New York State Department of Health, Bureau of Early Intervention

Application for the Approval of Agencies

As Early Intervention Evaluators, Service Coordinators & Service Providers

This application is to be used to apply for approval of agencies as early intervention evaluators, service providers and service coordinators for the statewide Early Intervention (EI) Program under Title II-A of Article 25 of the Public Health Law.

Who May Apply for Approval as an Early Intervention Agency:

- A legal business entity authorized to do business in New York State which directly employs EI qualified personnel, and may contract with individual providers or other agencies which are approved by the Department, for the provision of early intervention program evaluations, service coordination, and/or early intervention services.
- Applicants must have an organizational structure that complies with all federal and state statutes and regulations, including practice acts established by the State Education Department Office of Professions.
- Applicants must have a National Provider Identifier (NPI) for the proposed EI agency.

Minimum Agency Staffing Requirements:

- Agency must **employ** a **full-time Early Intervention (EI) Program Director** who has:
  - A minimum of two years full time or equivalent of experience in an early intervention, clinical pediatric or early childhood education program that includes serving children ages birth to five years of age,
  - provided that the experience includes direct experience in delivering services to children with disabilities and their families and,
  - at least one year of the experience was in the delivery of services to children less than three years of age and their families.
  - The program director's duties may include provision of services.
  - This individual must be available a sufficient amount of time to develop and ensure implementation of a Program Standards Plan and to ensure that the agency is in compliance with federal and state requirements.

- Agency must **employ a minimum of two individuals** (excluding the program director) who are:
  - recognized as qualified personnel by the Early Intervention Program, as defined in 10 NYCRR Section 69-4.1, or
  - service coordinators meeting the qualifications in 10 NYCRR Section 69-4.4,and,
  - each available to provide a minimum of 20 hours per week early intervention services and/or evaluations and/or service coordination which may also include the delivery of services to individuals with disabilities outside of the EI program.
- When seeking approval to use applied behavioral analysis (ABA) aides to assist in the provision of ABA services, agency must provide**:**

- designation of at least one **employed ABA supervisor**
- identification of **employed ABA aides**
- statement of child/aide/supervisor ratio and,
- submission of personnel, training and supervisory plans specific to the provision of ABA services, and,
- a plan to ensure the quality and effectiveness of services.

➢ The agency must **employ Quality Assurance Professionals.**

- A Quality Assurance Professional is a professional employed by the agency whose responsibilities include monitoring and overseeing implementation of the agency's quality assurance plan for a particular early intervention service/profession.
- The agency must have a Quality Assurance Professional for each early intervention service/profession.
- Each Assurance Professional must hold a license, certification, or registration for each type of early intervention service/profession/service coordination.
- There does not need to be separate QA Professionals for evaluation and services. For instance an SLP Quality Assurance Professional can cover both services and evaluations.
- Dually licensed/certified individuals can hold a dual QA position.
- An individual with a background in service coordination can also be a QA professional for service coordination.
- The agency Program Director and one or both of the minimum two staff can also be designated as a Quality Assurance Professional if they hold the appropriate license/certification for that function.
- The agency owner/operator and the QA professionals should determine the required number of hours necessary for quality assurance professionals to implement a plan to ensure that quality services are being provided by the agency.

Written Plans

- The Agency must **submit a Quality Assurance (QA) Plan** for all services provided by an agency.
- The plan should take into account the size of the agency, type of service, location of service, whether contractors or employees, experience of the professionals, requirements of the professions, EI state & federal requirements and in general what is necessary to ensure that quality services are being provided to children & families by the agency.
- The plan will be unique to each agency and probably many of the QA practices already exist and will just need to be formalized into the QA plan.
- The Quality Assurance (QA) Plan should be submitted with this application, and must be available for review by local or State Early Intervention Program personnel or their designees.

- Agencies must **have a Program Standards Plan** that ensures:
    - services delivered by employees and contractors of the agency are delivered in accordance with federal and state laws and regulations
    - in adherence to guidance issued by the Department that clarifies requirements of law and regulation related to the Early Intervention Program.
    - The Program Standards Plan **does not have to be submitted** with this application, but must be available for review by local or State Early Intervention Program personnel or their designees.

- The Program Standards must include policies and procedures to ensure the following:
    - provision of services on a twelve month basis and flexibility in the hours of service delivery including evening and weekend hours;
    - provision of services that are family-centered;
    - teaming and communication with parents and other service providers;
    - clinical mentorship opportunities;
    - case conferencing and consultation;
    - opportunities for continuing education and in-service training on policies and procedures related to the Early Intervention Program and Early Intervention Program core competencies;
    - opportunities for participation in State Department of Health sponsored EI training depending on the professional's role (e.g., service coordinator, evaluator, service provider);
    - resolution of questions, concerns, and problems involving parents, county personnel, and other service providers; and,
    - routine assessment and improvement of the quality of service delivery.

- Once approved, EI regulations require that approved **EI agencies enroll in Medicaid**.
    - While the June 3, 2010 regulations require approved early intervention agencies to become enrolled Medicaid providers, this would not affect the rate that you are paid in the Early Intervention Program or require that you bill Medicaid directly for early intervention services. Municipalities will continue to reimburse contracted providers for the services rendered and the municipality will bill all third party insurers including Medicaid.

