NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Early Intervention

Application for Approval of Agencies or Incorporated Groups of Individuals as Evaluators, Service Providers and Service Coordinators

NOTE: THIS APPLICATION IS FOR APPROVAL OF AGENCIES OR GROUPS OF INCORPORATED PROFESSIONALS ONLY (Use form #DOH -3735 for individual applicants).

INSTRUCTIONS: See detailed instructions for DOH-3736.

SCHEDULE 1 - GENERAL AGENCY INFORMATION

A. Applicant Identification

Agency Name			
Tax Identification Number /____/____/ - /____/____/____/____/____/____/____/			
Agency Address (Number & Street)			
City	County	Zip	Telephone ( ) Fax Number ( )

B. Name of Service Delivery Site(s) (if different from above; use additional sheets if necessary)

Name			
Address (Number & Street)			
City	County	Zip	Telephone ( )

C. Name and Title of Contact Person for Additional Information Regarding this Application

Name			
Address (Number & Street)			
City	County	Zip	Telephone ( )

SCHEDULE 2 - OPERATOR INFORMATION

A.

Name of Operator (Chief Executive Officer/Executive Director/Other)			
Address (Number & Street)			
City	County	Zip	Telephone ( )

B. Record of Legal Actions:

1. Except for minor traffic violations, were you ever convicted of any violation of the law (e.g. criminal, civil or malpractice charges)? ❑ **Yes** ❑ **No**

2. Have you ever been involved in a hearing before an official body in relation to the operation of an agency which provides human services? ❑ **Yes** ❑ **No**

3. Are there any criminal charges pending against you? ☐ **Yes** ☐ **No**

If the answer to any of these questions is “Yes”, complete below:

Date of Action: ___________________________

Type of Action: ____

Location: ____

Persons and/or agencies involved: ____

C. **Type of Ownership:** (Check only one – copies of documentation for Individual, Corporate or Partnership must be submitted with this application)

1) ☐ Individual
2) ☐ Corporation (*Date of Incorporation*) _____/_____/_____
3) ☐ Partnership
4) ☐ State
5) ☐ County – government agency
6) ☐ Other (Specify)

D. **Class of Operator:** (Check only one)

1) ☐ Proprietary (*for-profit*)
2) ☐ Voluntary (*not-for-profit*)
3) ☐ Public

SCHEDULE 3 - AGENCY AFFILIATION

A. Is the agency currently approved by any of the following state early intervention service agencies? (Check “Yes” or “No”)

	Yes	**No**
1) New York State Department of Health	☐	☐
2) State Education Department (Approved 4410 Program)	☐	☐
3) Office of Mental Retardation and Developmental Disabilities	☐	☐
4) Office of Mental Health	☐	☐
5) Department of Social Services	☐	☐
6) Office of Alcoholism and Substance Abuse Services	☐	☐

If “yes” to any of the above, specify in what capacity the agency is approved ________________________ (*e.g. hospital, certified home health agency, clinic, day treatment program*)

If “yes” to any of the above, provide the date of the most current site visit or program review by the agency(ies) listed above, if known.

State Agency: ____

Date of Site Visit/Program Review: ___________________________

State Agency: ____

Date of Site Visit/Program Review: ___________________________

B. Has the agency ever had approval revoked by any of the above state agencies? **Yes** ☐ **No** ☐
If “yes” to above, attach separate sheets providing the following information:

1) Date of action (revoking of license or certification)

2) Reason(s) for action

3) Resolution of action (include corrective action that was taken and whether approval has been reinstated)

SCHEDULE 4 - PROJECT OUTLINE

A. Services – Check the services for which your agency is seeking approval.

1) ❑ Evaluation Services (requires the availability of a licensed physician, who must be included in Schedule 5)
2) ❑ Supplemental Evaluation Services Only (Specify which type___________________________)
3) ❑ Service Coordination Services
4) ❑ Service Provider (If seeking approval as a service provider, check all that apply)
   - a) ❑ Home and community based individual/collateral visits
   - b) ❑ Facility-based individual/collateral visits (______check if provided at agency site(s). If checked, copies of health and safety policies, including fire evacuation, must be submitted with this Application).
   - c) ❑ Parent-child groups (______ check if provided at agency site(s). If checked, copies of health and safety policies, including fire evacuation, must be submitted with this Application).
   - d) ❑ Group developmental intervention (______ check if provided at agency site(s). If checked, copies of health and safety policies, including fire evacuation, must be submitted with this Application).
   - e) ❑ Family/caregiver support group

B. Languages - Indicate the languages, other than English (if any), spoken by the staff in the agency providing evaluation services, service coordination services and early intervention services.

1) Evaluation Services Specify language(s) ________________________________
2) Supplemental Evaluation Specify language(s) ________________________________
3) Service Coordination Services Specify language(s) ________________________________
4) Early Intervention Services Specify language(s) ________________________________

C. Service Catchment Area and Population Served

Check all counties for which the agency is seeking approval to provide early intervention services.

