independence.

(5) **Companion Services** are services that are nonmedical, provided in accordance with a therapeutic goal.

(A) Companion services include, but are not limited to, the following:

(i) Supervision and socialization services;
(ii) assistance with or supervision of meal preparation;
(iii) assistance with laundry that is being performed by the individual; and
(iv) light housekeeping tasks that are incidental to the care.

(B) Companion services shall not entail the provision of hands on care.

(6) **Environmental Accessibility Adaptation Services** are physical changes made to the individual's home that are of direct medical or remedial benefit to the individual; that seek to ensure the health, welfare and safety of the individual; or enhance and promote greater independence, without which the individual would require institutionalization.

(A) Adaptation services include, but are not limited to, the following:

(i) Installation of ramps;
(ii) widening of doorways;
(iii) modifications to meet egress requirements;
(iv) modification of bathroom facilities; and
(v) addition of specialized electrical and plumbing devices.

(B) All adaptation services shall be provided in accordance with applicable state or local building codes.

(C) Adaptation services not covered include, but are not limited to: carpeting; central air conditioning; roof repair; and house adaptations that add to the square footage of the home.

(7) **Prevocational Services** are services designed to prepare an individual with employment-related goals for paid or unpaid employment, by providing learning and work experiences through which the individual can develop strengths and skills that contribute to employability in integrated community settings.

(A) Prevocational Services focus on teaching the concepts of taking direction, attendance, task completion, problem solving and safety, with the goal of enhancing attention span and motor skills.

(B) Prevocational services shall not be provided to an individual who is participating in a supported employment program.

(C) Individuals may be compensated at a rate not to exceed 50% of the minimum wage. The prevocational service provider or other source may provide compensation.

(D) Prevocational Service provided under the ABI Waiver may not otherwise be available under a program funded under the Rehabilitation Act of 1973, 20 USC 1401 et seq., or the Education for All Handicapped Children Act, Pub. L. No. 94-142.

(E) Transportation is included in the rate paid to the ABI Waiver prevocational provider.

(8) **Supported Employment Services** are ongoing supportive services provided to an individual who, because of their disability, needs intensive support to obtain and maintain employment at or above the minimum wage and meets personal and career goals.

(A) Supported employment may be conducted in a variety of settings, including work sites where persons without disabilities are employed. When supported employment services are provided in such integrated settings, payments may be made only for adaptations, supervision and training needed by the individual, and shall not include payment for any modifications or activities rendered or required within the normal business setting.

(B) Supported employment services may not otherwise be available under a program funded under the Rehabilitation Act of 1973, 20 USC 1401 et seq., or Education for All Handicapped Children Act, Pub. L. No. 94-142.

(C) Transportation is included in the rate paid to the supported employment provider.

(9) **Homemaker Services** are general household activities including, but not limited to, meal preparation and routine household chores such as: dusting; bed making; and vacuuming. The department shall pay for homemaker services when the individual is unable to manage household activities or when the person primarily responsible is absent or unable to perform such household activities.

(10) **Home Delivered Meals** or "meals on wheels," is the preparation and delivery of 1 or 2 meals per day to an individual who is unable to prepare or obtain nourishing meals on their own, or for an individual who normally has someone who is responsible for preparing and delivering meals, but that person is temporarily absent or unable to perform this service.

(11) **Independent Living Skills Training**

(A) Independent Living Skills Training is a teaching service designed and delivered to an individual or a group to improve an individual's ability to live independently in the community and to carry out strategies developed in cognitive or behavioral programs.

(B) Supervision is not a discrete service provided under this component.

(C) Independent Living Skills Training may include, but is not limited to the following:

(i) Training in self-care;
(ii) medication management;
(iii) task completion;
(iv) interpersonal communication skills;
(v) socialization skills;
(vi) sensory/motor skills;
(vii) mobility and community transportation skills;
(viii) problem solving skills;
(ix) money management skills; and
(x) household management skills.

(D) Independent Living Skills Training is provided in the individual's home or community.

(12) **Personal Care Assistance**

(A) Personal Care Assistance is assistance with the following:

(1) Eating, bathing, dressing, personal hygiene and other activities of daily living that are performed by a qualified provider in the individual's home or community; or

(2) supervision and cueing of these activities without actual hands-on assistance.

(B) Personal care assistance is provided only if the individual's physical ability to perform activities of daily living is impaired, or if the individual's cognitive or behavioral impairments interfere with the individual's ability to perform these tasks.

(C) A member of the individual's family, except the individual's spouse, may provide personal care assistance as long as the family member meets the training requirements specified by the department.

(13) **Personal Emergency Response Systems** ("PERS")

(A) A PERS is an electronic device connected to the individual's telephone that enables an individual at high risk of institutionalization to secure help in an emergency.

(B) The PERS is available only to an individual who lives alone, or who is alone for significant parts of the day and who does not have providers, or to an individual who would otherwise require extensive routine supervision.

(14) **Respite Care**

(A) Respite care services are provided to individuals who are unable to care for themselves and the person normally performing such services is absent or in need of relief.

(B) Services shall be furnished on a short-term basis in the individual's home.

(15) **Specialized Medical Equipment and Supplies**

(A) Specialized medical equipment and supplies include, but are not limited to, the following:

(i) Devices, controls or appliances, specified in the service plan, that enable the individual to increase their ability to perform ADLs or to cognitively perceive, control or communicate in the individual's environment within the community;
(ii) items necessary for life support and those ancillary supplies and equipment that are necessary for the proper functioning of such items; and
(iii) durable and non-durable medical equipment that is not available as a covered medical service under the Medicaid program.

(B) Specialized medical equipment and supplies paid for under the ABI waiver program shall be of direct medical or remedial benefit to the individual; meet all applicable standards of manufacture, design and installation; and be in addition to any medical equipment and supplies furnished under the Medicaid State plan.

(16) **Substance Abuse Programs** are individually designed interventions to reduce or eliminate the individual's use or abuse of alcohol or drugs when such use or abuse may interfere with the individual's ability to remain in the community.

(A) Substance abuse programs shall include, but are not limited to, the following services:

(i) Performing an in-depth assessment of the relationship between the individual's use or abuse of alcohol or drugs and brain injury;
(ii) performing a learning and behavioral assessment;
(iii) developing and implementing a structured treatment plan;
(iv) providing ongoing education and training of the individual, family members and other service providers concerning support needs of the individual;
(v) developing individualized relapse strategies;
(vi) conducting periodic reassessment of the treatment plan; and
(vii) providing ongoing support to the individual.

(B) Substance abuse programs shall be provided on an outpatient basis in a congregate setting or the individual's community.

(C) The individual's structured treatment plan may include both group and individual interventions and shall reflect the use of curriculums and materials adopted from substance abuse programs designed to meet the needs of individuals with cognitive impairment.

(D) The treatment plan shall include linkages to existing community-based, self-help or support groups, such as Alcoholics Anonymous and organizations that promote and support sobriety.

(E) With the individual's consent, the substance abuse program provider shall communicate with the individual's other service providers concerning the individual's treatment regimens.

(17) **Transitional Living Services** are short-term, individualized, residential services providing support to an individual transitioning in to a community living situation. Services and supports designed to improve the individual's skills and ability to live in the community. Services include: assessment; communication and interpersonal skills; socialization; sensory/motor skills; mobility and community transportation skills; problem solving skills; money management and skills necessary to maintain a household. The intent of transitional living services is to "step-down" from a higher level of care. Services may be provided up to 24 hours per day.

(A) Transitional living services shall be provided only when the individual is unable to be supported in a permanent residence and is in need of intensive clinical interventions provided by this service.

(B) Transitional living services may be provided only once and are expected to meet all of the ABI waiver services and support needs of the individual.

(C) Prior to discharge from transitional living services, the provider shall work with the individual and the DSS social worker to develop a community living plan of care. Upon discharge, other ABI purchasable services shall become available to the individual in accordance with the revised service plan.

(D) ABI waiver funds shall not be used to pay for the room and board component of transitional living services.