Additional information related to National Provider Identifier (NPI):

- To apply for EI agency approval, your agency **must have a National Provider Identifier (NPI) for your agency.**
- The agency must also indicate an NPI for each of the agency's **licensed** individuals who deliver EI services on the agency's behalf.
- If the licensed individuals have not already obtained an NPI, they should do so immediately so that your agency can complete the application.
- Obtaining an NPI may be done online and is a fairly simple process to complete.
- Most EI service providers who have a NYS license to practice certain health-related professions are subject to the 1996 federal Health Insurance Portability

and Accountability Act (HIPAA) requirement for providers to obtain and report a National Provider Identifier (NPI). Individuals who are otherwise qualified to deliver early intervention services but who are not licensed professionals (eg. special educators, service coordinators, respite providers and transportation providers) do not have to obtain or report an NPI.

How to Apply for Approval as an Early Intervention Agency:

- To obtain approval, the applicant must submit a completed application, including all required schedules and attachments, to the New York State Health Department.
- Signatures must be original and the application must be notarized.

The Review of your *Application for the Approval of Agencies as Early Intervention Evaluators, Service Coordinators & Service Providers*:

- Staff within the NYSDOH Bureau of Early Intervention will review the application for completeness.
- If the application is incomplete, the application and all attachments will be returned to the applicant with an information sheet stating what additional information is required for approval and the application must be notarized again prior to resubmission.
- When an application is determined to be complete, it will be reviewed.
- The Department shall consider applications for approval and reapproval utilizing the criteria set forth in 10 NYCRR Section 69-4.
- The applicant will receive notification of approval or denial upon completion of the review process.

The following references may be of assistance when completing this application:

- Individuals with Disabilities Education Act (IDEA) Part C (Title 20 USC Sec. 1431 et. seq.) and Title 34 Code of Federal Regulations Part 303 (http://www.ed.gov/about/offices/list/osers/osep/index.html)

- Title II-A of Article 25 of the Public Health Law and Title 10 NYCRR Subpart 69-4 (Early Intervention Program State Program Regulations) (www.health.state.ny.us/nysdoh/eip)

- The Office of Children and Family Services provides support for people and organizations that are interested in starting day care programs in their communities. http://www.ocfs.state.ny.us/main/childcare/regionaloffices.asp

- The Bureau of Day Care in NYC provides support for people and organizations that are interested in starting day care programs in one of the *five boroughs of New York City*. Please contact the Bureau of Day Care in NYC at (212) 676-2444.

- The NPI is obtained by applying online at: https://nppes.cms.hhs.gov

Application Instructions

- **The application must be typed or printed neatly in black ink.**
- **Definitions of terms used in this application are included in the back of this application.**
- **All attachments must be numbered and referenced to the appropriate application schedule.**
- **All applicants must complete all required schedules. Specific instructions for completion are on each schedule.**
- **Please review the application for completeness prior to submission. Incomplete applications will be returned.**
- **Only applications with original signatures on all Disclosure Information forms (Schedule 3), Statement of Reassignment forms (Schedule 8) and Provider Agreement forms (Schedule 9) will be accepted.**
- **The acknowledgment to the Assurances form (Schedule 10) must be signed and notarized.**
- **Keep a copy of your application for your records.**
- **The applicant will receive written notification of approval or denial upon completion of the review process.**

Submit the original signed and notarized application to:

NYS Department of Health
Bureau of Early Intervention
Corning Tower, Room 287
Empire State Plaza
Albany, New York 12237-0660

Inquiries concerning this application can be directed to the New York State Department of Health, Bureau of Early Intervention at the above address, by telephone at (518) 473-7016 or by e-mail at eip@health.state.ny.us.

New York State
Department of Health
Bureau of Early Intervention

Application for the Approval of Agencies as Evaluators, Service Coordinators & Service Providers

THIS APPLICATION IS FOR APPROVAL OF **AGENCIES ONLY**
ALL ATTACHMENTS MUST BE NUMBERED AND REFERENCED TO THIS APPLICATION WHERE INDICATED
ONLY APPLICATIONS WITH ORIGINAL SIGNATURES WILL BE ACCEPTED

SCHEDULE 1 – BACKGROUND INFORMATION

A. Applicant Information

Enter the agency's legal name, NPI number and federal employer identification number. If conducting business under an assumed name (doing business as; e.g., d/b/a), also provide the d/b/a. Enter the mailing address of the agency. Enter the main telephone number for the agency and a fax number, if available. If the address of the main office is different than the mailing address or if files and records are located at a different address than the mailing address, enter that address under office address. Enter an e-mail address if available.

AGENCY NAME NPI#- _____				***Federal Employer Identification Number*** /__/ __/ -/ __/ __/ __/ __/ __/ __/ __/
d/b/a (where applicable)				
Mailing Address (Street)				
City	County	State	Zip	Telephone # ( ) Fax # ( )
Office Address (location of files and records)				
E-mail Address				

1. Has this agency ever been previously approved by the Department of Health or other state agency, to deliver early intervention evaluations, service coordination or services under this name or d/b/a or NPI number?

   ☐ Yes ☐ No

2. Has this agency ever been previously approved by the Department of Health or other state agency to deliver early intervention evaluations, service coordination or services under a different name or organizational structure?

   ☐ Yes ☐ No

If yes, complete all information requested below pertaining to that agency.

Name of entity	Type of entity
Address (include county)	Date of Ownership From (date) _____/_____/_____ To (date) _____/_____/_____ Type of Ownership/Interest:
Current status of entity (check one) ❒ Open ❒ Closed	
State agency approval of entity (Check all that apply) ❑ Department of Health ❑ State Education Department ❑ Office of Mental Health ❑ Office of Mental Retardation and Developmental Disabilities	

B. Designated EI Program Director

Enter the name, title, address, telephone number and e-mail address of the full-time EI Program Director for the agency. This person must be an employee or owner of the agency.