❑ Albany
❑ Allegany
❑ Broome
❑ Cattaraugus
❑ Cayuga
❑ Chautauqua
❑ Chemung
❑ Chenango
❑ Clinton
❑ Columbia
❑ Cortland
❑ Delaware
❑ Dutchess
❑ Erie
❑ Essex
❑ Franklin
❑ Fulton
❑ Genesee
❑ Greene
❑ Hamilton
❑ Herkimer
❑ Jefferson
❑ Lewis
❑ Livingston
❑ Madison
❑ Monroe
❑ Montgomery
❑ Nassau
❑ Niagara
❑ Oneida
❑ Onondaga
❑ Ontario
❑ Orange
❑ Orleans
❑ Oswego
❑ Otsego
❑ Putnam
❑ Rensselaer
❑ Rockland
❑ St. Lawrence
❑ Saratoga
❑ Schenectady
❑ Schoharie
❑ Schuyler
❑ Seneca
❑ Steuben
❑ Suffolk
❑ Sullivan
❑ Tioga
❑ Tompkins
❑ Ulster
❑ Warren
❑ Washington
❑ Wayne
❑ Westchester
❑ Wyoming
❑ Yates

New York City
❑ Bronx
❑ Kings
❑ New York
❑ Queens
❑ Richmond

D. Special Populations

Is there a specific category of infants and toddlers with disabilities to which the agency plans to provide early intervention services (e.g. sensory impairment)? **Yes** ❑ **No** ❑

If "yes", attach separate sheet(s) describing the population.

SCHEDULE 5 - QUALIFIED PERSONNEL

A. Indicate the qualified personnel that will be available, or are needed to provide evaluation services, service coordination services or early intervention services who will be either members of the agency's staff or under contract with the agency. Indicate the FTE of the qualified personnel checked for an unduplicated count of the agency's early intervention personnel. (Refer to instructions)

Qualified Personnel	**Employed Directly (FTE)**	**Employed by Contract (FTE)**	**Additional Personnel Needed (FTE)**
Certified Low Vision Specialist			
Certified Occupational Therapy Assistant			
Certified School Psychologist			
Certified Social Worker			
Certified Special Education Teacher			
Certified Teacher of the Blind and Partially Sighted			
Certified Teacher of the Deaf and Hearing Impaired			
Certified Teacher of the Speech and Hearing Handicapped			
Licensed Audiologist			
Licensed Occupational Therapist			
Licensed Physical Therapist			
Licensed Physician			
Licensed Psychologist			
Licensed Practical Nurse			
Licensed Speech and Language Pathologist			
Nurse Practitioner			
Orientation and Mobility Specialist			
Physical Therapy Assistant			
Physician Assistant			
Registered Dietician			
Registered Nurse			
Other professional staff (list profession and FTE)			
Other paraprofessional staff (e.g. aides, etc. List paraprofessional FTE)			

B. If qualified personnel are available through contract, attach separate sheets describing the arrangement for **each** contractor:

- name and address
- dates of contract period
- type of contract (1-year, open-ended, etc.)
- whether or not the contractor has already received state approval as an early intervention provider and, if so, from which state agency (NYS Dept. of Health, Office of Mental Retardation and Developmental Disabilities, State Education Department, or Office of Mental Health)
- whether or not the contractor will provide early intervention services using contracted individuals or agencies

SCHEDULE 6 - ASSURANCES

The applicant assures the Commissioner of Health and, if applicable, the Commissioner of Education, Commissioner of the Office of Mental Retardation and Developmental Disabilities, and the Commissioner of the Office of Mental Health, of compliance with all regulations pursuant to Part H of the Federal Individuals with Disabilities Education Act and Title II-A of Article 25 of the Public Health Law, and;

A. The applicant assures the agency is appropriately staffed with qualified personnel with state licensure or certification as appropriate, and maintains a copy of current registration or certification for those personnel;

B. The applicant agrees to enter into an approved Medicaid Provider Agreement and to reassign Medicaid benefits to the local county early intervention program or City of New York early intervention program;

C. The applicant has the capacity to deliver services on a twelve-month basis and to provide flexibility in hours of service delivery;

D. The applicant has the capacity to deliver early intervention services in natural environments, where appropriate;

E. The applicant assures that personnel have access to and participate in ongoing in-service training on best practices in the delivery of early intervention services;

F. The applicant assures that the agency is in compliance with all local fire and health safety codes, and, if providing early intervention services in a facility-based setting, the applicant assures that the agency maintains a policy for addressing health, safety and sanitation issues;

G. The applicant attests to the program operator's character and competence, including fiscal viability of the agency; and,

H. The applicant assures compliance with the confidentiality requirements as set forth in regulation.

CERTIFICATION

I, the undersigned, hereby certify under penalty of perjury, that I am duly authorized to subscribe and submit this application and that the information contained herein and attached hereto is accurate, true and complete. I further acknowledge that the application will be processed pursuant to the provisions of Title II-A of Article 25 of the Public Health Law, and the pertinent regulations adopted thereto.

