NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Early Intervention

Application for Approval of Individual Evaluators, Service Providers and Service Coordinators

NOTE: THIS APPLICATION IS FOR APPROVAL OF INDIVIDUALS ONLY
(Use Form # DOH-3736 for agencies, sole proprietorships, partnerships, corporations or state-operated facilities)

SCHEDULE 1 - GENERAL INFORMATION

A. Applicant Identification

Applicant Name		Social Security No.	
Address (Number and Street)			
(City)	(County)		(Telephone) ( )
(State)		(Zip)	(Fax) ( )

I will deliver services at the address listed above ___ Yes ___ No
I will deliver services at other site(s) I operate ___ Yes ___ No
If **"Yes"**, list the site(s) below. Use additional sheets if necessary.

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

I will deliver services in children's homes or community settings ___ Yes ___ No
(e.g., YMCAs, child care facilities, community centers)

B. Personal Qualifying Information

Registration or Certification (Enclose copy of current registration or certification with application)

1. Name of Profession	License/Certification Number
2. Granted By (State Agency or other entity)	
3. Date License/Certificate Issued	Date Registration/Certification Expires
4. Have you ever had your license suspended or revoked? ___Yes ___ No If "Yes", attach separate sheet and describe the reasons for suspension/revocation, date of reinstatement and corrective action that facilitated reinstatement.	

C. Inservice/Continuing Education

Indicate any educational program(s) attended during the previous three years focusing on early intervention for infants and toddlers, birth to age three and their families. Use additional sheets if necessary.

Name of Program | Length and content | Date of attendance

____

____

____

____

D. Employment History

Specify professional employment experience for the past five (5) years, including experience with infants and toddlers at risk of developmental delay or disabilities, with most recent experience listed first. A copy of a current resume is sufficient, if it contains the above listed information.

Employed From	To	Employer Name	Address	Position Held	Job Responsibility

E. Record of Legal Actions

a) Except for minor traffic violations, were you ever convicted of any criminal or other violation of the law ?

☐ Yes ☐ No

b) Are there any criminal or other 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/agencies involved ____

Description of violations/charges ____

SCHEDULE 2 – SERVICE PROVISION

A. The applicant is seeking approval to provide:

1) ______ Evaluation Services (Supplemental evaluations only)

2) ______ Service Coordination Services

3) ______ Service Provision (If "Yes", check all that apply):

a) ____ Home and community based individual/collateral visits

b) ____ Facility-based individual/collateral visits*

c) ____ Parent-child group*

d) ____ Group developmental intervention*

e) ____ Family/caregiver support group*

* If site is operated by you, you must provide copy of health and safety policies and fire evacuation procedure for each site.

B. Can you provide early intervention services in languages(s) other than English? ___ Yes ___ No

If "Yes", specify language(s)______________________________ ________________________
______________________________ ________________________

SCHEDULE 3 – SERVICE CATCHMENT AREA AND POPULATION SERVED

Check all counties in which you will 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 _________

SCHEDULE 4 – QUALIFIED PERSONNEL

Indicate your availability to provide early intervention services in full-time equivalents (FTE) for your discipline(s). To calculate the full time equivalent (FTE), divide the number of hours you are available each week by 40 (e.g. 40 hours = 1 FTE, 20 hours = 0.5 FTE, 10 hours = 0.25 FTE).

Please Note: Your FTE total **cannot** exceed 1.0 (40 hours/week).

Qualified Personnel	Availability in FTE
Audiologist	
Dietitian (Registered or Certified)	
Fellows of the College of Optometrists in Vision Development (FCOVD)	
Low Vision Specialist	
Nurse Practitioner	
Registered Nurse	
Licensed Practical Nurse*	
Occupational Therapy Assistant *	
Occupational Therapist	
Orientation and Mobility Specialist	
Physical Therapy Assistant *	
Physical Therapist	
Physician	
Physician Assistant *	
Psychologist	
Social Worker	
Speech and Language Pathologist	
Special Education Teacher	
Teacher of the Blind and Partially Sighted	
Teacher of the Deaf and Hearing Impaired	
Teacher of the Speech and Hearing Handicapped	

* Licensed Practical Nurses, Occupational Therapy Assistants, Physical Therapy Assistants, and Physician Assistants may only be approved, as individuals, to provide Service Coordination Services (see Schedule 2)

SCHEDULE 5 – ASSURANCES

The applicant assures the Commissioner of Health of compliance with all regulations pursuant to Part C of the Federal Individuals With Disabilities Education Act and Title II-A of Article 25 of the Public Health Law and:

A. The applicant attests to his/her character and competence;
B. The applicant assures the maintenance of current state licensure and/or certification and demonstrated proficiency in early childhood development, e.g., previous experience in the delivery of services to infants and toddlers with developmental delay or disability;
C. The applicant assures that he/she will notify the Department within two working days of suspension, expiration, or revocation of licensure, certification or registration;
D. The applicant provides assurances of participation in in-service training or other forms of professional training and education related to the delivery of early intervention services;
E. 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;
F. The applicant provides assurances of the ability to act as a member of a multidisciplinary team, including demonstration of prior experience in collaborating with other professionals in the design and delivery of services;
G. The applicant provides assurances of the capacity to deliver services on a twelve-month basis and to provide flexibility in hours of service delivery; and,
H. The applicant assures compliance with the confidentiality requirements 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.

______________________________	______________________________
Signature	**Date**
______________________________	______________________________
Print or Type Name	**Title**

INDIVIDUAL ACKNOWLEDGMENT

STATE OF NEW YORK)

COUNTY OF) SS.:
)

On this ______day of ___________________20____, before me personally appeared ____________________

_________________________________residing at____
Name Street, City, State, Zip

To me known and known by me to be the person who executed the foregoing instrument.

Notary Stamp

____
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, 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**

____

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.

INDIVIDUAL APPLICATION CHECKLIST

- ☐ A copy of current registration or certification is enclosed for all disciplines listed in Schedule 4.
- ☐ Inservice/continuing education and employment sections are completed and related to infants and toddlers with or at risk of developmental delay or disabilities (can include lectures, seminars, conferences etc.)
- ☐ If you will provide any services in a site operated by you, copies of health and safety and fire evacuation procedures are enclosed.
- ☐ Schedule 4, full time equivalents (FTE'S) is completed and FTE total is not greater than 1.0 FTE.
- ☐ All boxes are checked and all questions are answered.
- ☐ An original signature is on Certification page.
- ☐ The Individual Acknowledgment is completed and notarized.
- ☐ The STATEMENT OF REASSIGNMENT and the PROVIDER AGREEMENT forms are signed and attached to the application.

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