Name (Mr., Mrs., Ms, Miss, Dr.)	Title
Address (if different from above) E-mail Address:	Office Telephone # ( )

C. Board Resolution

Corporate applicants must attach a copy of a board resolution authorizing the agency to submit this application. Public applicants must attach a resolution from the local legislature, board of supervisors or other governing body having jurisdiction over the applicant agency authorizing an individual to submit this application. (Attachment # _____)

SCHEDULE 2 – Corporate Structure/Disclosure Requirements

A. Type of Ownership

Check the box that indicates the Type of Ownership of the applicant agency. If applicable, attach a certified copy of the Assumed Name Certificate (d/b/a). Where certified copies are required, such documents can be obtained by the issuing agency, either the New York State Department of State, Division of Corporations, 41 State Street, Albany, New York 12231 or the county clerk's office in which the business is located.

1. ❑ Sole Proprietor

a. The sole proprietor must complete Schedule 3 - Disclosure Information.
b. The EI Program Director must complete Schedule 3 and attach a resume detailing experience in early intervention, clinical pediatric or early childhood education programs that include children with special needs.
c. Attach a certified copy of the Assumed Name Certificate. (Attachment #_____).

2. ❑ Partnership

a. Each partner must complete Schedule 3 - Disclosure Information.
b. The EI Program Director must complete Schedule 3 and attach a resume detailing experience in early intervention, clinical pediatric or early childhood education programs that include children with special needs.
c. Attach a photocopy of the applicant's fully executed Partnership Agreement. (Attachment #_____)
d. Attach a certified copy of the Assumed Name Certificate. (Attachment #_____)

3. ❑ Professional Limited Liability Company (PLLC)

a. Each officer of the applicant PLLC must complete Schedule 3 - Disclosure Information.
b. The EI Program Director must complete Schedule 3 and attach a resume detailing experience in early intervention, clinical pediatric or early childhood education programs that include children with special needs.
c. Attach a list of all the PLLC's members' names and date of birth. (Attachment #_____)
d. Attach a photocopy of the applicant's fully executed Articles of Organization and filing receipt. (Attachment #_____)

4. ❑ Limited Liability Partnership (LLP)

a. Each partner must complete Schedule 3 - Disclosure Information.
b. The EI Program Director must complete Schedule 3 and attach a resume detailing experience in early intervention, clinical pediatric or early childhood education programs that include children with special needs.
c. Attach a photocopy of the applicant's fully executed Partnership Agreement. (Attachment #_____)
d. Attach a photocopy of the applicant's fully executed Certificate of Limited Partnership and filing receipt. (Attachment #_____)

5. ❑ **Not-For-Profit Corporation**

a. Each officer must complete Schedule 3 - Disclosure Information.
b. The EI Program Director must complete Schedule 3 and attach a resume detailing experience in early intervention, clinical pediatric or early childhood education programs that include children with special needs.
c. Attach a list of all the corporation's board members' names and date of birth. (Attachment #_____)
d. Attach a certified copy of the Certificate of Incorporation, and filing receipt. (Attachment #_____)

6. ❑ **Business Corporation**

a. Each officer and principal stockholder (holder of 10% or more of the issued and outstanding stock) must complete Schedule 3 - Disclosure Information.
b. The EI Program Director must complete Schedule 3 and attach a resume detailing experience in early intervention, clinical pediatric or early childhood education programs that include children with special needs.
c. Attach a list of all the corporation's board members' names and date of birth. (Attachment #_____)
d. Attach a certified copy of the Certificate of Incorporation, and filing receipt. (Attachment #_____)

7. ❑ **Professional Corporation (PC)**

a. Each officer of the corporation must complete Schedule 3 - Disclosure Information.
b. The EI Program Director must complete Schedule 3 and attach a resume detailing experience in early intervention, clinical pediatric or early childhood education programs that include children with special needs.
c. Attach a list of all the corporation's board member's names and date of birth. (Attachment #_____)
d. Attach a certified copy of the Certificate of Incorporation and filing receipt. (Attachment #_____)

8. ❑ **Limited Liability Company (LLC)**

a. Each officer of the applicant LLC must complete Schedule 3 - Disclosure Information.
b. The EI Program Director must complete Schedule 3 and attach a resume detailing experience in early intervention, clinical pediatric or early childhood education programs that include children with special needs.
c. Attach a list of all the LLC's members' names and date of birth. (Attachment #_____)
d. Attach a photocopy of the applicant's fully executed Articles of Organization and filing receipt. (Attachment #_____)

9. ❑ **Government Subdivision**

a. Authorized individual must complete Schedule 3 – Disclosure Information.
b. The EI Program Director must complete Schedule 3 and attach a resume detailing experience in early intervention, clinical pediatric or early childhood education programs that include children with special needs.

B. Foreign Entities

Foreign entities are those already formed in another state that may apply for authority to conduct business in New York State. In addition to the documentation required in Section A, foreign entities must provide:

a. Schedule 3 - Disclosure Information as required for the type of organizational structure noted above (e.g., sole proprietorship, partnership, PLLC, LLP, Not-For-Profit Corporation, Business Corporation, PC, LLC or Government Subdivision).
b. The EI Program Director must complete Schedule 3 and attach a resume detailing experience in early intervention, clinical pediatric or early childhood education programs that include children with special needs.
c. Attach a copy of the Application for Authority to Do Business in New York and the Department of State filing receipt. (Attachment # _____)

C. Parent Organization Information

For all organizations with a parent organization, complete related organization information as indicated. A parent organization is any entity that wholly owns or has a majority interest in the applicant entity.

