Please attach a current copy of all certifications.

Attestation Statement

Licensed Clinicians

This page pertains to all employed and contracted licensed clinicians authorized to provide or to supervise MFP/MH Waiver Services offered by the agency. This page does not apply to the Chief Clinical Officer who completed the data on page 8 of this application.

I understand and agree that as part of the credentialing process for participation in MFP/MH Waiver Services, I attest that the agency has verified and assured the following provisions related to its licensed clinicians. At any time an audit may be conducted to confirm the attested information.

If you are unable to check a box off relating to the statement please see note below.

For **each** licensed clinician providing or supervising MFP/MH Waiver Services, I certify:

☐ License is in good standing and has not been revoked, refused, restricted or voluntarily surrendered

☐ There is no action pending to revoke a license

☐ Clinician has not had nor has sanctions imposed by Medicaid and/or Medicare

☐ Clinician has not been the subject of a disciplinary proceeding by a professional association

☐ Clinician has no history of chemical dependency or substance abuse that might adversely affect his/her performance

☐ Clinician has no ongoing physical or mental impairment which would make him/her unable to perform duties without reasonable accommodation

☐ Clinician has not been denied hospital privileges or has not had privileges revoked, limited or suspended ☐ N/A

☐ Clinician has not been convicted of, or pled guilty to a crime other than a minor traffic violation

☐ Clinician has not been named in any malpractice claims in the last five years

☐ Clinician has not been a defendant in any lawsuit or has any malpractice claims where there has been award or payment of $25,000 or more

Completed/ signed by:_____Date:

Print the Name of the Person completing form:_____Title_____

Note: If you are unable to check a statement to certify accuracy please provide the current status and details on a separate sheet of paper. Please include the following: Clinicians name, position, title, description of incident, including correspondence with state licensing boards, and/or a detailed description of any litigation, including settlements, court awards, etc. This application cannot be processed without the necessary official documentation.

SECTION V

WAIVER SERVICES

- The specific service applications are on the following pages. Prior to each service application is a description of the service, including the DMHAS qualifications.

- Complete only those service applications which your agency plans to provide.

- Service Reimbursement Schedules can be found on the DMHAS website: **http://www.ct.gov/dmhas/site/default.asp**

Assertive Community Treatment (ACT) RFP Awarded Agencies Only

Definition

Assertive Community Treatment (ACT) is a recovery focused, high intensity, community based service for individuals discharged from multiple or extended stays in hospitals, or who are difficult to engage in treatment. The service utilizes an interdisciplinary team to provide intensive, integrated, rehabilitative community support, crisis, and treatment interventions/services that are available 24-hours/7days a week.
ACT includes a comprehensive array of rehabilitative services integrated with medical care, most of which is provided in non-office settings by a mobile multidisciplinary team. The team provides community support services interwoven with treatment and rehabilitative services and regularly scheduled team meetings to no fewer than 60 active participants.
The ACT team provides nearly all the treatment needed by the participant. ACT community and clinical services are guided by the participant's strengths and preferences. The service involves an assertive approach, individually tailored programming, ongoing monitoring, variable support, *in vivo* service, relating to participants as responsible citizens, utilizing a variety of community resources and collaborating with the family. Community-based treatment enables the team to become intimately familiar with the participant's surroundings, strengths and challenges, and to assists the participant in learning skills applicable to his/her actual living environment. The team is persistent in engaging the participant, doing whatever is necessary to keep the individual involved in community life and active in treatment.
ACT services are targeted to individuals with the most complex and persistent psychiatric problems (including those with co-occurring psychiatric and substance use disorders) seen among persons living outside institutional settings. ACT service recipients also are likely to have interlocking social, economic and legal problems that complicate their behavioral health treatment. ACT service users often have erratic behaviors, are frequent users of crisis services, are often difficult to engage in care, have poor adherence to treatment plans, have had multiple hospitalizations, have not benefited from the traditional array of community-based services and, were it not for ACT care, would likely require hospitalization or care in some other institutional setting.

Provider Qualifications/Conditions for Participation

Certificate: The Joint Commission (TJC) or Commission of Accreditation of Rehabilitation Facilities (CARF) and DMHAS ACT Certification
Other Standards: The supervisor must be a licensed clinician. ACT General Practitioners shall hold either a Master's degree in a behavioral health-related specialty (may include special education or rehabilitation) or be licensed. Paraprofessionals on an ACT team must have a Bachelor's degree OR have two years experience in the provision of mental health services (may include special education and/or services to persons with developmental disabilities), OR be a Certified Peer Specialist. An ACT service provider must meet the State of Connecticut certification standards to provide both Clinical Services and ACT services as defined by the Department of Mental Health and Addiction Services (DMHAS).
Entity Responsible for Verification: DMHAS/ABH
Frequency of Verification: Upon enrollment and reenrollment

Covered services

ACT services of at least 15-minutes duration provided to the participant by a direct-care member of the ACT team in the participant's home and in other community settings. These services include:

1. Mental health services, including:
    a. Comprehensive Assessment that contains a psychiatric history, risk assessment, functional history, mental status examination, and diagnosis; and assessments of physical health; use of drugs and alcohol; education and employment; social development and functioning; activities of daily living; family structure and relationships; and environmental supports;
    b. Treatment and rehabilitation planning, including a timeline of past events;
    c. Service coordination;
    d. Crisis assessment and face-to-face or telephonic crisis intervention and monitoring;
    e. Symptom assessment and management;
    f. Development of skills for recognizing stressors, and building coping mechanisms and recovery strategies;

g. Medication prescription, administration, monitoring and education (Note: These services may be provided in an office setting);
h. Counseling and psychotherapy;

2. Co-occurring substance abuse services, using the Integrated Dual Disorders Treatment (IDDT) model;
3. Clarification of goals and motivational support for pursuing goals related to employment, education, community involvement, and use of natural supports (***NOTE:*** *Documentation shall be maintained in the file of each participant receiving work and education-related services that such services are not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.));*
4. Motivating the participant to find and lease an apartment, and assistance with tenancy issues and problems;
5. Skill building and support for Activities of Daily Living, including:
    a. Teaching, coaching and assisting with daily living and self-care skills such as the use of transportation, nutrition, meal planning and preparation, housekeeping and basic household tasks, dressing, personal grooming and hygiene, management of financial resources, shopping, use of leisure time, interpersonal communication, personal safety, child care and parenting, basic first aid, and problem solving;
    b. Other skill development activities directed at reducing disability, restoring functioning and achieving independent participation in social, interpersonal, family, or community activities and full community re-integration and independence as identified in the waiver Recovery Plan;
    c. Social/interpersonal relationship and leisure-time skill training;
6. Education, support, and consultation to family members (and significant others) of the participant, provided these activities are directed exclusively toward the treatment of the participant;
7. Participation in waiver Recovery Plan development and quarterly Recovery Plan update meetings, if requested by the DMHAS Support Coordinator;
8. Travel with a participant or family member when the ACT Service provider is also engaged in a qualifying waiver service activity; and
9. Group treatment, involving not more than four persons receiving care, focusing on any of the activities listed in items #1-G through #5-C, above. (NOTE: Group rates are 30 percent of the individual ACT rate. See applicable rate schedule for details).

