

# EI-Hub Provider Enrollment Management (PEM) User Guide



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## Revision History

Version Number	Release Date	Author	Revision Summary
v.1.0.0	3.4.2021	Paul Michael Ross	First Draft
v.1.1.0	6.3.2021	Paul Michael Ross	<ul style="list-style-type: none"> <li>• Add the EI Hub logo to the title page.</li> <li>• The ‘Important Note’ icons are changed to B&amp;W.</li> <li>• Add a version history table (release date, version number, and highlights of changes).</li> <li>• Remove logos from the header of each page to save some pages, keep just the document title and page numbers (<b>listed in document Footer sections</b>), and add the version number.</li> <li>• To adequately show size and clarity for visual aids (screenshots) – capture the top portion or capture sections of the screen/panel to indicate that the page is longer.</li> <li>• Add section 5.1 Text Hyperlinks.</li> </ul>
v.1.2.0	6.24.2021	Paul Michael Ross	<ul style="list-style-type: none"> <li>• Addressed BEI comments concerning their email [sent: Thu 6/17/2021 9:07 AM] attachment “<b>user guide review.docx.</b>”</li> </ul>
v.1.3.0	2.10.2022	Paul Michael Ross	<ul style="list-style-type: none"> <li>• Added PE and PM (CM) Data Points Transfer data in Appendix C.</li> <li>• Added PE and PM (CM) Process Flows in Appendix D</li> </ul>
v.1.4.0	3.11.2022	Paul Michael Ross	<ul style="list-style-type: none"> <li>• SME (D.P.) reviewed the user guide. As a result, I revamped the user guide on grids and panel changes (locations, labels, and fields) and made the appropriate changes.</li> </ul>
v.1.5.0	1.18.2023	Paul Michael Ross	<ul style="list-style-type: none"> <li>• I removed all approval information and transferred the content into a PAU User Guide.</li> </ul>
v.1.5.1	7.10.2023	Jessica Yorkman	<ul style="list-style-type: none"> <li>• Updated screenshots</li> </ul>

PEM Version	Release Date
v1.17.0	9.20.2024

## Unit 1. System Requirements

### 1.1 User Software Requirements

REQUIREMENTS	OS (CLIENT)	CPU	RAM	HDD
<b>Minimum System Requirements</b>	Windows 7 SP2 Windows 10	Dual-Core 1.6GHz	1GB	1.5GB
<b>Recommended System Requirements</b>	Windows 10 17763.134 1809 (Oct 2018 Update) and higher	Intel Core 2 Duo (2GHz) or equivalent processor	2GB	2GB
<b>Software/Browser Requirements</b>	Microsoft Internet Explorer 11 and higher Microsoft Edge 42.17134.1.0 and higher Google Chrome version 70.0.3538.102 and higher Safari (MACOS only)			
<b>General Browser Requirements</b>	TLS 1.2 encryption enabled Browser set to accept cookies JavaScript must be enabled			

## Unit 2. System Overview

### 2.1 Systems Components

COMPONENT NAME	DESCRIPTION
<b>EI-Hub Identity Service</b>	The EI-Hub Identity Service component provides EI-Hub user account, role, and access management by interoperating with the NYS Health Commerce System (HCS). It uses its' security token to open access and set functions across EI-Hub components.
<b>EI-Hub Provider Enrollment</b>	<p>The EI-Hub Provider Enrollment component provides a portal for Provider Enrollment outside of HCS and is accessible to all applicants. It consists of two tools to support the New York State Department of Health (NYS DOH) provider enrollment processes:</p> <ul style="list-style-type: none"> <li>• The Pre-Application Screening Tool (PAST) enables the first review of an applicant's suitability to become an early intervention provider.</li> <li>• The Provider Application Tool (PAT) enables the applicant to complete their application, and NYS DOH reviews the application and determines its suitability to become an early intervention provider.</li> </ul> 
<b>EI-Hub Case Management</b>	<p>The EI-Hub Case Management component provides a web-based system for tracking child, practitioner, and service information to report and facilitate service log capture and billing.</p> <p><b>The EI-Hub Case Management component includes Provider Management (image shown below). Unit 10, in the Case Management User Guide, is used to grant DOH-approved providers the ability to view and maintain their records in the following ways comprehensively:</b></p> <ol style="list-style-type: none"> <li>1. View status in the EI Program,</li> <li>2. Print a provider profile,</li> <li>3. View previous applications and amendment requests,</li> <li>4. Initiate new re-approval and amendment requests.</li> </ol>

COMPONENT NAME	DESCRIPTION
	
<b>EI-Hub Service Logging</b>	<p>The EI-Hub Service Logging component provides a web-based system for Early Intervention service providers to enter their service logs and record a family's signature sign-off.</p>
<b>EI-Hub Billing and Claiming</b>	<p>The EI-Hub Billing and Claiming components provide a web-based system for Early Intervention (EI) Service Providers to submit billing for early intervention services to the Department's State Fiscal Agent. It is an access point for Municipalities and EI Service Coordinators to obtain information about the EI fiscal process.</p>
<b>EI-Hub Learning Management System</b>	<p>The EI-Hub Learning Management System component provides a web-based system for users to take training courses leading to EI-Hub certification or use. All EI-Hub user guides and training resources are in the <a href="#"><u>EI-Hub Learning Management System</u></a>.</p>

## 2.2 External Dependencies

SYSTEM NAME / ENTITIES	DESCRIPTION
Health Commerce System (HCS)	<ul style="list-style-type: none"> <li>HCS is a secure website for web-based interactions with the New York State Department of Health.</li> <li>The EI-Hub application resides within HCS, and users will log into HCS to access EI-Hub.</li> </ul>
Clearinghouse	<ul style="list-style-type: none"> <li>The Clearinghouse is the intermediary that forwards the claims information from health providers to insurance payers. The clearinghouse for EI-Hub is Change Healthcare.</li> <li>The Clearinghouse interface is a file transfer.</li> </ul>
Commercial Payers	<ul style="list-style-type: none"> <li>Commercial Payers are commercial Health Insurance companies that cover the insured's medical expenses and disability income.</li> <li>The Commercial Payers interface is a file transfer.</li> </ul>

SYSTEM NAME / ENTITIES	DESCRIPTION
NYS Medicaid (eMedNY)	<ul style="list-style-type: none"> <li>• Medicaid is a federal/state program covering medically necessary care, services, and supplies for New York state citizens who qualify based on income/resources.</li> <li>• The eMedNY interface is a file transfer of X12 format 835, 837, 270, and 271 files and remit processing files.</li> <li>• Appendix providers are required to be enrolled with Medicaid as an EIP provider.</li> </ul>
OHIP (Code 35)	<ul style="list-style-type: none"> <li>• BEI sends PCG a set of 4 files per month due to code 35 research.</li> <li>• These files are processed through our system, and the resulting files are created for uploading through SFTP to the eMedNY server. The response files are manually downloaded the following day for data integration.</li> <li>• The current schedule is as follows: <ul style="list-style-type: none"> <li>• PCG-generated file – weekly</li> <li>• OHIP Code 35 File – once per month</li> <li>• Code 35 Conflicts Correction files (based on OHIP data) – 2 files every other week.</li> <li>• Manual Code 35 Correction File – on an as-needed basis.</li> </ul> </li> </ul>
Providers	<ul style="list-style-type: none"> <li>• NYS DOH approves individuals, agencies, and municipalities as “providers” to deliver EIP services. Agencies and municipalities can employ rendering providers (without DOH approval) to deliver EIP services, and they can also contract with DOH-approved individual or agency providers to deliver EIP services.</li> <li>• Providers must maintain their DOH approval/agreement (expires every five years).</li> <li>• Individuals can be approved by NYS DOH as billing providers (Appendix 1 agreement) or approved with a basic agreement (must work under an agency or municipality).</li> <li>• Providers send claim files to supplement or in place of using EI-Hub components.</li> <li>• The Provider’s interface is a file transfer of X12 format 835 and 837 files.</li> </ul>

## Unit 3. Introduction

### 3.1 What is PEM?

 The Provider Enrollment Management (PEM) component of the EI-Hub simplifies the current Early Intervention Program provider application process by transitioning from paper to online. The online process has several advantages:

- Online and completely automated, meaning no more mailing multiple documents
- Built-in, automated validations for address, NPI, duplicate entry, entry format and number of digits checks, and required fields, which will improve data quality and reduce the need for corrections
- Smart fields reveal required fields as needed based on previous entries and hide unneeded fields
- On-screen directions and tooltips to guide/assist the applicant
- The approval process allows for internal notes to be added and more accessible external communication of denial reasons/automated approval communications

The Provider Enrollment component is comprised of two online tools – the Provider Application Screening Tool (PAST) and Provider Application Tool (PAT) – and follows this process:

1. Individual Applicants or the Agency's Main Contact Person completes the PAST to determine if they qualify for the full application (PAT)
  - a. Unsuccessful submissions can be re-worked and resubmitted
  - b. Successful submissions issue on-screen messages/instructions and confirmation email
2. Once successful, the data entered in the PAST transfers to the PAT, preventing the need for re-entry
3. Successful completion of the PAT by the Applicant, including all required fields and uploads, displays an on-screen message and sends a confirmation email
4. The submitted application appears in a queue for initial review by the Bureau of Early Intervention's Provider Approval Unit (PAU) users
  - a. PAU staff can review the application, leaving internal comments on each page
  - b. If approved by the initial approver, it moves on to the final review
  - c. If not approved, PAU indicates external comments to be sent to the applicant
  - d. The applicant can rework the completed application, making necessary changes for re-submission
5. The approved application appears in the PAU final review queue
  - a. The final approver may add internal notes on each page
  - b. If not approved, the final approver will move back to the initial approval queue for the initial approver to work with the applicant to make necessary changes
  - c. If approved, the provider data transfers to the EI-Hub Case Management component, and the Applicant is directed to complete the required training in the EI-Hub Learning Management System (LMS) component to gain access

 This document describes the user interaction with the Provider Enrollment web portal for Individuals licensed, registered, or certified by the New York State Education Department in one of the fields designated as qualified personnel for the Early Intervention Program (EIP).

Individuals who wish to provide early intervention services must submit their applications through an application module. New York State's EIP application module comprises a Pre-Application Screening Tool (**PAST**) and a Provider Application Tool (**PAT**). The PAST quickly determines if an applicant qualifies to complete the full PAT. In addition, the PAST helps the applicant determine if they are eligible to apply as an Agency or an Individual.

-  Individuals can be approved to bill for services with an Appendix 1 agreement or contract with agencies with a basic agreement.
-  Agency employees do not need individual approval or to complete the PAST/PAT process.
-  Agencies must designate a contact person to submit the application (PAST/PAT) and must agree to Appendix 1 agreement to apply.

### 3.2 Application Rejection Reasons/Denials

- 'PAST' denials are automated and display the denial reasons on-screen upon submission.

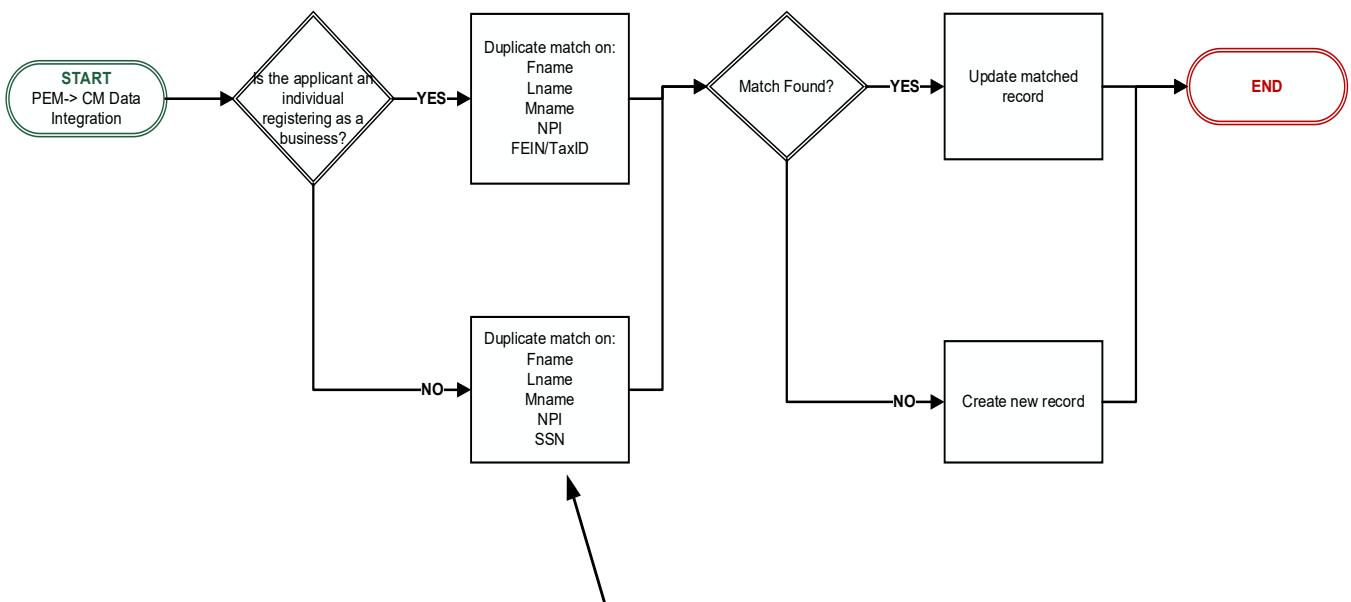
'PAT' denials issue an email notification with the Rejection Reason (from a drop-down) and a Rejection Comment (manually entered by the Department of Health Provider Approval Unit). These Rejection Comments are not available on the rejected application. Applicants should reference the denial email to see what corrections must be made before re-submitting the application. **NOTE:** The email contains a link to rework the application request, and applicants can log into PEM to make corrections to their application and re-submit.



### 3.3 Before You Begin

 **What happens in the therapist record (Case Management) when an existing therapist becomes an approved provider?**

The tool will attempt to match a few fields; if the **entries match** the existing therapist record, the record is updated. A new therapist record will be created if any fields **don't match exactly**. Please refer to the diagram below; this demonstrates the duplicate check process. **You (the applicant) should review/update your therapist record before starting an application to ensure matching entries.**



 **If a user incorrectly enters any one or more values the tool cannot match properly, a new record is created.**

The applicant should ensure that the following information in the Therapist record matches the information entered into the Provider Enrollment (PEM) tool EXACTLY. Any differences will result in a duplicate record being created. Note that any necessary updates the applicant makes to the Therapist record should be made before starting the new application.

- First name
- Middle name/Initial
- Last name
- NPI
- Either SSN or FEIN/Tax ID, depending on the individual application type

## Unit 4. Navigation Overview

If a required field is not populated and you advance to the next tab, the application tab changes colors (red), informing you of an error (example below).

DUPLICATE CHECK	Agency Contact Information	Agency Staffing Requirements	Available Personnel	Attestation
-----------------	----------------------------	------------------------------	---------------------	-------------

### 4.1 Text Hyperlinks

A text hyperlink is a word, phrase, or image you can click on to jump to a specific section within this user guide. Text hyperlinks are often blue and underlined, but for Accessibility requirements, the font color is black.

### 4.2 \* (Required field)

A ‘Required field’ (\* bold red Asterix) means users must enter an answer or populate data in the field to submit their entry. When users try to submit an entry without filling out a required field, the system highlights the problematic areas (fields) and displays an error message to let them know the **field** needs to be populated. The error message may be general or specific. If general, review the entire tab to determine what field is missing information.

### 4.3 Tooltip/Comment

 Hover your mouse pointer over this icon to view a tip or help on the adjacent field.

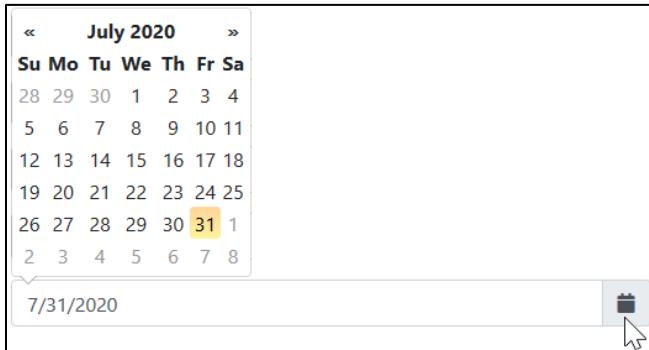
### 4.4 Additional Reference

 Click this icon to invoke the additional reference (example below). Click the icon again to close it.

Additional information on the requirements can be found here: [NYCRR 69-4.5](#). If you have specific questions related to the individual approval, please contact the Bureau's Provider Approval Unit at (518) 473-7016, press 1 or provider@health.ny.gov.

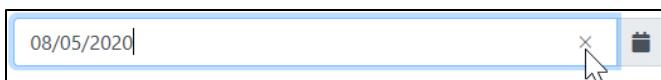
## 4.5 Calendar Picker

 To use the calendar picker for a date field, click this icon. The calendar picker appears above the date field (example shown below).