(E) Transitional living services cannot be provided with any services except, case management, environmental modifications, specialized medical equipment and vehicle modifications.

(18) **Transportation Services**

(A) Transportation services shall be available under the ABI Waiver Program for the purpose of transporting individuals to ABI waiver services as set forth in the service plan.

(B) Transportation services shall not be provided when friends, family, neighbors or community agencies are able to provide transportation free of charge.

(C) All reasonable alternatives shall be explored and exhausted prior to receiving approval for transportation services.

(D) Transportation services may be provided when the transportation needed does not qualify as medical transportation under 42 CFR §440.170(a).

(19) **Vehicle modification services** are alterations made to a vehicle when such alterations are necessary improve the individual's independence and so that the individual may avoid institutionalization.

(A) The vehicle shall be the individual's primary means of transportation. The vehicle shall be owned by the individual; a relative with whom the individual lives or has consistent and ongoing contact; or a non-relative who provides primary long-term support to the individual and is not a paid provider of such services.

(B) All modifications and adaptations shall be provided in accordance with applicable federal and state vehicle codes.

(NEW) **Sec. 17b-260a-6. Services Not Covered Under the ABI Waiver**

(1) The department shall not pay for any services that are not set forth in section 17a-260a-5 of the Regulations of Connecticut State Agencies, including, but not limited to:

(1) Basic needs such as food, shelter, clothing, utilities, routine transportation and personal incidental expenses;
(2) medical services already covered under the department's medical assistance program including, but not limited to: hospital care; physician's fees; and prescription drugs;
(3) services not listed in the individual's service plan;
(4) services not provided in accordance with the terms of the approved service plan, including, but not limited to, the number of hours specified in the plan;
(5) services not performed by the designated provider listed in the service plan;
(6) services billed for an amount that exceeds the department's approved rate and maximum limit for such service;
(7) services billed by a single household employee or private provider, alone or in combination with other services, in excess of 25.75 hours per week, except as otherwise provided in section 17b-260a-5 (E)(12) of the Regulations of Connecticut State Agencies;
(8) for scheduled hours that a provider did not keep;
(9) for transportation of the provider to and from the individual's home;
(10) chore services, companion services, homemaker services, personal care assistance and transportation services when the provider performed such services free of charge before the individual became eligible for the ABI waiver program; or
(11) any services billed for dates during which the participant is an inpatient at a hospital, skilled nursing facility or other institution.

(NEW) **Sec. 17b-260a-7. Assessment and Development of a Cost-Effective Service Plan**

(a) The department shall conduct an initial level-of-care assessment following the receipt of the individual's application to determine whether the individual meets one of the level-of-care criteria described in this section and the requirements described in section 17b-260a-4 of the Regulations of Connecticut State Agencies.

(b) The level-of-care assessment is based upon information obtained from the individual; medical reports from the individual's physician, including a neuropsychologist; and any other clinical personnel who are familiar with the individual's case and history. The individual shall meet one of the following levels-of-care in order to qualify for services under the ABI Waiver:

(1) Category I - The individual is considered to require care in a nursing facility if the individual resides in such a facility, or has impaired cognition and, due to physical or cognitive deficits, requires physical assistance, supervision or cueing with two or more ADLs, including, but not limited to, eating, bathing, dressing, toileting and transferring;

(2) Category II - The individual is considered to require care in an ABI NF if the individual resides in such a facility, or has impaired cognition, impaired behavior requiring daily supervision or cueing, and a mental illness that manifested itself before the brain injury occurred;

(3) Category III - The individual is considered to require care in an ICF-MR if the individual resides in such a facility, or has impaired cognition, an ABI that occurred before the age of 22 and, due to physical deficits, requires physical assistance, with two or more ADLs; or

(4) Category IV - The individual is considered to require care in a chronic disease hospital if the individual resides in such a facility, or has impaired cognition, impaired behavior and, due to physical or cognitive deficits, requires physical assistance, supervision or cueing with two or more ADLs.

(c) If the individual meets the one of the level-of-care criteria in subsection (b) of this section, the department, in conjunction with the person-centered team, shall develop a cost-effective service plan.

(d) An individual who meets the level-of–care-requirements for more than one of the categories described in subsection (b) of this section shall be served at the lower level-of-care.

(e) The department shall reevaluate the level-of-care required by an individual at least once every twelve months or more frequently when necessary.

(NEW) **Sec. 17b-260a-8. Determining the Cost Effectiveness of the Service Plan**

(a) In order to determine the cost effectiveness of the individual's service plan, the department shall:

(1) Obtain the annualized alternative institutionalized care costs for the individual. For each level-of-care listed in subsection (b) of section 17a-260a-7 of the Regulations of Connecticut State Agencies, the alternative institutional care cost is equal to the state's weighted average cost for the specified facility type, as annually developed and published by the

department, minus the average applied income;

(2) determine the annualized cost of the individual's total service plan by totaling the 12-month cost of each covered service, described in subdivisions (A) to (C), inclusive, of this subsection, which may be provided to the individual, based on the department's established rates for such services.

(A) Determine the annualized cost of the waiver services, included under section 17b-260a-5 of the Regulations of Connecticut State Agencies, to be provided to the individual under the proposed service plan;

(B) determine the annualized cost of other medical services, as specified under section 17b-260a-3(27), provided in the individual's home that the individual may require in order to live in the community, by multiplying the expected frequency of utilization of these services by the Medicaid rates established by the department for such services; and

(C) determine the annualized cost of any community-based services that the individual may require in order to live in the community.

(3) Add the annualized cost of the waiver services, other home-based medical services and community based services to obtain the individual's total service costs.

(4) Compare the individual's total service costs to the individual and aggregate caps.

(b) Individual and Aggregate Caps

(1) The individual cap is equal to 200% of the individual's alternative institutional care costs. The aggregate cap is equal to 75% of the alternative institutional care costs for the entire waiver population.

(2) Two hundred per cent of the individual's alternative institutional care costs shall equal the maximum dollar amount available to fund the service plan. However, since no single plan may cause the aggregate cap to exceed 75%, every effort shall be made to provide services below the maximum dollar amount level, in the most cost-effective manner possible. In addition, the department may not exceed the funding limitations established in the approved waiver when determining whether an individual can be accepted into the program.

(c) The department shall not approve a plan that exceeds the individual or the aggregate caps as defined in this regulation.

(NEW) **Sec. 17b-260a-9. Individual's Responsibilities**

(a) The individual or, if applicable, the individual's legal representative and the person-centered team, shall collaborate and participate in the service plan development process and select qualified providers to deliver the services specified in the service plan.

(b) An individual whose gross income exceeds 200% of the federal poverty level shall be required to contribute toward the cost of services rendered under the waiver. The amount contributed shall be calculated according to section 5045 of the Uniform Policy Manual.

(c) The individual shall agree to pay the portion of their income calculated to be contributed toward their cost of care, directly to the department's fiduciary agent and the department shall deduct this same amount from its payment to the provider. This agreement shall be documented in the individual's service plan.

(d) The individual is the employer of household employees and private providers who are not employed by an agency. As the employer of these providers, the individual shall have free choice of all qualified providers of each service included in the individual's service plan and shall be responsible for:

(1) Selection of providers;
(2) supervision of the services that are provided in accordance with the service plan;
(3) notifying the department if they are dissatisfied with an agency provider or with the quality of the services performed by an agency provider and select a different provider; and
(4) if necessary, termination of the employment of a household employee or a private provider not otherwise employed by an agency.

(e) In accordance with section 31-284 of the Connecticut General Statutes, the individual shall obtain and maintain worker's compensation services for single providers who are employees under the definition provided in section 31-275(9)(B) of the Connecticut General Statutes.

(f) The individual shall provide documentation to the department to verify that worker's compensation insurance has been obtained and shall remain

in effect for at least one year from the date the personal care assistant begins providing personal care assistance services to the individual. Personal care assistance services provided more than 25.75 hours per week shall not be covered without the submission of such documentation.