Limitations

Coverage of ACT services shall be subject to the following limitations:

1. ACT services are subject to service volume (number of ¼ hours service units per day and/or week) and duration (number of months or specified service end date) limits established in the waiver Recovery Plan approved by DMHAS and DSS. The departments or their designee will enact these limits;
2. ACT services shall be based on the waiver Recovery Plan and shall be performed by or under the supervision of a licensed clinician who is a member of the ACT team;
3. ACT is a comprehensive team intervention. The department will not pay for ACT services concurrently with other Medicaid funded behavioral health services except to support a transition period (of up to 30 days) across levels of care. The department will pay for ACT services provided concurrently with inpatient psychiatric services, detoxification services, opioid treatment, neuropsychological testing, partial hospitalization, day treatment, intensive outpatient treatment, Transitional Case Management, Recovery Assistance, Short Term Crisis Stabilization, and Supported Employment services;
4. Except as noted in Limitations item # (3) above, ACT services cannot be provided concurrently with residential care;
5. ACT services must exclude services that are duplicative of Supported Employment services;
6. A claim for reimbursement may be submitted for the qualifying waiver services activities of only one direct-care member of an ACT team for services to a participant during a specific time period (i.e., billable unit of time);
7. The department shall not pay for:
    a. Time spent by the provider solely for the purpose of transporting participants;
    b. Programs, services or components of services that are of an unproven, experimental, cosmetic or research nature;
    c. Programs, services or components of services that do not relate to the participant's diagnosis, symptoms, functional limitations or medical history;
    d. Programs, services or components of services that are not included in the fee established by the department;

e. Services or components of services provided solely for social, recreational, educational or vocational purposes; and
f. Costs associated with room and board for participants.

Non-billable Activities

The following activities are not billable, but have been factored into payment rates:

1. Day-to-day monitoring regarding the participants health and welfare and problem solving to address concerns;
2. Communication and coordination with the DMHAS Support Coordinator, and with other service providers to relay information germane to the participant's needs and continued recovery;
3. Telephone contact with the department or its designated agent for the purpose of requesting or reviewing authorization of services;
4. Completion of progress notes or billing documentation;
5. Individual or group supervision, routine case reviews and rounds, ad hoc consultation with supervisors and discussion or consultation among ACT team members, including for the purpose of treatment planning;
6. Time spent performing routine services such as cleaning, cooking, shopping or child care designed to provide relief or respite for the primary caregiver;
7. No shows, missed or cancelled appointments, and visits to the participant when the participant is unavailable;
8. ACT services of less than fifteen minutes duration for recovery procedures whose billing codes are defined in 15-minute increments; and
9. Time spent engaged in activities required by a credentialing, certification or oversight entity such as gathering and submitting care plan, service data or other information.

ACT TEAM REQUIREMENTS:

Complete the following staff roster for the ACT Team within the agency. The roster should represent your agency's assigned ACT Team as of the date of application. The rehab experience and education must be documented for each ACT Team Member. By applying for ACT, it also means that the team will meet the fidelity standards as outlined by SAMHSA and have USPRA Certification *or* Attendance at DMHAS-sponsored Rehab Training– in person or through video and certified by DMHAS as an ACT Team. Specify Type and Date of training.

Is the organization currently certified by DMHAS to provide ACT Team Services? If yes, provide copy of certification	☐ YES ☐ NO	Date of certification / /

Please include a resume or summary of work experience for each staff listed in the roster.

ACT TEAM ROSTER

Last Name, First Name	Degree/ Experience	License	FTE	Job Title	Specific Rehab Experience		
					USPRA Certification	DMHAS Rehab Training	Dates of training or Certification Number
			1.0	Clinical Supervisor - Must be licensed	☐ Yes ☐ No	☐ Yes ☐ No	_____
			4 hrs/ week per 50 clients	Psychiatrist or APRN	☐ Yes ☐ No	☐ Yes ☐ No	_____
			1.0	Registered Nurse	☐ Yes ☐ No	☐ Yes ☐ No	_____
			1.0	General practitioner, either Master's prepared or licensed clinician	☐ Yes ☐ No	☐ Yes ☐ No	_____
			1.0	ACT Staff	☐ Yes ☐ No	☐ Yes ☐ No	_____
			1.0	ACT Staff	☐ Yes ☐ No	☐ Yes ☐ No	_____
			1.0	Peer Support (Recovery Support Specialist)	☐ Yes ☐ No	☐ Yes ☐ No	_____

Language Competence: In addition to English, please identify the languages available to participants

☐	American Sign Language	☐	German	☐	Korean	☐	Swedish
☐	Arabic	☐	Greek	☐	Laotian	☐	Tagalog (Philippines)
☐	Armenian	☐	Hebrew	☐	Norwegian	☐	Vietnamese
☐	Chinese	☐	Hindi	☐	Polish	☐	Yiddish
☐	Dutch	☐	Hungarian	☐	Portuguese	☐	Other:
☐	Farsi	☐	Italian	☐	Russian	☐	
☐	French	☐	Japanese	☐	Spanish	☐	

Supervisor Documentation Requirements for ACT Team Service

If the supervision for this service is not provided by the Chief Clinical Officer for the agency, please indicate if the supervisory functions for this program are provided by a staff or contracted position.

☐ - Employed by Agency

If the position is employed by the agency please include a copy of the employee's current license.

☐- Under Contract with Agency

If contracted with the agency, please provide a letter describing the arrangement by which this person is providing supervisory services and a copy of the contracted supervisor's current license.

Primary Service Locations

Program Name:
Address:
Program Name:
Address:
Program Name:
Address:

Checklist for application for ACT Team is below

If applying for ACT Team services also include the following documents in your application:

If the supervisor is employed as staff by the agency	
a copy of the supervisor's current license	☐
Resume or summary work history for every member listed on the team roster	
Supervisor	☐
Psychiatrist/APRN (Unless They Are The Chief Clinical Officer Of The Agency)	☐
Registered Nurse	☐
General Practitioner	☐
ACT Staff	☐
ACT Staff	☐
ACT Peer Support (Recovery Support Specialist)	☐
Copy of DMHAS Certification	☐
If the supervisor for this service is not an agency employee, supply	
a letter describing the supervisory arrangement	☐
a copy of the contracted supervisor's current license	☐

Community Support Program (CSP)

Definition

Community Support Program (CSP) consist of mental health and substance abuse rehabilitation services and supports necessary to assist the individual in achieving and maintaining the highest degree of independent functioning. The service utilizes a team approach to provide intensive, rehabilitative community support, crisis intervention, group and individual psycho-education, and skill building for activities of daily living.
CSP includes a comprehensive array of rehabilitation services most of which are provided in non-office settings by a mobile team. Services are focused on skill building with a goal of maximizing independence. Community-based treatment enables the team to become intimately familiar with the participant's surroundings, strengths and challenges, and to assist the participant in learning skills applicable to his/her living environment. The team services and interventions are highly individualized and tailored to the needs and preferences of the individual.

