# Assurance Agreement
## To the Department of Developmental Services

The following assurances are made by:

Name: _____
Title: _____
Agency Name: _____

| Assurance | Check Each Statement |
|---|---|
| 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 90 days | ☐ |
| Will accept payment from DDS as payment in full | ☐ |
| Will retain financial and statistical records for six years from date of service provision | ☐ |
| 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 | ☐ |
| When transporting a consumer as part of the service:<br>• 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<br>• Vehicles must be maintained in safe working order<br>• Consumers with special mobility needs shall be provided transportation in a vehicle adapted to those needs as required to facilitate adequate access to services<br>• If the vehicle is used to transport consumers in wheel chairs , 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 DDS | ☐ |
| Will participate in individual's person centered planning if requested | ☐ |
| 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:<br>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 DDS training on Individual Support Procedures and self advocacy prior to providing the service. | ☐ |

_____ Date _____
* Name of Person Submitting Application

*Certification: I certify that the information provided is true. If any statements are willfully false, I realize I am subject to perjury/false statements.

*Revised 9/2014*