New York State Department of Health, Bureau of Early Intervention

Application for the Approval of Individuals

As Early Intervention Evaluators, Service Providers & Service Coordinators

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

Who May Apply: Individuals recognized as qualified personnel by the Early Intervention Program, as defined in 10 NYCRR Section 69-4.1(aj) and with the requisite experience, will be considered for approval as Early Intervention Program Individual Providers. Refer to the definition of Individual Provider contained in the Definition Section of this application packet. The New York State Department of Health is not able to issue approvals to individuals who are in the United States (U.S.) on an H-1B visa, to provide early intervention services.
H-1B visas are nonimmigrant classifications used by aliens who will be employed temporarily in specialty occupations. Federal immigration law requires that individuals in the U.S. on H-1B visas be employed by the U.S. employers that petitioned the federal government for approval to hire the individuals and only in the H-1B activities described in the petition.

Occupational therapy assistants, physical therapy assistants, licensed practical nurses and physician assistants can be approved as individuals only for service coordination. The New York State Department of Health is not able to issue approvals to them for the direct provision of services. To provide direct services, they must be directly employed by an approved agency.

Minimum Requirements: Applicants must be currently licensed and registered or certified in a profession recognized by the Early Intervention Program as qualified personnel.

Applicants must have documentation of a minimum of 1,600 clock hours prior to the date of application to the Department for approval, delivering such service to children under five years of age in an early intervention, clinical pediatric, early childhood education program, which may include relevant experience obtained as part of a supervised educational program and/or clinical internship as a prerequisite for professional licensure, certification, or registration, and provided that such experience must have included direct experience in delivering services to children with disabilities and their families.

How to Apply for Approval as an Individual Early Intervention Provider: 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.

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 a letter stating what additional information is required for approval. The application must be notarized again prior to resubmission. When an application is determined to be complete, it will be reviewed. 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) (http://www.health.state.ny.us/community/infants_children/early_intervention/index.htm)

- 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.

Submit your original signed and notarized application to:

Bureau of Early Intervention
NYS Department of Health
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 **bei@health.state.ny.us**.

Incomplete applications will be returned. The applicant will receive written notification of approval or denial upon completion of the review process.

NEW YORK STATE
DEPARTMENT OF HEALTH
Bureau of Early Intervention

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

THIS APPLICATION IS FOR APPROVAL OF **INDIVIDUALS 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 Identification

Enter your name and social security number below and at the top of each page.
Enter your mailing address. If using a P.O. Box, you must include a street address.

Name (Mr., Ms.) (Last)	(First)	(Middle)	
Social Security Number:		Date of Birth	
Mailing Address Street:			
City:	County:	State :	Zip:
Telephone # ( )	Fax# ( )	E-mail :	

B. Credentials

Enter information regarding professional license(s)/certificate(s). For licensed professions (does not include teachers), the last name on the license and registration **MUST** match the name on the application.

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: _______	

Social Security Number

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Has your professional license, registration or certificate ever been suspended or revoked, or have you ever been the subject of any other enforcement actions (e.g., fines, sanctions, etc.)?

☐ No ☐ Yes

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

(Attachment #________)

C. Employment History

(1) Are you authorized to work in the United States? Yes [ ] No [ ]

(2) Are you in the United States on an H-1B Visa? Yes [ ] No [ ]

The following experience requirements apply to all individuals seeking approval to provide early intervention services as a professional individual provider:

- A minimum of 1600 clock hours of experience in a clinical pediatric, early intervention or early childhood program setting delivering services to children under five years old that includes children with disabilities and their families.
- Supervised experience required for licensure or certification may be counted toward this requirement when clinical experience has been in a clinical pediatric, early intervention or early childhood education program delivering services to children aged birth to five years that includes children with disabilities and their families.