Provider Qualifications/Conditions for Participation

Certificate: Commission on Accreditation of Rehabilitation Facilities (CARF) or The Joint Commission (TJC) or is in an active process of becoming accredited.
Other Standards: The supervisor, Team Leader, must be a licensed clinician; staff shall hold either a bachelor's degree in a behavioral health-related specialty (may include special education or rehabilitation) OR have two years experience in the provision of mental health services (may include special education and/or services to persons with developmental disabilities) OR be a Certified Peer Specialist. A CSP provider must meet the State of Connecticut certification standards to provide CSP services as defined by the Department of Mental Health and Addiction Services (DMHAS), this will be determined by a site visit.
Entity Responsible for Verification: DMHAS/ABH
Frequency of Verification: Upon enrollment and reenrollment

Covered services

CSP services of at least 15-minutes duration provided to the participant by a direct-care staff member of the CSP team in the participant's home and in other community settings. These services include:

1. Rehabilitation assessment and development of the rehabilitation plan;
2. Re-evaluation and adjustment of the rehabilitation plan;
3. Crisis response services either face-to-face or telephonic;
4. Psycho-education services for rehabilitation from psychiatric or substance abuse disorders;
5. Clarification of goals and motivational support for pursuing goals related to employment, education, community involvement, and use of natural supports. *(**NOTE:** Documentation shall be maintained in the file of each participant receiving work or education-related services that such services are not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.));*
6. Residential supports, such as motivating the participant to find and lease an apartment, and assistance with tenancy issues and problems;
7. Skill building and support for Activities of Daily Living, including:
    a. Teaching, coaching and assisting with daily living and self-care skills such as the use of transportation, nutrition, meal planning and preparation, housekeeping and basic household tasks, dressing, personal grooming and hygiene, management of financial resources, shopping, use of leisure time, interpersonal communication, personal safety, child care and parenting, basic first aid, and problem solving;
    b. Other skill development activities directed at reducing disability, restoring participant functioning and achieving independent participation in social, interpersonal, family, or community activities and full community re-integration and independence as identified in the waiver Recovery Plan;
    c. Teaching of recovery skills in order to prevent relapse such as symptom recognition, coping with symptoms, emotional management, relaxation skills, self administration and appropriate use of medications, and preparation of illnesses related advance directives;
    d. Development of self-advocacy skills for the purpose of accessing natural supports, self-help, and other advocacy resources; and
    e. Health and wellness education.
8. Education, support, and consultation to family members (and significant others) of the participant, provided these activities are directed exclusively toward the rehabilitation treatment of the participant;

9. Participation in waiver Recovery Plan development and quarterly Recovery Plan update meetings, if requested by the DMHAS Support Coordinator;
10. Travel to an appointment with a participant or family member when the CSP provider is also engaged in a qualifying waiver service activity; and
11. Group treatment, involving not more than four persons receiving care, focusing on any of the activities listed in items #4 through #7 above.

Limitations

Coverage of Community Support Program services shall be subject to the following limitations:

1. CSP services are subject to service volume (number of ¼ hours service units per day and/or week) and duration (number of months or specified service end date) limits established in the waiver Recovery Plan approved by DMHAS and DSS. The departments or their designee will enact these limits;
2. CSP services shall be based on the waiver Recovery Plan and shall be performed by or under the supervision of a licensed clinician employed by or under contract to the provider;
3. A claim for reimbursement may be submitted for the qualifying waiver services activities of only one direct-care member of a CSP team for services to a participant during a specific time period (i.e., billable unit of time);
4. With the allowable exception of a transition period to CSP (up to 30-days), CSP services cannot be provided concurrently with residential care;
5. CSP services must exclude services that are duplicative of Supported Employment services; and
6. The department shall not pay for:
    a. Psychiatric evaluation and treatment, medication management, individual, group and family psychotherapy;
    b. Time spent by the provider solely for the purpose of transporting participants;
    c. Programs, services or components of services that are of an unproven, experimental, cosmetic or research nature;
    d. Programs, services or components of services that do not relate to the participant's diagnosis, symptoms, functional limitations or medical history;
    e. Programs, services or components of services that are not included in the fee established by the department;
    f. Services or components of services provided solely for social, recreational, educational or vocational purposes; and
    g. Costs associated with room and board for participants.

Non-billable Activities

The following activities are not billable, but have been factored into payment rates:

1. Day-to-day monitoring regarding the participants health and welfare and problem solving to address concerns;
2. Communication and coordination with the DMHAS Support Coordinator, and with other service providers to relay information germane to the participant's needs and continued recovery;
3. Telephone contact with the department or its designated agent for the purpose of requesting or reviewing authorization of services;
4. Completion of progress notes or billing documentation;
5. Individual or group supervision, routine case reviews and rounds, ad hoc consultation with supervisors and discussion or consultation among CSP team members, including for the purpose of treatment planning;
6. Time spent performing routine services such as cleaning, cooking, shopping, or child care designed to provide relief or respite for the family;
7. No shows, missed or cancelled appointments, and visits to the participant when the participant is unavailable;
8. CSP services of less than fifteen minutes duration for recovery procedures whose billing codes are defined in 15-minute increments; and
9. Time spent engaged in activities required by a credentialing, certification or oversight entity such as gathering and submitting care plan, service data or other information.

CSP TEAM REQUIREMENTS:
Complete the following staff roster for each proposed CSP Team within the agency. (If more than one team is proposed, attach a roster for each team.) The application should represent your agency's assigned CSP Team as of the date of application. Note: the Team Leader must be an licensed clinician. At a minimum, a CSP team requires one (1) licensed Team Lead and one (1) CSP Staff (these individuals need not be full-time employees). The agency must have received an "Interim" Certification Letter from DMHAS. USPRA Certification *or* Attendance at DMHAS- sponsored CSP Training– in person or through video. Specify type and date of training. A site visit will be conducted by DMHAS as part of the credentialing process. Provider must have a positive site visit documented by DMHAS to be Certified and credentialed.

Site Visit: Upon receipt of a completed application a "**Site Visit Certification Letter**" will be sent to the Provider. ABH will contact the Provider to schedule a site visit.

Please include a resume or summary of work experience for each staff listed in the roster.

CSP TEAM ROSTER							
Last Name, First Name	**Degree/ Experience**	**License**	**FTE**	**Job Title**	**Specific Rehab Experience**		
					USPRA Certification	DMHAS Rehab Training	Dates of training or Certification Number
				Team Leader. Must be licensed clinician	☐ Yes ☐ No	☐ Yes ☐ No	_____
				CSP Staff	☐ Yes ☐ No	☐ Yes ☐ No	_____
				CSP Staff	☐ Yes ☐ No	☐ Yes ☐ No	_____
				CSP Staff	☐ Yes ☐ No	☐ Yes ☐ No	_____

Language Competence: In addition to English, please identify the languages in available to participants

	American Sign Language		German		Korean		Swedish
	Arabic		Greek		Laotian		Tagalog (Philippines)
	Armenian		Hebrew		Norwegian		Vietnamese
	Chinese		Hindi		Polish		Yiddish
	Dutch		Hungarian		Portuguese		Other:
	Farsi		Italian		Russian		
	French		Japanese		Spanish		

Supervisor Documentation Requirements for CSP Team Service

If the supervision for this service is not provided by the Chief Clinical Officer for the agency, please indicate if the supervisory functions for this program are provided by a staff or contracted position.

