



FMS-Outreach & Training Services
P.O. Box 479, East Windsor CT. 06088-0479
Phone: (860) 627-9500 Fax: (860) 627-0230
Toll-Free Fax: 1-877-722-8833

Date: _____

From: _____

Fax to: 860-627-0230

of Pages: _____ of _____

Transportation Application Packet CHECKLIST: ABI Program

The attached application packet is complete when all items have been checked off. All forms must be completed and submitted to Allied Community Resources. Please refer to the directions on the following page as they pertain to completing the Application Packet. You may use this page as a cover sheet when mailing or faxing your forms.

- 1. ABI Waiver Provider Directory Application

- 2. ABI Waiver Provider Directory Application-Provider Agreement

- 3. W9 Form

- 4. Transportation Services Application Supplement

- 5. Clear copy of your driver's license and vehicle insurance card with all pertinent information shown.

ABI Waiver Program
Provider Directory Application Instructions

The following information is provided to assist you in completing this Provider Directory application. Please enter the information requested in Parts A and B according to the instructions that follow. Then carefully read the Provider Agreement, found on the back of the application, which must be signed and returned with all required documentation to:

Allied Community Resources
Attn: Outreach & Training Services
Financial Management Services Division
P.O. Box 479
East Windsor, CT 06088-0479

Part A.

For #1 - #8, enter the information as requested:

If you are applying as an **agency**, please check Agency and write the agency's name as the Provider Name. Enter a contact person for the agency. Enter the agency's address, phone number, fax number, FEIN number, and indicate in which DSS regions the agency will provide Waiver services based on the list below.

If you are applying as an **individual**, please check Individual and write your name as the Provider Name. Do not enter anything for Contact. Enter your address, phone number, fax number (if applicable), Social Security number.

9 Indicate in which DSS regions you will provide Waiver services based on the list below.

Below are the five Ct. Dept. of Social Service regions and the regional offices serviced under each:

North Central: Hartford, Manchester, New Britain

Southwest: Bridgeport, Stamford

South Central: New Haven, and Middletown

Northwest: Waterbury, Danbury, and Torrington

Eastern: Norwich

Part B.

Col. 1 There are 19 covered services in the ABI program. Each is listed as a Provider Specialty in Column 2. You may wish to be a provider for more than one service. In Column 1, check all that apply. Refer to the Provider Manual for specific descriptions of services as they are defined and utilized under this program.

Col. 3 Are you applying as an agency or an individual.

Col. 4 In the Provider Manual under your provider specialty, the specific qualifications for each provider type are described. In column 4 of this application, list your qualifications for each provider specialty that you checked.

PLEASE BE SURE TO ATTACH COPIES OF YOUR PROVIDER QUALIFICATION DOCUMENTATION. Make sure you have written verification of ALL of the qualification guidelines listed in the manual. Please highlight pertinent experience, skills, settings, etc., in your application, Vitae or resume that are required for that specific service. Services which include qualifications standards that cannot be documented through an application or resume (ie. have ability to maintain confidentiality, or implement cognitive/behavioral strategies) must be verified through a letter of reference. Include verification of trainings if required for services as well. Agencies that do not meet the certification standard for a particular service as a whole and need to qualify specific staff member must submit applications obtained through Allied and gain individual approval. If training is required and has not been attended yet, please contact the Outreach & Training Services Department at 860-627-9500 for information and registration.

If you have any questions about provider qualifications, documentation, or need information on A.B.I. trainings, contact the Outreach & Training Services Department at (860) 627-9500.