## 4.6 Clearing Data from a Field

You can highlight data in a field and either hit the [backspace] or [delete] keys or, using your mouse pointer, click in the area (field), an 'X' appears, and then click the 'X' (example shown below).



## 4.7 Submit Application Button

**Submit Application**

Please **save** your progress often, and remember that you can only save if all required fields on the page are complete and no errors need to be resolved.

The **Submit Application** button will initiate a systematic review of your application and report any errors.

Typically, popup panels require that all fields be complete before you save anything. Therefore, gather all the information needed **before** beginning data entry on a popup panel or any panel(s) with the required fields.

## 4.8 NPI Verification

The applicant's name in the National Plan & Provider Enumeration System (NPPES) database must match the legal name on the application.

### Step / Action

- The system looks up/verifies if the applicant's National Provider Identifier (NPI) exists in the National Plan & Provider Enumeration System (NPPES) database by sending the applicant's NPI to NPPES.
- The Provider's name is returned from NPPES and matched to the entered NPI. If there is a match by NPPES, the system will match the name and ask the applicant to verify their information. If there is no system match, a message will indicate this, and applicants will be asked to resubmit with the appropriate NPI.
- If there is no match, the applicant must correct their name in the NPPES database before applying.

## 4.9 Save Changes

Please save your progress often, and remember that you can only save if all required fields on the page have been completed and no errors are to be resolved.

The Submit Application button will initiate a systematic review of your application and report any errors.

Typically, pop-up panels require all fields to be completed before you can save anything. Therefore, gather all the information needed before beginning data entry on a pop-up panel or any panel(s) with the required fields.

## Unit 5. Pre-Application Screening Tool (PAST) and Provider Application Tool (PAT)

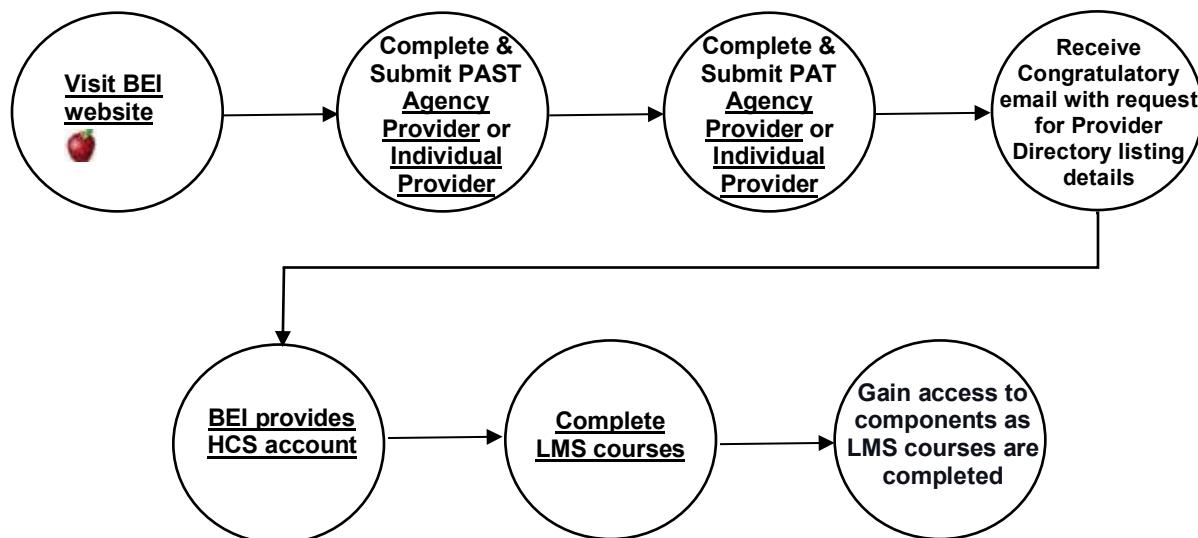
 New York State's Early Intervention Program (EIP) application module consists of a Pre-Application Screening Tool (PAST) and a Provider Application Tool (PAT). The PAST quickly determines if an applicant qualifies to complete the full PAT. In addition, the PAST helps the applicant identify if they are qualified to apply as an Agency or an Individual.

 For more details on PAST and PAT, please refer to the Appendix sections in this document.

### 5.1 Enrollment Path

To access a specific task in this user guide, hold down the Ctrl key, hover your mouse pointer over the round shape symbol, and click the hyperlink.

- The following data symbols (round shape), called 'Tape Data,' means data is accessed sequentially.

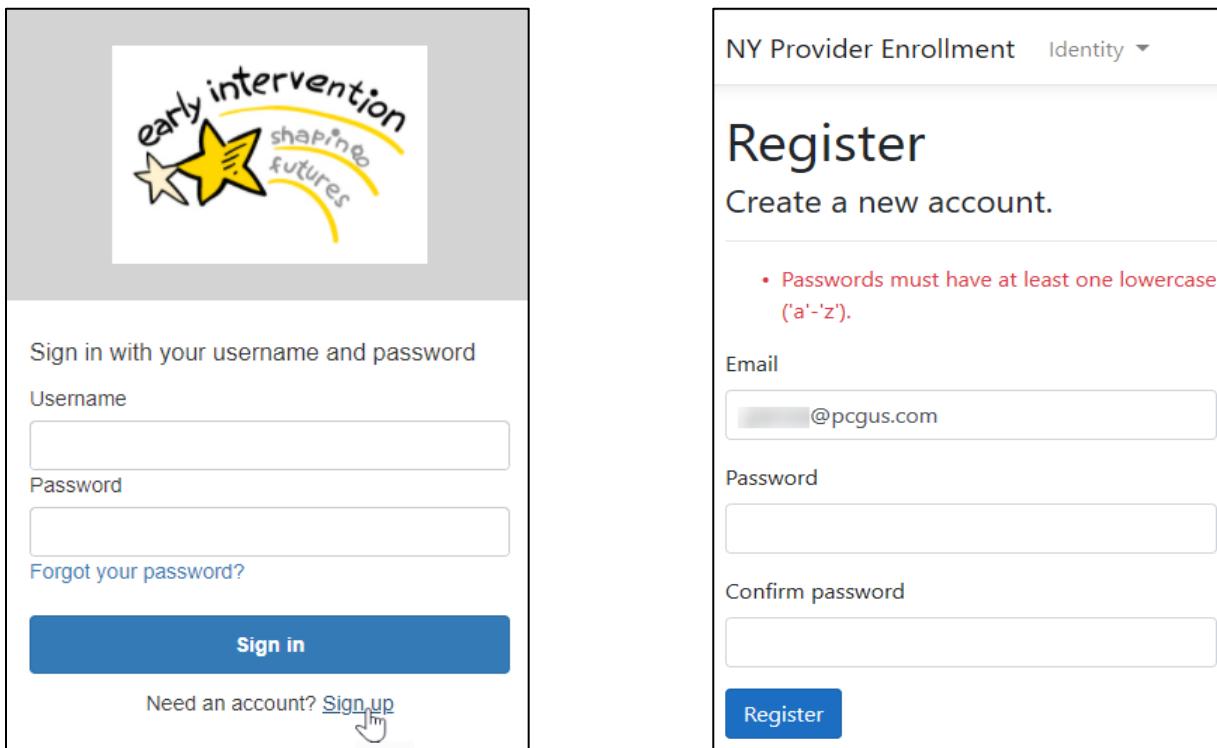


## Unit 6. Register – Create a new account

 To create and submit an application, you must create a user account.

### Step / Action

- Click the 'Sign up' hyperlink beside 'Need an account? (Shown below)'





Sign in with your username and password

Username

Password

[Forgot your password?](#)

**Sign in**

Need an account? [Sign up](#)

NY Provider Enrollment Identity ▾

## Register

Create a new account.

- Passwords must have at least one lowercase ('a'-'z').

Email

Password

Confirm password

**Register**

**Note:** On the screen, you will see a message instructing you to verify that you are a human. You will need to complete a security puzzle before proceeding to your request.

- Populate the following fields listed in the table below.

FIELD	DESCRIPTION
Email	Enter your email address.  <b>(i)</b> The email address is the username. Please contact the PCG Help Desk if you need assistance with access or are locked out.
Password	Enter a password.
Confirm password	Retype your password.

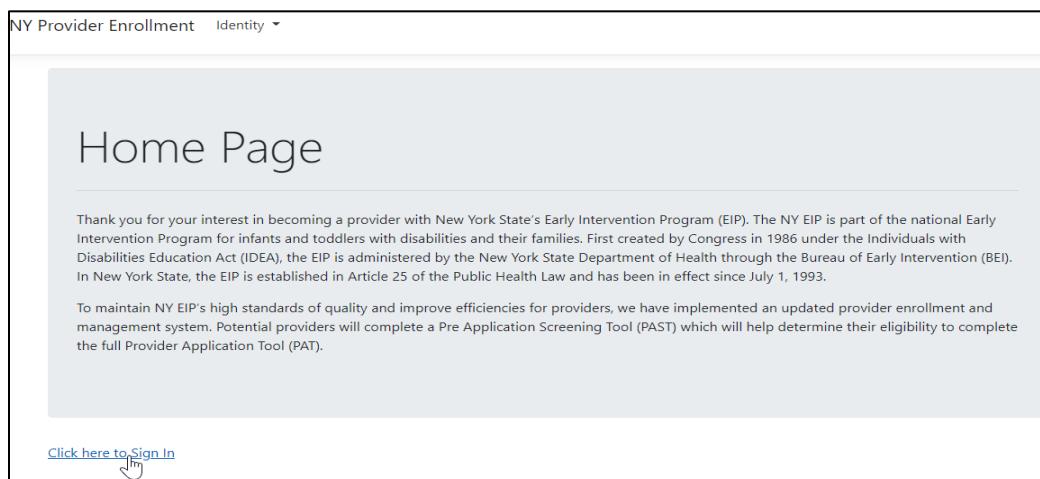
BUTTON	DESCRIPTION
Register <input type="button" value="Register"/>	<b>Step /Action</b> <ol style="list-style-type: none"> <li>To confirm your account, The Forgot Password Confirmation page appears to check your email (e.g., below).</li> <li>Go to your email client (e.g., Outlook), open the email, and click the 'here' hyperlink, which takes you to the Provider Enrollment 'Sign in' panel/page.</li> </ol>

## 6.1 Sign In

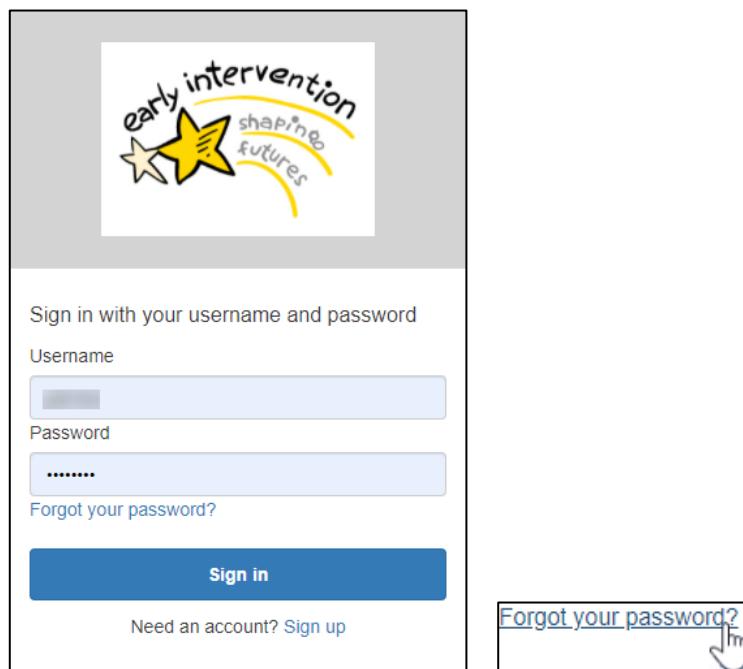
 The PEM link is located on the NYS DOH EIP website.

### Step / Action

1. Click the 'Click here to sign in' hyperlink on the NY Provider Enrollment Home Page.



2. A sign-in panel appears when clicked (shown below). Next, sign in (log in) with your correct credentials (Username and Password).



### If you forgot your password:

1. Select/click the 'Forgot your password' hyperlink; this initiates the password reset process. The system generates an email and sends it to your email address on file.
2. Next, access the email sent to your inbox. If you do not see the email, check your spam folder.
3. After opening the email, select/click the hyperlink in the body of the email.

## Unit 7. NY Provider Enrollment

Click here to initiate the application process hyperlink on the NY Provider Enrollment Home Page. A new screen appears with descriptions and buttons for 'Agency Provider' and Individual Provider' (shown below).

Home Page

Thank you for your interest in becoming a provider with New York State's Early Intervention Program (EIP). The NY EIP is part of the national Early Intervention Program for infants and toddlers with disabilities and their families. First created by Congress in 1986 under the Individuals with Disabilities Education Act (IDEA), the EIP is administered by the New York State Department of Health through the Bureau of Early Intervention (BEI). In New York State, the EIP is established in Article 25 of the Public Health Law and has been in effect since July 1, 1993.

To maintain NY EIP's high standards of quality and improve efficiencies for providers, we have implemented an updated provider enrollment and management system. Potential providers will complete a Pre Application Screening Tool (PAST) which will help determine their eligibility to complete the full Provider Application Tool (PAT).

[Click here to initiate the application process](#)  If you experience technical difficulties, please contact [NYEHubEnroll@pcgus.com](mailto:NYEHubEnroll@pcgus.com).

New York State currently approves two types of early intervention providers: Agencies and Individuals. Please review the definitions and information for the appropriate application documents.

To begin the application process, please indicate the applicant's provider type from the choices below:

- An **Agency Provider** is an entity that employs qualified personnel and may contract with DOH-approved individual or agency providers to provide early intervention program (EIP) evaluations, service coordination, and/or services.
  - An agency must employ a full-time early intervention program director and employ two additional service providers who deliver EIP services at least 20 hours per week.
  - Qualified personnel are those who are approved as required by Subpart 69-4 to deliver services to the extent authorized by their licensure, certification, or registration to eligible children and have appropriate licensure, certification, or registration in the area where they provide services. Only a designated representative from an Agency should submit the PAST (e.g., program director, clerical administrator, primary contact).
- An **Individual Provider** is a person who holds a New York State-recognized certificate or license with current registration in the professions outlined in the early intervention regulation (Subpart 69-4.1). This person wants to contract (paid with W-1099) with a municipality or agency provider or take cases directly (requiring them to submit claims to Medicaid).
  - Individual providers may operate under their legal name (with a Social Security Number) or a business name (Federal Employee Identification Number).

Review all the information provided and hyperlinks to determine if you should apply as an agency or individual provider. Select the appropriate button to begin the PAST.

## 7.1 Agency Provider

### 7.1.1 Agency Pre-Application Screening Tool (PAST)

 Complete the Pre-Application Screening Tool (PAST), a preliminary step to the Provider Application Tool (PAT).

### 7.2.2 Agency PAST Fields

 You may tab through or click into individual fields. To change tabs, click the next tab button or click on the individual tab name above to move to the next tab. Your progress may be saved at any time if all the required fields have been completed and there are no errors on the page.

**Fields marked with a red asterisk are mandatory fields that must be populated. Conditional fields are only revealed based on answers to other questions.**

The Provider Enrollment Tool is only needed if you are new to the NY EI Program or an existing provider with significant changes. A new application is only required of an existing EI Provider if any of the following apply:

- Change in FEIN (Agency or an Individual with a DBA)
- Provider is Withdrawn, Disqualified, or Disapproved (Agency)
- Agency Ownership Changes
- If the information has already been provided through the Amendment process in EI-Hub Provider Management, and the denial indicates that a new application is required.

**If any of the above situations pertain to you, a new application must be submitted.**

Existing agencies will change their approved records in Case Management if the abovementioned situations don't apply to you.

### 7.2.3 Duplicate Check Tab

 The Duplicate Check tab will verify if the agency already has an existing record in the Case Management System (has previously been approved). The system will provide additional instructions on proceeding if a match is found. This tab verifies the NPI you enter against the NPPES online verification system.

 **Please note the following for this tab:**

- If a matching record exists in the system, creating a duplicate record is unnecessary. However, if you are trying to request an amendment to your record, please submit an amendment request in EI-Hub's Provider Management section.
- If substantial changes to the agency require a new application, please continue to include which changes are needed.
- When required fields on the Duplicate Check are not completed, error messages will populate below the required field.

# Pre-Application Screening Tool

Agency Form

DUPLICATE CHECK

Agency Contact Information

Agency Staffing Requirements

Available Personnel

Attestation

You may tab through or click into individual fields. To move to the next tab, you may click the next tab button or click on the individual tab name above. You may save your progress at any time if all the required fields have been completed and there are no errors on the page.

The first step is to determine if you already have an existing entry in the EI Hub Case Management system. To initiate the duplicate search, enter the agency's legal name, NPI (National Provider Identifier) FEIN (Federal Employee Identification Number), and DBA (if applicable). If a match is found additional instructions will be provided on how to proceed.