1. List the full legal name, addresses of the principal office and place of doing business and Federal Employee Identification Number (FEIN) of any parent organization. (Attachment #_____)

2. For each parent organization identified in C 1:

a. List the full name and title of each member of the Board of Directors, board officers, principal stockholders or sponsors of such parent organization. (Attachment #_____)
b. List the full legal name and the addresses of the principal office and place of doing business of any agencies or facilities owned or operated by the parent organization or subsidiary corporation that are certified or licensed for the provision of health or human services or educational services, including preschool programs for children with disabilities. (Attachment #_____)

Describe in detail the relationship between the applicant agency and any parent organization, including the method or mechanism by which control over the applicant agency is or will be effectuated (e.g. stock ownership, membership arrangement, common officers, directors or stockholders or other arrangement). (Attachment # _____)

SCHEDULE 3 – DISCLOSURE INFORMATION – all three pages must be completed by each individual identified in Schedule 2**.** This form may be duplicated as necessary**.**

A. Personal Information

Name (Mr., Mrs., Ms, Dr.)			Date of Birth
Title			
Address			
City	County	Zip	Telephone #: ( )

B. Licenses/Certificates Held

1. Enter information regarding professional license(s) or teacher certification.

   Check if not currently registered or certified: NONE: _____

Name of Profession:	NYS License/Certification No:
Dates of Registration/Certification: From:_____/_____/_____ To: _____/_____/_____ Permanent: _____	
Name of Profession:	NYS License/Certification No:
Dates of Registration/Certification: From:_____/_____/_____ To: _____/_____/_____ Permanent: _____	

2. Has your professional license, registration or certification ever been suspended or revoked?

   ☐ Yes ☐ No

   If "yes", attach a separate sheet providing the following information:

   a. Date(s) of action(s)

   b. Reason(s) for action(s)

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

   d. Date of reinstatement

C. Offices/Positions Held in Health or Human Service Agencies/Facilities

Enter information regarding any offices/positions held in other health or human service agencies or facilities, including early intervention and/or special education preschool programs, over the past ten (10) years. Attach additional sheets if necessary (Attachment #_____)

None:_____

Name of Facility/Agency	Office/position held: From: / / to: / /
Address:	
Name of Facility/Agency	Office/position held: From: / / to: / /
Address:	

D. Record of Legal Actions

1. Except for minor traffic violations, have you ever been convicted of any violation of the law (e.g., criminal, civil, or administrative charges)?

   ❑ No ❑ Yes

2. Have you or any agency that provides health and human services in which you held an office or position ever been restricted, suspended, revoked or fined by any Federal, State or local agency?

   ❑ No ❑ Yes

3. Have you or any agency that provides health and human services in which you held an office or position ever been subject to an audit that resulted in recoupment?

   ❑ No ❑ Yes

4. Have you or any agency that provides health and human services in which you held an office or position ever had a contract terminated, suspended or restricted for failure to perform or for any other reason?

   ❑ No ❑ Yes

5. Has the applicant agency ever been the subject of any child care enforcement actions (e.g., fines, sanctions, etc) or had its approval, certification, or licensure restricted, revoked or suspended by the Office of Children and Family Services?

6. Have you ever been restricted, suspended or excluded from participation as a Medicaid provider?

   ❑ No ❑ Yes

7. Are there any criminal, civil or administrative charges pending against you?

   ❑ No ❑ Yes

If the answer to any of these questions is "yes", complete the following for each action. Attach additional sheet(s) as necessary. Submit a copy of the certificate of disposition and a brief statement of circumstances (Attachment #_____)

Date of Action _____ Type of Action _____

Location _____

Explanation of Violation _____

_____

E. Ownership/Interest in any other entity

Enter the name, address and other data indicating other health or human service agencies or facilities you have owned or had a controlling interest in over the past ten (10) years. Include all entities that were approved to provide early intervention or early childhood services. Attach additional sheets, if necessary (Attachment #_____)
None: _____

Name of entity	Type of entity
Address	Date of Ownership From (date) _____/_____/_____ To (date) _____/_____/_____ Type of Ownership/Interest:
Current status of entity (check one) ❒ Open ❒ Closed ❒ Proposed	
State agency approval of entity (Check all that apply) ❑ Department of Health ❑ State Education Department ❑ Office of Mental Health ❑ Office of Mental Retardation and Developmental Disabilities ❑ Office of Children and Family Services ❑ Office of Alcohol and Substance Abuse Services	

F. Certification

The Certification must contain the signature of the individual named in Schedule 3 A.
The undersigned hereby certifies under penalty of perjury that the information contained in Schedule 3, and all attachments to Schedule 3 herein, is accurate, true and complete in all material respects.

_____ Title_____

Print Name

_____ Date_____

Signature

SCHEDULE 4 – APPLICANT AGENCY AFFILIATION

A. Health, Education, Developmental Disabilities, and Mental Hygiene Agencies

Please complete the following questions regarding the applicant agency's affiliation with other government entities. Please answer all questions.

1. Is the applicant agency currently approved, certified or licensed by any of the following state agencies for services other than early intervention? Check below to indicate status and if yes, provide the license or certification number, if any.

1) New York State Department of Health ❑ No ❑ Yes

[ ] Article 28 PHL Diagnostic and Treatment Center #_____
[ ] Article 28 PHL Hospital Based Outpatient Clinic #_____
[ ] Article 36 CHHA (Certified Home Health Agency) #_____
[ ] Article 36 LHCSA (Licensed Home Care Service Agency) #_____
[ ] Approved Medicaid Provider #_____
(If more than one Medicaid Provider number, provide all numbers.)

