Dear Early Intervention Program Individual Provider Candidate:

Attached you will find the *New York State Department of Health Bureau of Early Intervention Application for the Approval of Individuals as Early Intervention Evaluators, Service Providers & Service Coordinators*.

To be approved you must have:

* current NYS licensure and/or certification in a profession recognized by the Early Intervention Program
* 1600 hours working with children age birth up to the age of five years old with a disability or developmental delay. This experience can be gained as an employee or during a practicum/internship required to obtain your licensure/certification.

Please review the application to determine if you meet the minimum qualifications.

 The **application**must be:

* Completed in full (please print legibly). The section title Employment History must be completed in full, including: From/To Dates must include month/day/year; Employer Information must include employers name in full, address, telephone number, supervisor's name; the number of hours you worked per week.
* Include a Cover Letter (see below for details).
* Submitted via US Mail (copies will not be accepted).

 As part of the Application you will find the *Early Intervention Provider****Agreement****(effective 2018)*. This document:

* Must be completed in full. All pages must be submitted.
* You will be selecting between a “Basic” or "Appendix 1" Agreement. See the attached brochures for further information.

**Page 1: Write your full name. Leave NYS Provider ID/State ID blank.**

**Basic Agreement:**

**Last Page (Authorization/Signature Page): Complete as follows:**

* Check the YES box next to “I have read and understand my obligations as stated in this 2018 Agreement”
* Check the NO box next to “I request the additional terms outlined in Appendix 1”
* Complete the Individual Provider Name, Address, Email Address, and NPI sections. Leave the “Agency Provider’s Authorizing Office” section blank.
* Service Catchment Area(s) – only circle counties where you are currently available to provide early intervention services
* Complete the Applicant Authorized Signature: Sign (only ink signatures are accepted), record your primary phone number, and title (e.g., SLP, special education teacher, PT, OT, etc.)

**OR**

**Appendix 1 Agreement:**

**Page 2:** Check the box next to “Appendix 1- Payee Provider Agreement/Service Authorizations and Payment"

**Last Page (Authorization/Signature Page): Complete as follows:**

* Check the YES box next to “I have read and understand my obligations as stated in this 2018 Agreement”
* Check the YES box next to “I request the additional terms outlined in Appendix 1”
* Complete the Individual Provider Name, Address, Email Address, and NPI sections. Leave the “Agency Provider’s Authorizing Office” section blank.
* Service Catchment Area(s) – only circle counties where you are currently available to provide early intervention services
* Complete the Applicant Authorized Signature: Sign (only ink signatures are accepted), record your primary phone number, and title (e.g., SLP, special education teacher, PT, OT, etc.)

**Cover Letter**

The cover letter must include the following:

Information:

* Your contact information: Name, Mailing Address, Primary Phone Number, Primary E-mail Address.

Confirming Statements:

* I am:
  + in compliance with federal and state labor standards, tax and finance standards, and federal and state early intervention law and regulations. *(These statements confirm that you understand that you are an independent contractor, pay your taxes, and follow EI laws and regulations.)*
  + in compliance with NYSED practice of the professions *[if applicable i.e., you are a licensed professional such as an OT. This statement is not required if you are a certified professional (teachers)].*
  + in compliance with Medicaid standards and requirements. *(Lets us know that you have not been restricted or excluded by Medicaid.)*
  + *if applicable*, a compelling statement for why you should be approved for an Appendix Agreement i.e., what is your experience with billing commercial insurance and/or Medicaid. If a county has reached out to you to provide early intervention services please include the name of the county, name and phone number of the county staff person that contacted you. If you have a colleague that has an appendix agreement and is experienced with the billing process for EI, and is willing to mentor you, please include his/her full name and phone number with area code.

In order for your application to be processed you **MUST return 1) notarized Application, 2) Early Intervention Provider Agreement, and 3) Cover Letter** to:

NYS Department of Health

Bureau of Early Intervention

ESP- Corning Tower, Room 287

Albany, New York 12237-0660

Attn: Provider Approval Unit

We have attached four informational brochures regarding the *Early Intervention Provider Agreement*(do not include them in your application packet). In addition, Department regulations may be found on the following Webpage, <http://www.health.ny.gov/community/infants_children/early_intervention/>

**All documents should be sent together as one packet. Incomplete information will delay review.**

Please allow up to 12 weeks for your approval to be processed.

You will receive written notification of approval (US Mail) or denial (email) upon completion of the review process.

Inquiries concerning the Application, Provider Agreement and Cover Letter can be directed to the Bureau of Early Intervention via e-mail, [provider@health.state.ny.us](mailto:provider@health.state.ny.us).

 Thank you.

NYS Department of Health

Bureau of Early Intervention

Provider Approval and Due Process Unit

Phone: (518) 473-7016 (press 1)

Fax: (518) 486-1090