(**NEW) Sec. 17b-260a-10. Department Responsibilities**

The department shall:

(a) Inform individuals of any feasible alternatives available under the ABI waiver program and offer individuals the choice of either institutional or home and community-based services;

(b) provide social work services to individuals that include, but are not limited to, the following:

(1) An assessment of the individual's eligibility for the ABI waiver program;

(2) coordination and development of a service plan designed to deinstitutionalize or divert the individual from institutional placement;

(3) assistance with implementation of the approved service plan by coordinating services provided to the individual;

(4) review with the individual, on a regular basis, the effectiveness of the service plan and make appropriate and cost-effective revisions to the plan, as required, based on achievement of the expected outcomes, the individual's degree of satisfaction with the services and providers, the individual's changing capabilities and the ongoing availability of community-based services;

(5) complete a formal review of the service plan with the individual at least once every 12 months;

(6) initiating a reassessment of the individual's level-of-care every 12 months from the date of the initial service plan;

(7) maintaining records for at least 5 years; and

(8) initiating a re-assessment of the service plan when the individual has experienced a significant improvement or decline in the individual's ability to function in the community.

(c) advise the individual of their right to an administrative hearing if they are aggrieved by the department's decision with respect to the individual's application or eligibility for the ABI waiver;

(d) maintain a waiting list of individuals who are ineligible for ABI services for reasons listed in section 17b-260a-4(d) of the Regulations of Connecticut State Agencies;

(e) establish provider qualifications and, through its fiduciary agent, establish and maintain a directory of qualified providers;

(f) establish payment rates for all services offered under the waiver program;

(g) pay for approved ABI waiver services delivered by qualified providers through its fiduciary agent, on behalf of the individual; and

(h) determine within 45-days of application the individual's financial eligibility for the program, and complete, as expeditiously as possible, the level-of-care assessment and development of a cost-effective service plan.

(NEW) **Sec. 17b-260a-11. Provider Responsibilities**

(a) General Provider Responsibilities

(1) All household employees, private providers or agency shall report any arrest of a provider to the department within 10 business days. The failure of the household employee, private provider or agency to report such arrest may result in termination of the provider agreement.

(2) The department may deny payment of services performed by any household employee, private provider or agency provider who does not meet the department's qualifications as set forth in this section.

(3) Any household employee, private provider or agency provider may be suspended from participation in the program if the provider accepted payment for services that were never provided to the individual client or otherwise violates the rules, regulations, standards or laws governing the program in accordance with sections 17-83k-1 to 17-82k-7, inclusive, of the Regulations of Connecticut State Agencies.

(4) All providers are required to report to the department an occurrence involving an individual that results in a physical injury to or by the individual that requires a physician's treatment or an admission to a hospital; results in someone's death; requires emergency mental health treatment for the consumer; or requires the intervention of law enforcement. Critical incident reports shall be made in accordance with the manner, format and time frame set forth in the provider agreement or as directed by the DSS Manager or the individual's designee.

(5) Agency providers shall have policies in place regarding the provision of language services and should not rely on patients' friends, family or other "ad hoc" interpreters.

(6) Individuals who apply to become a qualified provider under the ABI Waiver program are required to complete a state and federal criminal background check and include, with their submitted Provider Directory Application, the fee to pay for the processing of the application. The fee shall be submitted in the amount, form and manner as set forth in the Provider Directory Application that is in effect at the time the application is submitted.

(7) The commissioner shall have the discretion to refuse to list an individual in the Provider Directory, remove an individual's name from the Provider Directory or refuse payments to a household employee if the household employee performing the services has been convicted in this state or any other state of a felony, as defined in section 53a-25 of the Connecticut General Statutes; involving forgery under sections 53a-138 and 53a-139 of the Connecticut General Statutes; involving robbery under section 53a-133 of the Connecticut General Statutes; involving larceny under sections, 53a-119, 53a-122, 53a-123, and 53a-124 of the Connecticut General Statutes; involving vendor fraud under 53a-290 and 53a-296 the Connecticut General Statutes; involving cruelty to persons under section 53-20 of the Connecticut General Statutes; involving sexual assault under sections 53a-70, 53a-70a, 53a-70b, 53a-71, 53a-72a, 53a-72b, 53a-73a of the Connecticut General Statutes; involving assault under section 53a-59 and 53a-59a of the Connecticut General Statutes; or involving the abuse of elderly, blind, disabled or mentally retarded persons under sections 53a-320 and 53a-323 of the Connecticut General Statutes.

(b) Agency Providers

(1) Agencies seeking application to become a qualified provider or that are currently a qualified provider under the ABI Waiver program are required to ensure that all staff, volunteers, interns or other person employed by, supervised by or representing the agency who may have direct contact with individuals receiving ABI Waiver funding, that the agency meet and maintain all criminal background standards as set forth in subsection (a)(6) of this section.

(2) Provider agencies shall deliver training to staff members regarding the provision of services that are person-centered and culturally competent.

(3) Provider agencies shall have policies and procedures in place regarding employee standards of conduct. These policies and procedures shall include the following topics, but are not limited to:

(A) Person-centered provision of services;

(B) respect of participant's rights, including privacy and self-determination;

(C) neglect, abuse and harassment of participants;

(D) the provision of services while using, or under the influence of drugs or alcohol;

(E) confidentiality of all participant information collected, used or maintained; and

(F) critical incident reporting requirements.

(NEW) **Sec. 17b-260a-12. Provider Participation**

(a) In order to participate in the ABI Waiver program and receive payment from the department, provider shall:

(1) Enroll with the department or its agent and have on file a valid provider agreement;

(2) Meet and maintain applicable programmatic credentialing criteria and federal and state licensing, certification and accreditation requirements;

(3) Comply with all Medicaid documentation and other requirements, including but not limited to, those in the provider agreement;

(4) Maintain good standing within State of Connecticut (e.g., no fraud, loss of contract for cause, or suspension for any state of Connecticut funded program within past 5 years);

(5) Deliver and bill for services that are outlined in the participant's service plan; and

(6) Comply with the stipulations outlined in any corrective action plans implemented.

(b) If the department has reason to believe that a provider is a threat to the health of a waiver participant, the department may summarily suspend the provider agreement.

(c) The commissioner shall have the discretion to refuse provider participation to persons who have been convicted in this state or any other state of a felony, as defined in section 53a-25 of the Connecticut General Statutes.

(NEW) **Sec. 17b-260a-13. Corrective Action**

(a) If a provider is out of compliance with sections 17b-260a-11 to 17b-260a-17 of the Regulations of Connecticut State Agencies or provider agreement, the department shall have the discretion to implement a corrective action plan. Failure to develop or meet the requirements of the corrective action plan shall result in termination or suspension of the provider agreement.

(1) The provider shall, reply to, and cooperate in arranging compliance with, a program or fiscal audit or program violation exception that a state or federal audit or review discovers.

(2) The provider shall cooperate fully with the department or its agent, prepare and send to the department a written plan of correction or response to any adverse findings.

(3) The provider shall correct all deficiencies in the manner and times required by the department.

(4) The provider shall report any arrests of agency employees or themself within 10 business days and provide status updates periodically at the request of the department.

(NEW) **Sec. 17b-260a-14. Fiscal responsibility**

(a) For purposes of this section

(1) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

(2) "Abuse" means practices that are inconsistent with generally accepted fiscal or business practices and result in unnecessary cost to the ABI Waiver program.

(a) The provider agrees that it shall not engage in or commit fraud or abuse including, but not limited to:

(1) Billing for services not rendered;

(2) billing for services not in the service plan;

(3) billing for services not medically necessary;

(4) inappropriate or lack of documentation to support services billed;

(5) billing for services for ABI Waiver participants who are institutionalized during the dates of billed service provision; or

(6) violating Medicaid policies, procedures, rules, regulations or statutes.

(NEW) **Sec.17b-260a-15. Quality Assurance**

(1) All providers shall submit program data in a form that is set forth by the department.

(2) Agency providers shall complete random checks of staff.

(3) Agency providers shall establish a quality assurance plan at the time of application.