2) State Education Department ❑ No ❑ Yes

[ ] Section 4410 Education Law #_____
[ ] BOCES/School District #_____
[ ] VESID #_____

3) Office of Mental Retardation and Developmental Disabilities ❑ No ❑ Yes

[ ] Article 16 OMRDD Clinics #_____
[ ] Comprehensive Medicaid Case Management #_____

4) Office of Mental Health ❑ No ❑ Yes

[ ] Article 31 MHL Clinics #_____

5) Office of Alcohol and Substance Abuse Services ❑ No ❑ Yes

[ ] Article 22 Service Provider # _____

2. If "yes" to any of the above, provide the date of the most current site visit, program review and, if applicable, audit by the relevant government agency(ies). Attach additional sheets if necessary (Attachment # _____)

State Agency _____ Date of Review: ___/__/____

State Agency _____ Date of Review ___/__/____

3. Has the applicant agency ever been the subject of any enforcement actions (e.g., fines, sanctions, etc) or had its approval, certification or licensure restricted, revoked or suspended by any of the above State agencies? No ❑ Yes ❑

If "yes" attach separate sheet providing the following information:

a. Dates of action

b. Reason(s) for action

c. Resolution of action (include corrective action that was taken and whether approval has been reinstated) (Attachment #_____)

B. Managed Care Plan Affiliations

List all managed care plans that recognize the agency as an approved or in-network provider. (Attachment #_____)

SCHEDULE 5 –PERSONNEL

A. Available Personnel

In addition to the early intervention program director, there must be a minimum of two employed qualified personnel (QP) or service coordinators who meet qualifications as required by 10NYCRR 69-4. The two QP must provide evaluations, service coordination, or services to individuals with disabilities for a minimum of twenty hours each per week.

Complete the chart below, indicating the number of personnel that the agency intends to use to provide early intervention services.

Profession	**Directly Employed**	**Available by Contract (must be state approved)**
Audiology:		
Audiologist		
Medical/Nursing:		
Pediatrician		
Physician other than Pediatrician		
Physician Assistant*****		Cannot be contracted for professional services
Nurse Practitioner		
Registered Nurse		
Licensed Practical Nurse*		Cannot be contracted for professional services
Nutrition:		
Certified Dietitian/Nutritionist		
Registered Dietitian		
Occupational Therapy:		
Occupational Therapist		
Occupational Therapy Assistant*****		Cannot be contracted for professional services
Physical Therapy:		
Physical Therapist		
Physical Therapist Assistant*****		Cannot be contracted for professional services
Psychology:		
Licensed Psychologist		
School Psychologist******		Cannot be contracted for professional services

Profession	**Directly Employed**	**Available by Contract (must be state approved)**
Social Work:		
Licensed Master Social Worker		
Licensed Clinical Social Worker		
Speech Pathology:		
Speech-Language Pathologist		
Special Education:		
Teacher of Special Education		
Teacher of Students with Disabilities (Birth – Grade 2)		
Teacher of Blind and Partially Sighted		
Teacher of Blind and Visually Impaired		
Teacher of Deaf and Hearing Impaired		
Teacher of Deaf and Hard of Hearing		
Teacher of Speech and Hearing Handicapped		
Teacher of Speech and Language Disabilities		
Vision Services:		
Certified Orientation and Mobility Specialist		
Certified Low Vision Specialist		
Fellows of the College of Optometrists in Vision Development (FCOVD)		
Optometrist		
Service Coordination Services:		
Service Coordinators***		Cannot be contracted
Paraprofessional		
1:1 Aide – Group Developmental Interventions		
ABA aides****		Cannot be contracted

*These professionals can only provide early intervention services in an employment setting with appropriate supervision, with the exception of service coordination services.

** Per Article 153 of Section 7605 of the State Education Law, certified school psychologists may only provide services when directly employed by a federal, state, county or municipal government, chartered elementary, secondary school or degree granting institution.

***Use this category for service coordinators who are not in one of the professions otherwise listed in schedule 5.

**** Per 10NYCRR 69-4.9a, these individuals must be directly employed and supervised by the approved agency.

B. Personnel Information

All agencies must have, in addition to the early intervention program director, a minimum of two qualified personnel or service coordinators who meet qualifications as required by 10NYCRR Section 69-4, each of whom provides evaluations, service coordination, or services to individuals with disabilities for a minimum of twenty hours each per week.

All contracted individuals and all contracted agencies **MUST** be approved by the New York State Department of Health Early Intervention Program to deliver early intervention services. All names listed on this form as "Available by Contract" will be verified for DOH approval to provide early intervention services.

All agencies must have a Quality Assurance Professional for each early intervention service/profession. Each Assurance Professional must hold a license, certification, or registration for each type of early intervention service/profession/service coordination. There does not need to be separate QA Professional for evaluation and services.

For each of the following personnel categories, attach a list that includes the following:

- Directly employed individuals that deliver early intervention services (include name, address, phone numbers, e-mail address, profession and license/certification number, dates of Registration/Certification and where applicable national provider identification) (Attachment #_____)

- Contracted individuals that deliver early intervention services (name, profession and license/certification number, EI Provider ID number and where applicable national provider identification) (Attachment #_____)

- Contracted agencies that are available by contract to deliver early intervention services (name and Federal Employee Identification Number [FEIN], EI Provider ID number and where applicable national provider identification) (Attachment #_____)

- Directly employed QA Professional (include name, address, phone numbers, e-mail address, profession and license/certification number, dates of Registration/Certification and where applicable national provider identification) (Attachment #_____)

SCHEDULE 6 – SERVICE AVAILABILITY

A. Services

Check the early intervention service types for which you are seeking approval (see Definitions). *Please check all that apply*.