☐ - Employed by Agency

If the position is employed by the agency please include a copy of the employee's current license.

☐- Under Contract with Agency

If contracted with the agency, please provide a letter describing the arrangement by which this person is providing supervisory services and a copy of the contracted supervisor's current license.

Primary Service Locations

Program Name:
Address:
Program Name:
Address:
Program Name:
Address:

Checklist for application for CSP Team is below

If applying for CSP Team services also include the following documents in your application:

If the supervisor is employed as staff by the agency		
	a copy of the supervisor's current license	☐
Resume or summary work history for every staff member listed.		
	Team Leader/Supervisor	☐
	CSP Staff	☐
	CSP Staff	☐
	CSP Staff (Recovery Support Specialist)	☐
	CSP Staff(Recovery Support Specialist)	☐
If the supervisor for this service is not an agency employee, supply		
	a letter describing the supervisory arrangement	☐
	a copy of the contracted supervisor's current license	☐

Peer Support

Not currently open for credentialing

ABH will post description and requirements at a later date.

Recovery Assistant

Definition

Recovery Assistant - A flexible range of supportive assistance provided face-to-face in accordance with a Waiver Recovery Plan that enables a participant to maintain a home/apartment, encourages the use of existing natural supports, and fosters involvement in social and community activities. Service activities include: performing household tasks, providing instructive assistance, or cuing to prompt the participant to carry out tasks (e.g., meal preparation; routine household chores, cleaning, laundry, shopping, and bill-paying; and participation in social and recreational activities), and; providing supportive companionship. The Recovery Assistant may also provide instruction or cuing to prompt the participant to dress appropriately and perform basic hygiene functions; supportive assistance and supervision of the participant, and; short-term relief in the home for a participant who is unable to care for himself/herself when the primary caregiver is absent or in need of relief.

Provider Qualifications/Conditions for Participation:

Certificate: Commission on Accreditation of Rehabilitation Facilities (CARF),The Joint Commission (TJC), The Community Health Accreditation Program(CHAP), Accreditation Commission for Health Care (ACHC) or Medicare Certification or is in an active process of becoming accredited and has DMHAS Certification to provide Recovery Assistant Services
Entity Responsible for Verification: DMHAS/ABH
Frequency of Verification: Upon enrollment and reenrollment
Other Standards: RA staff must be supervised by a licensed clinician. The RA must have completed the DMHAS Recovery Assistant Training and have received the Certification or have USPRA Certification
A Recovery Assistant shall:

- Be at least 18 yrs old;
- Possess at least a high school diploma or GED;
- Possess a valid Connecticut driver's license; and
- Be registered with the Department of Mental Health and Addiction Services (DMHAS) as having completed an approved Recovery Assistant training program and will be able to meet any continuing education and/or training requirements set by DMHAS.

Training requirement: Training programs will address abilities to:

- Follow instructions given by the participant or the participant's conservator;
- Report changes in the participant's condition or needs;
- Maintain confidentiality;
- Meet the participant's needs as delineated in the waiver Recovery Plan;
- Implement cognitive and behavioral strategies;
- Function as a member of an interdisciplinary team;
- Respond to fire and emergency situations;
- Accept supervision in a manner prescribed by the department or its designated agent;
- Maintain accurate, complete and timely records that meet Medicaid requirements;
- Use crisis intervention and de-escalation techniques; and
- Provide services in a respectful, culturally competent manner.

Covered services

Recovery Assistant services of at least 15-minutes duration provided to the participant in his/her home and in other community settings. These services include:

1. Performing the following tasks if the participant (by reason of physical or psychiatric disability) is unable to perform them, or assisting, or cueing the participant to perform them:
    a. Meal planning and preparation, shopping, housekeeping (e.g., changing linens, washing dishes, vacuuming/dusting, laundry, mending clothing repairs), basic household tasks (e.g., regulating home temperature, storing food appropriately, resolving issues about bill paying).
    b. Dressing, personal grooming and hygiene (e.g., bathing, dressing, and oral care).
    c. Appropriate use of emergency medical services.
2. Assisting or cueing the participant to perform or become engaged in:
    a. Family, social, and recreational activities.
    b. Appropriate use of natural community supports (e.g., social clubs, faith-based supports).
    c. Appropriate use of routine medical/dental services.

d. Use of medications as prescribed, including self administration of medications.
e. Healthy habits (e.g., healthy diet, exercise, and behaviors designed to alleviate stress).
f. Fulfillment of personal commitments, and adherence to scheduled appointments/meetings (e.g., clinical, vocational, educational, and judicial/court).

3. Assisting or cueing the participant to avoid:
    a. Risky behaviors (e.g., unprotected sex, smoking/excessive use of tobacco products, unsafe driving/driving without seatbelt, unsafe relationships, criminal activities).
    b. Substance abuse.
    c. Overspending.
    d. Unnecessary conflicts.
4. Supportive and problem solving-oriented discussions with the participant.
5. Establishing and maintaining a helpful, supportive, companionship relationship with the participant that involves such activities as:
    a. Escorting the participant to necessary medical, dental, or personal business appointments;
    b. Reading to or for the participant;
    c. Engaging in or discussing recreational, hobby, or sport-related activities;
6. Other activities directed at reducing disability, restoring participant functioning and achieving independent participation in social, interpersonal, family, or community activities and full community re-integration and independence;
7. Participation in waiver Recovery Plan development and quarterly Recovery Plan update meetings, if requested by the DMHAS Support Coordinator; and
8. Travel with a participant when the Recovery Assistant is also engaged in a qualifying waiver service activity.

Limitations

1. Coverage of Recovery Assistant services shall be subject to the following limitations:
2. Recovery Assistant services are subject to service volume (number of ¼ hours service units per day and/or week) and duration (number of months or specified service end date) limits established in the waiver Recovery Plan approved by DMHAS and DSS. The departments or their designee will enact these limits;
3. Recovery Assistant services shall be based on the waiver Recovery Plan;
4. A claim for reimbursement may be submitted for the qualifying waiver services activities of only one Recovery Assistant for services to a participant during a specific time period (i.e., billable unit of time);
5. Individuals receiving residential rehabilitation services paid for by Medicaid in a group home are excluded from Recovery Assistant services, except during a brief transition phase to a lower level of care (not to exceed 30 days);
6. The department shall not pay for:
    a. Time spent by the provider solely for the purpose of transporting participants;
    b. Programs, services or components of services that are of an unproven, experimental, cosmetic or research nature;
    c. Programs, services or components of services that do not relate to the participant's diagnosis, symptoms, functional limitations or medical history;
    d. Programs, services or components of services that are not included in the fee established by the department;
    e. Services or components of services provided solely for educational or vocational purposes;
    f. Waiver services provided by a relative of the participant; and
    g. Costs associated with room and board for participants.

