Provider Name Carli Bryan **Date of Submission** 3/3/2020

	Complete	In Progress	N/A	Comments
1 This application check list for independent contractors				
2 Complete and submit the Administrative Office of the Courts form on line or by mail.	✓			
3 Complete and mail the Cabinet for Families and Children form for a background check.	✓			
4 Proof of Professional liability insurance	✓			
5 Provide a copy of your professional license with expiration date or if you do not have a license, submit a copy of your transcripts. Associates must also provider the approved supervisor agreement with the name and contact information	✓			
6 Provide a copy of your driver's license.	✓			
7 Copy of your social security card	✓			
8 Copy of the IRS letter documenting your Federal Employer Identification Number (FEIN) if you have one.			✓	
9 Email confirming your NPI number and taxonomy code.	✓			
10 Provide proof of current automobile insurance and a copy of your insurance policy if you intend to transport clients.	✓			
11 Download, sign and return the Statement of Disclosure.	✓			
12 Signature Page: Regulations for Independent Provider services or Targeted Case Mangement Services	✓	-		
13 Copy of the letter you received from Medicaid documenting Medicaid number with MAP-347 and direct deposit form.			✓	
14 Complete and return three releases for references along with their contact information.	✓			
16				

Transformations
Hope for today's families
IMPACT PLUS PROVIDER

AUTHORIZATION TO SHARE INFORMATION

Applicant Name Carli Bryan Birth Date 05/25/1990

I, Carli Bryan authorize Transformations, and

Reference Name: Valencia Dickerson
Address: 677 Hawthorne Ave
Cincinnati, Ohio
606.356.9741

To share with one another the following items: work history, current employment, personal impressions of work and other information needed from Transformations.

I understand that the purpose of sharing this information is for contract employment reference.

This authorization will expire on 2/25/2021, or immediately following the revoking of the authorization, or after the following event has occurred if this is a one time release.

I understand that pursuant to KRS 304.17A-555-Patient's Right of Privacy Regarding Mental health or Chemical Dependency-Authorization Disclosure, my Protected Health Information, used and /or shared under this authorization may not be shared by the recipient of the information beyond the purpose for which my authorization was given, without first obtaining my specific written consent to the re-disclosure.

I have read and understand this authorization.

Carli Bryan, 2/25/20
Signature/date

Carli Bryan
Printed Name

Witness/date

Transformations
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AUTHORIZATION TO SHARE INFORMATION

Applicant Name Carli Bryan Birth Date 05/25/1990

I, Carli Bryan authorize Transformations, and

Reference Name: Kimberly Bailey
Address: 6819 Hatfield Ln, 40258
502.541.5673

To share with one another the following items: work history, current employment, personal impressions of work and other information needed from Transformations.

I understand that the purpose of sharing this information is for contract employment reference.

This authorization will expire on 2/25/2021, or immediately following the revoking of the authorization, or after the following event has occurred if this is a one time release.

I understand that pursuant to KRS 304.17A-555-Patient's Right of Privacy Regarding Mental health or Chemical Dependency-Authorization Disclosure, my Protected Health Information, used and /or shared under this authorization may not be shared by the recipient of the information beyond the purpose for which my authorization was given, without first obtaining my specific written consent to the re-disclosure.

I have read and understand this authorization.

Carli Bryan, 2/25/20
Signature/date

Carli Bryan
Printed Name

Witness/date

Transformations
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AUTHORIZATION TO SHARE INFORMATION

Applicant Name Carli Bryan Birth Date 05/25/1990

I, Carli Bryan authorize Transformations, and

Reference Name: Ariel Campbell
Address: 839 Ezzard Charles Drive
Cincinnati, Oh 45219
859.916.0025

To share with one another the following items: work history, current employment, personal impressions of work and other information needed from Transformations.

I understand that the purpose of sharing this information is for contract employment reference.

This authorization will expire on 2/25/2021, or immediately following the revoking of the authorization, or after the following event has occurred if this is a one time release.

I understand that pursuant to KRS 304.17A-555-Patient's Right of Privacy Regarding Mental health or Chemical Dependency-Authorization Disclosure, my Protected Health Information, used and /or shared under this authorization may not be shared by the recipient of the information beyond the purpose for which my authorization was given, without first obtaining my specific written consent to the re-disclosure.

I have read and understand this authorization.

Carli Bryan, 2/25/20
Signature/date

Carli Bryan
Printed Name

x [signature] 2/25/20
Witness/date