1. ❑ Core Evaluations
2. ❑ Supplemental Evaluations
3. ❑ Service Coordination Services
4. ❑ Home/community-based individual/collateral visits
5. ❑ Parent–child groups
6. ❑ Group developmental intervention
7. ❑ Family/caregiver support group

❑ Check this box **only** if you will be providing any of the above services at a site you rent, own, lease or operate. If box is checked you **must** complete Schedule 7.

- Submit a quality assurance plan for each type of service offered by the agency, including evaluations and service coordination. Identify a professional or professionals who hold a license, certification, or registration in the type of service offered by the agency whose responsibilities include monitoring and overseeing implementation of the quality assurance plan for that service. (Attachment #_____)

B. Optional Services

Is the applicant agency seeking approval to use applied behavioral analysis (ABA) aides to assist in the provision of ABA services in accordance with 10NYCRR 69-4.9a?
☐ Yes ☐ No **If no, skip this section.**

Indicate ratio of children to employed supervisors and employed ABA aides _____

Indicate the number of employed ABA supervisors _____

Indicate the number of employed ABA aides _____

Indicate the number of qualified personnel who will provide ABA services _____

- Submit a personnel table of organization indicating the relationship of the above ABA staff. (Attachment #_____)

- Submit written policies and procedures in accordance with 10NYCRR 69-4.9a(a)(6). (Attachment #_____)

- Submit personnel policies, including employment, supervision, and training of all staff delivering ABA services in accordance with 10NYCRR 69-4.9a. (Attachment #_____)

- Submit a description of the methods by which the agency will ensure the quality and effectiveness of ABA services and the health and safety of eligible children. (Attachment #_____)

C. Languages and Other Forms of Communication

Indicate the languages (other than English) and other forms of communication that can be used by agency staff that provide early intervention services.

Provision	**Evaluations**	**Service Coordination**	**Service**
Spanish	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Russian	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Chinese Mandarin	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Arabic	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
HaitianCreole	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hebrew	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Bengali	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
French	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Vietnamese	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Sign Language	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Yiddish	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Urdu	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other (Specify)	_____	_____	_____

	Special Instruction	Occupational Therapy	Physical Therapy
Spanish	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Russian	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Chinese Mandarin	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Arabic	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
HaitianCreole	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hebrew	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Bengali	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
French	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Urdu	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Vietnamese	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Sign Language	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Yiddish	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other (Specify)	_____	_____	_____

	Audiology/Speech	Psychology	Social Work
Spanish	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Russian	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Chinese Mandarin	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Arabic	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
HaitianCreole	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hebrew	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Bengali	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
French	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Urdu	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Vietnamese	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Sign Language	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Yiddish	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other (Specify)	_____	_____	_____

	Vision Services	Nutrition	Nursing
Spanish	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Russian	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Chinese Mandarin	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Arabic	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
HaitianCreole	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hebrew	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Bengali	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
French	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Urdu	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Vietnamese	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Sign Language	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Yiddish	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other (Specify)	_____	_____	_____

D. Specialized Services

Can you provide specialized services for specific populations of infants and toddlers?

☐ Yes ☐ No

If yes, please specify service method (e.g., behavioral interventions)
Attach additional sheets if necessary. (Attachment# ____)

Population	**Service Method**
Autism/PDD	
Autism/PDD	
Communication disorder	
Communication disorder	
Down syndrome	
Down syndrome	
Hearing impaired	
Hearing impaired	
Motor disorder	
Motor disorder	
Visually impaired	
Visually impaired	

E. Service Catchment Area

Check all counties for which the agency is seeking to provide early intervention services at time of application.

- ❑ 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 Area

- ❑ Bronx
- ❑ Kings
- ❑ Queens
- ❑ New York
- ❑ Richmond

If counties are not in proximity to the main site or additional sites, please explain how the agency will be able to deliver services to this area. (Attachment # _____)

SCHEDULE 7 – FACILITY SITES

Complete a copy of this schedule for each facility site operated by the applicant agency.

Name/Address of Site

Name (if different than agency name)			
Site Address			
City	County	Zip	Telephone ( )

Early Intervention Service Model Options

Check the early intervention service model options that you are seeking to provide at this site:

- ❑ Evaluations
- ❑ Facility-based individual/collateral visits
- ❑ Parent-child groups
- ❑ Group developmental intervention
- ❑ Family/caregiver support group

Health and Safety Policy

The agency must provide assurances that it will be in compliance with all local fire, health and safety codes; will employ a policy for addressing health, safety and sanitation issues that conform to standards established by the Department; and is in compliance with the Americans with Disabilities Act. In addition, the applicant must submit the following for this site:

1. A building inspection by local authorities from the last 12 months and either a copy of the Certificate of Occupancy or Certificate of Compliance. (Attachment # _____)

2. A fire evacuation plan, site diagram and a fire inspection report from the last 12 months. (Attachment #_____)

3. Procedures to ensure the availability of staff to administer cardiopulmonary resuscitation and first aid. (Attachment # _____)

Child Care Providers

Individuals Providing Services Outside of New York City

1. Do you now or do you intend to provide care at this site to three or more children together for more than three hours per day per child?

   ❑ No ❑ Yes

2. If yes, is the site registered or licensed by the Office of Children and Family Services (OCFS) to deliver child care services?