Non-billable Activities

The following activities are not billable, but have been factored into payment rates:

1. Day-to-day monitoring regarding the participants health and welfare and problem solving to address concerns;
2. Communication and coordination with the DMHAS Support Coordinator, and with other service providers to relay information germane to the participant's needs and continued recovery;
3. Telephone contact with the participant;
4. Telephone contact with the department or its designated agent for the purpose of requesting or reviewing authorization of services;
5. Completion of progress notes or billing documentation;

6. Individual or group supervision, routine case reviews and rounds, ad hoc consultation with supervisors and discussion or consultation among recovery team members, including for the purpose of treatment planning;
7. No shows, missed or cancelled appointments, and visits to the participant when the participant is unavailable;
8. Recovery Assistant services of less than fifteen minutes duration for recovery procedures whose billing codes are defined in 15-minute increments; and
9. Time spent engaged in activities required by a credentialing, certification or oversight entity such as gathering and submitting care plan, service data or other information.

RECOVERY ASSISTANT REQUIREMENTS:
Agency must be accredited by a nationally accredited body: CARF, Joint Commission, CHAP, ACHC or Medicare Certified to provide Recovery Assistant Services. Each individual Recovery Assistant must have specific training in behavioral health, home health care and homemaker services, demonstrated through an exam or observed supervision. Staff must have USPRA Certification *or* Certified DMHAS-sponsored Certified Recovery Assistant/Support Specialist Training. Indicate date of training or certification number for each individual. Include copies of State of Connecticut background checks which must be dated no more than 6 months prior to the date of this application.

Does the agency have staff Certified by DMHAS for Recovery Assistant Services?	YES ☐ No ☐	/ / Certification Date

Please include a resume or summary of work experience for each staff listed below.

Last Name, First Name	**Degree/ Experience**	**License**	**FTE**	**Job Title**	**Name and Specific Experience**			
					USPRA Certification	DMHAS Recovery Assistant Training	Dates of training or Certification Number	Background Checks
				Supervisor. Must be licensed clinician	☐ Yes ☐ No	☐ Yes ☐ No	_____	N/A
				Recovery Assistant	☐ Yes ☐ No	☐ Yes ☐ No	_____	☐
				Recovery Assistant	☐ Yes ☐ No	☐ Yes ☐ No	_____	☐
				Recovery Assistant	☐ Yes ☐ No	☐ Yes ☐ No	_____	☐

Language Competence: In addition to English, please identify the languages in available to participants of this service.

	American Sign Language		German		Korean		Swedish
	Arabic		Greek		Laotian		Tagalog (Philippines)
	Armenian		Hebrew		Norwegian		Vietnamese
	Chinese		Hindi		Polish		Yiddish
	Dutch		Hungarian		Portuguese		Other:
	Farsi		Italian		Russian		
	French		Japanese		Spanish		

Supervisor Documentation Requirements for Recovery Assistant Service

If the supervision for this service is not provided by the Chief Clinical Officer for the agency, please indicate if the supervisory functions for this program are provided by a staff or contracted position.

☐ - Employed by Agency

If the position is employed by the agency please include a copy of the employee's current license.

☐- Under Contract with Agency

If contracted with the agency, please provide a letter describing the arrangement by which this person is providing supervisory services and a copy of the contracted supervisor's current license.

Primary Service Locations

Program Name:
Address:
Program Name:
Address:
Program Name:
Address:

Checklist for application for Recovery Assistant services is below.

If applying for Recovery Assistant services also include the following documents in your application:

If the supervisor is employed as staff by the agency:	
a copy of the supervisor's current license	☐
Copies of background checks for each Recovery Assistant	☐
Resume or summary work history for every member listed on the team roster	
Supervisor	☐
Recovery Assistant	☐
Recovery Assistant	☐
If the supervisor for this service is not an agency employee, supply:	
a letter describing the supervisory arrangement	☐
a copy of the contracted supervisor's current license	☐

Short-Term Crisis Stabilization

Definition

Short-term Crisis Stabilization - consist of face-to-face mental health and substance abuse services provided to individuals within the home and community. The service involves brief, concentrated interventions to stabilize psychiatric conditions or behavioral and situational problems including substance abuse, prevent escalation of psychiatric symptoms, reduce the risk of harm to self or others, avert loss of housing, and wherever possible to avoid the need for hospitalization or other more restrictive placement. Services and interventions are highly individualized and tailored to the needs and preferences of the participant, with the goal of maximizing independence and supporting recovery.

Provider Qualifications/Conditions for Participation

Certificate: Commission on Accreditation of Rehabilitation Facilities (CARF) or The Joint Commission (TJC) or is a DMHAS designated Local Mental Health Authority (LMHA) or contracted affiliate of an LMHA
Other Standards: The supervisor must be a licensed clinician. Short-term Crisis Stabilization staff shall have three years experience in the provision of mental health services (may include special education and/or services to persons with developmental disabilities) The agency must meet the State of Connecticut certification standards to provide Short-term Crisis Stabilization services defined by the Department of Mental Health and Addiction Services
Entity Responsible for Verification: DMHAS/ABH
Frequency of Verification: Upon enrollment and reenrollment
Agency based: A Short-term Crisis Stabilization staff member shall:

- Be at least 18 yrs old;
- Possess at least a high school diploma or GED; and
- Possess a valid Connecticut driver's license
- Three years experience in the provision of mental health services

Training requirement: Training programs will address abilities to:

- Follow instructions given by the participant or the participant's conservator;
- Report changes in the participant's condition or needs;
- Maintain confidentiality;
- Meet the participant's needs as delineated in the waiver Recovery Plan;
- Implement cognitive and behavioral strategies;
- Function as a member of an interdisciplinary team;

Respond to fire and emergency situations;

- Accept supervision in a manner prescribed by the department or its designated agent;
- Maintain accurate, complete and timely records that meet Medicaid requirements;
- Use crisis intervention and de-escalation techniques;
- Provide services in a respectful, culturally competent manner; and
- Use effective and evidence-based Short-term Crisis Stabilization practices.

Covered services

Short-term Crisis Stabilization services of at least 15-minutes duration provided to the participant in his/her home and in other community settings. These services include:

1. Observation, evaluation and monitoring in order to reduce the participant's risk of harm to self or others, and to determine whether additional supports are necessary;
2. Practical problem-solving advice and assistance designed to address and remediate the antecedent causes of an emerging psychiatric or behavioral crisis;
3. Crisis intervention and supportive counseling designed to stabilize functioning, reduce stress, calm the participant and prevent further deterioration;
4. Communication with supervisory staff to report the participant's condition and whether any additional assistance is needed;
5. Participation in waiver Recovery Plan development and quarterly Recovery Plan update meetings, if requested by the DMHAS Support Coordinator; and

6. Travel with a participant when the Short-term Crisis Stabilization provider is also engaged in a qualifying waiver service activity.

Limitations

Coverage of Short-term Crisis Stabilization services shall be subject to the following limitations:

1. Short-term Crisis Stabilization services are subject to service volume (number of ¼ hours service units per day and/or week) and duration (number of months or specified service end date) limits established in the waiver Recovery Plan approved by DMHAS and DSS. The departments or their designee will enact these limits;
2. Short-term Crisis Stabilization services shall be based on the waiver Recovery Plan and shall be performed by or under the supervision of a licensed clinician employed by or under contract to the provider;
3. A claim for reimbursement may be submitted for the qualifying waiver services activities of only one staff member providing Short-term Crisis Stabilization services to a participant during a specific time period (i.e., billable unit of time);
4. The department shall not pay for:
    a. Time spent by the provider solely for the purpose of transporting participants;
    b. Programs, services or components of services that are of an unproven, experimental, cosmetic or research nature;
    c. Programs, services or components of services that do not relate to the participant's diagnosis, symptoms, functional limitations or medical history;
    d. Programs, services or components of services that are not included in the fee established by the department;
    e. Services or components of services provided solely for social, recreational, educational or vocational purposes; and
    f. Costs associated with room and board for participants.