(NEW) **Sec. 17b-260a-16.** C**lient Documentation and Provider Reporting**

(a) Providers are required to retain records to document services submitted for Medicaid reimbursement for at least five years from the date the service or item was provided. Documentation shall include the following:

(1) Individual's name and the signature of the individual or their legal representative;

(2) provider's name and signature;

(3) dates of service;

(4) start time for each visit;

(5) end time for each visit; and

(6) a brief description of duties performed.

(b) Upon written request presented to the provider, the department or its authorized agent may be given immediate access to, and permitted to review and copy any and all records and documentation used to support claims billed to Medicaid.

(c) For purposes of subsection (b) of this section, "immediate access" means access to records at the time the written request is presented to the provider.

(d) The provider shall submit monthly reports and written updates on the individual's progress in a form that is set forth by the department.

(e) The failure of a provider to comply with subsections (a) to (e), inclusive, of this section, may result in the nonpayment of the services.

(NEW) **Sec. 17b-260a-17. Provider Termination or De-Qualification**

Providers shall remain in good standing. Failure to comply with the aforementioned provider requirements or to remediate, within prescribed timeframes as set forth in provider agreement or required by the DSS ABI Waiver manager or designee, any requirements herein may result in the suspension or termination of the provider's service contract, removal from the Provider Directory, or disqualification as a provider.

ACQUIRED BRAIN INJURY PROGRAM
COMMUNITY OPTIONS
1-800-445-5394

The Acquired Brain Injury Program

The Department of Social Services operates the Acquired Brain Injury Program which provides a range of non-medical, home and community based services to help adults who have an acquired brain injury live in the community. Without these services, the adult may require placement in an institutional setting.

The program is designed to assist participants to relearn, improve or retain the skills needed to live successfully in the community. The program follows the principles of person-centered planning to develop an adequate, appropriate and cost-effective plan of care from a menu of home and community-based services to achieve personal outcomes that support the individual's ability to live in his/her community of choice.

An adult determined eligible for the ABI Program qualifies for all Medicaid covered services.

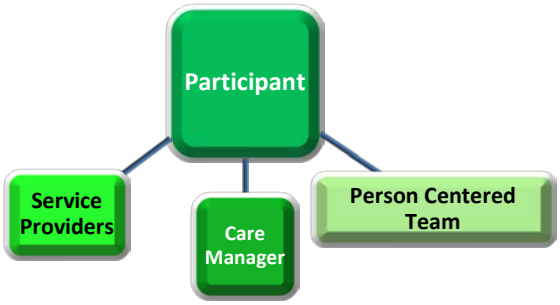
Functional Needs Requirement

Adults must be age 18-64 to apply, and meet the functional requirements of the program. Applicants must require assistance with two Activities of Daily Living (ADLS) such as:

- Bathing
- Dressing
- Toileting
- Eating
- Transfers (i.e., getting in and out of bed)

Self Direction

Participants are the employer for household employees and are responsible for directing the hiring, firing, assignment of duties and signing timesheets. Supports in these activities are provided to those who need it. Case management services are included in the service plans of participants who need assistance with these activities. Participants are afforded the opportunity to speak with and/or interview prospective agency providers prior to selection.



Plan of Care
Once a slot becomes available, a referral will be sent to the Access Agency in your region. Access Agency Care Managers, in consultation with the participant, their family and care providers (e.g., skilled nursing/ABI facility staff, primary care physicians, and neuropsychologists) develop plans of care to meet an individual's cognitive, physical, and behavioral support needs.

What you can expect:
Providers collaborate with the participant and members of the Team to implement strategies to support community living such as:

- Instruction and training in one or more areas of need to enhance the participant's ability to live independently at home.
- Implement strategies to address behavioral, medical or other needs identified in the service plan
- Provide assistance with personal care or activities of daily living.
- Support the attainment of vocational goals.
- Provide training or practice in consumer skills (e.g., budgeting, shopping, banking).

How Do I Qualify?
The Level of Care Requirement ensures that individuals who would otherwise need to be placed in a long term care facility can remain the community with the assistance of program services.

Financial Requirements
The applicant must apply for Medicaid when a slot becomes available. In addition to the functional and financial criteria, the applicant must be able to participate in the development of a Service Plan in partnership with a Care Manager, or have a Conservator to do so, must meet all technical, procedural and financial requirements of the Medicaid program.

Med-Connect
Applicants may also meet the financial eligibility rules for the program through the Medicaid for Employed Disabled coverage group. Under that program working individuals can have income up to $75,000 per year, $10,000 in assets and receive Medicaid subject to payment of a monthly premium.

Application Process
Applicants or their representatives may contact the Community Options Unit for instructions on how to be placed on the waiting list. You will be contacted when a space is available.

Applicants who wish to apply for the ABI II waiver program must submit the Acquired Brain Injury (ABI) Waiver Request Form (W-1130) to:

Department of Social Services
55 Farmington Ave. 9th floor
Hartford, CT 06105
Attn: ABI Waiver

The W-1130 Acquired Brain Injury Form can be found on the Department of Social Services website under Applications and forms.
http://portal.ct.gov/DSS/Lists/Publications/Applications-and-Forms

Nursing staff of the Community Options Unit screen the application to determine if the applicant appears to meet basic functional and financial eligibility criteria. If it appears the applicant is eligible, a neuropsychological evaluation is required. If the neuropsychological evaluation shows functional eligibility, the applicant is placed on the waiting list.

What Services Can I Receive?
Services may include:
- ABI Group Day
- Adult Day Health
- Care Management
- Chore Services
- Cognitive Behavioral Programs
- Community Living Support Services
- Companion
- Consultation
- Homemaker
- Independent Living Skills Training
- Pre-vocational Services
- Respite
- Recovery Assistant
- Specialized Medical Equipment and Supplies
- Substance Abuse Programs
- Transportation
- Vehicle Modification Services

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

ABI WAIVER PROVIDER AGREEMENT FOR AGENCY EMPLOYEES

1. All of the statements and information contained in my Agency employee Application Supplement 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 Fiscal Intermediary - Allied Community Resources - 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** Allied Community Resources 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 terms of the ABI Waiver participant's service plan.

7. I acknowledge that I may be suspended or terminated from the provider directory if I am found by the Department to have engaged in fraudulent or abusive activities.

8. 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.

9. I acknowledge that I am 18 years of age or older and eligible to provide services for the agency by which I am employed.

10. I understand that if I provide a service for which I have not gained approval, I will not be paid under the Waiver.

11. I understand that I **MAY NOT** provide services both privately and as an agency employee to the same ABI Waiver participant as this creates a conflict of interest and is strictly against program rules.

12. I understand that this is a State and Federal Government program. Altering timesheets, hours worked, or reporting of false hours is considered fraud. I know I will be subject to prosecution for fraud to the fullest extent of the law. I may be subject to prosecution on both a State and Federal level should I commit this crime.

13. I understand that this program does not provide Worker's Compensation coverage. This is the responsibility of the agency.

14. I understand that **I am not employed by Allied Community Resources**.

15. I understand that if I have previously worked for any other agencies, I must have left that agency in good standing and that Allied Community Resources may contact said agency and obtain any and all employment records.

16. I understand that I may not work with a participant on the ABI Medicaid Waiver Program if I am a relative of his/her conservator, if applicable

17. **I HAVE READ AND ACCEPT THE TERMS OF THE PROVIDER AGREEMENT AS STATED ABOVE**.

_____

Provider Name (please print)

_____

Provider Signature

_____

Agency Name

_____

Date Signed

FMS-Provider Services
PO Box 479, East Windsor, CT 06088-0479
Phone: (860) 627-9500 Fax: (860) 627-0230
Toll Free: 877-722-8833

ABI Waiver Program - PROVIDER APPLICATION – Cognitive Behavioral Service

Complete this application in detail and include experience specifically related to cognitive/behavioral programming to people with a brain injury, delivered in community settings. Please note that applications not completed and approved within 90 days from the date they are initially received by Allied Community Resources (ACR) will be considered invalid and the applicant will be required to complete a new application and submit it to ACR for review. Please complete this form carefully and include a copy of your license, credentials or resume depicting your qualifications for Cognitive Behavioral services under the A.B.I. Waiver program.

