State of Connecticut
Department of Social Services
Division of Autism Services

- Division of Autism Services "Application for Qualified Vendors"
  - The Provider Agreement, Provider Service Checklist, and the DSS & Autism Agency Assurance Agreement need to be completed and accompanied with the DSS Waiver Application and all required documentation.

1) The completed application form and attachments should be submitted to:

   Email to lisa.bonetti@ct.gov or
   Fax: 860-920-3170

   Did you remember to include….
   Attachments:
   - A Letter of Intent
   - A summary of how your agency and staff meet the minimum qualifications
   - Signed Provider Agreement
   - Signed Assurance Agreement
   - Signed Provider Agency Acknowledgement
   - Licenses and Qualifications of **all** consultants as applicable (see Rates & Qualifications in dark red)

2) The DSS will notify the Qualified Vendor applicant in writing within 30 days if the application is complete and identify what information is missing or incomplete. The applicant will be given a time frame to provide the missing information.

3) The DSS will notify a Qualified Vendor applicant in writing whether the application has been accepted within 60 days of the receipt of a complete application.

STATE OF CONNECTICUT

Department of Social Services, Division of Autism Services
55 Farmington Avenue • Hartford, CT 06105

PROVIDER AGREEMENT

Date: _____

Agreement between the Connecticut Department of Social Services (DSS) and

Provider _____

Address
_____

Phone _____ Fax _____

The provider agrees to accept check(s) for item(s) or service(s) purchased for individuals served through the DSS Autism Program. Financial management, for these purchases, is provided by DSS contracted fiscal intermediaries, which is not a Connecticut government agency. Acceptance and endorsement of the check(s) will signify that the provider agrees to the following terms and conditions:

a. Accept payment, in form of check(s), from DSS contracted fiscal intermediaries doing business in Connecticut.
b. Agree to keep records of the service(s) or purchase(s).
c. Provide only the service(s) or item(s) authorized on the check(s).
d. Accept the check(s) as payment in full for the service(s) or item(s) purchased.
e. No additional charges will be made or accepted from clients.
f. Upon request, provide DSS or its designee information regarding the service(s) or purchase(s) for which payment was made.

_____	_____	_____	_____
DSS Autism Representative	Date	Provider Representative	Date

The applicant (check one) ( ) is ( ) is not a current DSS Service provider

For initial enrollment or reapplication/re-enrollment, use **X** to indicate services the provider agency will provide under each program. Complete second column to indicate locations where service will be provided. Complete the third column to list the names of applicant(s).

Provide Service	Service	Specific Towns	Name(s) of Applicant(s)
	Community Companion Homes (formerly Community Training Homes)		[redacted]
	Live-in Companion		
	Respite – In Home		
	Respite - Out of Home		
	Assistive Technology		
	Clinical Behavioral Support Services ****see rates and qualifications page for necessary credentials to be submitted with application**		
	Community Mentor		[redacted]
	Individual Goods and Services		
	Interpreter Services ****see rates and qualifications page for necessary credentials to be submitted with application**		
	Job Coaching		[redacted]
	Life Skills Coach		
	Non-Medical Transportation		
	Personal Emergency Response System		
	Social Skills Group ****see rates and qualifications page for necessary credentials to be submitted with application**		
	Specialized Driving Assessment ****see rates and qualifications page for necessary credentials to be submitted with application**		

1. Provider Agency Acknowledgement

I understand that the provider agency is responsible for submitting to DSS verification and documentation of its qualifications to render the Division of Autism Services indicated on this application.

Signature of Authorized Agent for Provider Agency	Typed or Printed Name and Title of Authorized Agent

Date:_____

Agency Assurance Agreement
To the Department of Social Services

The following assurances are made by:
Name: _____
Title: _____
Agency Name: _____

Assurance	Initials
Will meet all applicable federal and state regulations	
Understands and will follow all applicable DSS policies and procedures	
Will protect the confidentiality of the individual and family's information	
Will bill only for services that are actually provided	
Will submit billing documents after service is provided and within 60 days	
Will accept payment from DSS as payment in full	
Will submit a financial report on forms or software provided by DSS.	
Will submit an audited financial report if receiving more than $100,000 from DSS.	
Will retain financial and statistical records for six years from date of service provision.	
Understands and will follow all Waiver requirements detailed in the HCBS Waiver Manual.	
Will provide the False Claims Act to all staff, including new hires.	
Will allow state and federal offices responsible for program administration and audit to review service records and have access to program sites	
Will comply with State of Connecticut Ethics Protocols	
When transporting a consumer as part of the service: The vehicle in which the transportation is provided must have valid license plates and at a minimum the state of CT required level of liability insurance Vehicles must be maintained in safe working order Consumers with special mobility needs shall be provided transportation in a vehicle adapted to those needs as required to facilitate adequate access to services If the vehicle is used to transport consumers in wheelchairs, it should be equipped with floor mounted seat belts and wheel chair lock downs for each wheel chair it transports	
Will not require a participant to sign an agreement that they will not change agencies as a condition of providing services	
Will make information about staff qualifications and training records and Direct Service staff's time and attendance records available to DSS	
Will participate in individual's person centered planning	
Will obtain adequate information necessary to meet the needs of the individual	
In the delivery of services, specific service related activities as well as staffing are: Available and provided at any time as specified in the individual's Individual Plan. Delivered in a manner that takes into consideration the primary language of the consumer and their representatives as well as cultural diversity issues	
Will not sub-contract services	
Will participate in DSS training on Individual Support Procedures and self-advocacy prior to providing the service.	
Contractor will establish a secured email account using a secured program from the State of Connecticut software.	
Principal of the Entity, the Connecticut Administrator, other principals or owners will notify the	

Operation Center immediately if arrested or convicted of a crime.	
ASD Specific Assurances	Initials
Understands and will follow all applicable DSS Division of Autism Services policies and procedures	
Any staff and their supervisor will complete DSS Division of Autism Services Orientation Training Level 1 prior to providing the services as outlined in Division of Autism Services Guidelines.	
Any staff and their supervisor will complete DSS Autism Spectrum Adult Program Level 2 training as required for staff providing services as outlined in Division of Autism Services Guidelines.	
Will provide a copy of written documentation of services provided to the autism service coordinator and to the participant if applicable by the 15th of the month following the provision of that service. The documentation will include: participant name, service provider name, dates and length of service, activities that occurred that support the goals and objectives of the Individual Service Plan, and suggested activities for the participant.	
Will provide supervision to staff to ensure quality services.	
Will meet and keep current all state licensing/certification requirements for service provision.	
Will provide quality services to individuals with ASD and their families.	

Signed _____ Date _____

Services

- The services defined are for participants of the DSS Autism Division only;
- How much of each service a person will receive, how often it will be provided, and how long it will be provided must be specified in the person's Individual Plan and approved by the DSS Division Director before payment is available;
- An individual may only receive one service at a time with the exception of consultation services which will be specifically outlined in the Individual Plan;
- The definitions of services do not specify any named technique or therapy. These definitions have been written to meet general best practice principles and not to approve/deny any type of technique. The decisions regarding technique will be based on the needs and preferences of the individual, the development of the Individual Plan, keeping in mind evidence based practices;
- All services and supports are to be provided with a staffing ration of one direct service employee to the person unless otherwise specified in the services