ABI WAIVER PROVIDER DIRECTORY APPLICATION-PROVIDER AGREEMENT

1. All of the statements made by me on this application and all information contained in my supporting provider qualification documentation are true and correct.
 2. I acknowledge that I can perform all the standards and duties for the services for which I am applying as stated in the provider manual.
 3. I will immediately notify the Department and the Fiduciary Agent if any information provided by me on this application changes.
 4. I will maintain current standing with respect to any license and/or certification requirement established by the Department for my ABI provider type and service specialty.
 5. I will immediately notify the Department and the Fiduciary Agent if such licenses and/or certifications expire, are revoked, suspended or otherwise terminated for any reason.
 6. I will provide (**EXCEPT while the participant is in a hospital/skilled nursing facility**), all services in accordance with the ABI Waiver participant's service plan.
 7. The rate paid by the Department for the performance of ABI Waiver Services is the complete payment in full for all service(s), goods or products delivered to eligible ABI Waiver participants.
 8. Except for authorized co-payments made by eligible waiver participants, the Department's payments to me for the performance of ABI services constitute sole and complete payment in full.
 9. I will maintain records that fully disclose services and goods rendered and/or delivered to ABI Waiver participants. These records will be made available to authorized representatives to the Department upon request.
 10. I acknowledge that I may be suspended or terminated from the ABI provider registry if I am found by the Department to have engaged in fraudulent or abusive program services.
 11. I agree to not use or disclose protected health information (PHI) other than as permitted or as required by law and to use appropriate safeguards to prevent improper use or disclosure of PHI.
 12. I acknowledge that I am 18 years of age or older and eligible to provide services under the ABI Waiver Program.
 13. I understand that if I provide a service for which I have not gained approval, I will not be paid under the waiver.
 14. I understand that I am required to undergo a Criminal Background Check upon consideration of employment by any ABI Waiver participant AND that the criminal activity, if any, revealed by the Criminal Background Check may result in disqualification from continued enrollment in the Provider Directory, consideration for employment by any ABI Waiver participant, and possible further legal action.
 15. I understand that no private or self-employed provider may perform services in excess of 25.75 hours per week per waiver participant.
 16. I understand that I may not provide services both privately and as an agency employee to the same waiver participant as this creates a conflict of interest.
 17. I understand that PCA is the only service a family member may provide except in the situation that they are the spouse, parent (if the consumer is under the age of 21), conservator, or member of the conservator's family.
 18. This is a State and Federal Government program. Altering timesheets, hours worked, or reporting of false hours is considered fraud. You will be subject to prosecution for fraud to the fullest extent of the law. You may be subject to prosecution on both a State and Federal level should you commit this crime.
 19. I understand that this program does not provide Worker's Compensation Coverage.
 20. I understand that I am not employed by Allied Community Resources. Allied Community Resources is a Fiduciary Agent on behalf of the client that I am employed by. The Fiduciary Agent processes payments/payroll on behalf of the employer and handles withholding for private household employees.
 21. I have read and accept the terms of this provider agreement as stated to me above and I also understand that the addition of my name to the Statewide Provider Directory as well as any possible employment may be contingent upon the results of the Criminal Background Check.
 22. By signing this provider agreement, I consent to have a Criminal Background Check performed prior to providing services under the ABI Waiver Program by the Department or the Fiduciary Agent. In addition, I acknowledge that said results of the Criminal Background Check may be released to any potential employer or his/her designated representative.
 23. I understand that failure to comply with the above statements may result in removal from the active ABI Waiver Program Directory.
 24. I understand that if I have previously worked for any agencies, I have left that agency in good standing and that the Fiduciary Agent may contact said agency and obtain any and all employment records.
- 25. I HAVE READ AND ACCEPT THE TERMS OF THE PROVIDER AGREEMENT AS STATED ABOVE.**

Provider Name (Please Print)

Provider Signature

Date Signed

If Agency, Representative's Name (Please Print)

Agency Representative's Signature

Date Signed



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Transportation Services Application Supplement
(Complete ONLY if you wish to apply to provide Transportation services)

Please provide the following information in the space provided along with a clear copy of your valid Driver's license and insurance information.

Driver Information:

License/Operator Number: _____

State issuing license: _____

Expiration date of license: _____

Has your license ever been revoked or suspended? (please check one) Yes No

If yes, please explain in the space below:

List any accidents or violations in the past three years:

Have you even been convicted of driving under the influence, leaving the scene, or reckless driving?

Please check one: Yes No

If yes, please explain in the space below:

I certify that answers given herein are true and complete to the best of my knowledge. By signing below, I authorize an investigation of my driving record at any point while I am an authorized approved provider at the discretion of the fiscal intermediary.

Provider Signature

Provider Name (please print)

Date Signed

For office use only:

Driver's license photocopy received

Insurance card photocopy received

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: <input type="checkbox"/> Individual/ Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other ▶	
	<input type="checkbox"/> Exempt from backup withholding	
	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.

Social security number									

or

Employer identification number									

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

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. person (including a U.S. resident alien).

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 ▶
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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.

U.S. person. 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.

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.

For federal tax purposes you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or

- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien.

Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.