Please note and record the pre-filled Applicant ID field. This number is unique to your application process and may be used by PAU staff to locate your application, if a problem were to occur.

**Applicant ID**

1046

**Agency Legal Name \***

?
**Doing Business As**

?
**Agency Organization NPI \***

?

*National Provider Identifier, must be your organizational NPI for EI services. Additional NPIs will be captured later in the process, if appropriate.*

Approved providers seeking to make changes to services offered, service sites or agency director will need to complete the Amendment Request process in the EI-Hub Case Management System. Any other changes to provider data can be completed directly in the Provider section of Case Management.

**Agency's FEIN \***

dd-ddddddd



Please save your progress often and remember that you can only save if there are no errors to be resolved. The submit application button will initiate a system review of your application and report any errors. Successful submission of the PAST will result in an on-screen message and email notification detailing next steps.

[Next Tab](#)[Save Progress](#)[Submit Application](#)

FIELD	FIELD TYPE	DESCRIPTION
<b>Applicant ID</b>	System Generated, Numeric Entry	A read-only field. The generated number used to locate applications in the Provider Enrollment tool doesn't transition to EI-Hub Case Management after approval.
<b>Agency Legal Name *</b> <small>exactly as registered with the Dept. of State or County where the business was registered</small>	Required Text Entry	Enter the agency's legal name.  <span style="color: #0070C0; font-size: 2em; vertical-align: middle;">i</span> <b>The Agency Name is verified against the Agency Name in NPPES. In addition, the agency must have an "Active" status with the Department of State.</b>

FIELD	FIELD TYPE	DESCRIPTION
<b>Doing Business As (DBA)</b>  Enter the agency's DBA, if applicable, leave blank if not needed.	Optional Text Entry	Enter the agency's DBA; if applicable, leave it blank if not.  <b>i</b> DBA is ‘when a business operates using a name different from the owner’s name or the legal name of the partnership, LLC, or corporation, and it is said to be ‘doing business as,’ or ‘DBA,’ another name.’
<b>Agency's Organization NPI *</b>  Agencies/Municipalities Service: Service Coordination- Organization Provider Type Code- 25 Agencies, Classification Name, Area of Specialization- 251B0000X – Case Management and252Y0000X – Early Intervention Provider Agency; Agencies/Municipalities Service: All Other EI Services- Organization Provider Type Code- 25 Agencies, Classification Name, Area of Specialization- 252Y0000X – Early Intervention Provider Agency	Required, Numeric Entry	The National Provider Identifier must be your organizational NPI for EI services. Additional NPIs will be captured later in the process if appropriate.  <b>i</b> <ul style="list-style-type: none"> <li>• Agency applicants must have an Organizational National Provider Identifier (NPI) for the proposed Early Intervention (EI) agency.</li> <li>• If the agency does other business besides EI, a separate Organizational NPI is recommended to be explicitly obtained for EI services.</li> <li>• Agencies must have the following Taxonomy codes associated with their Organizational NPI: 252Y0000X – Early Intervention Provider Agency.</li> <li>• If providing service coordination services: 251B0000X – Case Management.</li> </ul>
<b>Agency's FEIN *</b>  Federal Employer Identification Number	Required, Numeric Entry	Enter the agency's Federal Employer Identification Number (FEIN).  <b>i</b> A FEIN, also known as a Federal [Tax] Identification Number or an Employer Identification Number (EIN), is issued to entities doing business in the United States. The FEIN is a unique nine-digit corporate ID number that works like a Social Security number for individuals.
<b>System Action:</b> The Provider Enrollment tool contacts the NPPES verification system. The Organizational NPI entered will return the associated provider name.		
<b>System Displays:</b> The following provider is associated with the NPI number entered:		
<b>Is the provider displayed above the individual or agency applying for entry into the EI program?</b>	Require, Yes or No	Select the appropriate radio button.
<b>Are you a new provider seeking initial approval in the EI Program?</b>	Conditional, Yes or No	Select the appropriate radio button.

FIELD	FIELD TYPE	DESCRIPTION
Will a new application be required because of any of the four (4) situations listed above?	Conditional, Yes or No	Select the appropriate radio button.
Agency's FEIN* Federal Employer Identification Number	Require, Numeric Entry	Enter the numeric value.
<b>When the system identifies</b> an existing entry in Case Management that may be a duplicate of the agency you are entering, the Agency Legal Name field will display this message: " <b>The Provider may already exist.</b> And the Agency Organization NPI field will display: <b>The NPI number may already exist.</b> "		
<b>Once you have completed the Duplicate Check tab, remember to select/click the 'Save Progress' button. Any errors or required fields left blank will be noted, and all issues must be resolved to save the page. Once this tab has been successfully saved, you may navigate freely throughout the entire PAST or leave and return later to continue where you left off. You will also see other informational messages advising that other required information is needed to submit your request, but it won't stop you from saving your progress.</b>		



The Button Description table below applies to all the following screens/panels as we advance.

BUTTON	DESCRIPTION
Next Tab 	Click this button to advance to the next tab on the screen (panel). Alternatively, click the next tab on the top (below the screen's header name).  <b>(i)</b> This button appears in the remaining tabs after advancing to the second tab on the screen.
Previous Tab 	To return to the previous tab. Click this button.  <b>(i)</b> This button appears in the remaining tabs after advancing to the second tab on the screen.
Save Progress 	Click this button to save your data entry progress before submitting your application.
Submit Application 	Click this button if you have completed all the tabs and are ready to submit your application.  <b>(i)</b> If an error is encountered when completing the PAST, you must clear all errors before the system allows you to submit the application successfully.

## 7.2 Agency Contact Information Tab

 Please provide details about the agency and the person serving as the agency's primary contact. Agencies must identify a qualified and authorized representative to complete the PAST on behalf of the organization and serve as the agency's direct contact. The representative must access the information and documentation required to complete the tools.

Please save your progress often and remember that you can only save if there are no errors. The submit application button will systematically review your application and report any errors. Successful PAST submission will result in an on-screen message and email notification detailing the next steps.

 **The agency contact person receives the notifications about the application. The agency contact person must have access to the information and documentation required to complete the application process and will receive notifications at the email address provided.**

## Pre-Application Screening Tool

Agency Form

[DUPLICATE CHECK](#)[Agency Contact Information](#)[Agency Staffing Requirements](#)[Available Personnel](#)[Attestation](#)

Please provide the following details about the agency and the person serving as the agency's main contact. Agencies must identify a representative who is qualified and authorized to complete the PAST on behalf of the organization and who will serve as the main contact for the agency. It is important that the representative has access to the information and documentation required to complete the tools.

**Agency Mailing Address \***

Enter the address where mail is actually delivered. Enter the Zip +4, if you know it. Otherwise, just enter the ZIP and the +4 can be determined from the other fields. ZIP +4 will autopopulate the City & State.

**Line1**

Line 1

**Line2**

Line 2

**Line3**

Line 3

**Zip Code**

ZIP+4

**City/Town**

City/Town

**State****Mailing and location addresses are the same? \***

If the agency's physical location is the same as the mailing address, indicate that here. Otherwise, enter the location where the agency is actually physically located. Enter the Zip +4, if you know it. Otherwise, just enter the ZIP and the +4 can be determined from the other fields. ZIP +4 will autopopulate the City & State.

 Yes No**Agency Physical Location Address****Line1**

Line 1

**Line2**

Line 2

**Line3**

Line 3

**City/Town**

City/Town

**State****Zip Code**

Zip+4

**Agency Primary Phone Number \***

(ddd) ddd-dddd

**Agency Main Contact Person Salutation \*****Agency Main Contact Person First Name \*****Agency Main Contact Person Middle Name/Initial****Agency Main Contact Person Last Name \*****Agency Main Contact Person Title \*****Agency Main Contact Person AKA Name/Maiden Name****Main Contact Person Primary Phone Number \***

(ddd) ddd-dddd

**Main Contact Person's Primary Email \*****Email**

Re-enter the same email for verification

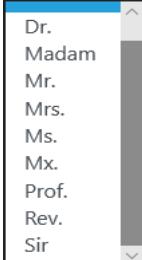
**Email (verify)**

Verify Email

Please save your progress often and remember that you can only save if there are no errors to be resolved. The submit application button will initiate a system review of your application and report any errors. Successful submission of the PAST will result in an on-screen message and email notification detailing next steps.

[Previous Tab](#)[Next Tab](#)[Save Progress](#)[Submit Application](#)

FIELD	FIELD TYPE	DESCRIPTION		
Agency Mailing Address *	Required, Text Entry	<p><b>The process follows:</b> The provider enters their address, and it's verified with United State Postal Service (USPS).</p> <ul style="list-style-type: none"> <li>If USPS indicates that <b>line 2</b> is required (no listing exists without line 2), then the system requires info for line 2. The info entered in line 2 is not verified, but you must enter something on that line.</li> <li>If USPS shows both addresses with/without a line 2 at that location, the system does not require a line 2.</li> </ul> <ul style="list-style-type: none"> <li><b>Line1:</b> Enter the address where mail is physically delivered.</li> <li><b>Line2:</b> If applicable</li> <li><b>Line3:</b> If applicable</li> <li><b>Zip Code:</b> Enter the Zip +4.</li> <li><b>City/Town:</b> Enter the city/town where mail is delivered.</li> <li><b>State:</b> Use the drop-down and select where mail is physically delivered.</li> </ul>  <p><b>i</b> Enter the address where mail is delivered. Enter the Zip +4 if you know it. Otherwise, enter the Zip to determine the +4 from the other fields. For example, zip +4 will auto-populate the City and State.</p>		
Mailing and location addresses are the same? *	Required, Yes or No	<p>Select the appropriate radio button.</p> <p><b>i</b> Please verify the county selected is accurate based on the address in PEM. This information transfers into Case Management.</p> <p><b>Step/Action</b></p> <ol style="list-style-type: none"> <li>If you select/tick 'Yes,' the "<b>Agency Location Address County/Borough*</b>" field appears (example below).</li> </ol> <table border="1"> <tr> <td><b>Agency Location Address County/Borough*</b></td> </tr> <tr> <td><small>County is a required field if in NY.</small></td> </tr> </table> <ol style="list-style-type: none"> <li>Next, select the correct county/borough from the list using the drop-down. Please note the county/borough is not a validated field. Users should verify the county/borough selected is accurate.</li> </ol>	<b>Agency Location Address County/Borough*</b>	<small>County is a required field if in NY.</small>
<b>Agency Location Address County/Borough*</b>				
<small>County is a required field if in NY.</small>				

FIELD	FIELD TYPE	DESCRIPTION
		<p><b>(i)</b> If the agency's physical location is the same as the mailing address, indicate that here. Otherwise, enter the physical location where the agency resides. Enter the Zip +4 if you know it. Otherwise, enter the ZIP and the +4 so the system can verify the other fields. ZIP +4 will auto-populate the City and State. ZIP +4 will auto-populate the City and State.</p>
<b>Agency Physical Location Address</b>  Physical locations can't contain PO Boxes; the Physical Address is the location where Agency's records and files are maintained.	Required, Text Entry	<ul style="list-style-type: none"> <li><b>Line1:</b> Enter the address where mail is physically delivered.</li> <li><b>Line2:</b> If applicable</li> <li><b>Line3:</b> If applicable</li> <li><b>Zip Code:</b> Enter the Zip +4.</li> </ul> 
<b>Agency Location Address County/Borough*</b>	Conditional, Drop-Down	<p>This only displays if the agency location address is in NY.</p> <p><b>(i)</b> The PAU must verify that the county is an accurate address in PEM. When approving a PEM application, this information transfers to Case Management, so if accurate when approved, EI-Hub will display the correct county in the system.</p>
<b>Agency Primary Phone Number *</b>  The best way to reach the agency by phone, general phone number.	Required, Numeric Entry	Enter the best phone number to reach the agency.
<b>Agency Main Contact Person Salutation *</b>	Required, Drop-Down	Select the appropriate salutation from the list. 

FIELD	FIELD TYPE	DESCRIPTION
When BEI contacts the agency, who is the person they should be directed to? This should be someone with the authority to discuss/submit applications and amendments, and access to the proper (required) documentation.		
<b>Agency Main Contact Person First Name *</b>	Required, Text Entry	<p>Enter the person's first name as the agency's primary contact.</p> <p><b>(i) This person must have the authority to discuss/submit applications and amendments and access the proper (required) documentation.</b></p>
<b>Agency Main Contact Person Middle Name/Initial</b>	Optional, Text Entry	<p>Enter the middle name or initial of the person serving as the primary contact for the agency.</p> <p><b>(i) If entering an initial, please do not enter a period (.).</b></p>
<b>Agency Main Contact Person Last Name *</b>	Required, Text Entry	Enter the person's last name as the agency's primary contact.
<b>Agency Main Contact Person Title *</b>	Required, Text Entry	Enter the person's job title as the agency's primary contact.
<b>Agency Main Contact Person AKA Name/Maiden Name</b>		Enter the name others would associate with you if different from your First Name or record your former name here if recently changed (e.g., maiden name).
Enter the name others would associate with you , if different from your First Name, or record your former name here (maiden name).		
<b>Main Contact Person Primary Phone Number *</b>	Optional, Text Entry	Enter the best number to reach (e.g., while at work) the Main Contact Person by phone.
While at work, the best number to reach the Main Contact Person by phone.		
<b>Main Contact Person's Primary Email *</b>	Required, Text Entry	<ul style="list-style-type: none"> <li><b>Email:</b> Enter the email address you want the information sent to regarding the application.</li> <li><b>Email (verify):</b> Re-enter the same email address for verification.</li> </ul> <p><b>(i) Information related to your application will be sent to this email.</b></p>
While at work, the best number to reach the Main Contact Person by email.		

## 7.2.1 Agency Staffing Requirements Tab

 **Qualifications as an Agency in NYS:** There must be a full-time employed EI Program Director and at least two (2) employed Qualified Personnel. More detailed information about the requirements for each is listed below. In addition, enter the middle name or initial of the person serving as the primary contact for the agency.

**An agency must employ a full-time Early Intervention (EI) Program Director** who has a minimum of two (2) years of full-time or the equivalent of experience in early intervention, clinical pediatric, or early childhood education programs, which includes:

- Delivering services to children from birth up to five years of age.
- Provided that the experience consists of direct experience delivering services to children with disabilities and their families.
- At least one year of experience delivering services to children less than three years of age and their families.
- The Program Director's duties may include providing services. This individual must be available for enough time to develop and implement a Program Standards Plan and ensure that the agency complies with all federal and state requirements.

**An agency must employ a minimum of two individuals** (excluding the Program Director) who are recognized as Qualified Personnel by the EI program, as defined in either:

- 10 NYCRR Section 69-4.1, or service coordinators who meet the qualifications in 69-4.4. Each is available to provide a minimum of 20 hours per week of EI services and/or evaluations and/or service coordination.

### 7.1.1.1 Director (Agency Director)

 Below, please complete all required and optional fields as appropriate for the Agency Director and both Qualified Professional sections.

Director

**Is the Director also the Agency's Main Contact Person? \***

*Indicate if the agency's director is also the agency's main contact person, if so the main contact person information will autopopulate the associated director fields to prevent the need for manual re-entry.*

Yes  
 No

**Director's Salutation \***

**Director's First Name \***

**Director's Middle Name/Initial**

**Director's Last Name \***

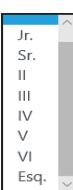
**Director's Suffix**

**Does the Director Meet the Stated Requirements (above)? \***

Yes  
 No



FIELD	FIELD TYPE	DESCRIPTION
<b>Is the Director also the Agency's Main Contact Person? *</b>	Required, Yes or No	Select the appropriate radio button to indicate if the agency's director is also the agency's main contact person; if so, the primary contact information will auto-populate the associated director fields to prevent the need for manual re-entry.
<b>Director's Salutation *</b>	Required, Drop-Down	Select the appropriate salutation from the list.
<b>Director's First Name *</b>  <div style="background-color: black; color: white; padding: 5px; width: fit-content;"><p>The name entered must exactly match the name on all licenses and certifications.</p></div>	Required, Text Entry	Enter the first name of the agency Director.

