Assurance Agreement
To the Department of Developmental Services

HEALTHCARE COORDINATION – Individual Practitioner

The following assurances are made by:

Name: _____

Title: _____

Name of LLC, if applicable: _____

Assurance	Check each statement
Will meet all applicable federal and state regulations	☐
Understands and will follow all applicable DDS policies and procedures	☐
Will protect the confidentiality of the individual and family's information	☐
Will bill only for services that are actually provided	☐
Will submit billing documents after service is provided and within 60 days	☐
Will accept payment from DDS as payment in full	☐
Will not require a participant to sign an agreement that they will not change Healthcare Coordinator as a condition of providing services	☐
Understands and will follow all Waiver requirements detailed in the HCBS Waivers manual	☐
Will allow state and federal offices responsible for program administration and audit to review service records and have access to program sites	☐
Will sign a provider agreement with the individual and family	☐
Will comply with State of Connecticut Ethics Protocols	☐
Will comply with the Drug Free Policy of the Department	☐
I have read understand and will follow the Abuse and Neglect Policy and Procedures of the Department	☐
I have read, understand and will follow the Incident Reporting Procedure of the Department	☐
I have read, understand and will follow the Behavior Modifying Medications Policy and Procedures of the Department	☐
I have read, understand and will follow the Program Review Committee Policy and Procedures of the Department	☐
I have read, understand and will follow the Mortality Review and Reporting Policy and Procedures of the Department	☐
I have read, understand and will follow the End of Life Policy and Procedures of the Department	☐
I have read, understand and will follow the Medication Administration Regulations of the Department	☐
I have read, understand and will follow the False Claims Policy and Procedures of the Department	☐
Will obtain adequate information necessary to meet the needs of the individual	☐
I will not hire employees to perform any clinical components of the role	☐
Will not sub-contract services to fulfill any clinical components of the role unless the subcontractor is also a qualified provider through DDS	☐
Will observe and report all changes which affect the individual to key people within the individual's circle of support	☐

Assurance	Check each statement
Will carry professional liability insurance of a minimum of $500,000 per occurrence and $1.5 million in aggregate. Will provide documentation of such coverage annually upon request.	☐
Will notify the Operation Center immediately if I am arrested or convicted of a crime.	☐
Holds current licensure as a RN in the state of Connecticut	☐
By mutual consent or without cause, either party can cancel this agreement and qualified status with a 30 day notice.	☐

_____ Date _____

* Name of Person Submitting Application

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

Revised 4/2015