Non-billable Activities

The following activities are not billable, but have been factored into payment rates:

1. Communication and coordination with the DMHAS Support Coordinator, and with other service providers to relay information germane to the participant's needs and continued recovery;
2. Telephone contact with the participant;
3. Telephone contact with the department or its designated agent for the purpose of requesting or reviewing authorization;
4. Completion of progress notes or billing documentation;
5. Individual or group supervision, routine case reviews and rounds, ad hoc consultation with supervisors and discussion or consultation among CSP team members, including for the purpose of treatment planning;
6. No shows, missed or cancelled appointments, and visits to the participant when the participant is unavailable;
7. Short-term Crisis Stabilization services of less than fifteen minutes duration for procedures whose billing codes are defined in 15-minute increments; and
8. Time spent engaged in activities required by a credentialing, certification or oversight entity such as gathering and submitting care plan or service data or other information.

SHORT-TERM CRISIS STABILIZATION:

Agency must be accredited by a nationally recognized accrediting body (CARF or Joint Commission). Each individual must have at least 3 years experience working with individuals with mental health disorders, de-escalation training and experience, and the proven ability to stay safe in the community. The team must also be able to take direction from the local Crisis Team. Must have USPRA Certification or Certified DMHAS-sponsored De-escalation Training, Behavior Management Strategies (BMS), and 3 years experience with individuals with MI.

Please include a resume or summary of work experience for each staff listed below

Last Name, First Name	Degree/ Experience	License	FTE	Job Title	Name and Specific Experience **			
					USPRA Certification	DMHAS De-escalation Training, Behavioral Management Strategies (BMS)	Dates of training	3 Yrs experience with individuals with MI
				Supervisor. Must be licensed clinician				☐
				Crisis Support Staff				☐
				Crisis Support Staff				☐
				Crisis Support Staff				☐

Language Competence: In addition to English, please identify the languages available to participants

☐	American Sign Language	☐	German	☐	Korean	☐	Swedish
☐	Arabic	☐	Greek	☐	Laotian	☐	Tagalog (Philippines)
☐	Armenian	☐	Hebrew	☐	Norwegian	☐	Vietnamese
☐	Chinese	☐	Hindi	☐	Polish	☐	Yiddish
☐	Dutch	☐	Hungarian	☐	Portuguese	☐	Other:
☐	Farsi	☐	Italian	☐	Russian	☐	
☐	French	☐	Japanese	☐	Spanish	☐	

Supervisor Documentation Requirements for Short Term Crisis Stabilization Service

If the supervision for this service is not provided by the Chief Clinical Officer for the agency, please indicate if the supervisory functions for this program are provided by a staff or contracted position.

☐ - Employed by Agency

If the position is employed by the agency please include a copy of the employee's current license.

☐- Under Contract with Agency

If contracted with the agency, please provide a letter describing the arrangement by which this person is providing supervisory services and a copy of the contracted supervisor's current license.

Primary Service Locations

Program Name:
Address:
Program Name:
Address:
Program Name:
Address:

Checklist for application for Short Term Crisis Stabilization below

If applying for Short Term Crisis Stabilization services also include the following documents in your application:

If the supervisor is employed as staff by the agency:		
	a copy of the supervisor's current license	☐
Resume or summary work history for every Short Term Crisis Staff		
	Supervisor	☐
	Support Specialist	☐
	Support Specialist	☐
If the supervisor for this service is not an agency employee, supply:		
	a letter describing the supervisory arrangement	☐
	a copy of the contracted supervisor's current license	☐

Supported Employment- For RFP Awarded Agencies Only

Definition

Supported Employment – Services consist of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. Supported employment may include assisting the participant to locate a job or develop a job on behalf of the participant. Supported employment is conducted in a variety of settings; particularly work sites where persons with disabilities are employed. Supported employment includes activities needed to sustain paid work by participants, including supervision and training. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptation, supervision and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.

Provider Qualifications/Conditions for Participation

Certificate: Commission on Accreditation of Rehabilitation Facilities (CARF) or The Joint Commission (TJC)
Other Standards: Meet State of CT Standard to provide rehabilitation service for Bureau of Rehabilitation (BRS), Department of Developmental Services (DDS), and Department of Mental Health and Addiction Services (DMHAS)
Entity Responsible for Verification: DMHAS/ABH
Frequency of Verification: Upon enrollment and reenrollment
Agency based: A Supported Employment staff member shall:

- Be at least 18 yrs old;
- Possess at least a high school diploma or GED; and
- Possess a valid Connecticut driver's license;
- Training requirement: Training programs will address abilities to:
- Follow instructions given by the participant or the participant's conservator;
- Report changes in the participant's condition or needs;
- Maintain confidentiality;
- Meet the participant's needs as delineated in the waiver Recovery Plan;
- Implement cognitive and behavioral strategies;
- Function as a member of an interdisciplinary team;
- Respond to fire and emergency situations;
- Accept supervision in a manner prescribed by the department or its designated agent;
- Maintain accurate, complete and timely records that meet Medicaid requirements;
- Use crisis intervention and de-escalation techniques;
- Provide services in a respectful, culturally competent manner; and
- Use effective and evidence-based Supported Employment practices.

Covered services

Supported Employment services of at least 15-minutes duration provided to the participant face-to-face or telephonically in the participant's home, employment location, or other community settings. These services include:

1. Training, skill building and support to assist the participant with managing his/her symptoms or other manifestations of disability in the workplace or job interview;
2. Assessment of the participant's:
    a. a)Individualized career development goals and employment ideas/preferences; and
    b. b)Work related skills and vocational functioning;
3. Assistance in developing and periodically evaluating the individualized employment services component of the participant's waiver Recovery Plan.
4. Support and guidance through the process of obtaining and maintaining employment, including:
    a. Teaching strategies to explore career development, write a resume, conduct job networking, pursue job leads, complete job applications, obtain interviews, and succeed in obtaining and maintaining employment;
    b. Training and skill building regarding proper work habits, and appropriate interactions with coworkers and the public;

c. Advocating for the participant with potential and current employers; and
d. Assisting with and reinforcing work-related problem solving skills;

5. Reinforcement of recovery skills designed to promote job retention and success in the workplace, including:
    a. Healthy habits (e.g., healthy diet, exercise, medication management and behaviors designed to alleviate stress);
    b. Fulfillment of personal and work-related commitments (e.g., adherence to the work schedule, avoidance of unnecessary tardiness and absences from work); and
    c. Identification and use of natural supports;
6. Assistance to support self-employment, including:
    a. Aiding the participant to identify potential business opportunities;
    b. Assisting in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business;
    c. Identification of the supports that are necessary in order for the participant to operate the business; and
    d. Ongoing assistance, counseling and guidance once the business has been launched.
7. Participation in waiver Recovery Plan development and quarterly Recovery Plan update meetings, if requested by the DMHAS Support Coordinator; and
8. Travel with a participant when the Supported Employment provider is also engaged in a qualifying waiver service activity.