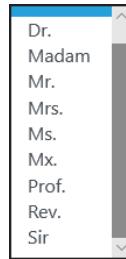
FIELD	FIELD TYPE	DESCRIPTION
Director's Middle Name/Initial  If entering an initial, please do not enter the period (.)	Optional, Text Entry	Enter the middle name or initials of the agency Director.
Director's Last Name *	Required, Text Entry	Enter the last name of the agency Director.
Director's Suffix	Optional, Drop-Down	Select the appropriate suffix from the list.  
Does the Director Meet the Stated Requirements (above)? *	Required, Yes or No	<p>Select the appropriate radio button.</p> <p>Select 'No,' a message displays as follows:</p> <p>"Thank you for your interest in becoming an EI agency provider in NYS. Unfortunately, you cannot proceed to an EIP application because the agency can only be approved if the program director meets the minimum requirements. Additional information on the requirements can be found here: <a href="#">Title: SubPart 69-4 - Early Intervention Program   New York Codes, Rules, and Regulations (ny.gov)</a>. If you have specific questions related to agency requirements, please contact the Bureau's Provider Approval Unit at (518) 473-7016, press 1, or <a href="mailto:provider@health.ny.gov">provider@health.ny.gov</a>."</p> <ul style="list-style-type: none"> <li>• An agency must employ a full-time Early Intervention (EI) Program Director who has a minimum of two (2) years full-time or the equivalent of experience as follows:</li> <li>• Early Intervention, clinical pediatric, or early childhood education program includes serving children ages birth to five years of age. The experience consists of direct experience delivering services to children with disabilities and their families.</li> <li>• Should have at least one year of experience delivering services to children less than three years of age and their families. The Program Director's duties may include the provision of services. This individual must be available for a sufficient amount of time to develop and ensure the implementation of a Program Standards Plan and ensure that the agency complies with all federal and state requirements.</li> </ul>

### 7.1.1.2 Qualified Professional 1 & 2 Panels

 All personnel must be certified, licensed, and hold a current registration in NYS and/or meet the minimum qualifications for a service coordinator outlined in EI regulations. In addition, the two Qualified Personnel must provide evaluations, service coordination, or services to children in the Early Intervention Program for a minimum of twenty hours each per week.

Qualified Professional 1	
All personnel must be certified, licensed and hold a current registration in NYS, or meet the minimum qualifications outlined in EI regulations. The two Qualified Personnel must provide evaluations, service coordination or services to individuals with disabilities for a minimum of twenty hours each per week.	-
<b>Qualified Professional 1 Salutation *</b>	<input type="text"/>
<b>Qualified Professional 1 First Name *</b>	<input type="text"/> 
<b>Qualified Professional 1 Middle Name/Initial</b>	<input type="text"/> 
<b>Qualified Professional 1 Last Name *</b>	<input type="text"/>
<b>Qualified Professional 1 Suffix</b>	<input type="text"/>
<b>Qualified Professional 1 Social Security Number *</b>	<input type="text"/> ddd <input type="text"/> dd <input type="text"/> dddd
<b>Qualified Professional 1 NPI *</b>	<input type="text"/> 
<b>Qualified Professional 1 Profession *</b>	<input type="text"/> 
<b>Qualified Professional 1 License/Certification Control Number</b>	<input type="text"/>
*	

 The field description table below applies to the Qualified Professionals 1 & 2. Let's use the 'Qualified Professional 1' table as an example.

FIELD	FIELD TYPE	DESCRIPTION
<b>Qualified Professional 1 Salutation*</b>	Required, Drop-Down	Select the appropriate salutation from the list.   All personnel must be certified, licensed, hold a current registration in NYS, and/or meet the minimum qualifications as a service coordinator outlined in EI regulations.

FIELD	FIELD TYPE	DESCRIPTION
<b>Qualified Professional 1 First Name*</b>  The name entered must exactly match the name on all licenses and certifications.	Required, Text	Enter the first name of the agency-qualified professional 1 (QP).  <b>(i)</b> The two QPs must be available to provide evaluations, service coordination, or services to children in the EIP for a minimum of twenty hours per week.
<b>Qualified Professional 1 Middle Name/Initial</b>  If entering an initial, please do not enter the period (.)	Optional, Text	Enter the middle name or initial of the QP.
<b>Qualified Professional 1 Last Name*</b>	Required, Text	Enter the last name or initial of the QP.
<b>Qualified Professional 1 Suffix</b>	Optional, Drop-Down	Select the appropriate suffix from the list.  
<b>Qualified Professional 1 Social Security Number*</b>	Required, Numeric	Enter the SSN for the QP.
<b>Qualified Professional 1 NPI*</b> National Provider Identifier	Required, Numeric	Enter the National Provider Identifier (NPI) number for the QP.
<b>Qualified Professional 1 Profession*</b>  Must be an EI recognized profession	Required, Drop-Down	Select the appropriate profession from the Qualified Professional (QP) list.  <b>(i)</b> When selecting “Physician” (QP1 & QP2- Profession = Physician), a specialty field appears (shown below).  
<b>Qualified Professional 1 License/Certification Control Number</b>	Optional, Text	Enter the license/certification control number for the Qualified Professional (QP).

### 7.1.1.2 Available Personnel Tab

 Including the Qualified Professionals listed above, select the number of professional personnel the agency seeks to provide services.

 **All staff must be certified, licensed, hold a current registration in NYS, and/or meet the minimum qualifications as a service coordinator outlined in EI regulations.**

## Pre-Application Screening Tool

Agency Form

DUPLICATE CHECK    Agency Contact Information    Agency Staffing Requirements    Available Personnel    Attestation

Including the Qualified Professionals listed previously, select the number of professional personnel for which the agency is seeking approval to provide services. Note: All personnel must be certified, licensed and hold a current registration in NYS, or meet the minimum qualifications outlined in EI regulations.

Employees and Contractors

Profession	Number Employed by Profession	Number Contracted by Profession	Actions
			

Please save your progress often and remember that you can only save if there are no errors to be resolved. The submit application button will initiate a system review of your application and report any errors. Successful submission of the PAST will result in an on-screen message and email notification detailing next steps.

[Previous Tab](#)

[Next Tab](#)



To add employees and contractors, click the 'Add' button, and the Employees and Contractors popup form will appear (shown below).

### 7.1.2.1 Employees and Contractors Popup Form

 Employees' duties are defined, directed, and supervised by the agency. An employee receives wages; at the end of the year, an employee receives an IRS wage and tax statement (W-2). EI Agencies can employ individuals who meet the regulatory requirements identified in Subsection 69-4.1 or 4.4 (service coordinators).

A contractor does not receive wages and generally receives an IRS form 1099 at the end of the year; this refers to individual qualified personnel available to an agency or municipality through a contractual agreement. An agency does not employ an individual under contract. Agencies can only contract with individuals who have DOH individual approval and an active agreement.

Please note not all professions can be added as contractors. Some professions including occupational therapist assistants, physical therapy assistants, certified behavior analyst assistants, and licensed practice nurses must be employed.

**Employees and Contractors** X

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).

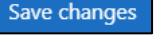
A contractor does not receive wages, and generally receives an IRS form 1099 at the end of the year. Refers to individual qualified personnel available to an agency or municipality through a contractual agreement. An individual under contract is not employed by an agency.

Please note, not all professions can be added as contractors.

<b>Profession *</b>	
<b>Number Employed by Profession</b>	
<span style="border: 1px solid #ccc; padding: 2px 10px; margin-right: 10px;">Close</span> <span style="background-color: #0070C0; color: white; border: 1px solid #0070C0; padding: 2px 10px; font-weight: bold;">Save changes</span>	

FIELD	FIELD TYPE	DESCRIPTION						
<b>Profession *</b>	Required, Drop-Down	<p>Select the appropriate employee or contract profession from the list.</p> <p> Depending on the profession selection, an additional field appears in the Employees and Contractors popup form. For example, I am selecting “Audiologist” (see example below).</p> <div style="border: 1px solid #ccc; padding: 5px; margin-top: 10px;"> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; padding: 5px;"><b>Profession *</b></td> <td style="width: 85%; padding: 5px; height: 40px; vertical-align: top;">Audiologist</td> </tr> <tr> <td colspan="2" style="padding: 5px;"><b>Number Employed by Profession</b></td> </tr> <tr> <td colspan="2" style="padding: 5px;"><b>Number Contracted by Profession</b></td> </tr> </table> </div> <p> An additional field appears in the Employees and Contractors popup form depending on the profession selection. For example,</p>	<b>Profession *</b>	Audiologist	<b>Number Employed by Profession</b>		<b>Number Contracted by Profession</b>	
<b>Profession *</b>	Audiologist							
<b>Number Employed by Profession</b>								
<b>Number Contracted by Profession</b>								

FIELD	FIELD TYPE	DESCRIPTION
		select “Physician,” and the ‘Physician Specialty’ field appears (see example below).
<b>Physician Specialty*</b>	Conditional, Text Entry	
<b>Number Employed by Profession</b>	Optional, Numeric Entry	Use this field and enter the number employed by the employee by profession.
<b>Number Contracted by Profession</b>	Conditional, Numeric Entry	Use this field and enter the number contracted by the employee by profession.

BUTTON	DESCRIPTION								
<b>Close</b> 	When clicked, changes do not save, and it closes the popup panel.								
<b>Save Changes</b> 	Click this button to save your data entry; the popup panel closes and displays your listings (an example below). <p> Employees and Contractors</p> <table border="1"> <thead> <tr> <th>Profession</th> <th>Number Employed by Profession</th> <th>Number Contracted by Profession</th> <th>Actions</th> </tr> </thead> <tbody> <tr> <td>Audiologist</td> <td>10</td> <td>1</td> <td><a href="#">Display</a>   <a href="#">Delete</a>   <a href="#">Edit</a></td> </tr> </tbody> </table> <p> The three (3) hyperlink labels and their descriptions are as follows:</p> <ul style="list-style-type: none"> <li>• <b>Display:</b> The Professions popup panel appears (read-only) when clicked.</li> <li>• <b>Delete:</b> When clicked, the Professions popup panel appears with ‘Close’ (gray button) and ‘Delete’ (red button). <ul style="list-style-type: none"> <li>○ To cancel the deletion, click the <b>Close</b> button.</li> <li>○ To confirm the removal of the record, click the <b>Delete</b> button. The record is removed (deleted) from the Professions Panel when clicked.</li> </ul> </li> <li>• <b>Edit:</b> When clicked, the Professions Panel popup panel appears (edit mode).</li> </ul> <p> The ‘Close’ and ‘Save Changes’ buttons work the same as described above.</p>	Profession	Number Employed by Profession	Number Contracted by Profession	Actions	Audiologist	10	1	<a href="#">Display</a>   <a href="#">Delete</a>   <a href="#">Edit</a>
Profession	Number Employed by Profession	Number Contracted by Profession	Actions						
Audiologist	10	1	<a href="#">Display</a>   <a href="#">Delete</a>   <a href="#">Edit</a>						

### 7.1.3 Attestation Tab

 Please complete the attestations and correct the submitter information (imported from the Contact Information tab) below. Then, save your progress and review the other tabs, making necessary corrections. Once satisfied with the entered information, select the **Submit Application** button. The system will then review your submission for completeness and notify you if any required fields have been missed.

Completed applications will be reviewed for eligibility in the EI program against a set of established requirements. On-screen and email notifications of the results will be instantaneous, allowing you to make any necessary corrections, resubmit the application, begin the PAT immediately, or return later.

Please save your progress often and remember that you can only save if there are no errors. The submit application button will systematically review your application and report any errors.

Successful PAST submission will result in an on-screen message and email notification detailing the following steps (example below).

**Dear...**

"Thank you for your interest in becoming an EI provider in NYS. Your Pre-Application Screening Tool has been successfully submitted. The link to complete your Provider Application Tool is [here](#). This link is unique to your account and should not be shared with or forwarded to others. Please monitor your email for correspondence confirming successful submission and instructions on how to proceed to the next step in the application process. Contact [provider@health.ny.gov](mailto:provider@health.ny.gov) if you have not received an email within three (3) business days. It will facilitate the completion of the application if you have the following information easily accessible. \*Certificate of Occupancy, Building Inspection, Fire Inspection, Fire/Disaster Evaluation Plan, and Site Diagram are not needed if the site has a daycare permit/license."

**"If you have questions or need additional information, please contact the BEI PAU at [provider@health.ny.gov](mailto:provider@health.ny.gov) or (518) 473-7016, press 1. Additional information on requirements may also be found here: [Title: Subpart 69-4 - Early Intervention Program | New York Codes, Rules and Regulations \(ny.gov\)](#)"**



Sincerely,

"NYS Department of Health Bureau of Early Intervention Provider Approval, Due Process, and Monitoring Unit."

**(i)** Unsuccessful PAST submission will result in an on-screen message and email notification detailing why the applicant cannot proceed with the application. An applicant may submit a new PAST in the future if, at any time, they resolve the reason for the denial (e.g., obtain the required employees or obtain a Program Director who meets the requirements).

# Provider Application Screening Tool

Agency Form

[DUPLICATE CHECK](#)   [Agency Contact Information](#)   [Agency Staffing Requirements](#)   [Available Personnel](#)   [Attestation](#)

**My agency is a legal business entity authorized to do business in New York State. \***

- Yes  
 No

**My organizational structure complies with all federal and state statutes and regulations, including practice acts established by the State Education Department Office of Professions. \***

- Yes  
 No

**I verify the information contained on this form is accurate, I have reviewed it carefully, and it is ready to be submitted. I have authority to submit this document on behalf of the Agency indicated herein. \***

- Yes  
 No

**First Name of Person Submitting Application \***

**Middle Name/Initial of Person Submitting Application**

\*

**Last Name of Person Submitting Application \***

**Submitter's Title \***

**Submission Date \***

[Previous Tab](#)

[Save Progress](#)

[Submit Application](#)

FIELD	FIELD TYPE	DESCRIPTION
<b>My agency is a legal business entity authorized to do business in New York State. *</b>	Required, Yes or No	<p>Select the appropriate radio button.</p> <p><b>i</b> Selecting No will cause the PAST to deny upon submission. Select 'No,' a message displays as follows:</p> <p>"Thank you for your interest in becoming an EI agency provider in NYS. Unfortunately, you cannot proceed to an EIP application because approval cannot be granted to Agencies that lack the proper Authority to Do Business in New York State. Additional information on the requirements can be found here: <a href="https://regs.health.ny.gov/content/section-69-45-approval-service-coordinators-evaluators-and-service-providers">https://regs.health.ny.gov/content/section-69-45-approval-service-coordinators-evaluators-and-service-providers</a>. If you have specific questions related to the EI Agency Application/Provider Agreement, please contact the Bureau's Provider Approval Unit at (518) 473-7016, press 1, or <a href="mailto:provider@health.ny.gov">provider@health.ny.gov</a>."</p>

FIELD	FIELD TYPE	DESCRIPTION
<b>My organizational structure complies with all federal and state statutes and regulations, including practice arts established by the State Education Department Office of Professions. *</b>	Required, Yes or No	<p>Select the appropriate radio button.</p> <p><b>(i)</b> Selecting No will cause the PAST to deny upon submission. Select 'No,' a message displays as follows:</p> <p>"Thank you for your interest in becoming an EI agency provider in NYS. Unfortunately, you cannot proceed to an EIP application because approval cannot be granted to Agencies that lack the proper Authority to Do Business in New York State. Additional information on the requirements can be found here: <a href="https://regs.health.ny.gov/content/section-69-45-approval-service-coordinators-evaluators-and-service-providers">https://regs.health.ny.gov/content/section-69-45-approval-service-coordinators-evaluators-and-service-providers</a>. If you have specific questions related to the EI Agency Application/Provider Agreement, please contact the Bureau's Provider Approval Unit at (518) 473-7016, press 1 or <a href="mailto:provider@health.ny.gov">provider@health.ny.gov</a>."</p>
<b>I verify the information contained on this form is accurate; I have reviewed it carefully, and it is ready to be submitted. I have authority to submit this document on behalf of the Agency indicated herein. *</b>	Required, Yes or No	<p>Select the appropriate radio button.</p> <p><b>(i)</b> Selecting No will cause the PAST to deny upon submission. Select 'No,' a message displays as follows:</p> <p>"You must agree to the verification in order to continue to the Provider Application Tool."</p>
<b>First Name of Person Submitting Application</b>	Required, Autofill	This field prefills the first name of the person applying.
<b>Middle Name/Initial of Person Submitting Application*</b>	Required, Autofill	<p>This field prefills the person's middle name or initial.</p> <p><b>(i)</b> If entering an initial, please do not enter a period (.).</p>
<b>Last Name of Person Submitting Application</b>	Required, Autofill	This field prefills the last name of the person applying.
<b>Submitter's Title *</b>	Required, Autofill	This field prefills the title of the person applying.
<b>Submission Date *</b>	Required, Autofill	This field prefills the application's submission date (manually typing or using the calendar picker).

BUTTON	DESCRIPTION
<b>Submit Application</b> 	Click this button if you have completed all the tabs and are ready to submit your application.

 Please complete the attestations and verify the submitter information (imported from the Contact Information tab) below. Then, save your progress and review the other tabs, making necessary corrections. Once satisfied with the entered information, select the **Submit Application** button. The system will then review your submission for completeness and notify you if any required fields need to be included.

Completed applications will be reviewed for eligibility in the EI program against a set of established requirements. On-screen and email notifications of the results will be instantaneous, allowing you to make any necessary corrections, resubmit the application, begin the PAT immediately, or return later.

## 7.1.4 Notifications

### 7.1.4.1 Timelines Notification

#### The PAST:

- After an unsubmitted PAST has aged 30 days, The user sees (when logging back into PEM) the following flag:

 59	Active	Edit
It has been 30 or more days since this record was created.		
 30	Active	Edit

- After 80 days have gone by without submission:

 115	Active	Edit
It has been 80 or more days since this record was created.		
N/A	Approved	view

 If the PAST goes beyond 90 days and is submitted, then the PAST processes as usual, regardless of the date.