Name: _____ Phone: _____
Address: _____ Cell: _____
City: _____ State: _____ Zip Code: _____
Email address: _____ Social Security Number: _____
Date-of-Birth*: _____ *(*required for criminal history background check of private providers)*

If Agency Employee, Name of Agency: _____
Do you speak languages other than English? ☐ YES* ☐ NO
*Please list: _____

Education:
Name of College: _____ Year of graduation: _____
Type of Degree: ☐ Bachelors ☐ Masters ☐ Doctorate
In what concentration is your degree? _____

Qualifications:
The State of Connecticut Department of Social Services has specific criteria that must be met in order for you to be considered as a provider of **Cognitive Behavioral** services. Professional licensure is required in any of the following fields: Psychologist, Neuropsychologist, Educational Psychologist or Speech, Occupational or Physical Therapist. Three years of experience working with individuals in a community setting is required as well as successful completion of the ABI Basic Informational Session.

Check here if a copy of your credentials is included. ☐

Have you ever completed an Allied Community Resources sponsored Informational Session on Acquired Brain Injury?
☐ YES ☐ NO If yes, Date: _____

Please include your resume with this application which should reflect experience in the development of a structured cognitive/behavioral intervention plan, which has as its primary focus the teaching of socially appropriate behaviors and the elimination of maladaptive behaviors through the development and implementation of cognitive compensatory strategies. You may use the back side of this page to provide specific examples. Check here if back of page was used. ☐

By signing and dating below, I understand that a Criminal History Background check will be performed on private providers as part of the application process. I attest that all of the information outlined on my application is a true and accurate depiction of my qualifications.

_____

Provider Name (Please Print) Provider Signature Date Signed

Name: Date:

ABI Waiver Program

ABI Program Services – Cognitive Behavioral Services Description:

Individual interventions designed to increase an individual's cognitive and behavioral capabilities and to further the individual's adjustment to successful community engagement including:

- Comprehensive assessment of cognitive strengths and liabilities, quality of adjustment and behavioral functioning
- Development and implementation of cognitive and behavioral strategies
- Development of a structured cognitive/behavioral intervention plan
- Ongoing or periodic consultation with the waiver participant, support system and providers concerning cognitive and behavioral strategies and interventions specified in the cognitive/ behavioral intervention plan
- Ongoing or periodic assistance with training of the waiver participant, support system and providers concerning cognitive behavior strategies and interventions
- Periodic reassessment and revision as needed, of the cognitive/behavioral intervention plan.

This service is performed within the context of the individual's person-centered team, in concert with the case manager. Cognitive/behavioral programs may be provided in the individual's home or in the community in order to reinforce the training in a real-life situation.

The service will be delivered utilizing two procedure codes, one for in person face to face visits that include the participant, providers and/or supporters. A quarterly, in person meeting with the waiver participant is required for this service.

The second procedure code is for non-face-to-face service that includes development of the cognitive behavioral plan and phone or other types of interactions with participants, providers or supporters.

Provider Qualifications:

Agency: CARF certification in Brain Injury, or JCAHO, or Accreditation for Behavioral Health Care; Employ individual who meet qualifications below.

Individual: Professional licensed as any of the following with at least three years of experience in cognitive/behavioral programming for people with a brain injury, delivered in community settings:

- Behavior Analysts
- Psychologists
- Neuropsychologists
- Occupational therapists
- Educational Psychologists
- Speech therapists
- Physical therapists

Training requirement (if not proven as part of educational record):

Attend the **ABI Basic Information Session** and pass the associated quiz with a grade of 80 or higher.

- Provider will have completed an approved training program(s) concerning acquired brain injury and person-centered planning, given by a state agency, the fiduciary, community providers, Brain Injury

Alliance of CT, or an Independent Living Center prior to providing services to a ABI Waiver Program participant.

Form **W-9**
(Rev. August 2013)
Department of the Treasury
Internal Revenue Service

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/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____

☐ Other (see instructions) ▶

Exemptions (see instructions):
Exempt payee code (if any) _____
Exemption from FATCA reporting code (if any) _____

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 the "Name" line 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.

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

Social security number
			–		–				

Employer identification number
		–							

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. citizen or other U.S. person (defined below), and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

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 3.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. The IRS has created a page on IRS.gov for information about Form W-9, at *www.irs.gov/w9*. Information about any future developments affecting Form W-9 (such as legislation enacted after we release it) will be posted on that page.

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, payments made to you in settlement of payment card and third party network transactions, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

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. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct.

Note. If you are a U.S. person and 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.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

FMS – Financial Management Services
PO Box 479 East Windsor, CT 06088-0479
Phone: 860-627-9500 Fax: 860-627-0230
Toll Free: 877-722-8833 www.acrfi.org

Agency/Vendor Information Update

Check all that apply: ☐ Mailing Address ☐ Physical Address ☐ Phone /Fax /E-mail ☐ Business Name

**For changes to be made, please provide your information for verification purposes:*

Agency Name: _____

Agency Representative:_____

FEIN: _____
-OR-
Last 4 of SSN: _____

☐ New Agency Name _____
Please send updated W9 form and new provider agreement

New Address:

_____

_____

_____

Old Address:

_____

_____

_____

Business Phone: (_____) _____-_____ ☐ New ☐ Same

Fax Number: : (_____) _____-_____ ☐ New ☐ Same

E-Mail Address: _____ ☐ New ☐ Same

Please sign, date, and return this form to Allied. Your signature authorizes the above changes to be made. Changes will not be made until the completed, signed formed is returned and processed by Allied.

Agency Representative Signature: _____ Date: _____

FOR OFFICE USE ONLY

Database # _____ Date Processed: _____ by (initials): _____

ALLIED COMMUNITY RESOURCES, INC.
Consent and Acknowledgment Form

I consent to the use or disclosure of my protected health information by Allied Community Resources, Inc. to any person or organization for the purposes of carrying out treatment, obtaining payment or conducting certain healthcare operations.

If I am a fiscal intermediary consumer, such as in the Medicaid Waiver or similar program, I understand that Allied Community Resources uses my protected information for the purposes of my employer tax reporting and payments as well as reimbursement payment claims submissions.

I understand that information regarding how Allied Community Resources, Inc. will use and disclose my information can be found in Allied Community Resources, Inc.'s Notice of Privacy Practices. I understand that this consent is effective for as long as Allied Community Resources, Inc. maintains my protected health information. (Protected health information used or disclosed by Allied Community Resources, Inc. may include HIV/AIDS related information, psychiatric and other mental health information, and drug and alcohol treatment information, **as long as such information is used or disclosed in accordance with State and Federal law**, which may require me to provide specific authorization.)

By signing below, I understand and acknowledge the following:

- I have read and understand this consent; and
- I have received Allied Community Resources, Inc.'s Notice of Privacy Practices currently in effect.

_____ _____

Print Name of Individual

and if any, Print Name of Personal Representative

_____ _____

Signature of Individual or Personal Representative

Date

If signed by the individual's representative, describe the legal authority of the representative to act on behalf of the individual: _____

Unable to obtain written consent and acknowledgment because:

☐ Individual refused

☐ Emergency treatment situation

☐ Individual not able to sign due to incompetence or other medical reason

☐ Other: _____

For Alabama Programs, Toll Fax to: 888-249-9998 or Mail to: P.O. Box 509 East Windsor, CT 06088-0509
For CT DDS Programs, Fax to: 860-627-0330 or Mail to: P.O. Box 509 East Windsor, CT 06088-0509
For CT DSS Programs, Fax to: 860-627-0230 or Mail to: P.O. Box 479 East Windsor, CT 06088-0479

FOR OFFICE USE ONLY AFTER FORM IS SIGNED- Please Indicate Program for Filing Purposes

☐ Alabama ☐ ABI ☐ BRS ☐ CHCPE ☐ DDS ☐ MFP ☐ PCA ☐ CFC

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 _____**

Application Packet CHECKLIST: Transportation

The attached application packet is complete when all items have been completed and checked off. All forms must be completed and submitted to Allied Community Resources. You may use this page as a cover sheet when mailing or faxing your forms.