   ❑ No ❑ Yes (please provide type of daycare and registration license number below)

Type: _____ License #_____

*If you **are not** a licensed child care provider but answered yes to (1) above, you should contact the Office of Children and Family Services regarding obtaining licensure as a child care provider*

3. If "yes" to (2) above, provide the date of the most current site visit, program review or audit by the Office of Children and Family Services:

   Date of Review: ___/_____/_____

Individuals Providing Services in New York City

1. Do you now, or do you intend to provide care at this site, to seven or more children together for five or more hours per week?

   ❑ No ❑ Yes

2. If yes, are you licensed by the New York City Department of Health and Mental Hygiene to deliver day care services at this site?

   ❑ No ❑ Yes

If yes, provide your permit number below and append a copy of your permit:

Permit #_____

If you are not a licensed day care provider but answered yes to (1) above, you should contact the New York City Department of Health and Mental Hygiene regarding obtaining licensure as a day care provider.

3. If "yes" to (2) above, provide the date of the most current site visit, program review or audit by the New York City Department of Health and Mental Hygiene:

Date of Review: ___/_____/_____

SCHEDULE 8 – STATEMENT OF REASSIGNMENT OF MEDICAID

_____

(Applicant Name)

By this reassignment, the above-named agency provider of early intervention services agrees:

1. To reassign all Medicaid reimbursement for early intervention services to the municipal early intervention agency (county) that you contract with to provide early intervention services.

2. To accept as payment in full from the municipal early intervention agency (county) 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 (county).

4. To comply with all the rules and policies as described in your contract(s) with the municipal early intervention agency (county).

_____

Signature Date

_____

Address

_____

City State Zip

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

SCHEDULE 9 - PROVIDER AGREEMENT

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,

_____(Agency's Name), 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, sexual orientation, religion, HIV 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 and Regulations of the State of New York.

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 (Early Intervention Program).

Authorized Signature: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

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

SCHEDULE 10 - ASSURANCES

The applicant assures the Commissioner of Health and, if applicable, the Commissioner of Education, of compliance *during the term of approval* with all requirements under Title II-A of Article 25 of the Public Health Law; 10 NYCRR: Subpart 69-4; Part C of the Federal Individuals with Disabilities Education Act and 34 CFR Part 303.

- The applicant assures that the agency will abide by department policies as stated in guidance issued by the Department that clarifies requirements of law and regulation related to the Early Intervention Program.

- The applicant assures that 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;

- The applicant assures that the agency will contract only with state-approved individual or agency early intervention providers;

- The applicant assures that agency personnel have access to, and participate in, ongoing in-service training on the delivery of early intervention services;

- The applicant assures that the agency has the capacity to and will provide services to children in accordance with IFSPs and in natural settings to the maximum extent appropriate;

- The applicant assures that the agency has the capacity to deliver services on a twelve-month basis and to provide flexibility in hours of service delivery, including weekend and evening hours;

- The applicant assures that the agency has the capacity to deliver all approved service model options applied for in this application to the catchment area, in its entirety;

- The applicant assures that the agency is in compliance with all local fire, health and safety codes; that the agency employs a policy for addressing health, safety and sanitation issues that conforms with standards established by the Department; and, where applicable, is in compliance with the Americans with Disabilities Act;

- The applicant assures that agency personnel will immediately notify the Early Intervention Official if s/he becomes aware of any health or safety hazard posed in community-based settings where s/he is providing parent-child groups, family support groups, or group developmental interventions;

- The applicant assures that it will comply with the confidentiality requirements as set forth in federal and state statute and regulation; and,

- The applicant assures that it will request, in writing, approval from the State Agency granting approval, if the agency wishes to modify any of the information contained in this application, including catchment area, target population, qualified personnel available to deliver services or service models provided or transfers, assignments, or other dispositions of less than ten percent of an interest or voting rights of the agency.

- The applicant assures that if the agency intends to cease services or intends to cease ownership, possession or operation of the agency, or chooses to voluntarily terminate status as an approved provider, the agency will submit to the Department and early intervention official written notice of such intention and a plan for transition of children not less than 90 days prior to the intended effective date of such action.

ACKNOWLEDGMENT

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, with the exception of those schedules pertaining to personal and disclosure information which must be individually certified, is accurate, true and complete in all material aspects. 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.

_____ _____

Print Name (Mr. Mrs., Ms., Dr) Title

_____ _____

Signature Date

Notarization

State of New York)
SS:
County of)

On this _____day of _____, 20____, before me personally appeared _____ residing at
(Name)
_____ to me known and known by me to be_____
(Street, City, State, Zip) *(Title)*

of_____ and the person who executed this Agency Application in the name of said
(Corporation/Agency)
_____ and (s)he duly acknowledged to me that (s)he executed the same as and for the
(Corporation/Agency)
act and deed of said _____.
(Corporation/Agency)