#### The PAT:

- Uses the same flags as above at 30 and 80 days.
- If the PAT reaches 90 days without being submitted, the PAT is considered inactive and will display a red indicator flag.
- If submitted, the PAU team may decide whether to approve or deny the PAT based on the situation. If you have questions about whether you should start a new application or submit the existing application, please get in touch with the provider approval unit by emailing [provider@health.ny.gov](mailto:provider@health.ny.gov).

#### 7.1.4.2 Successful Notifications

 Successful PAST submission will result in an on-screen message and email notification detailing the following steps (example below).

Dear...

"Thank you for your interest in becoming an EI provider in NYS. Your Pre-Application Screening Tool has been successfully submitted. The link to complete your Provider Application Tool is [here](#). This link is unique to your account and should not be shared with or forwarded to others. Please monitor your email for correspondence confirming successful submission and instructions on how to proceed to the next step in the application process. Contact [provider@health.ny.gov](mailto:provider@health.ny.gov) if you have not received an email within three (3) business days. It will facilitate the completion of the application if you have the following information easily accessible. \*Certificate of Occupancy, Building Inspection, Fire Inspection, Fire/Disaster Evaluation Plan, and Site Diagram are not needed if the site has a daycare permit/license."

"If you have questions or need additional information, please contact the BEI PAU at [provider@health.ny.gov](mailto:provider@health.ny.gov) or (518) 473-7016, press 1. Additional information on requirements may also be found here: Title: Subpart 69-4 - Early Intervention Program | New York Codes, Rules and Regulations (ny.gov)"

Sincerely,

"NYS Department of Health Bureau of Early Intervention Provider Approval, Due Process, and Monitoring Unit."

#### 7.1.4.1.1 Successful Printing Submissions

 Once approved, the PAST can be printed for your records. The applicant selects the view link from the user's Homepage next to the approved PAST. Once the PAST displays, use the Print button at the bottom of the screen to print a copy.

#### 7.1.4.2 Denials

 Unsuccessful PAST submission will result in an on-screen message and email notification detailing why the applicant cannot proceed with the application. An applicant may submit a new PAST in the future if, at any time, they resolve the reason for the denial (e.g., obtain the required employees or obtain a Program Director who meets the requirements).

 **The next panel shows your record submission when successfully submitted/validated by the system. Use the 'Print' button located at the panel/screen bottom for your records.**



This section concludes the **Agency Provider** Pre-Application Screening Tool (PAST) enrollment process. Please refer to the [PAT Agency Applications](#) section in this User Guide.

### 7.1.5 PAST Agency Applications Dashboard



The example below shows the PAST Agency application is successfully submitted/approved.

#### PAST Agency Applications

Created Date	Last Modified Date	Status	Actions
12/8/2020	12/15/2020	Approved by	<a href="#">View</a>



**The Dashboard will include the history of all pre-application screening and applications.**

## 7.3 Individual (PAST)

### 7.3.1 Duplicate Check Tab

 The applicant's name must match the name on all licenses and certifications exactly.

You may tab through or click into individual fields. You may click the next tab button or click on the individual tab name above to move to the next tab. You may save your progress at any time if all the required fields have been completed and there are no errors on the page.

The first step is determining if you already have an existing EI Hub Case Management system entry. Then, to initiate the duplicate search, enter your legal name, NPI (National Provider Identifier), FEIN (Federal Employee Identification Number), and DBA (if applicable). **The system will provide additional instructions on proceeding if a match is found.** For example, a series of duplicate verification questions prompt you the following (example below).

The system has located an existing record matching the name or NPI entered. This enrollment tool is only required if you are submitting a new application.

**Are you a new provider seeking initial approval in the EI Program?**

Yes  
 No

A new application is only required of an existing EI Provider if any of the following apply:

- Change in FEIN (Agency or an Individual with a DBA); or
- Provider is Withdrawn, Disqualified, or Disapproved and wishes to reapply; or
- Agency ownership has changed; or
- A previous amendment request was denied, indicating that a new application would be required instead.

**Will a new application be required because of any of the 4 situations listed above?**

Yes  
 No

Approved providers seeking to make changes to services offered, service sites or agency director will need to complete the Amendment Request process in the EI-Hub Case Management System. Any other changes to provider data can be completed directly in the Provider section of Case Management.

**Please note and record the pre-filled Applicant ID field.** This number is unique to your application process and may be used by PAU staff to locate your application if a problem occurs.

## Pre-Application Screening Tool

Individual Form

DUPLICATE CHECK

[Contact Information](#)[Professions](#)[Employment History](#)[Attestation](#)

The applicant's name must exactly match the name on all licenses and certifications.

You may tab through or click into individual fields. To move to the next tab, you may click the next tab button or click on the individual tab name above. You may save your progress at any time if all the required fields have been completed and there are no errors on the page.

The first step is to determine if you already have an existing entry in the EI Hub Case Management system. To initiate the duplicate search, enter your legal name, NPI (National Provider Identifier) FEIN (Federal Employee Identification Number), and DBA (if applicable). If a match is found additional instructions will be provided on how to proceed.

Please note and record the pre-filled Applicant ID field. This number is unique to your application process and may be used by PAU staff to locate your application, if a problem were to occur.

**Applicant ID**

1046

**Salutation \***

Dr.

**First Name \***

Buck

**Middle Name/Initial****Last Name \***

Austin

**Suffix****AKA Name/Maiden Name****Individual Provider Type \***

- I am interested in becoming an early intervention provider using my legal name and Social Security number
- I am interested in becoming an early intervention provider using a business name and a Federal Employer Identification number (FEIN)

**Business Name \***

*Business Name exactly as registered with the Dept. of State or County where business was registered.*

21 Century Space

**FEIN \***

11-1111111

**Individual NPI \***

1111111111

**Are You Eligible to Work in the US? \***

*An individual in the US with a temporary Employment Authorization Card (EAD) cannot be approved as an individual provider of early intervention services.*

- Yes
- No

**Are you on an H-1B Visa? \***

*An individual in the US on an H-1B visa cannot be approved as an individual provider of early intervention services. To obtain an H-1B visa, a US employer must petition the government to allow a professional residing in a foreign country to come to the US to perform professional services for that employer. Therefore, to provide services in the early intervention program, persons in the US on an H-1B visa must be employed by the early intervention provider who sponsored him or her for the H-1B visa.*

- Yes
- No

[Next Tab](#)[Save Progress](#)[Submit Application](#)

FIELD	FIELD TYPE	DESCRIPTION
<b>Applicant ID</b>	System Generated, Numeric Entry	A read-only field. Please note and record the pre-filled Applicant ID field. This number is unique to your application process and may be used by PAU staff to locate your application if a problem occurs.
<b>Salutation *</b>	Required, Drop-Down	Select the appropriate salutation for the individual from the list.
<b>First Name *</b>	Required, Text Entry	Enter the person's (individual) first name.
<b>Middle Name/Initial</b>  If entering an initial, please do not enter the period (.)	Required, Text Entry	Enter the person's (individual) middle name or middle initial.  <b>(i) If entering an initial, please do not enter a period (.)</b>
<b>Last Name *</b>	Required, Text Entry	Enter the person's (individual) last name.
<b>AKA Name/Maiden Name</b>  Enter the name others would associate with you, if different from your First Name, or record your former name here (maiden name).	Optional, Text Entry	Enter the name others would associate with you if different from your First Name, the individual, or record your former name here if recently changed (e.g., maiden name).

FIELD	FIELD TYPE	DESCRIPTION
Individual Provider Type *	Required, Yes or No	<p>Select the appropriate radio button based on the individual provider.</p> <p><b>If you select:</b></p> <ul style="list-style-type: none"> <li>‘I am interested in becoming an early intervention provider using my legal name and Social Security number’; the ‘SSN’ field appears on this tab (shown below). Enter your social security number (SSN).</li> <li>SSNs are a required field for individual applicants in the PEM.</li> </ul>  <ul style="list-style-type: none"> <li>‘I am interested in becoming an early intervention provider using a business name and a Federal Employer Identification Number (FEIN); the ‘Business Name’ and ‘FEIN’ fields appear on this tab (shown below). <ul style="list-style-type: none"> <li>Enter the business name. <ul style="list-style-type: none"> <li>Exactly as registered with the Dept. of State or County where the business is registered.</li> </ul> </li> <li>Enter the agency’s Federal Employer Identification Number (FEIN). <ul style="list-style-type: none"> <li>A FEIN, also known as a Federal [Tax] Identification Number or an Employer Identification Number (EIN), is issued to entities that do business in the United States. The FEIN is a unique nine-digit corporate ID number that works like a Social Security number for individuals.</li> </ul> </li> </ul> </li> </ul> 
Individual NPI *	Required, Text Entry	<p>Enter the Individual National Provider Identifier (NPI) number.</p> <p><b>Additional requirements can be found here: <a href="https://regs.health.ny.gov/content/section-69-45-approval-service-coordinators-evaluators-and-service-providers">https://regs.health.ny.gov/content/section-69-45-approval-service-coordinators-evaluators-and-service-providers</a>.</b> If you have specific questions related to the individual approval, please contact the Bureau's Provider Approval Unit at (518) 473-7016, press 1, or provider@health.ny.gov.</p> <p><b>Individual applying with legal name and SS#, should enter their Individual NPI.</b></p> <p><b>Individuals applying with a business name and FEIN, should enter their Organizational NPI.</b></p>

FIELD	FIELD TYPE	DESCRIPTION
Are you Eligible to Work in the US? *	Required, Yes or No	Select the appropriate radio button.  Additional requirements can be found at <a href="https://regs.health.ny.gov/content/section-69-45-approval-service-coordinators-evaluators-and-service-providers">https://regs.health.ny.gov/content/section-69-45-approval-service-coordinators-evaluators-and-service-providers</a> . If you have specific questions about the individual approval, please contact the Bureau's Provide Approval Unit at (518) 473-7016, press '1,' or email provider@health.ny.gov.
Are you on an H-1B Visa? *	Required, Yes or No	Select the appropriate radio button.  Select 'Yes,' the system displays the following message:  Additional requirements can be found at <a href="https://regs.health.ny.gov/content/section-69-45-approval-service-coordinators-evaluators-and-service-providers">https://regs.health.ny.gov/content/section-69-45-approval-service-coordinators-evaluators-and-service-providers</a> . If you have specific questions about the individual approval, please contact the Bureau's Provide Approval Unit at (518) 473-7016, press '1,' or email provider@health.ny.gov.



The button description table below applies to all the following screens/panels as we advance.

BUTTON	DESCRIPTION
Next Tab 	Click this button to advance to the next tab on the screen (panel). Alternatively, click the next tab on the top (below the screen's header name).  <b>(i)</b> This button appears in the remaining tabs after advancing to the second tab on the screen.
Previous Tab 	To return to the previous tab. Click this button.  <b>(i)</b> This button appears in the remaining tabs after advancing to the second tab on the screen.
Save Progress 	Click this button to save your data entry progress before submitting your application.
Submit Application 	Click this button if you have completed all the tabs and are ready to submit your application.  <b>(i)</b> Applicant - Individual PAST > 'SSN' field: If you submit the PAST without this required field, the box is red, but the error message appears above the NPI field below. This functionality is due to the fact that the NPI field behaves differently due to the new NPI process.

### 7.3.2 Contact Information Tab

 Please save your progress often and remember that you can only save if no errors are resolved. The submit application button will systematically review your application and report any errors. Successful PAST submission will result in an on-screen message and email notification detailing the next steps.

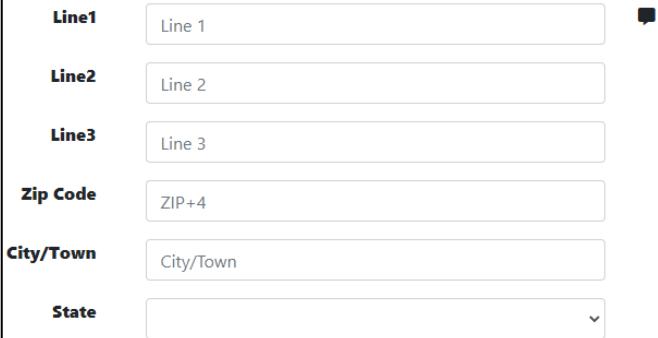
## Pre-Application Screening Tool

Individual Form

DUPLICATE CHECK
Contact Information
Professions
Employment History
Attestation

<b>Primary Phone Number *</b> <i>Enter the best way to contact you by phone during working hours.</i>	<input style="width: 100%; height: 25px; border: 1px solid #ccc; padding: 2px; margin-bottom: 5px;" type="text"/>
<b>Primary Email Address *</b> <i>Re-enter the same email for verification</i>	
<b>Mailing Address *</b> <i>Enter the address where mail is actually delivered. Enter the Zip +4, if you know it. Otherwise, just enter the ZIP and the +4 can be determined from the other fields. ZIP +4 will autopopulate the City &amp; State.</i>	<b>Email</b> <input style="width: 100%; height: 25px; border: 1px solid #ccc; padding: 2px; margin-bottom: 5px;" type="text"/> <b>Email (verify)</b> <input style="width: 100%; height: 25px; border: 1px solid #ccc; padding: 2px; margin-bottom: 5px;" type="text"/>
<b>Line1</b> <input style="width: 100%; height: 25px; border: 1px solid #ccc; padding: 2px; margin-bottom: 5px;" type="text"/> <b>Line2</b> <input style="width: 100%; height: 25px; border: 1px solid #ccc; padding: 2px; margin-bottom: 5px;" type="text"/> <b>Line3</b> <input style="width: 100%; height: 25px; border: 1px solid #ccc; padding: 2px; margin-bottom: 5px;" type="text"/>	
<b>Zip Code</b> <input style="width: 100%; height: 25px; border: 1px solid #ccc; padding: 2px; margin-bottom: 5px;" type="text"/>	
<b>City/Town</b> <input style="width: 100%; height: 25px; border: 1px solid #ccc; padding: 2px; margin-bottom: 5px;" type="text"/>	
<b>State</b> <input style="width: 100%; height: 25px; border: 1px solid #ccc; padding: 2px; margin-bottom: 5px;" type="text"/>	
<b>Mailing and physical location addresses are the same? *</b> <i>If your physical location is the same as the mailing address, indicate that here. Otherwise, enter the location where you are actually located. The physical address is the location where your records and files are maintained.</i>	
<input type="radio"/> Yes <input type="radio"/> No	
<b>Physical Location Address</b> <i>Enter the Zip +4, if you know it. Otherwise, just enter the ZIP and the +4 can be determined from the other fields. ZIP +4 will autopopulate the City &amp; State.</i>	
<b>Line1</b> <input style="width: 100%; height: 25px; border: 1px solid #ccc; padding: 2px; margin-bottom: 5px;" type="text"/> <b>Line2</b> <input style="width: 100%; height: 25px; border: 1px solid #ccc; padding: 2px; margin-bottom: 5px;" type="text"/> <b>Line3</b> <input style="width: 100%; height: 25px; border: 1px solid #ccc; padding: 2px; margin-bottom: 5px;" type="text"/>	
<b>City/Town</b> <input style="width: 100%; height: 25px; border: 1px solid #ccc; padding: 2px; margin-bottom: 5px;" type="text"/>	
<b>State</b> <input style="width: 100%; height: 25px; border: 1px solid #ccc; padding: 2px; margin-bottom: 5px;" type="text"/>	
<b>Zip Code</b> <input style="width: 100%; height: 25px; border: 1px solid #ccc; padding: 2px; margin-bottom: 5px;" type="text"/>	
Please save your progress often and remember that you can only save if there are no errors to be resolved. The submit application button will initiate a system review of your application and report any errors. Successful submission of the PAST will result in an on-screen message and email notification detailing next steps.	
<span style="border: 1px solid #ccc; padding: 2px; margin-right: 10px;">Previous Tab</span> <span style="border: 1px solid #ccc; padding: 2px; margin-right: 10px;">Next Tab</span> <span style="background-color: #0070C0; color: white; border: 1px solid #0070C0; padding: 2px 10px; border-radius: 5px; cursor: pointer;">Save Progress</span> <span style="background-color: #0070C0; color: white; border: 1px solid #0070C0; padding: 2px 10px; border-radius: 5px; cursor: pointer;">Submit Application</span>	

FIELD		DESCRIPTION
<b>Primary Phone Number *</b> <i>The best way to contact you by phone during working hours.</i>	<input style="width: 100%; height: 25px; border: 1px solid #ccc; padding: 2px; margin-bottom: 5px;" type="text"/>	Required, Numeric Entry

FIELD		DESCRIPTION
<b>Primary Email Address *</b> <div style="background-color: black; color: white; padding: 5px;">           The best way to contact you by email during working hours.         </div>	Required, Text Entry	<ul style="list-style-type: none"> <li><b>Email:</b> Enter the best email address to reach (e.g., while at work) the Main Contact Person by email.</li> <li><b>Email (verify):</b> Re-enter the same email for verification.</li> </ul> <p><b>i</b> Please ensure that this email is correct and that you are actively monitoring this email account for correspondence related to your application; this is the method the NYS DOH Provider Approval Unit (PAU) will use to contact you regarding your application.</p>
<b>Mailing Address *</b> <div style="background-color: black; color: white; padding: 5px;">           If entering a PO Box in any of the 3 address fields, please do not enter the periods(.).         </div>	Required, Text Entry	<p><b>The process follows:</b> The provider enters their address, and it's verified with USPS.</p> <ul style="list-style-type: none"> <li>If USPS indicates that <b>line 2</b> is required (no listing exists without line 2), then the system requires info for line 2. The info entered in line 2 is not verified, but you must enter something on that line.</li> <li>If USPS shows both addresses with/without a line 2 at that location, the system does not require a line 2.             <ul style="list-style-type: none"> <li><b>Line1:</b> Enter the address where mail is physically delivered.</li> <li><b>Line2:</b> If applicable</li> <li><b>Line3:</b> If applicable</li> <li><b>Zip Code:</b> Enter the Zip +4.</li> <li><b>City/Town:</b> Enter the city/town where mail is physically delivered.</li> <li><b>State:</b> Use the drop-down and select the state where mail is physically delivered.</li> </ul> </li> </ul>  <p><b>i</b> Enter the Zip +4 if you know it. Otherwise, enter the Zip to determine the +4 from the other fields. For example, zip +4 will auto-populate the City and State.</p>
<b>Mailing and physical location address are the same? *</b>	Required, Yes or No	<p>Select the appropriate radio button.'</p> <p><b>i</b> If your physical location is the same as the mailing address, indicate that here. Otherwise, enter the location where you are located. The physical address is the location where your records and files are maintained.</p>

FIELD		DESCRIPTION
<b>Physical Location Address</b>  This field may not contain PO Boxes	Required, Text Entry	<ul style="list-style-type: none"> <li><b>Line1:</b> Enter the address where mail is physically delivered.</li> <li><b>Line2:</b> If applicable</li> <li><b>Line3:</b> If applicable</li> <li><b>Zip Code:</b> Enter the Zip +4.</li> </ul>  <p><i>(i)</i> Enter the address where mail is delivered. Enter the Zip +4 if you know it. Otherwise, enter the Zip to determine the +4 from the other fields. For example, zip +4 will auto-populate the City and State.</p>

### 7.3.3 Professions Tab – Professions Panel – Grid/Table

 Enter each profession you seek approval for and the corresponding license/certification numbers; include all licenses held while obtaining the required 1,000 hours of the required experience.