☐ 1. **ABI Waiver Provider Directory Application-Provider Agreement**
**This document is only required if you are not currently a provider under the program.*

☐ 2. **Transportation Application Supplement**

☐ 3. **W9 Form**

Please submit clear copies of your current and valid driver's license and vehicle insurance card. Your name must be on this card as an insured driver. Thank you!

FMS-Provider Services
PO Box 479, East Windsor, CT 06088-0479
Phone: 860-627-9500 Toll Free: 877-722-8833
Fax: 860-627-0230

DSS ABI MEDICAID WAIVER PROGRAM
PROVIDER SERVICES APPLICATION - SELF EMPLOYED

Provider Information:

Provider Name:_____

Former Name(s) used (if applicable): _____

Provider Address: _____

Mailing Address (if different):_____

Telephone: _____ **Email**: _____

Cell Phone: _____ **Fax:** _____

SS #: _____-_____-_____ **FEIN**: _____-_____
(if applicable)

Date of Birth: _____ (required for Criminal Background Check)

☐ Please check here if you **DO NOT** want your name included on the ABI Provider Directory which is distributed to DSS Offices and participants on the ABI Waiver Program.*****Please note that you will not be contacted by potential employers if you choose not to have your name listed on the directory*****

See attached list of Self-Employed provider services. Please ✓ each service you would like to be considered for and determine if you meet the requirements for this service in the column to the right.

See attached list of Connecticut towns and regions. Please indicate individual towns or regions of the state in which you will provide services.

DSS ABI MEDICAID WAIVER SELF EMPLOYED PROVIDER AGREEMENT

1. I acknowledge that I am qualified to perform all the standards and duties for the services for which I am applying.
2. I will immediately notify the Fiduciary Agent- **Allied Community Resources (ACR),** if any information provided by me on this application changes.
3. I will maintain current standing with respect to any license and/or certification requirement established by the **Department of Social Services (DSS)** for my service approval(s). I understand that I will be requested for copies of updated contracts, licenses, and accreditations as they become renewed or extended. I will immediately notify ACR if such licenses and/or certifications expire, are revoked, suspended or otherwise terminated for any reason.
4. I will adhere to the units and services assigned in accordance with the ABI Waiver participant's service plan when I am named as a service provider.
5. If the program participant is hospitalized or in a skilled nursing facility, I understand that I **MAY NOT** provide services, submit invoices, and receive payment during this time.

6. The rate paid by DSS for the performance of ABI Waiver Services is the complete payment in full for all service(s) or products delivered to eligible ABI Waiver participants. Payments to me for the performance of ABI services or delivery of goods constitute sole and complete payment in full.
7. 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 of DSS upon request.
8. I acknowledge that I may be suspended or terminated from the ABI Provider Directory if I am found by DSS to have engaged in fraudulent or abusive program services.
9. 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.
10. I understand that I may **NOT** provide services to any ABI Waiver participant and receive payment **until I have been notified in writing by ACR** that I am an approved provider on the ABI Medicaid Waiver Program and that I have been named to a program participant's service plan by DSS.
11. I understand that I may not provide services both privately and as an agency employee (if applicable) to the same waiver participant as this creates a conflict of interest. ***This is against program rules and is strictly prohibited.*** I understand that a Conflict of Interest form is required along with other required paperwork deemed necessary by ACR before I may work as a self employed provider and as an agency employee.
12. This is a State and Federal Government program. Altering invoices or falsely claiming hours worked is considered fraud. I will be subject to prosecution for fraud to the fullest extent of the law. I may be subject to prosecution on both a State and Federal level should I commit this crime.
13. I understand that this program does not provide Worker's Compensation Coverage.
14. I understand that I **may not** provide services to a participant on the ABI Medicaid Waiver Program if I am a relative of the participant's conservator, if applicable.
15. I understand that I am not employed by Allied Community Resources.
16. I understand that failure to comply with the above statements will result in removal of my approval status and listing as a provider on the ABI Waiver Program Provider Directory.
17. I understand that once I am approved, my provider status will be classified as **SELF EMPLOYED.** When named to a participant's plan, **I will be responsible for my own taxes** and ACR will provide me, at the end of the year, with a 1099-MISC to reflect other income earned for tax reporting purposes.
18. I understand that if my name appears on the OIG (Office of Inspector General) list of excluded entities/individuals, I am prohibited from becoming a paid provider under any DSS Program.
19. I understand that I am required to undergo a Criminal Background Check and that the criminal activity, if any, revealed by the Criminal Background Check may result in disqualification from enrollment in the Provider Directory, consideration for employment by any ABI Waiver participant, and possible further legal action.

I HAVE READ AND ACCEPT THE TERMS OF THE PROVIDER AGREEMENT AS STATED ABOVE. ALL OF THE STATEMENTS MADE BY ME ON THIS APPLICATION AND ALL INFORMATION CONTAINED IN ANY SUPPORTING QUALIFICATION DOCUMENTATION ARE TRUE AND CORRECT.

_____
Applicant Name (please print)

_____ _____
Applicant Signature Date

Provider Services Department
P.O. Box 479, East Windsor, CT 06088-0479
Phone: (860) 627-9500 Fax: (860) 627-0230

Transportation Services - Application Supplement

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

Full Legal Name: _____

Address: _____

Date-of-Birth: _____ Last 4 digits Social Security Number: XXX-XX-_____

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

Driver Information:

License/Operator Number: _____ State: _____

Date Issued: _____ Expiration Date: _____

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.

******PLEASE CHECK WITH YOUR INSURANCE AGENT REGARDING YOUR COVERAGE WHEN TRANSPORTING AN INDIVIDUAL IN YOUR VEHICLE WHO WOULD BE YOUR EMPLOYER*******

_____ _____

Provider Signature Date Signed

For Office Use Only: ☐ Driver's license photocopy received/attached ☐ Insurance card photocopy received/attached

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

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.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____

Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

6 City, state, and ZIP code

7 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 generally 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.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

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. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

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 3.

Sign Here	**Signature of U.S. person** ▶	**Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

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. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

Note. If you are a U.S. person and 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.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States:

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (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 payee 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.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code* on page 3 and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships* above.

What is FATCA reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code* on page 3 and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account, list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note. ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C Corporation, or S Corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box in line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box in line 3.

Limited Liability Company (LLC). If the name on line 1 is an LLC treated as a partnership for U.S. federal tax purposes, check the "Limited Liability Company" box and enter "P" in the space provided. If the LLC has filed Form 8832 or 2553 to be taxed as a corporation, check the "Limited Liability Company" box and in the space provided enter "C" for C corporation or "S" for S corporation. If it is a single-member LLC that is a disregarded entity, do not check the "Limited Liability Company" box; instead check the first box in line 3 "Individual/sole proprietor or single-member LLC."

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space in line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2—The United States or any of its agencies or instrumentalities

3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a)

11—A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5[2]
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note. You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited Liability Company (LLC)* on this page), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at *www.ssa.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting IRS.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, or 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor[2]
4. a. The usual revocable savings trust (grantor is also trustee) b. So-called trust account that is not a legal or valid trust under state law	The grantor-trustee[1] The actual owner[1]
5. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity[4]
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 2.

***Note.** Grantor also must provide a Form W-9 to trustee of trust.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov.* You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: *spam@uce.gov* or contact them at *www.ftc.gov/idtheft* or 1-877-IDTHEFT (1-877-438-4338).