Using the chart below, indicate a minimum of 1600 clock hours/clinical experience (listing the most recent experience first) in which you provided services in your discipline to infants and young children (**age birth to 5 years**) and their families **in the settings described above**. This may include supervised clinical experience required for licensure or certification, provided that such experience includes direct experience in delivering services to children with disabilities and their families. This information may be verified as part of the Bureau of Early Intervention provider application process. Copy this form if additional space is needed to report your 1600 hours.

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From: M/D/Year To: M/D/Year	Employer Name & Address Telephone Number Supervisor's Name	Employed (E) or Contracted (C) or (S) Student	Total Hours By Age Group	Clinic (CL) or Early Intervention (EI) or early childhood education (ED)
		E ❑ or **C** ❑ **S** ❑	Birth-5 years No. of Hours per week ____	
		E ❑ or **C** ❑ **S** ❑	Birth-5 years No. of Hours per week ____	
		E ❑ or **C** ❑ **S** ❑	Birth-5 years No. of Hours per week ____	
		E ❑ or **C** ❑ **S** ❑	Birth-5 years No. of Hours per week ____	

D. Inservice/Continuing Education

Attach a summary of continuing education programs related to professional development, learning experiences and in-services attended during the previous five years that focused on the provision of services for infants and toddlers with disabilities.
(Attachment # _____)

E. Affiliations

1. Are you an approved Medicaid Provider?

No ❑ Yes ❑

If yes: Please provide your Medicaid Provider number: ______________________

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___ ___ ___-___ ___-___ ___ ___ ___

SCHEDULE 2 – DISCLOSURE INFORMATION

A. Offices Held in Health or Human Service Agencies/Facilities

Enter information regarding any offices you held in any health or human service agencies or facilities, including early intervention or special education preschool programs, within the past five (5) years. Attach additional sheets if necessary (Attachment #______)

Check here if ❒ Not Applicable

Name of Facility/Agency	Title of Office Held: From: ______/______/_______ To: ______/_______/________
Address:	
Name of Facility/Agency	Title of Office Held: From: ______/______/_______ To:______/_______/________
Address:	

B. Ownership/Interest in Any Other Entity

Enter the name, address and other data of any health or human service agencies or facilities you have or had a fiscal or operating interest in within the past five (5) years. Include all entities that were approved to provide early intervention or childhood education services.

Check here if ❒ Not Applicable

Name of Entity	Type of Entity
Address	Date of Ownership From _______/______/______ To_______/______/______ Type of Ownership/Interest:
Current Status of Entity (check one) ❒ Open ❒ Closed ❒ Proposed	
State Agency Approval of Entity Listed Above (check one) ❑ Department of Health ❒ State Education Department ❒ Office of Mental Health ❒ Office of Mental Retardation and Developmental Disabilities ❒ Office of Alcohol and Substance Abuse Services	

Attach additional sheets if necessary (Attachment #______)

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C. 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 administrative charges)?

   ❑ No ❑ Yes

2. Have you or any health and human services or educational agency 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 health and human services or educational agency 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 health and human services or educational agency 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. Have you ever been the subject of any childcare-related enforcement actions (e.g., fines, sanctions, etc.) or operated a daycare center that had its registration or license restricted, revoked or suspended by the Office of Children and Family Services OR New York City Department of Health and Mental Hygiene?

   ❑ No ❑ Yes

If the answer to any of these questions is "yes", complete the following for each action. Attach additional sheet(s) as necessary. If criminal or civil action has been taken against you, attach documents from the court describing the disposition of the action. (Attachment #_______)

Date of Action: ___________ Type of Action: ____________________________________

Location: ____

Explanation of Violation:

____

____

____

____

____

____

____

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SCHEDULE 3 – PROFESSION

Complete the chart below, by inserting an "X" for each category/categories for which you are seeking approval to provide early intervention services.