#### Provider Application Screening Tool

Individual Form

[DUPLICATE CHECK](#) [Contact Information](#) [Professions](#) [Employment History](#) [Attestation](#)

In this tab the applicant will select one or more professions and provide a license/certification control number for each. Applicants should enter all licenses/certifications in effect while obtaining the required 1600 hours of experience, including any out of state licenses or certifications.

Professions Panel

Profession	License/Certification Control Number	Actions

[Add Profession](#)
[Previous Tab](#)
[Next Tab](#)
[Save Progress](#)
[Submit Application](#)

COLUMN	DESCRIPTION
Profession	After adding a profession, this column displays the type of profession (e.g., Audiologist).
License/Certification Control Number	After adding a profession, this column displays the license/certification control number.  <b>(i)</b> Please add the license or certification number exactly as identified in the NYS Education Department Office of Professions Online Verification system or the NYS Education Department TEACH Online Verification system.
Actions	After adding a profession, this column displays <b>Display   Delete   Edit</b> hyperlinks.

BUTTON	DESCRIPTION
<a href="#">Add Profession</a>	To add details to the Professions Panel, click this button. When clicked, a popup panel appears (example below).

### 7.3.3.1 Professional Panel

 The applicant will select one or more professions in this tab and provide a license/certification control number. Applicants should enter all licenses/certifications while obtaining 1,000 hours of experience, including out-of-state licenses or certifications. The professions included in the drop-down values are the professions that are recognized in the EIP for service delivery. To apply for individual approval and deliver EIP services, you must hold a valid/current license or certification in one of these professions.

Please save your progress often and remember that you can only save if no errors are resolved. The submit application button will systematically review your application and report any errors. Successful PAST submission will result in an on-screen message and email notification detailing the next steps.

Professions Panel

Enter each profession you are seeking approval for and the related license/certification numbers; include all licenses held while obtaining the required 1600 hours of required experience.

<b>Profession *</b>	<input type="text"/>
<b>License/Certification Control Number *</b>	<input type="text"/>

**Close** **Save changes**

Professions Panel

<b>Profession *</b>	<input type="text" value="Physician"/>
<b>Profession Specialty *</b>	<input type="text"/>
<b>License/Certification Control Number *</b>	<input type="text"/>
<b>License/Certification Type *</b>	<input type="text" value="Supervised Experience"/>
<b>License/Certification Effective Date *</b>	<input type="text" value="mm/dd/yyyy"/> 
<b>License/Certification Expiration Date *</b>	<input type="text" value="mm/dd/yyyy"/> 

**Close** **Save changes**

FIELD	FIELD TYPE	DESCRIPTION
<b>Profession *</b>	Required, Drop-Down	Select the appropriate profession from the list.   Selecting ‘Physician’ from the Profession drop-down list, an “Individual Specialty” field appears (example below).

FIELD	FIELD TYPE	DESCRIPTION
		<p><b>Profession *</b></p> <input type="text" value="Physician"/> <p><b>Individual Specialty *</b></p> <input type="text"/> <p><b>License/Certification Control Number *</b></p> <input type="text"/>
<b>License/Certification Control Number *</b>	Required, Text Entry	<p>Enter your license/certification control number.</p> <p><b>(i)</b> Please add the license or certification number exactly as identified in the NYS Education Department Office of Professions Online Verification system or the NYS Education Department TEACH Online Verification system.</p>

BUTTON	DESCRIPTION						
<b>Close</b>	When clicked, changes do not save, and it closes the popup panel.						
<b>Save Changes</b>	<p>To save your data entry, click this button. When clicked, the system saves the popup panel changes, closes it, and displays the listings you made (an example below).</p> <div style="border: 1px solid black; padding: 10px;"> <p>Professions Panel</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Profession</th> <th style="text-align: left;">License/Certification Control Number</th> <th style="text-align: right;">Actions</th> </tr> </thead> <tbody> <tr> <td>Audiologist</td> <td>20014556</td> <td style="text-align: right;"><a href="#">Display</a>   <a href="#">Delete</a>   <a href="#">Edit</a></td> </tr> </tbody> </table> </div> <p><b>(i)</b> The three (3) hyperlink labels and their descriptions are as follows:</p> <ul style="list-style-type: none"> <li>• <b>Display:</b> When clicked, the Professions popup panel appears (read-only).</li> <li>• <b>Delete:</b> When clicked, the Professions popup panel appears with 'Close' (gray button) and 'Delete' (red button). <ul style="list-style-type: none"> <li>○ To cancel the deletion, click the <b>Close</b> button.</li> <li>○ To confirm the removal of the record, click the <b>Delete</b> button. The record is removed (deleted) from the Professions Panel when clicked.</li> </ul> </li> <li>• <b>Edit:</b> When clicked, the Professions popup panel appears (edit mode).</li> </ul> <p><b>(i)</b> The 'Close' and 'Save Changes' buttons work the same as described above.</p>	Profession	License/Certification Control Number	Actions	Audiologist	20014556	<a href="#">Display</a>   <a href="#">Delete</a>   <a href="#">Edit</a>
Profession	License/Certification Control Number	Actions					
Audiologist	20014556	<a href="#">Display</a>   <a href="#">Delete</a>   <a href="#">Edit</a>					

### 7.3.4 Employment History Tab

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

1. A minimum of 1000 clock hours of experience in a clinical pediatric, early intervention, or early childhood program delivering services to children under five years old, including children with disabilities and their families.
2. Supervised experience required for licensure or certification may be counted toward this requirement, such as clinical experience in a clinical pediatric, early intervention, or early childhood education program that delivers services to children aged birth to five years, including children with disabilities. Indicate a minimum of 1000 clock hours/clinical experience (listing the most recent experience first).
  - a. You provided direct therapeutic/clinical services in your discipline to infants and young children (aged birth to 5 years) and their families in the settings described above. Also, it 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.
  - b. This information may be verified as part of the Bureau of Early Intervention provider application process.

 Please enter each employer separately.

### Pre-Application Screening Tool

Individual Form

[DUPLICATE CHECK](#) [Contact Information](#) [Professions](#) [Employment History](#) [Attestation](#)

The following experience requirements apply to all individuals seeking approval to provide early intervention services as a professional individual provider: (1) 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. (2) 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. 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. Provide the following information for each employer to be counted towards satisfying this requirement.

Employment History Panel

Employer Name	Type of Employment	Employment Setting	Hours per Week	Hours Employed	Actions

[Add Employer](#)

**Total hours of all Employers combined:**

0

[Previous Tab](#)

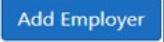
[Next Tab](#)

[Save Progress](#)

[Submit Application](#)

### 7.3.4.1 Employment History Panel Grid/Table

COLUMN	DESCRIPTION
<b>Employer Name</b>	This column displays the employer's name.
<b>Type of Employment</b>	This column displays the type of employment (e.g., Employed, Contract).
<b>Employment Setting</b>	This column displays the employment setting (e.g., Clinic).
<b>Hours per Week</b>	This column displays the hours per week the Provider worked delivering direct services to children aged birth up to five (5) years old.
<b>Hours Employed</b>	<p>This column displays the total hours employed.</p> <p>This column is a system-generated field.</p>
<b>Actions</b>	After adding a profession, this column displays <b>Display   Delete   Edit</b> hyperlinks.
<b>Total hours of all Employers combined</b>	This field displays the total hours of ALL Employers combined.

BUTTON	DESCRIPTION
<b>Add Employer</b> 	To add details to the Employment History Panel, click this button. When clicked, a popup panel appears (example below).

### 7.3.4.2 Employment History Panel

**Employment History Panel**

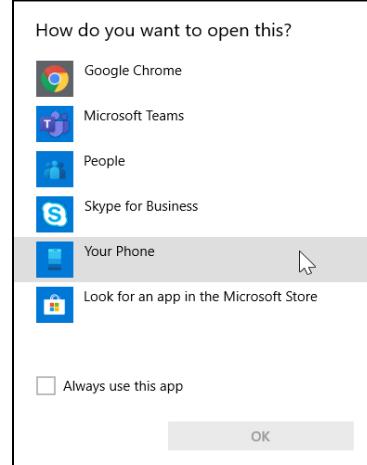
<b>Employer Name *</b>	<input type="text"/>
<b>Employer Address *</b>	<b>Line1</b> <input type="text"/> <b>Line2</b> <input type="text"/> <b>Line3</b> <input type="text"/>
<b>Zip Code</b>	<input type="text"/>
<b>City/Town</b>	<input type="text"/>
<b>State</b>	<input type="text"/>
<b>Phone Number *</b>	<input type="text"/>
<b>Type of Employment *</b>	<input type="text"/>
<b>Employment Setting *</b>	<input type="text"/>
<b>Employment Start Date *</b>	<input type="text"/>
<b>Employment End Date</b>	<input type="text"/>
<b>Hours per Week *</b>	<input type="text"/>
<b>Hours Employed</b>	<input type="text"/>

**Close** **Save changes**

FIELD	FIELD TYPE	DESCRIPTION
<b>Employer Name *</b>	Required, Text Entry	Enter the name of the employer for the Individual Provider.
<b>Employer Address *</b>  <small>If entering a PO Box in any of the 3 address fields, please do not enter the periods(.)</small>	Required, Text Entry	<ul style="list-style-type: none"> <li>• <b>Line1:</b> Enter the address where mail is physically delivered.</li> <li>• <b>Line2:</b> If applicable</li> <li>• <b>Line3:</b> If applicable</li> <li>• <b>Zip:</b> Enter the Zip +4</li> <li>• <b>City/Town:</b> Enter the city/town where mail is physically delivered.</li> <li>• <b>State:</b> Use the drop-down and select the state where mail is physically delivered.</li> </ul>

FIELD	FIELD TYPE	DESCRIPTION
<b>Employer Phone Number *</b>	Required, Numeric Entry	Enter the best phone number to reach the employer.
<b>Type of Employment *</b>  Select only 1 for each row 	Required, Drop-Down	Select the appropriate type of employment from the list.
<b>Employment Setting *</b>	Required, Drop-Down	Select the appropriate employment setting for the employer.
<b>Employment Start Date *</b>	Required, Date/ Calendar	Manually enter or use the calendar picker for the start date for the individual provider working for the employer.
<b>Employment End Date</b>	Required, Date/ Calendar	Manually enter or use the calendar picker for the end date for the individual provider working for the employer.
<b>Hours per Week *</b>  Only include time spent with birth to 5-year-olds 	Required, Text Entry	Enter the work hours per week that you worked explicitly with children aged birth to five (5) years old.
<b>Calculated Total Hours</b>	Optional, Text Entry	Based on the Employment Start Date, Employment End Date (if applicable), and Hours per Week (worked), the system uses the date duration built-in calculator to determine the number of days and hours between the times on two dates.

BUTTON	DESCRIPTION																		
<b>Close</b>  	When clicked, changes do not save, and it closes the popup panel.																		
<b>Save Changes</b>  	To save your data entry, click this button. When clicked, the system saves the popup panel changes, closes it, and displays the listings you made (an example below). <div style="border: 1px solid black; padding: 10px; margin-top: 10px;"> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="6">Employment History Panel</th> </tr> <tr> <th>Employer Name</th> <th>Type of Employment</th> <th>Employment Setting</th> <th>Hours per Week</th> <th>Calculated Total Hours</th> <th>Actions</th> </tr> </thead> <tbody> <tr> <td>John Doe</td> <td>Employed</td> <td>EI Program</td> <td>40</td> <td>2118</td> <td><a href="#">Display</a>   <a href="#">Delete</a>   <a href="#">Edit</a></td> </tr> </tbody> </table> </div> <p><b>Note</b> the three (3) hyperlink labels and their descriptions below:</p> <ul style="list-style-type: none"> <li>• <b>Display:</b> When clicked, the Employment History Panel popup panel appears (read-only).</li> <li>• <b>Delete:</b> When clicked, the Employment History panel appears with two buttons, 'Close' (gray) and 'Delete' (red).           <ul style="list-style-type: none"> <li>○ To cancel the deletion, click the <b>Close</b> button.</li> </ul> </li> </ul>	Employment History Panel						Employer Name	Type of Employment	Employment Setting	Hours per Week	Calculated Total Hours	Actions	John Doe	Employed	EI Program	40	2118	<a href="#">Display</a>   <a href="#">Delete</a>   <a href="#">Edit</a>
Employment History Panel																			
Employer Name	Type of Employment	Employment Setting	Hours per Week	Calculated Total Hours	Actions														
John Doe	Employed	EI Program	40	2118	<a href="#">Display</a>   <a href="#">Delete</a>   <a href="#">Edit</a>														

BUTTON	DESCRIPTION
	<ul style="list-style-type: none"> <li>○ To confirm the removal of the record, click the <b>Delete</b> button. The record is removed (deleted) from the Professions Panel when clicked.</li> <li>● <b>Edit:</b> When clicked, the Employment History popup panel appears (edit mode).</li> </ul> <p><b>(i)</b> The ‘Close’ and ‘Save Changes’ buttons work the same as described above.</p> <p><b>(i)</b> While the Employment History Panel displays when clicking either the ‘Display’ or ‘Delete’ hyperlinks, the Employer Phone Number is also hyperlinked (an example below).</p>  <p><b>(i)</b> Clicking the phone number hyperlink, your Windows OS application selection pad (example shown below) prompts you to make the call by choosing an app (if configured by your IT Admin).</p> 

### 7.3.5 Attestation Tab / Panel

 Save your progress and review the other tabs, making necessary corrections. Once satisfied with the entered information, select the Submit Application button. The system will then review your submission for completeness and notify you if any required fields have been missed. Completed applications will be reviewed for eligibility in the EI program against a set of established requirements. On-screen and email notifications of the results will be instantaneous, allowing you to make any necessary corrections, resubmit the application, begin the PAT immediately, or return later.

"I hereby certify, under penalty of perjury, that I am duly authorized to subscribe and submit this application and that the information contained herein and uploaded 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."

Please save your progress often and remember that you can only save if no errors are resolved. The submit application button will systematically review your application and report any errors. **Successful PAST submission** will result in an on-screen message and email notification detailing the next steps.

 **Unsuccessful PAST submissions that cause denials get onscreen notifications.**

## Pre-Application Screening Tool

Individual Form

DUPLICATE CHECK Contact Information Professions Employment History Attestation

Save your progress and review the other tabs, making any corrections as needed. Once you are satisfied with the entered information, select the Submit Application button. The system will then review your submission for completeness and notify you if any required fields have been missed. Completed applications will be reviewed for eligibility in the EI program against a set of established requirements. On-screen and email notification of the results will be instantaneous, allowing you to make any necessary corrections and resubmit the application or begin the PAT immediately, or return later.