Limitations

Coverage of Supported Employment services shall be subject to the following limitations:

1. Supported Employment services are subject to service volume (number of ¼ hours service units per day and/or week) and duration (number of months or specified service end date) limits established in the waiver Recovery Plan approved by DMHAS and DSS. The departments or their designee will enact these limits;
2. Supported Employment services shall be based on the waiver Recovery Plan;
3. Documentation shall be maintained in the file of each participant receiving Supported Employment that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.);
4. Supported Employment must exclude services that are duplicative of the following psychosocial rehabilitation services: Assertive Community Treatment, Community Support Program, and Peer Support;
5. A claim for reimbursement may be submitted for the qualifying waiver services activities of only one staff member providing Supported Employment services to a participant during a specific time period (i.e., billable unit of time);
6. The department shall not pay for:
    a. Costs associated with starting up or operating a business;
    b. Sheltered work or any other similar types of vocational services furnished in specialized facilities;
    c. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
    d. Payments passed through to participants in supported employment programs;
    e. Training not directly related to an individual's supported employment program;
    f. Programs, services or components of services that are intended solely to prepare individuals for paid or unpaid employment or for vocational equipment and uniforms;
    g. Time spent by the provider solely for the purpose of transporting participants;
    h. Programs, services or components of services that are of an unproven, experimental, cosmetic or research nature;
    i. Programs, services or components of services that do not relate to the participant's diagnosis, symptoms, functional limitations or medical history;(programs, services or components of services that are not included in the fee established by the department;
    j. Services or components of services provided solely for social, recreational, educational or vocational purposes; and
    k. Costs associated with room and board for participants.

Non-billable Activities

The following activities are not billable, but have been factored into payment rates:

1. Day-to-day monitoring regarding the participants health and welfare and problem solving to address concerns;
2. Communication and coordination with the DMHAS Support Coordinator, and with other service providers to relay information germane to the participant's needs and continued recovery;
3. Telephone contact with the department or its designated agent for the purpose of requesting or reviewing authorization of services;
4. Completion of progress notes or billing documentation;
5. Individual or group supervision, routine case reviews and rounds, ad hoc consultation with supervisors and discussion or consultation among recovery team members, including for the purpose of treatment planning;
6. No shows, missed or cancelled appointments, and visits to the participant when the participant is unavailable;
7. Supportive Employment services of less than fifteen minutes duration for recovery procedures whose billing codes are defined in 15-minute increments;
8. Time spent engaged in activities required by a credentialing, certification or oversight entity such as gathering and submitting care plan and service data or other information

SUPPORTED EMPLOYMENT TEAM REQUIREMENTS:

Agency must be accredited by a behavioral health accreditation body (CARF, Joint Commission). Each individual must have experience in job development, support, and experience in working with individuals with mental health disorders.

Please include a resume or summary of work experience for each staff listed in the roster.

Last Name, First Name	Degree/ Experience	License	FTE	Job Title	Specific Experience and Education
				Supervisor – need not be licensed or Master's prepared	
				Supported Employment Specialist	
				Supported Employment Specialist	

Language Competence: In addition to English, please identify the languages available to participants

	American Sign Language		German		Korean		Swedish
	Arabic		Greek		Laotian		Tagalog (Philippines)
	Armenian		Hebrew		Norwegian		Vietnamese
	Chinese		Hindi		Polish		Yiddish
	Dutch		Hungarian		Portuguese		Other:
	Farsi		Italian		Russian		
	French		Japanese		Spanish		

Primary Service Locations

Program Name:
Address:
Program Name:
Address:
Program Name:
Address:

Checklist for application for Supported Employment

If applying for Supported Employment services also include the following documents in your application:

Resume or summary work history for every Supported Employment Staff	
Supervisor	☐
Support Employment Specialist	☐
Support Employment Specialist	☐
If the supervisor for this service is not an agency employee, supply	
a letter describing the supervisory arrangement	☐

Transitional Case Management

Definition

Services provided to persons residing in institutional settings prior to their transition to the waiver to prepare them for discharge, or during the adjustment period immediately following discharge from an institution to stabilize them in a community setting, and to assist them with other aspects of the transition to community life by helping them gain access to needed waiver and other state plan services, as well as medical, social, housing, educational and other services and supports, regardless of the funding source for the services or supports to which access is gained. The state shall claim the cost of case management services provided to institutionalized persons prior to their transition to the waiver for a period not to exceed 180 days.

Provider Qualifications/Conditions for Participation

Certificate: Commission on Accreditation of Rehabilitation Facilities (CARF) or The Joint Commission (TJC) and be designated by DMHAS as a Local Mental Health Authority(LMHA)
Other Standards: The supervisor must be a licensed clinician. Transitional Case Management staff shall hold either a bachelor's degree in a behavioral health-related specialty (may include special education or rehabilitation) OR have two years experience in the provision of mental health services (may include special education and/or services to persons with developmental disabilities) OR be a Certified Peer Specialist.
Entity Responsible for Verification: DMHAS/ABH
Frequency of Verification: Upon enrollment and reenrollment
Agency based: A Transitional Case Manager shall:

- Be at least 18 yrs old;
- Possess at least a high school diploma or GED; and
- Possess a valid Connecticut driver's license;
- Training requirement: Training programs will address abilities to:
- Follow instructions given by the participant or the participant's conservator;
- Report changes in the participant's condition or needs;
- Maintain confidentiality;
- Meet the participant's needs as delineated in the waiver Recovery Plan;
- Implement cognitive and behavioral strategies;
- Function as a member of an interdisciplinary team;
- Respond to fire and emergency situations;
- Accept supervision in a manner prescribed by the department or its designated agent;
- Maintain accurate, complete and timely records that meet Medicaid requirements;
- Use crisis intervention and de-escalation techniques;
- Provide services in a respectful, culturally competent manner; and
- Use effective Transitional Case Management practices.

Covered Services

Transitional case management services of at least 15-minutes duration include:

1. Referral and related activities to help an participant obtain needed services, including activities that help link eligible individuals with medical, social, educational providers or other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual;
2. Monitoring and follow-up activities, including activities and contacts that are necessary to ensure the waiver Recovery Plan is effectively implemented and adequately addressing the needs of the eligible individual, and which may be with the individual, family members, providers, or other entities and conducted as frequently as necessary to help determine such matters as:
    a. Whether services are being furnished in accordance with an individual's Recovery Plan;
    b. Whether the services in the Recovery Plan are adequate; and
    c. Whether there are changes in the needs or status of the eligible individual, and if so, making necessary adjustments in the Recovery Plan and service arrangements with providers.
3. Face-to-face, telephonic and other contacts with the participant to assist preparation for discharge from an institutional setting and adjustment to community life immediately following discharge;

4. Contacts with landlords and vendors designed to locate and secure suitable housing, and make preparations necessary for the arrival of the participant, including such items as assuring:
    a. A lease is signed and a security deposit is made, if needed;
    b. Utilities or service access is obtained (telephone, electricity, heating and water);
    c. Essential home/apartment furnishings are obtained and in place;
    d. Other basic essentials are obtained and are in place, including window coverings, food preparation items, bed and bath linens, and personal care items;
5. Introducing the participant to other professionals or paraprofessionals involved in the waiver Recovery Plan;
6. Providing information, education and training for the participant regarding:
    a. Household budget, living costs, and lease and utility arrangements;
    b. Security features and the safe operation of appliances in the home, and
    c. Availability and how to access Community resources;
7. Assisting with or making arrangement for setting up the new home, including procuring, moving, and arranging finishing, appliances, and other household items;
8. Supervised visits with the participant to the participant's home, or to locate a suitable home during the transition from an institutional setting;
9. Participation in waiver Recovery Plan development and quarterly Recovery Plan update meetings, if requested by the DMHAS Support Coordinator; and
10. Travel with a participant or family member(s) when the Transitional Case Manager is also engaged in a qualifying waiver service activity.