Visit IRS.gov to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

FMS-Intake Department
ABI, BRS, CHCPE, MFP, PCA Programs: PO Box 479 East Windsor, CT 06088-0479
Phone: 860-627-9500 Fax: 860-627-0230
DDS & Alabama Programs: PO Box 509, East Windsor, CT 06088-0509
Phone: 860-627-9500 Fax: 860-627-0330
www.acrfi.org

Authorized Representative Document

(For Individuals who are not legal representatives or established as the Employer of Record)

Please complete for each individual you wish to provide authorization for Allied to discuss your program information with. **Note that Representatives may not have access to other employee's personal information, payroll records, and year-end tax documents, make adjustments to employee timesheets or receive program materials. *CHC program representatives may receive monthly invoices and or billing statements ONLY.**

Participant Name: _____

Participant/EOR/Legal Rep. Signature: _____ Date: _____

Representative # 1 Name: _____ **Relationship**: ☐ Family Member ☐ Other: _____

Physical Address: _____ County: _____

Mailing Address: _____ ☐ Same as Physical

***Please indicate the order in which you prefer to be contacted by placing a corresponding number in the "Call" section.**

Home Phone: _____ Call _____ Cell Phone: _____ Call ____

Work Phone: _____ Call_____ Fax Number: _____

Email Address: _____@_____

Authorization to discuss: ☐ All items listed ☐ DiscussPlan ☐ DiscussTimesheet
☐ Discuss Employees ☐ Discuss Payroll

CHC ONLY: Authorization to receive: ☐ Billing Statement

Representative # 2 Name: _____ **Relationship**: ☐ Family Member ☐ Other: _____

Physical Address: _____ County: _____

Mailing Address: _____ ☐ Same as Physical

***Please indicate the order in which you prefer to be contacted by placing a corresponding number in the "Call" section.**

Home Phone: _____ Call _____ Cell Phone: _____ Call ____

Work Phone: _____ Call_____ Fax Number: _____

Email Address: _____@_____

Authorization to discuss: ☐ All items listed ☐ DiscussPlan ☐ DiscussTimesheet
☐ Discuss Employees ☐ Discuss Payroll

CHC ONLY: Authorization to receive: ☐ Billing Statement

For Office Use Only: Program: ☐ ABI ☐ Alabama ☐ BRS ☐ CHCPE ☐ DDS ☐ MFP ☐ CFC ☐ CHC
Database entry completed: Date: _____ Initials: _____ DB # _____

FMS-Intake Department
ABI, BRS, CHCPE, MFP, PCA Programs: PO Box 479 East Windsor, CT 06088-0479
Phone: 860-627-9500 Fax: 860-627-0230
DDS & Alabama Programs: PO Box 509, East Windsor, CT 06088-0509
Phone: 860-627-9500 Fax: 860-627-0330
www.acrfi.org

Authorized Representative Document Instructions

1. Enter the Participant Name.

2. The Participant, Employer of Record, or the Legal Representative signs and dates the form in this area. **The document MUST be signed and dated.** The signature allows Allied to add the Representatives listed on the form into our system.

3. List the Individual you would like to give authorization to. It is important to provide the following information for the individual:

    a. The Relationship between the Participant and the Individual listed

    b. The Mailing/Physical Addresses and County for the Individual listed

    c. The Contact Telephone numbers for the Individual listed. Please indicate the calling order of how we should contact this individual. For example, if the primary way to get in touch with the person is on their cell phone, put a "1" in the area labeled "Call".

    d. Enter the email address of the Individual listed.

4. Check the boxes of the items you want Allied to speak to this individual about. Remember that you cannot provide access to an employee about another employee for any of the below items or have program materials sent to Representatives:
    - Personal Information, including social security number, date of birth, mailing address, or contact information
    - Payroll records
    - Year-end tax documents such as W-2 forms
    - Make adjustments to employee timesheets

5. CHC ONLY: Check the boxes of the information you want Allied to send to this individual.
    - CHC Statements

You can list two Representatives on the form. You may use multiple forms if you need to.

***A different form will have to be filled out for anyone who is a legally documented Power of Attorney, Conservator, or Legal Guardian. ***

FMS-Intake Department
ABI, BRS, CHCPE, MFP, PCA Programs: PO Box 479 East Windsor, CT 06088-0479
Phone: 860-627-9500 Fax: 860-627-0230
DDS & Alabama Programs: PO Box 509, East Windsor, CT 06088-0509
Phone: 860-627-9500 Fax: 860-627-0330
www.acrfi.org

SAMPLE

Authorized Representative Document

(For Individuals who are not legal representatives or established as the Employer of Record)

1. Enter the Participant Name in this

ividual you wish to provide authorization for Allied to discuss your program information with. **Note that** e access to other employee's personal information, payroll records, and year-end tax documents, ee timesheets or receive program materials. *CHC program representatives may receive monthly invoices and or billing statements ONLY.

Participant Name: _____

Participant/EOR/Legal Rep. Signature: _____ Date: _____

Representative # 1 Name: _____ **Relationship**: amily

3a

3. List any individuals who you would like as Representatives in this area.

_____ ☐ Same as Physical

er in which you prefer to be contacted by placing a corresponding nu

_____ Call ___ l Phone: _____

3c

Work Phone: _____ Call____ Fax Number: _____

Email Address: _____@_____

2. The Participant, Employer or Legal Representative signs and dates here to authorize the addition of the Representatives indicated on the form. The form must be signed and dated.

Authorization to discuss: ☐ All items listed ☐ DiscussPlan ☐ DiscussTimeshee
☐ Discuss Employees ☐ Discuss Payroll

CHC ONLY: Authorization to receive: ☐ Billing Statement

4. Check the boxes for the things you would like Allied to speak about or send to the Representative about. (if applicable)

Representative # 1 Name: _____

Physical Address: _____

Mailing Address: _____ ☐ Same as Physical

***Please indicate the order in which you prefer to be contacted by placing a corresponding number in the "Call" section.**

Home Phone: _____ Call ____ Cell Phone: _____ Call ____

Work Phone: _____ Call____ Fax Number: _____

Email Address: _____@_____

Authorization to discuss: ☐ All items listed ☐ DiscussPlan ☐ DiscussTimesheet
☐ Discuss Employees ☐ Discuss Payroll

CHC ONLY: Authorization to receive: ☐ Billing Statement

For Office Use Only: Program: ☐ ABI ☐ Alabama ☐ BRS ☐ CHCPE ☐ DDS ☐ MFP ☐ CFC ☐ CHC
Database entry completed: Date: _____ Initials: _____ DB # _____

F3-V 8/29/19

Submission ID: 912556

Success!

Your FOIA request has been created and is being sent to the Center for Medicare and Medicaid Services.

You'll hear back from the agency confirming receipt in the coming weeks using the contact information you provided. If you have questions about your request, feel free to reach out to the agency FOIA personnel using the information provided below.

Contact the agency

Hugh Gilmore, FOIA Officer
410-786-5353
hugh.gilmore@cms.hhs.gov

FOIA Requester Service Center
410-786-5353

Joseph Tripline, FOIA Public Liaison
410-786-5353
joseph.tripline@cms.hhs.gov

Hugh Gilmore, FOIA Officer, North Building, Room C5-11-06
7500 Security Boulevard
Baltimore, MD 21244
FOIA_Request@cms.hhs.gov

Request summary

Request submitted on**October 23, 2023**.

The confirmation ID for your request is **912556**.

The confirmation ID is only for identifying your request on FOIA.gov and acts as a receipt to show that you submitted a request using FOIA.gov. This number does not replace the

information you'll receive from the agency to track your request. In case there is an issue submitting your request to the agency you selected, you can use this number to help.