I hereby certify under penalty of perjury, that I am duly authorized to subscribe and submit this application and that the information contained herein and uploaded 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.

<b>First Name of Person Submitting Application *</b>	<input type="text"/>
<b>Middle Name/Initial of Person Submitting Application</b>	<input type="text"/>
<b>Last Name of Person Submitting Application *</b>	<input type="text"/>
<b>Submission Date *</b>	<input type="text" value="3/7/2022"/>

Please save your progress often and remember that you can only save if there are no errors to be resolved. The submit application button will initiate a system review of your application and report any errors. Successful submission of the PAST will result in an on-screen message and email notification detailing next steps.

[Previous Tab](#)

[Save Progress](#)
[Submit Application](#)

FIELD	FIELD TYPE	DESCRIPTION
<b>First Name of Person Submitting Application *</b>	Required, Text Entry	Enter the first name of the person applying.
<b>Middle Name/Initial of Person Submitting Application</b> <small>If entering an initial, please do not enter the period (.)</small>	Required, Text Entry	Enter the middle name or middle initial of the person applying.
<b>Last Name of Person Submitting Application *</b>	Required, Text Entry	Enter the last name of the person applying.
<b>Submission Date *</b>	System Generated, Date/Calendar	The system populates the current submission date for the Individual Provider application. (Read-Only field)

BUTTON	DESCRIPTION
<b>Submit Application</b> 	Click this button if you have completed all the tabs and are ready to submit your application.



**(i)**This section concludes the Individual Provider Pre-Application Screening Tool (PAST) enrollment process. Please refer to the [PAT Individual Applications](#) section in this User Guide.

## Unit 8. PAST Agency and PAST Individual Applications

### 8.1 PAST



Individuals wishing to provide early intervention services as an independent provider, contractor of an approved early intervention agency provider, and agencies interested in becoming NYS Early Intervention providers will need to visit the EI Hub website <https://pem.prod.nyeihub.com/> and navigate to the information about becoming an early intervention provider.

- Potential providers will originate an account by creating a username and password. Establishing an account will enable the applicant to return to review, respond to requests for additional information, and resubmit additional Pre-Application Screening Tools (PASTs). It will also enable the system to store the data for future NYS data mining and report purposes (e.g., comparing the number of PAST submissions with the number of completed applications and analyzing the types of professions completing the PAST).
- The information page will contain a link to the web-based PAST, which will help potential providers determine if they qualify as individual or agency providers before accessing and completing the full application. Applicants will first see how BEI defines the two categories (as shown below) and choose only one.

An **Agency Provider** is an entity that employs qualified personnel and may contract with DOH-approved individual or agency providers for the provision of early intervention program evaluations, service coordination, and/or services.

- An agency must have an early intervention program director and employ at least two additional qualified personnel who deliver EI services for a minimum of 20 hours per week.
- Qualified personnel are those individuals who are approved as required by Subpart 69-4 to deliver services to the extent authorized by their licensure, certification, or registration to eligible children and have appropriate licensure, certification, or registration in the area where they are providing services.
- Only a designated representative from an agency should submit the PAST (e.g., agency owner, program director, clerical administrator, primary contact).
- Agencies need to identify the following:
  - a. A qualified and authorized representative to complete the PAST on behalf of the organization and serve as the primary contact for the Agency.
  - b. In addition, the representative must have access to the information and documentation required to complete the tools.

An **Individual Provider** is a person who holds a New York State certificate or license with a current registration in the professions outlined in the early intervention regulations who wishes to contract (paid with 1099) with either a municipality or agency provider or take cases directly (requiring the provider to submit claims to Medicaid and insurance).

- Individual providers may operate under their legal name (with a Social Security Number) or a business name (with a Federal Employee Identification Number).
- Once the applicant has selected the provider type, the appropriate PAST will generate and require completion. Suppose the applicant successfully fulfills all the requirements of the PAST. In that case, they will receive an on-screen and email message notifying them of the results, any next steps, and BEI contact information if any follow-up is needed.
- If the applicant does not successfully fulfill the PAST requirements, they are notified that they were unsuccessful upon submission. The data point(s) that do not meet the minimum

requirements are identified. The applicant will receive both on-screen and email messages explaining the reason(s) they were unsuccessful. Specific information and links to resources are also provided if the results of the PAST indicate the applicant does not currently qualify to provide early intervention services in NYS. BEI contact information will also be provided.

- Accepted submissions will generate a congratulatory message and email containing the link (URL) to the full application and a checklist of required documentation. A contact phone number and email for the BEI are included in all messages. Please see sample messages in the table below, noting that some messages will be exclusive to Individual or agency applications, and others will apply to both.



The examples below show the PAST Agency Applications and PAST Individual Applications are successfully submitted/approved.

## PAST Agency Applications

Created Date	Last Modified Date	Status	Actions
12/8/2020	12/15/2020	Approved by	<a href="#">View</a>

## PAST Individual Applications

Created Date	Last Modified Date	Status	Actions
12/9/2020	12/15/2020	Approved by	<a href="#">View</a>



The next panel shows your record submission when successfully submitted/validated by the system. Use the 'Print' button located at the panel/screen bottom for your records.

Print



After successfully submitting your PAST (Agency or Individual) application, your application 'Status' appears in the 'PAT Agency Applications' history panel as 'Active' (shown below Unit 9.).

## Unit 9. PAT Agency Applications

### PAT Agency Applications

Created Date	Last Modified Date	Status	Actions
12/15/2020	12/15/2020	Active	<a href="#">Edit</a> 

Once the PAST has been approved, the PAT (Provider Application Tool) needs to be completed and submitted. The PAT may be initiated by clicking the link in the on-screen or email notifications. Alternatively, select the **Edit** link on the Homepage under the PAT Agency Applications section.

"Thank you for your interest in becoming an EI provider in NYS. Your Pre-Application Screening Tool has been successfully submitted. The link to complete your Provider Application Tool is [here](#). This link is unique to your account and should not be shared with or forwarded to others. Please monitor your email for correspondence confirming successful submission and instructions on how to proceed to the next step in the application process. Contact [provider@health.ny.gov](mailto:provider@health.ny.gov) if you have not received an email within three (3) business days. It will facilitate the completion of the application if you have the following information easily accessible."

 Users can also access this screen by clicking on the link in the auto-generated email they will receive.

#### 9.1 Agency PAT Fields

 The information entered in the Agency PAST will transfer to the Agency PAT, eliminating the need to re-enter the information. Screen navigation is the same as in the PAST. Successful submission of the PAT will result in your application being reviewed for approval by the BEI Provider Approval Unit.

#### 9.2 Basic Information Tab / Panel

 Congratulations on the successful submission of your PAST. The information entered in the PAST was transferred to the PAT, eliminating the need to reenter the same information. You always have the option to update these pre-filled fields if the information is no longer accurate. Please review each tab and panel and complete all appropriate fields, including the required fields. Screen navigation is the same as in the PAST.

Please save your progress often and remember that you can only save if all required fields on the page have been completed and there are no errors to be resolved. The submit application button will systematically review your application and report any errors. Successful submission of the PAT will result in your application being reviewed for approval by the BEI Provider Approval Unit.

## Agency Application

Basic Information   Director   Agency Background   Disclosures   Seeking to Provide   Uploads   Agreements

Congratulations on the successful submission of your PAST. The information you entered in the PAST has been transferred to the PAT, eliminating the need to reenter the same information. Please review each tab and panel, completing all appropriate fields, including all required fields. Screen navigation is the same as in the PAST.

### Contact Info

#### Applicant ID

1040

#### Agency Legal Name \*

1 AMBULETTE INC

#### Doing Business As

#### FEIN \*

12-3344567

#### National Provider Identifier (NPI) \*

1548866189

#### Website

#### Agency Primary Phone Number \*

(518) 951-5555

#### Agency Fax Number

(ddd) ddd-dddd

#### Mailing Address \*

Enter the address where mail is actually delivered.

#### Line1

236 SHERIDAN AVE

#### Line2

Line 2

#### Line3

Line 3

#### Zip Code

12210-2409

#### City/Town

ALBANY

#### State

New York

#### Physical Location Address \*

Location where files and records are maintained

#### Line1

1 AMBULETTE INC

#### Line2

Line 2

#### Line3

Line 3

#### City/Town

Albany

#### State

New York

#### Zip Code

Zip +4

Albany

#### County/Borough \*

#### Does your Billing/Claiming address match one of the addresses previously entered? \*

- Mailing
- Physical
- Neither

#### Billing Address \*

Address to which all claims payments are to be sent

#### Line1

236 SHERIDAN AVE

#### Line2

Line 2

#### Line3

Line 3

#### Zip Code

12210-2409

#### City/Town

ALBANY

#### State

New York

#### Agency Main Contact Person Salutation \*

Mr.

#### Agency Main Contact Person First Name \*

Steve

#### Agency Main Contact Person Middle Name/Initial

#### Agency Main Contact Person Last Name \*

Austin

#### Main Contact Person AKA/Maiden name

#### Agency Main Contact Person Title \*

Bionics Department

#### Main Contact Person's Primary Email \*

#### Email (verify)

austin.s@AMBULETTE.com

Re-enter the same email for verification.

austin.s@AMBULETTE.com

#### Main Contact Person Primary Phone Number \*

(518) 951-5554

#### Main Contact Person Fax Number

(ddd) ddd-dddd

Please save your progress often and remember that you can only save if all required fields on the page have been completed and there are no errors to be resolved. The submit application button will initiate a system review of your application and report any errors. Successful submission of the PAT will result in your application being reviewed for approval by the BEI Provider Approval Unit.

Next Tab

Save Progress

Submit Application



## Excerpt of the Agency Application - Basic Information Tab (below)

- County/Borough \***: Use the drop-down and select the appropriate county/borough that matches the list's location address. Please note the county/borough is not a validated field. Users should verify the county/borough selected is accurate.
- Does your Billing/Claiming address match one of the addresses previously entered? \***: Select the appropriate radio button (Mailing, Physical, or Neither).
- Billing Address**: Enter the address to send all claims payments.



If the physical location address is not in NY, additional checkboxes appear to capture the agency's other states (example below).

State(s) in which the Agency Operates other than New York State	
<b>State *</b>	<input type="checkbox"/> Alabama <input type="checkbox"/> Alaska <input type="checkbox"/> Arizona <input type="checkbox"/> Arkansas <input type="checkbox"/> California <input type="checkbox"/> Colorado <input type="checkbox"/> Connecticut <input type="checkbox"/> Delaware <input type="checkbox"/> District of Columbia <input type="checkbox"/> Florida <input type="checkbox"/> Georgia <input type="checkbox"/> Hawaii <input type="checkbox"/> Idaho <input type="checkbox"/> Illinois <input type="checkbox"/> Indiana <input type="checkbox"/> Iowa <input type="checkbox"/> Kansas <input type="checkbox"/> Kentucky <input type="checkbox"/> Louisiana <input type="checkbox"/> Maine <input type="checkbox"/> Maryland <input type="checkbox"/> Massachusetts <input type="checkbox"/> Michigan <input type="checkbox"/> Minnesota <input type="checkbox"/> Mississippi <input type="checkbox"/> Missouri <input type="checkbox"/> Montana <input type="checkbox"/> Nebraska <input type="checkbox"/> Nevada <input type="checkbox"/> New Hampshire <input type="checkbox"/> New Jersey <input type="checkbox"/> New Mexico <input type="checkbox"/> North Carolina <input type="checkbox"/> North Dakota <input type="checkbox"/> Ohio <input type="checkbox"/> Oklahoma <input type="checkbox"/> Oregon <input type="checkbox"/> Pennsylvania <input type="checkbox"/> Rhode Island <input type="checkbox"/> South Carolina <input type="checkbox"/> South Dakota <input type="checkbox"/> Texas <input type="checkbox"/> Tennessee <input type="checkbox"/> Vermont <input type="checkbox"/> Utah <input type="checkbox"/> Washington <input type="checkbox"/> Virginia <input type="checkbox"/> Wisconsin <input type="checkbox"/> West Virginia <input type="checkbox"/> American Samoa <input type="checkbox"/> Guam <input type="checkbox"/> Northern Mariana Islands <input type="checkbox"/> Puerto Rico <input type="checkbox"/> US Virgin Islands



The Provider Enrollment application will indicate the required information to submit a PAT application. For example, message bars appear on top of your screen when you click the Save Progress button at the bottom of the Basic Information form (shown below). You cannot successfully submit your application to the state until all listed errors are cleared.

X
 Record saved

X
 Upload IRS FEIN Assignment Letter (required): This field is required.

X
 Upload Program Standards Table of Contents and Outline (required): This field is required.

X
 Upload Statement of Fiscal Viability (required): This field is required.

X
 Upload NYS DMV Driver's License or Non-driver photo ID or other photo identification if outside of NYS of the Authorized Representative submitting the application: This field is required.

## 9.2.1 Director Tab

**(i)** The Agency PAT, Director tab/Director Section, Director Profession, Director Experience, Out of State Addresses panels & Disclosures tab, and related panels, many fields will pre-fill. Review this information carefully for accuracy. If inaccurate, update.

### 9.2.1.1 Director Panel

**Agency Application**

Basic Information   Director   Agency Background   Disclosures   Seeking to Provide   Uploads   Agreements

Director

**Is the Director also the Agency's Main Contact Person? \***

Yes  
 No

**Director's Salutation \***

Mr.

**Director's First Name \***

Steve

**Director's Middle Name/Initial**

**Director's Last Name \***

Austin

**Director's Suffix**

**Director's AKA Name**

**Director's Date of Birth \***

mm/dd/yyyy

**Director Social Security Number \***

ddd dd dddd

**Director's Effective Date with this Agency \***

mm/dd/yyyy

**Director's HCS Username**

**Alternate ID**

**Director's Office Phone Number**

(518) 951-5554

**Primary Email \***  
Re-enter the same email for verification

**Email** austin.s@AMBULETTE.com

**Email (verify)** austin.s@AMBULETTE.com

**Home Mailing Address \***

**Line1** Line 1

**Line2** Line 2

**Line3** Line 3

**Zip Code** ZIP+4

**City/Town** City/Town

**State**

**Mailing and Physical location addresses are the same? \***

Yes  
 No

**Physical Location Address \***

**Line1** 235 Sheridan Ave

**Line2** Line 2

**Line3** Line 3

**City/Town** Albany

**State** New York

**Zip Code** Zip+4

FIELD	FIELD TYPE	DESCRIPTION
Is the Director also the Agency's Main Contact Person? *	From PAST	<p>Select the appropriate radio button ('Yes' or 'No').</p> <p>(i)</p> <ul style="list-style-type: none"> <li>• Selecting the 'Yes' radio button pre-fills the salutation and name fields below.</li> <li>• Selecting 'Yes' under this person, the Program Director will cause multiple fields to pre-fill.</li> <li>• Changing the Yes to a 'No' doesn't clear the populated info.</li> <li>• Changing populated fields to the correct info is the same keystroke as entering the same info on a blank panel.</li> <li>• Please review the information carefully to ensure you have updated all the fields with accurate information.</li> </ul>
Director's Salutation *	From PAST	Use the drop-down and select the appropriate salutation from the list.
Director's First Name *	From PAST	Enter the director's first name.
Director's Middle Name/Initial <small>If entering an initial, please do not enter the period (.)</small>	From PAST	Enter the director's middle name or initial.
Director's Last Name *	From PAST	Enter the director's last name.
Director's Suffix	From PAST	Use the drop-down and select the appropriate suffix from the list.
Director's AKA Name <small>Enter the name others would associate with you, if different from your First Name, or record your former name here (maiden name)</small>	Optional, Text Entry	Enter the name that others would associate with the director if it were different from the director's first name, or record the director's former name here if it has recently changed (e.g., maiden name).
Director's Date of Birth *	Required, Date/Calendar	Manually enter or use the calendar picker for the director's date of birth.
Director's Social Security Number *	Required, Numeric	Enter the director's social security number.
Director's Effective Date with this Agency *	Required Date/Calendar	Manually enter or use the calendar picker for the effective date for the director working for the agency.
Director's HCS Username	Optional, Text Entry	Enter the director's Health Commerce System (HCS) username.

FIELD	FIELD TYPE	DESCRIPTION
If already provided (assigned), otherwise leave blank <input type="checkbox"/>		
<b>Director's Office Phone Number</b>  Best way to contact the director via telephone during working hours <input type="checkbox"/>	Optional, Text Entry	Enter the director's office phone number.
<b>Primary Email *</b>  Best way to contact the director via email during working hours <input type="checkbox"/>	Required, Text Entry	<ul style="list-style-type: none"> <li><b>Email:</b> Enter the best email address to reach (e.g., while at work) the Main Contact Person by email.</li> <li><b>Email (verify):</b> Re-enter the same email for verification.</li> </ul> <p><b>i</b> The email address entered here is for any correspondence related to this agency application. Therefore, ensure that the primary email address is valid and monitored closely after applying to future communications from the NYS DOH Provider Approval Unit.</p>
<b>Home Mailing Address *</b>	Required, Text Entry	The system captures the director's home mailing address. These fields are editable if needed for correction.
<b>Mailing and Physical location addresses are the same? *</b>  If entering a PO Box in any of the 3 address fields, please do not enter the periods(.) <input type="checkbox"/>	Required, Conditional Yes or No	Select the appropriate radio button. <ul style="list-style-type: none"> <li><b>Yes:</b> When selected, the 'Mailing Address' fields populate.</li> <li><b>No:</b> Manually enter the mailing address below.</li> </ul>
<b>Physical Location Address *</b>	Required, Text Entry	The system captures the Physical Location Address of the director. These fields are editable if needed for correction.