Discipline	Seeking approval to provide early intervention services as:
Audiology:	
Audiologist	
Medical/Nursing:	
Pediatrician	
Physician other than Pediatrician	
Physician Assistant*	
Nurse Practitioner	
Registered Nurse	
Licensed Practical Nurse*	
Nutrition:	
Certified NYS Dietitian/Nutritionist	
Registered Dietitian	
Occupational Therapy:	
Occupational Therapist	
Occupational Therapy Assistant*	
Physical Therapy:	
Physical Therapist	
Physical Therapist Assistant*	
Psychology:	
Licensed Psychologist	
Social Work:	
Licensed Master Social Worker	
Licensed Clinical Social Worker	
Speech Pathology:	
Speech-Language Pathologist	

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Discipline	Seeking approval to provide early intervention services as:
Special Education:	
Teacher of Special Education	
Teacher of Students with Disabilities (Birth –2)	
Teacher of Blind and Partially Sighted	
Teacher of the Blind and Visually Impaired	
Teacher of Deaf and Hearing Impaired	
Teacher of the Deaf and Hard of Hearing	
Teacher of Speech and Hearing Handicapped	
Teacher of Speech and Language Disabilities	
Vision Services:	
Certified Orientation and Mobility Specialist (ACVREP)	
Certified Low Vision Specialist (ACVREP)	
Cert. Vision Rehabilitation Therapist (ACVREP)	
Cert. Low Vision Specialist (CLV)	
Fellow of the College of Optometrists in Vision Development (FCOVD)	
Vision Ophthalmologist	

*__As an individual, these professionals can only provide early intervention service coordination. To provide direct early intervention services, these professionals must be employees of an agency approved to provide Early Intervention services.__**

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SCHEDULE 4 – SERVICE PROGRAM

A. Services

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

1. ❑ Supplemental Evaluations*
2. ❑ Service Coordination Services
3. ❑ Early Intervention Service Model Options (Check all that apply)

    a. Home/community-based individual/collateral visits ❑

    b. Facility-based individual/collateral visits * ❑

    c. Group Services* ❑

    Check service model and all applicable site locations.

    ❑ Parent–child groups
    - On-site in facility operated by you ❑
    - Off-site in community settings ❑
    - Both ❑

    ❑ Group developmental intervention
    - On-site in facility operated by you ❑
    - Off site in community settings ❑
    - Both ❑

    ❑ Family/caregiver support group
    - On-site in facility operated by you ❑
    - Off site in community settings ❑
    - Both ❑

*Complete **Schedule 5** – **Facility Sites** if you intend to provide early intervention services using any of the above model options at a site you own and/or operate.

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B. Languages and Other Forms of Communication

Indicate the language(s) (other than English) and other forms of communication in which you are fluent, if any.

Spanish	☐ Yes	Russian	☐ Yes
Chinese Mandarin	☐ Yes	Arabic	☐ Yes
HaitianCreole	☐ Yes	Hebrew	☐ Yes
Bengali	☐ Yes	French	☐ Yes
Urdu	☐ Yes	Vietnamese	☐ Yes
Sign Language	☐ Yes	Yiddish	☐ Yes

Other (specify) ____

____

C. Specialized Services

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

☐ No ☐ Yes

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	
Other	
Other	

D. Service Catchment Area

Check all counties for which you are seeking to provide early intervention services at time of application. You must be available to provide services twelve months of the year in these counties. If you check counties that are not in proximity to your address or to each other, please provide an explanation as to how you will be able to deliver services in these counties. (Attachment # ______)

- ❑ 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

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SCHEDULE 5 - FACILITY SITES
Note- If you do not have a facility site, Skip this section.
Complete this schedule for each and every facility site operated by the applicant.

A. Name/Address of Site

Name		
Street Address		
City	County	Zip
Telephone: ( )		

B. Early Intervention Service Model Options

Check the early intervention service model options that you will provide at this site:

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

C. Health and Safety Policy

You must provide assurances that you will be in compliance with all local fire, health and safety codes; that you employ a policy for addressing health, safety and sanitation issues that conforms to standards established by the Department; and that the site is in compliance with the American 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 #______)

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D. 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 must contact the Office of Children and Family Services for their assistance in determining whether or not your facility meets the OCFS criteria as a child care site that should be licensed or registered by OCFS.*

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 for their assistance in determining whether or not your facility meets the NYCDOH criteria as a child care site that should be licensed or registered by NYCDOH or NYS OCFS.*

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: ___/_______/_____

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SCHEDULE 6 - STATEMENT OF REASSIGNMENT OF MEDICAID

Name of Applicant: ____

By this reassignment, the above-named 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(ies) (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.

