

Assurance Agreement To the Department of Developmental Services

CLINICAL BEHAVIORAL CONSULTANT - Individual Practitioner

The following assurances are made by:

Name: _____

Title: _____

Agency Name: _____

<i>Assurance</i>	<i>Initial</i>
Will meet all applicable federal and state regulations.	
Understands and will follow all applicable DDS 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 DDS as payment in full	
Will not require a participant to sign an agreement that they will not change Clinical Behavioral Consultants as a condition of providing services	
Understands and will follow all Waiver requirements detailed in the HCBS Waivers manual.	
Will allow state and federal offices responsible for program administration and audit to review service records and have access to program sites	
Will sign a provider agreement with the individual and family	
Will comply with State of Connecticut Ethics Protocols	
Will comply with the Drug Free Policy of the Department.	
Will have knowledge of approved and prohibited physical management techniques. If physical management techniques have to be utilized as part of a behavioral intervention only those that are part of DDS approved physical management curricula will be utilized.	
I have read understand and will follow the Abuse and Neglect Policy and Procedures of the Department.	
I have read, understand and will follow the Incident Reporting Procedure of the Department.	
I have read, understand and will follow the Behavior Support Plan Policy and Procedures of the Department.	
I have read, understand and will follow the Behavior Modifying Medications Policy and Procedures of the Department.	
I have read, understand and will follow the Program Review Committee Policy and Procedures of the Department.	
I have read, understand and will follow the Human Rights Committees Policy and Procedures of the Department.	
I have read, understand and will follow the Department Directive on Prohibited use of Prone restraint.	
I have read, understand and will follow the False Claims Policy and Procedures of the Department.	
Will obtain adequate information necessary to meet the needs of the individual	
I will not hire employees to perform any clinical components of the role.	
Will not sub-contract services to fulfill any clinical components of the role unless the subcontractor is also a qualified provider through DDS.	
Will observe and report all changes which affect the individual to key people within the individual's circle of support and planning and support team.	
Will carry professional liability insurance of a minimum of \$500,000 per occurrence and \$1.5 million in aggregate. Submit documentation of such coverage annually to the Operation Center and upon request.	
Will notify the Operation Center immediately if I am arrested or convicted of a crime.	

Signed _____

Date _____