_____

NOTARY STAMP Notary Public Signature

Definitions

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Term	Definition
Agency	"Agency" means an entity which employs qualified personnel, and may contract with individual providers or other agencies which are approved by the Department, for the provision of early intervention program evaluations, service coordination, and/or early intervention services.
Agency Program Director	A professional with specific experience as required by 10NYCRR 69-4.5(a)(4)(viii)(a) and employed on a full time basis whose duties may include early intervention program service delivery in addition to administration and oversight responsibilities.
Applied behavior analysis (ABA)	ABA means the design, implementation, and evaluation of systematic environmental changes to produce socially significant change in human behavior through skill acquisition and the reduction of problematic behavior. ABA includes direct observation and measurement of behavior and the identification of functional relations between behavior and the environment. These include contextual factors such as establishing operations, antecedent stimuli, positive reinforcers, and other consequences that are used to produce the desired behavior change.
Available by Contract	A contractor is a provider. See definition of provider. A contractor is independent and responsible for delivering a service. A contractor does not receive wages, and generally receives an IRS form 1099 at the end of the year. Refers to individual qualified personnel available to an agency or municipality through a contractual agreement. An individual under contract is not employed by an agency
Catchment Area	Counties for which the agency is seeking approval to provide early intervention services.
Employed	Refers to personnel directly employed by an agency. Employees' duties are defined by, directed by and, supervised by the agency. An employee receives wages and at the end of the year an employee receives an IRS wage and tax statement (W-2).
Facility Site	A site operated by an agency seeking early intervention approval where children receive early intervention evaluations or services.
Facility-based Individual Collateral Visits	The provision by appropriate qualified personnel of early intervention services to the child and/or parent or other designated caregiver at an approved early intervention provider's site.
Family/caregiver Support Group	The provision of early intervention services to a group of parents, caregivers (foster parents, day care staff) and/or siblings of eligible children for the purposes of: (a) enhancing their capacity to care for and/or enhance the development of the eligible child; and (b) providing support, education, and guidance to such individuals relative to the child's unique developmental needs.

Term	Definition
Group Developmental Intervention	The provision of early intervention services by appropriate qualified personnel to a group of eligible children at an approved provider's site or in a community-based setting where children under three years of age are typically found (this group may also include children without disabilities).
Home and Community- based Visits	The provision by appropriate qualified personnel of early intervention services to the child and/or parent or other designated agency at the child's home or other natural environment.
Individual Provider	"Individual" means a person who holds a state-approved or recognized certificate, license, or registration in one of the disciplines set forth in early intervention regulations and is under contract with either a municipality or an agency provider. **This person is not an employee.**
Multidisciplinary Evaluation	The procedures used by appropriate qualified personnel to determine a child's initial and continuing eligibility for the Early Intervention Program, including determining the status of the child in each of the following areas of development: cognitive, physical, communication, social or emotional, and adaptive development. Multidisciplinary evaluations can be comprised of: *Core Evaluations*: must include a developmental assessment; a review of pertinent records and a parent interview as specified in regulations and may include a family assessment. *Supplemental Evaluations:* Include physician and non-physician evaluations provided upon the recommendation of the multi-disciplinary team conducting the core evaluation and with the agreement of the parent. A supplemental evaluation may also be provided in conjunction with the core evaluation by a specialist trained in the area of the child's suspected delay or disability.
Natural Environments	Settings which are natural or normal for the child's age peers who have no disability, including the home, a relative's home when care is delivered by the relative, child care setting, or other community settings in which children without disabilities participate.
Parent-child Groups	A group comprised of parents or caregivers, children, and a minimum of one appropriate qualified provider of early intervention services at an early intervention provider's site or community based setting (e.g., day care center, family day care, or other community settings).
Provider	"Provider" means an agency or individual approved in accordance with section 69-4.5 of EI regulations to deliver service coordination, evaluations, and/or early intervention services.
Qualified Personnel	Individuals with the appropriate licensure, certification or registration in the area in which they are providing services. A list of such personnel can be found in early intervention regulations 10NYCRR 69-4.1(aj) and are either individuals who are approved by the State Department of Health and under contract with a municipality or agency provider or employed by agency providers.

Term	Definition
Quality Assurance Professional	A Quality Assurance Professional is a professional employed by the agency whose responsibilities include monitoring and overseeing implementation of the agency's quality assurance plan for a particular early intervention service/profession.
Required Employees	A minimum of two qualified personnel or service coordinators who meet qualifications as required by 10NYCRR, in addition to the early intervention program director, each of whom provides evaluations, service coordination, or services to individuals with disabilities for a minimum of twenty hours each per week, plus designated Quality Assurance Professionals.
Service Coordination	Includes assistance and services provided by a service coordinator to enable an eligible child and the child's family to receive the rights, procedural safeguards and services that are authorized under the Early Intervention Program.
Specialized Services	Expertise providing services to a specific population of children and/or families; e.g., children with autism, children with cerebral palsy**.**

APPLICATION CHECKLIST

- ❑ Make a copy of this application for your records.
- ❑ Federal employer (tax) identification number must appear on each page of the application.
- ❑ A summary/description of the proposed program standards plan.
- ❑ Copies of all organizational documents, such as partnership agreements or certificates of incorporation, and filing receipts (Schedule 2) must be enclosed with this application.
- ❑ Verify that all Qualified Personnel (Schedule 5) providing services under contract have current state approval to provide early intervention services.
- ❑ Provide a list of all contracted individuals and employees, including their name, profession, license and/or certification number and Social Security number.
- ❑ If "**CORE**" Evaluation Services (Schedule 6 A) is checked, a letter from a NYS licensed and registered physician on their letterhead must be enclosed.
- ❑ Verify that all counties (Schedule 6 E) checked for which the agency is seeking approval to provide early intervention services are within an appropriate geographical area.
- ❑ If you are seeking to provide facility-based services, Schedule 7 must be completed for each site. Copies of health, safety and fire evacuation policies; Certificate of Occupancy and assurance of ADA compliance must be enclosed for each site.
- ❑ All Schedule 3, Schedule 8, Schedule 9 and Schedule 10 forms must have original signatures.
- ❑ ***Statement of Reassignment and Provider Agreement Form*** *(*Schedule 8 and 9) must be signed, dated and returned with this application.

Failure to submit all required attachments and a fully completed application will result in the application being returned to the applicant for resubmission. All required Schedule 3 Disclosure Information forms must be submitted by the applicant with the application submission.