Limitations

Coverage of Transitional Case Management services shall be subject to the following limitations:

1. Transitional Case Management services are limited to a period of 180 days and two hundred (200) ¼ hour service units. However, additional limitations on the volume and duration of these services may be specified in the waiver Recovery Plan approved by DMHAS and DSS. The departments or their designee will enact these limits;
2. Transitional Case Management services shall be based on the waiver Recovery Plan and shall be performed by or under the supervision of a licensed clinician employed by or under contract to the provider;
3. A claim for reimbursement may be submitted for the qualifying waiver services activities of only one staff member providing Transitional Case Management services to a participant during a specific time period (i.e., billable unit of time);
4. The department shall not pay for:
    a. Transitional Case Management while the participant is receiving Medicaid funded Targeted Case Management services;
    b. Time spent by the provider solely for the purpose of transporting participants;
    c. Programs, services or components of services that are of an unproven, experimental, cosmetic or research nature;
    d. Programs, services or components of services that do not relate to the participant's diagnosis, symptoms, functional limitations or medical history;
    e. Programs, services or components of services that are not included in the fee established by the department;
    f. Services or components of services provided solely for social, recreational, educational or vocational purposes; and
    g. Costs associated with room and board for participants.
5. With the allowable exception of a transition period (up to 30-days), individuals receiving residential rehabilitation services paid for by Medicaid in a group home are excluded from Transitional Case Management.

Non-billable Activities

The following activities are not billable, but have been factored into payment rates:

1. Day-to-day monitoring regarding the participants health and welfare and problem solving to address concerns;
2. Communication and coordination with the DMHAS Support Coordinator, and with other service providers to relay information germane to the participant's needs and continued recovery;
3. Telephone contact with the department or its designated agent for the purpose of requesting or reviewing authorization;

4. Completion of progress notes or billing documentation;
5. Individual or group supervision, routine case reviews and rounds, ad hoc consultation with supervisors and discussion or consultation among recovery team members, including for the purpose of treatment planning;
6. No shows, missed or cancelled appointments, and visits to the participant when the participant is unavailable;
7. Transitional Case Management services of less than fifteen minutes duration for recovery procedures whose billing codes are defined in 15-minute increments; and
8. Time spent engaged in activities required by a credentialing, certification or oversight entity such as gathering and submitting care plan or service data or other information.

TRANSITIONAL CASE MANAGEMENT:
Agency must be accredited by a nationally recognized accrediting body (CARF or Joint Commission only and must be an LMHA). Transitional Case Management staff shall hold either a bachelor's degree in a behavioral health-related specialty (may include special education or rehabilitation) OR have two years experience in the provision of mental health services (may include special education and/or services to persons with developmental disabilities) OR be a Certified Peer Specialist. Meet any other certification standards defined by the Department of Mental Health and Addiction Services.

Please include a resume or summary of work experience for each staff listed in the roster.

Last Name, First Name	Degree/ Experience	License	FTE	Job Title	Specific Experience and Education
				Supervisor. Must be licensed clinician	
				Case Manager	
				Case Manager	

Language Competence: In addition to English, please identify the languages available to participants

	American Sign Language		German		Korean		Swedish
	Arabic		Greek		Laotian		Tagalog (Philippines)
	Armenian		Hebrew		Norwegian		Vietnamese
	Chinese		Hindi		Polish		Yiddish
	Dutch		Hungarian		Portuguese		Other:
	Farsi		Italian		Russian		
	French		Japanese		Spanish		

Supervisor Documentation Requirements for Transitional Case Management Service
If the supervision for this service is not provided by the Chief Clinical Officer for the agency, please indicate if the supervisory functions for this program are provided by a staff or contracted position.

☐ - Employed by Agency

If the position is employed by the agency please include a copy of the employee's current license.

☐- Under Contract with Agency

If contracted with the agency, please provide a letter describing the arrangement by which this person is providing supervisory services and a copy of the contracted supervisor's current license.

Primary Service Locations

Program Name:
Address:
Program Name:
Address:
Program:
Address:

Checklist for application for Transitional Case Management is below

If applying for Transitional Case Management services also include the following documents in your application:

If the supervisor is employed as staff by the agency:		
	a copy of the contracted supervisor's current license	☐
Resume or summary work history for every member listed on the team roster		
	Supervisor	☐
	Case Manager	☐
	Case Manager	☐
If the supervisor for this service is not an agency employee, supply:		
	a letter describing the supervisory arrangement	☐
	a copy of the contracted supervisor's current license	☐

Form **W-9**
(Rev. October 2007)
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, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ _____
☐ Other (see instructions) ▶

☐ Exempt payee

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 Line 1 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
___ ___ ___

or

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).

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 4.

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

General Instructions

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

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, 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.

Note. If 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 on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the 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 withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

Cat. No. 10231X Form **W-9** (Rev. 10-2007)

for more information go to
http://www.irs.gov/pub/irs-pdf/fw9.pdf?portlet=3

Advanced Behavioral Health, Inc.

Certification and Authorization

For purposes of making this application to become a participating provider, the applicant certifies that all information provided to Advanced Behavioral Health, Inc. (ABH) in this application is true and correct to the best of its knowledge and belief. The applicant agrees to notify ABH promptly if there are any material changes in the information provided, whether prior to or after acceptance as a provider. The applicant understands and agrees that if ABH determines that this application contains any significant misstatements, misrepresentations or omissions, acceptance of this application for participation and any subsequent participating provider agreement which ABH enters into with the applying applicant will be voidable at the sole discretion of ABH.

The applicant hereby authorizes the release to ABH of any information held by any person, entity or governmental agency, which 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 ABH harmless from any liability for providing such information.

The applicant hereby further authorizes 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 ABH with an authorization signed by the applicant; or (b) has a legal right to know under any state or federal law. To the extent permitted by law, the applicant agrees to hold ABH harmless from any liability for providing any such information specified herein.

The applicant understands and agrees that the certifications, authorizations, and other provisions contained herein shall remain in force for as long as the application is pending and, if accepted for participation, for as long as the provider agreement with ABH remains in force.

The applicant further understands and agrees that: (a) the applicant has the burden of producing all information required or requested by ABH in connection with this application; and (b) ABH is under no obligation to complete the processing of this application until such information is provided by the applicant.

Print Name: _____

Title: _____

Agency: _____

Signature: _____ Date:_____

(All signatures must be original)