Contact information

Name
David MEDEIROS

Mailing address
215 Mountain St
Willimantic, CT 06226
United States

Phone number
8604633638

Company/organization
ABI Resources LLC

Email
aabiwr@live.com

Your request

Subject: Freedom of Information Act Request – CMS Medicaid ABI Waiver Program and Connecticut Community Care Referrals Subject: Freedom of Information Act Request Pertaining to Connecticut Mediciad ABI Waiver Program. Dear Freedom of Information Officer, I am writing to submit a Freedom of Information Act (FOIA) request pursuant to the Connecticut Freedom of Information Act, C.G.S. § 1-200 et seq. I am seeking information related to the Acquired Brain Injury (ABI) Waiver Program, specifically concerning Connecticut Community Care's referral practices and any potential financial incentives provided to consumers for participating in services offered by the Supported Living Group. Please provide the following information: All records, communications, and documents pertaining to Connecticut Community Care's referral practices under the Medicaid ABI Waiver Program from January 1, 2019, to the present date. Any contracts, agreements, or MOUs between Connecticut Community Care and the Supported Living Group related to the ABI Waiver Program, including details on financial arrangements and incentives. Documentation of any payments, incentives, or benefits provided to consumers by the Supported Living Group as a result of their participation in services under the ABI Waiver Program. Policies, guidelines, or internal memos detailing the criteria and process for Connecticut Community Care's referrals to the Supported Living Group under the ABI Waiver Program. Records of any complaints, investigations, or audits concerning Connecticut Community Care's referral practices or the Supported Living Group's incentive programs related to the ABI Waiver Program. Correspondence between the State of Connecticut and Connecticut Community Care or the Supported Living Group regarding the ABI Waiver Program, referrals, and consumer incentives. Any evaluations, reports, or studies conducted by or on behalf of the State of Connecticut concerning the effectiveness, integrity, and compliance of the ABI Waiver Program, particularly in relation to referrals and consumer incentives. If my request is denied in whole or in part, I ask that you justify all deletions by reference to specific exemptions of the Act. I kindly request accommodations due to my disability. To facilitate my accessibility and participation, I would greatly appreciate the use of electronic records.

Your support in this matter is highly valued. Thank you for your understanding and assistance. Sincerely, David Medeiros ABI Resources

Fees

Fee waiver
no

Request expedited processing

Expedited processing
no

FOIA.gov

CONTACT

Office of Information Policy (OIP)
U.S. Department of Justice
441 G St, NW, 6th Floor
Washington, DC 20530
E-mail: National.FOIAPortal@usdoj.gov

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office for Civil Rights

New England Region ● Government Center
JFK Federal Building, Room 1875 ● Boston, MA 02203
Voice - (800) 368-1019 ● TDD - (800) 537-7697
Fax - (617) 565-3809 ● http://www.hhs.gov/ocr

10/05/2023

VIA ELECTRONIC MAIL

David Medeiros

Email: davidmedeiros@live.com

OCR Transaction Number: 01-23-547732

Dear Mr. Medeiros:

Thank you for your correspondence to the U.S. Department of Health and Human Services ("HHS"), Office for Civil Rights ("OCR").

OCR enforces federal civil rights laws which prohibit discrimination in the delivery of health and human services based on race, color, national origin, disability, age, sex, religion, and the exercise of conscience, and also enforces the Health Insurance Portability and Accountability Act ("HIPAA") Privacy, Security and Breach Notification Rules.

Based upon our review of your complaint, we have determined that the concerns you raise are more appropriately addressed by the U.S. Department of Justice ("DOJ"). For additional information and to file a complaint with DOJ, please see the following link.

Submitting a Complaint (justice.gov)

OCR's determination as stated in this letter applies only to the allegations in this complaint that OCR reviewed. If you have any questions regarding this matter, please contact William Lawton, Investigator, at 617-565-1354, or by email at William.Lawton@hhs.gov.

Sincerely,

Susan M. Pezzullo Rhodes
Regional Manager

ABI Waiver Program

ABI Program Services – Cognitive Behavioral Services Description:

Individual interventions designed to increase an individual's cognitive and behavioral capabilities and to further the individual's adjustment to successful community engagement including:

- Comprehensive assessment of cognitive strengths and liabilities, quality of adjustment and behavioral functioning
- Development and implementation of cognitive and behavioral strategies
- Development of a structured cognitive/behavioral intervention plan
- Ongoing or periodic consultation with the waiver participant, support system and providers concerning cognitive and behavioral strategies and interventions specified in the cognitive/ behavioral intervention plan
- Ongoing or periodic assistance with training of the waiver participant, support system and providers concerning cognitive behavior strategies and interventions
- Periodic reassessment and revision as needed, of the cognitive/behavioral intervention plan.

This service is performed within the context of the individual's person-centered team, in concert with the case manager. Cognitive/behavioral programs may be provided in the individual's home or in the community in order to reinforce the training in a real-life situation.

The service will be delivered utilizing two procedure codes, one for in person face to face visits that include the participant, providers and/or supporters. A quarterly, in person meeting with the waiver participant is required for this service.

The second procedure code is for non-face-to-face service that includes development of the cognitive behavioral plan and phone or other types of interactions with participants, providers or supporters.

Provider Qualifications: Agency: CARF certification in Brain Injury, or JCAHO, or Accreditation for Behavioral Health Care; Employ individual who meet qualifications below.

Individual: Professional licensed as any of the following with at least three years of experience in cognitive/behavioral programming for people with a brain injury, delivered in community settings:

- Behavior Analysts
- Psychologists
- Neuropsychologists
- Occupational therapists
- Educational Psychologists
- Speech therapists
- Physical therapists

Training requirement (if not proven as part of educational record):

Attend the **ABI Basic Information Session** and pass the associated quiz with a grade of 80 or higher.

- Provider will have completed an approved training program(s) concerning acquired brain injury and person-centered planning, given by a state agency, the fiduciary, community providers, Brain Injury Alliance of CT, or an Independent Living Center prior to providing services to a ABI Waiver Program participant.

Federal Agency Comment Form

Small Business Administration – Office of the National Ombudsman

OMB Control #3245-0313

Exp. Date 09/30/2022

Case #: 2309280095

PURPOSE: Small business owners may use this form to submit comments on Federal enforcement/compliance actions that they consider excessive or unfair. The National Ombudsman will use the information when it contacts the applicable Federal agency for a review of the action. Completion of this form is voluntary; however, failure to submit the requested information could impact whether SBA's Office of the National Ombudsman is able to provide you with assistance

Instructions

1. Complete, sign and date this form. (Signature not required if completed at Office-National-Ombudsman)
2. Provide a brief written statement on the reverse side or a separate sheet of paper regarding the specific enforcement or compliance action taken against your organization by the federal agency
3. Submit copies of substantiating documentation such as correspondence citation or notice (Note: canbe submitted separately from this form by fax or mail. Make sure to reference your name orcompany's name with this information).
4. If your comments concern the IRS, you must also submit a completed IRS Tax Information Authorization Form 8821, available at IRS.gov/forms (Can be sent by fax or mail.)
5. Fax, e-mail or send this form and requested information to: (1) Fax: (202) 481-5719; (2) Email:Ombudsman@sba.gov; (3) Address: SBA, Office of National Ombudsman,409 Third Street,SW,Washington, DC 20024.Telephone:(202) 205-2417.

Please Print

Organization/Company Name: ABI RESOURCES LLC

Address: 39 Kings Highway STE C

City: Gales Ferry State: CT Zip : 06335-

Phone: 860-942-0365 FAX: E-Mail: aabiwr@live.com

Contact Name: Mr. DAVID MEDEIROS Title: Founder Owner

Please indicate your organization type: Small Business

List the federal agency with which you are having a problem

Federal Agency Name: Connecticut Department of Social Services and COU Community Options Unit

Agency Contact Person:

Agency Office/Division:

Did the federal agency listed above inform you of your right to contact the SBA Office of the National ombudsman? No

If not how did you learn about this Office 0

Confidentiality/Disclosure

The National Ombudsman is required to keep confidential the identity of any person or small business providing a comment about an agency's compliance or enforcement action unless that person or small business provides consent, or disclosure is determined to be unavoidable. Confidentiality is governed by the Small Business Regulatory Enforcement Fairness Act 15 U.S.C. 657(b)(2(B) and the Inspector General's Act, 5 U.S.C. App., § 7(b). You may make a selection below to authorize SBA to share your identity with the federal agency with which you are having a problem so that agency can investigate your specific problem and offer a response tailored to your situation. By requesting confidentiality, the federal agency may not have sufficient information to investigate your specific problem, possibly delaying or preventing any potential resolution of your situation