Assurance Agreement
Providers Subcontracting for Remote Supports

The provider subcontracting for Remote Supports will be referred to as "Contracting Provider" in this document.

The following assurances are made by Contracting Provider:

_____

(Print Contracting Provider Agency Name)

Assurance **The Contracting Provider will:**	**Check each statement**
Meet all applicable federal and state regulations.	☐
Maintain primary responsibility for the oversight of all supports and services.	☐
Safeguard the use, publication, and disclosure of information on all individuals who receive services under the Contract, in accordance with all applicable federal and state laws regarding confidentiality. This includes, but is not limited to, HIPAA.	☐
Meet all DDS required qualifications and training for the service(s) provided.	☐
Bill only for services that are provided and accept payment, from DDS, as payment in full. Will submit billing documents after service is provided and within 60 days.	☐
Allow state and federal offices responsible for program administration and audit to review service records and have access to program sites.	☐
Sign a provider agreement with the individual and/or family.	☐
Report all incidents that potentially endanger the health and/or safety of the individual to the individual's Planning and Support Team (PST).	☐
Read, understand, and follow all applicable DDS policies and procedures, including but not limited to: State of Connecticut Ethics Protocols HCBS Waiver Manual Abuse and Neglect Policy and Procedures of the Department Incident Reporting Procedure of the Department False Claims Policy and Procedures of the Department	☐
Notify the Operations Center in writing, immediately, if a remote support staff is arrested, convicted of a crime.	☐
Carry professional liability insurance and will provide proof annually, upon request.	☐

The Contracting Provider's Executive Director will agree to CT State Police Fingerprinting and the following checks: DDS Abuse & Neglect Registry, CT Sex Offender Registry, and federal exclusion databases i.e., Office of Inspector General (OIG) and System for Award Management (SAM).	☐
By mutual consent, or without cause, either party can cancel this agreement with a 30-day notice.	☐
If this Agreement is terminated for any reason, cancelled, or it expires in accordance with its term, the Contractor shall do and perform all things which DDS determines to be necessary or appropriate to assist in the orderly transfer of Individuals served under this Agreement and shall assist in the orderly cessation of services it performs under this Agreement.	☐
The Contractor shall deliver to DDS any deposits, prior payment, advance payment or down payment if the Agreement is terminated by either party or cancelled within thirty (30) days after receiving demand from the Agency.	☐
In the event of any legal dispute, the laws of the state of Connecticut shall govern.	☐
Obtain Medicaid provider status for assistive technology and supplies or agency that obtains Medicaid performing provider status, as applicable.	☐
Complete orientation with Assistive Technology Director or designee prior to provision of services.	☐

_____ _____

* Signature of Person Submitting this form Date

*Certification: I attest that the information provided is true. If any statements are willfully false, I realize I am subject to perjury/false statements. I hereby certify that I am authorized to submit this document on behalf of the organization.

1/2023 dl