______________________________ ______________________________
Type/Print Name Title

______________________________ _____/_____/_____
Signature Date

CORPORATE ACKNOWLEDGMENT

STATE OF NEW YORK)
) SS:
COUNTY OF)

On this ______day of _______________, 20____, before me personally appeared ______________________________
(Name)

residing at, ______________________________ to me known and known by me to be ______________________
(Street, City, State, Zip) *(Title)*

of______________________________ and the person who executed ______________________________
(Corporation/Agency) *(The foregoing instrument)*

in the name of said ______________________________ and __he duly acknowledged to me that __he executed the
(Corporation/Agency)

same as and for the act and deed of said ____.
(Corporation/Agency)

____
Notary Public

PROVIDER AGREEMENT
BETWEEN THE NEW YORK STATE DEPARTMENT OF HEALTH
AND SERVICE PROVIDERS IN NEW YORK STATE EARLY INTERVENTION PROGRAM

Contingent upon approval by the New York State Department of Health to participate in the New York State Early Intervention Program, and the satisfactory completion of a Medicaid provider agreement and statement of reassignment for the purpose of establishing eligibility to participate in the New York State Medicaid Program under title XIX of the Social Security Act, ____, hereafter called the Provider, agrees as follows to:

A. (1) Keep any records necessary to disclose the extent of services the Provider furnishes to recipients receiving assistance under the New York State Plan for Medical Assistance;

(2) On request, furnish the New York State Department of Health, or its designee, and the Secretary of the United States Department of Health and Human Services, and the New York State Medicaid Fraud Control Unit any information maintained under paragraph (A) (1), and any information regarding any Medicaid claims reassigned by the Provider to the local early intervention agency;

(3) Comply with the disclosure requirements specified in 42 CFR Part 455, Subpart B;

B. Comply with Title VI of the Civil Rights Act of 1964, Section 504 of the Federal Rehabilitation Act of 1973, and all other State and Federal statutory and constitutional non-discrimination provisions which prohibit discrimination on the basis of race, color, national origin, handicap, age, sex, religion and marital status;

C. Abide by all applicable Federal and State laws and regulations, including the Social Security Act, the New York State Social Services Law, Part 42 of the Code of Federal Regulations and Title 18 of the Codes Rules and Regulations of the State of New York; and,

D. Provide services in accordance with Title II-A of Article 25 of the Public Health Law and Subpart 69-4 of Title 10 of the Codes Rules and Regulations of the State of New York (New York Early Intervention Program).

Authorized Signature: ____

Address: ____

City: ____ State: ________ Zip: __________

Telephone No.: ___________________________________ *Date Signed:* _____/_____/_____

STATEMENT OF REASSIGNMENT

____
Name of Early Intervention Program/Practitioner

By this reassignment, the above-named program or practitioner of early intervention services agrees:

1. To reassign all Medicaid reimbursement for early intervention services to the municipal early intervention agency that you contract with to provide early intervention services.
2. To accept as payment in full from the municipal early intervention agency the State Department of Health promulgated payment levels for covered early intervention services.
3. To not bill Medicaid for eligible early intervention services which are specified in a child's individualized family services plan (IFSP). These services will be directly billed to and reimbursed by the municipal early intervention agency.
4. To comply with all the rules and policies as described in your contract with the municipal early intervention agency.

_______________________________________ _____/_____/_____
Signature Date

____
Street Address

_______________________________ _____________ _____________
City State Zip

NOTE: NOTHING IN THIS STATEMENT OF REASSIGNMENT WOULD PROHIBIT A MEDICAID PROVIDER FROM CLAIMING REIMBURSEMENT FOR MEDICAID ELIGIBLE SERVICES RENDERED OUTSIDE THE SCOPE OF THE EARLY INTERVENTION PROGRAM.

AGENCY CHECKLIST

- ❑ Tax Identification Number (Schedule 1) must appear on application.
- ❑ Contact person (Schedule 1) must be located at the main agency site.
- ❑ Copies of all organizational documents, such as partnership agreements or certificates of incorporation, and filing receipts (Schedule 2) must be enclosed with this application.
- ❑ If you are seeking to provide facility-based services (Schedule 4) copies of health, safety and fire evacuation policies must be enclosed. Facility-based means services are being performed in a place you own, rent or lease.
- ❑ If “CORE” Evaluation Services (Schedule 4) is checked, a letter from a licensed physician on their letterhead and the FTE (availability) must be enclosed.
- ❑ Verify that ALL counties (Schedule 4) checked for which the agency is seeking approval to provide early intervention services are within an appropriate geographical area.
- ❑ Verify that ALL Qualified Personnel (Schedule 5) employed through “contract” have current state approval to provide early intervention services. Provide a list of all contracted employees including their name, address, social security number, and FTE’s.
- ❑ Complete and notarize the Corporate Acknowledgment (Schedule 6 of the application).
- ❑ Statement of Reassignment and Provider Agreement Form must be signed, dated and returned with this application.

Failure to supply all needed material at time of review will automatically render application incomplete and will be returned for compliance.