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SCHEDULE 7 – PROVIDER AGREEMENT

PROVIDER AGREEMENT

BETWEEN THE NEW YORK STATE DEPARTMENT OF HEALTH
AND SERVICE PROVIDERS IN THE 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,

____(Applicant'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:** ___________________________

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SCHEDULE 8 – ASSURANCES

The applicant assures the Commissioner of Health of compliance 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 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.
- The applicant assures that s/he will notify the Department within two working days of suspension, expiration, or revocation, limitation or annulment of licensure, certification or registration regardless of whether the suspension or limitation is stayed.
- The applicant assures that s/he has the ability to and will provide services to children in accordance with IFSPs and in natural settings to the maximum extent appropriate.
- The applicant assures that s/he will immediately notify the Early Intervention Official if s/he becomes aware of any health or safety hazard posed by community-based settings where s/he is providing parent-child groups, family support groups, or group developmental interventions.
- The applicant assures that s/he will participate in in-service training in the delivery of early intervention services.
- 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.
- The applicant assures s/he has 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.
- The applicant assures s/he has the capacity to deliver services on a twelve-month basis and provide flexibility in hours of service delivery, including weekend and evening hours.
- The applicant assures s/he will comply with the confidentiality requirements set forth in federal and state statute and regulation.
- The applicant assures that s/he will conform with health, safety and sanitation standards established by the Department;
- Where applicable, the applicant assures that any sites s/he operates and will use for the purposes of early intervention service delivery are compliant with all local fire, health and safety codes, and with the Americans with Disabilities Act.

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- The applicant assures that s/he will request, in writing, approval from the State Agency granting approval, if s/he wishes to modify any of the information contained in this application, including catchment area, target population or qualifications to deliver services.
- The applicant assures that s/he will abide by department policies as stated in the Department of Health's Early Intervention Program Memorandums and other forms of guidance.

Acknowledgement

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 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., Miss, 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 the person

(Street, City, State, Zip)

who executed the foregoing instrument.

NOTARY STAMP

____

Notary Public Signature

Definitions

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.
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 applicant 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 applicant seeking early intervention approval where children receive early intervention 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.
Group Developmental Intervention	The provision of early intervention services by appropriately 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 and/or caregiver at the child's home or other natural environment when children under three years of age are typically found.
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.**

Term	Definition
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 Environment	Settings that 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, childcare 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 appropriately 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,
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

- ☐ You have kept a copy of this application. Send original to DOH.
- ☐ Employment section is completed and experience is related to infants and toddlers with developmental delay or disabilities.
- ☐ A copy of your license and current registration or teaching certification is attached for all disciplines identified in Schedule 3. A TEACH Verification of an initial teaching certificate is acceptable.
- ☐ Verify that **ALL** counties (Schedule 4D) checked for which you are seeking approval to provide early intervention services are within an appropriate geographical area.
- ☐ If you are seeking to provide facility-based services, you must maintain health, safety and fire evacuation policies; you must submit a building inspection report and Certificate of Occupancy/Certificate of Compliance. You must submit fire evacuation information and in Schedule 8, you provided an assurance of ADA compliance. A Schedule 5 must be enclosed for each site. Facility-based means services are being provided in a place operated by the applicant.
- ☐ The Statement of Reassignment (Schedule 6) and Provider Agreement (Schedule 7) are signed, dated and attached.
- ☐ Complete and notarize the **Acknowledgment**. (Schedule 8)

Failure to submit all required attachments and a fully completed application will result in the application being returned to the applicant for resubmission.