### **9.2.1.2 Director Profession Panel**

Director Profession

**Will the Director provide direct service. \***

Yes  
 No

**Profession \***

**License/Certification Type \***

**License/Certification Control Number \***

**License/Certification Effective Date \***

mm/dd/yyyy 

Director Experience

Employer Name	Employed From	Employed To	Number of Hours Worked per Week	Calculated Total Hours	Actions
					

Director Profession

**Will the Director provide direct service. \***

Yes  
 No

**Profession \***

Physician

**Profession Specialty \***

**License/Certification Type \***

Professional License

**License/Certification Control Number \***

**License/Certification Effective Date \***

mm/dd/yyyy

**License/Certification Expiration Date \***

mm/dd/yyyy

Director Profession

**Will the Director provide direct service. \***

Yes  
 No

**Profession \***

**If Other: \***

**License/Certification Type \***

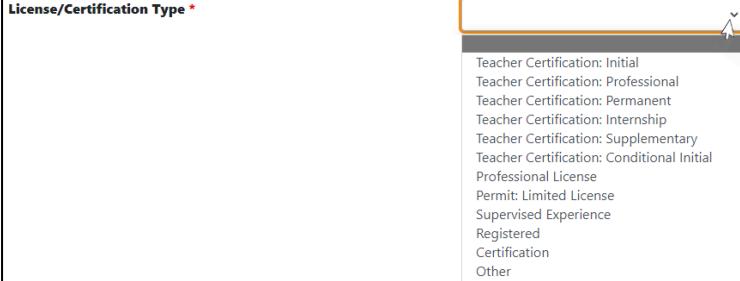
**If Other: \***

**License/Certification Control Number \***

**License/Certification Effective Date \***

**License/Certification Expiration Date \***

FIELD	FIELD TYPE	DESCRIPTION
Will the Director provide direct service? *	Required, Yes or No	<p>Select the appropriate radio button.</p> <ul style="list-style-type: none"> <li>If 'Yes' is selected, the 'NPI' field appears (below). Next, enter the National Provider Identifier (NPI) number.</li> <li>The 'Sex' field also appears (below). Next, enter the director's sex.</li> </ul> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <b>NPI *</b> <input type="text"/>  <b>Sex *</b> <input type="text"/> </div>
NPI*	Conditional, Numeric Entry	Enter the parent company's National Provider Identifier (NPI) number.
Sex *	Conditional, Drop-down	Enter the sex of the Director. <div style="border: 1px solid black; padding: 5px; width: fit-content; margin-top: 5px;"> <input checked="" type="button" value="Male"/>  <input type="button" value="Female"/>  <input type="button" value="Non-binary"/>  <input type="button" value="Prefer not to say"/> </div>
Profession *	Required, Drop-Down	<p>Use the drop-down and select the appropriate profession from the list.</p> <p><b>(i)</b> When selecting "Physician" (QP1 &amp; QP2- Profession = Physician), a specialty field appears.</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <b>Profession *</b> <input type="text" value="Physician"/>  <b>Profession Specialty *</b> <input type="text"/> </div>

FIELD	FIELD TYPE	DESCRIPTION
If Other*	Conditional, Text Entry	Displays if 'Other' is selected in the drop-down above.
Profession Specialty*	Conditional, Text Entry	Displays if 'Physician' is selected in the drop-down above.
License/Certification Type *	Required, Drop-Down	Use the drop-down and select the appropriate license/cert from the list.  
If Other*	Conditional, Text Entry	Displays if 'Other' is selected in the drop-down above.
License/Certification Control Number *	Required, Text Entry	Enter the director's license/certification control number.  
License/Certification Effective Date *	Required, Date/Calendar	Manually enter or use the calendar picker for the end date for the director's license/certification effective date.  
License/Certification Expiration Date*	Required, Date/Calendar	Manually enter or use the calendar picker from the end of the director's license/certification expiration date.

### 9.2.1.3 Director Experience Grid/Table

 The Director Experience grid captures the agency director's past work experience. Select the **Add** button to open the Director Experience pop-up screen, which captures the details of each employment record. Add a new record for each employer.

 **Attention Provider Approval Unit (PAU), Directors' Resumes are no longer uploaded; selecting/clicking the Add button on the Director Experience section invokes the Director Experience pop-up panel, an online form collecting experience.**

Director Experience						
Employer Name	Employed From	Employed To	Number of Hours Worked per Week	Calculated Total Hours	Actions	
					<a href="#">Add</a>	

 Click the **Add** button, and the 'Director Experience' popup panel appears (shown below).

#### 9.2.1.3.1 Director Experience Popup Panel

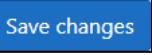
 Please note that Director Experience includes the specific experience that aligns with the regulatory requirements for an EIP Program Director.

**Director Experience**

<b>Employer Name *</b>	<input type="text"/>
<b>Employed From *</b>	<input type="text"/> mm/dd/yyyy 
<b>Employed To *</b>	<input type="text"/> mm/dd/yyyy 
<b>Employer Address *</b>	<b>Line1</b> <input type="text"/> <b>Line2</b> <input type="text"/> <b>Line3</b> <input type="text"/>
<b>Zip Code</b>	<input type="text"/> ZIP+4
<b>City/Town</b>	<input type="text"/> City/Town
<b>State</b>	<input type="text"/>
<b>Title of Position Held *</b>	<input type="text"/>
<b>Name of Supervisor *</b>	<input type="text"/>
<b>Supervisor's Title *</b>	<input type="text"/>
<b>Employers Phone Number</b>	<input type="text"/> (ddd) ddd-dddd
<b>Number of Hours Worked per Week *</b>	<input type="text"/> 0
<b>Calculated Total Hours</b>	<input type="text"/>

[Close](#) [Save changes](#)

FIELD	FIELD TYPE	DESCRIPTION
<b>Employer Name *</b>	Required, Text Entry	Enter the employer's name.
<b>Employed From *</b>	Required, Date/ Calendar	Manually enter or use the calendar picker for the employee's 'employed from date.'
<b>Employed To *</b>	Required, Date/ Calendar	Manually enter or use the calendar picker for the employee to date for the employee.
<b>Employer Address *</b>	Required, Text Entry	<ul style="list-style-type: none"> <li>• <b>Line1:</b> Enter the employer's address.</li> <li>• <b>Line2:</b> If applicable</li> <li>• <b>Line3:</b> If applicable</li> <li>• <b>Zip:</b> Enter the Zip +4</li> <li>• <b>City/Town:</b> Enter the employer's city/town.</li> <li>• <b>State:</b> Use the drop-down and select the state where the employer resides.</li> </ul>
<b>Title of Position Held *</b>	Required, Text Entry	Enter the employee's title/position.
<b>Name of Supervisor *</b>	Required, Text Entry	Enter the name of the employee's supervisor.
<b>Supervisor's Title *</b>	Required, Text Entry	Enter the employee's supervisor title.
<b>Employer Phone Number *</b>	Required, Numeric Entry	Enter the employer's phone number.
<b>Number of Hours Worked per Week *</b>	Required, Numeric Entry	Enter the employee's number of hours of work per week.
<b>Calculated Total Hours</b>	Optional, Text Entry	The system calculates total hours based on dates and hours worked per week, regardless of any license information entered.

BUTTON	DESCRIPTION
<b>Close</b> 	Click this button to close the Director Experience panel; changes do not save.
<b>Save changes</b> 	Click this button to save your changes, and it closes the Director Experience panel.

HYPERLINKS	DESCRIPTION
<b>Actions</b>  <a href="#">Display</a>   <a href="#">Delete</a>   <a href="#">Edit</a>	<p>After adding a record in a grid/table, there are the three (3) hyperlink labels and their descriptions below:</p> <ul style="list-style-type: none"> <li>• <b>Display:</b> A popup panel appears (read-only) when clicked.</li> <li>• <b>Delete:</b> When clicked, a popup panel appears with two buttons, 'Close' (gray button) and 'Delete' (red button).             <ul style="list-style-type: none"> <li>○ To cancel the deletion, click the <b>Close</b> button.</li> <li>○ To confirm the removal of the record, click the <b>Delete</b> button. When clicked, the record is removed (deleted) from the grid/table.</li> </ul> </li> <li>• <b>Edit:</b> A popup panel appears (edit mode).</li> </ul> <p> The <b>Close</b> and <b>Save Changes</b> buttons work the same as described above.</p>

#### 9.2.1.4 Out of State Addresses Section

Out of State Addresses -

Has the Director lived Outside of New York State in the past five (5) years? \*

Yes  
 No

FIELD	FIELD TYPE	DESCRIPTION
Has the Director lived Outside of New York State in the past five (5) years? *	Required, Yes or No	<p>Select the appropriate radio button.</p> <p>Selecting 'Yes,' the Director's out of State Addresses (shown below).</p>

##### 9.2.1.4.1 Director's out of State Addresses Grid/Table

Director's out of State Addresses

Line1	City/Town	State	Zip Code	Actions
				<b>Add</b>

 Click the **Add** button, and the 'Director out of State Addresses' popup panel appears (shown below).

### 9.2.1.4.1.1 Director's out of State Addresses Popup Panel

Director's out of State Addresses X

<b>Home Mailing Address *</b>	<b>Line1</b>	<input type="text" value="Line 1"/> <span style="color: red;">*</span>
	<b>Line2</b>	<input type="text" value="Line 2"/>
	<b>Line3</b>	<input type="text" value="Line 3"/>
<b>City/Town</b>	<input type="text" value="City/Town"/>	
<b>State</b>	<input type="button" value="▼"/>	
<b>Zip Code</b>	<input type="text" value="Zip+4"/>	

Close Save changes

FIELD		DESCRIPTION
<b>Home Mailing Address *</b>  <small>If entering a PO Box in any of the 3 address fields, please do not enter the periods(.)</small>	Required, Text Entry	<ul style="list-style-type: none"> <li>• <b>Line1:</b> Enter the director's home mailing address.</li> <li>• <b>Line2:</b> If applicable</li> <li>• <b>Line3:</b> If applicable</li> <li>• <b>City/Town:</b> Enter the city/town where mail is physically delivered.</li> <li>• <b>State:</b> Use the drop-down and select the state where mail is physically delivered.</li> <li>• <b>Zip Code:</b> Enter the Zip +4</li> </ul>

## 9.2.2 Agency Background Tab

 The Agency Background tab captures information about the agency's structure and ownership.

### Agency Application

- Basic Information
- Director
- Agency Background
- Disclosures
- Seeking to Provide
- Uploads
- Agreements

---

**Type of Ownership**

**Select the Agency's Type of Ownership**  
*as reported in the agency's business and taxation documentation*

**Associations**

Please complete the following questions regarding the applicant agency's affiliation with other government entities by indicating if currently approved, certified, or licensed by any of the following for services other than early intervention.

**Currently approved, certified, or licensed by the New York State Department of Health \***

Yes  
 No

**Currently approved, certified, or licensed by the New York State Education Department \***

Yes  
 No

**Office for People with Developmental Disabilities \***

Yes  
 No

**Comprehensive Medicaid Case Management**

Yes  
 No

**Office of Mental Health \***

Yes  
 No

**Office for Addiction Services and Support \***

Yes  
 No

**Restrictions**

Agency	Action Date	Reinstatement Date	Actions
			<b>Add</b>

**Enforcement Actions**

Agency	Action Date	Reinstatement Date	Actions
			<b>Add</b>

**Insurance**

Insurance Carrier	Insurance Carrier Provider ID#	In-Network Participation Effective Date	Actions
			<b>Add</b>

**Medicaid Tracking Number**

**Is the Agency Owned by a Parent Company? \***

Yes  
 No

**Does the Agency Own Any Subsidiaries? \***

Yes  
 No

Please save your progress often and remember that you can only save if all required fields on the page have been completed and there are no errors to be resolved. The submit application button will initiate a system review of your application and report any errors. Successful submission of the PAT will result in your application being reviewed for approval by the BEI Provider Approval Unit.

Previous Tab
Next Tab

Save Progress
Submit Application

### 9.2.2.1 Type of Ownership Popup Panel

**(i)** The type of Ownership determines Disclosures and Upload requirements. Answering 'Yes' to any associations opens related fields.

FIELD	FIELD TYPE	DESCRIPTION
Select the Agency's Type of Ownership as reported in the agency's business and taxation documentation.	Required, Drop-Down	<p>Select the appropriate type of ownership from the list.</p> <p><b>(i)</b> Your selection appears conditionally based on the type of ownership selected from this drop-down list. For example, in the following selections of the example shown below, the "Board Members" panel appears.</p> <div style="border: 1px solid black; padding: 5px;"> <p><b>Select the Agency's Type of Ownership</b> as reported in the agency's business and taxation documentation</p> <p>If Sole Proprietor, the following information is required:</p> <ul style="list-style-type: none"> <li>1. The Disclosures tab will need to be completed for           <ul style="list-style-type: none"> <li>1. Sole Proprietor</li> <li>2. EI Program Director</li> </ul> </li> </ul> </div> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p><b>Select the Agency's Type of Ownership</b> as reported in the agency's business and taxation documentation</p> <p>If Partnership, the following information is required:</p> <ul style="list-style-type: none"> <li>1. The Disclosures tab will need to be completed for           <ul style="list-style-type: none"> <li>1. Each partner</li> <li>2. EI Program Director</li> </ul> </li> <li>2. The fully executed Partnership Agreement will need to be uploaded on the Uploads tab</li> </ul> </div> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p><b>Select the Agency's Type of Ownership</b> as reported in the agency's business and taxation documentation</p> <p>If Professional Service Limited Liability Company (PLLC), the following information is required:</p> <ul style="list-style-type: none"> <li>1. The Disclosures tab will need to be completed for           <ul style="list-style-type: none"> <li>1. Each officer</li> <li>2. EI Program Director</li> </ul> </li> <li>2. The Board Members Panel will need to be completed</li> <li>3. The fully executed Partnership Agreement will need to be uploaded on the Uploads tab</li> </ul> <p>Professional Service Limited Liability Companies, Not-For-Profit Corporations, Business Corporations, Professional Services Corporations and Limited Liability Companies must add the names and dates of birth of each member of their Board of Directors.</p> </div> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p><b>Select the Agency's Type of Ownership</b> as reported in the agency's business and taxation documentation</p> <p>If Not-For-Profit Corporation, the following information is required:</p> <ul style="list-style-type: none"> <li>1. The Disclosures tab will need to be completed for           <ul style="list-style-type: none"> <li>1. Each officer</li> <li>2. EI Program Director</li> </ul> </li> <li>2. The Board Members Panel will need to be completed</li> <li>3. A certified copy of the Certificate of Incorporation will need to be uploaded on the Uploads tab</li> </ul> <p>Professional Service Limited Liability Companies, Not-For-Profit Corporations, Business Corporations, Professional Services Corporations and Limited Liability Companies must add the names and dates of birth of each member of their Board of Directors.</p> </div>

<b>FIELD</b>	<b>FIELD TYPE</b>	<b>DESCRIPTION</b>
		<p><b>Select the Agency's Type of Ownership</b>  <i>as reported in the agency's business and taxation documentation</i></p> <p>If <b>Business Corporation (Inc)</b>, the following information is required:</p> <ol style="list-style-type: none"> <li>1. The Disclosures tab will need to be completed for           <ol style="list-style-type: none"> <li>1. Each officer</li> <li>2. Each principal stockholder (10% or more)</li> <li>3. EI Program Director</li> </ol> </li> <li>2. The Board Members Panel will need to be completed</li> <li>3. A certified copy of the Certificate of Incorporation will need to be uploaded on the Uploads tab</li> </ol> <p>Professional Service Limited Liability Companies, Not-For-Profit Corporations , Business Corporations, Professional Services Corporations and Limited Liability Companies must add the names and dates of birth of each member of their Board of Directors.</p>
		<p><b>Select the Agency's Type of Ownership</b>  <i>as reported in the agency's business and taxation documentation</i></p> <p>If <b>Professional Services Corporation (PC)</b>, the following information is required:</p> <ol style="list-style-type: none"> <li>1. The Disclosures tab will need to be completed for           <ol style="list-style-type: none"> <li>1. Each officer</li> <li>2. EI Program Director</li> </ol> </li> <li>2. The Board Members Panel will need to be completed</li> <li>3. A certified copy of the Certificate of Incorporation will need to be uploaded on the Uploads tab</li> </ol> <p>Professional Service Limited Liability Companies, Not-For-Profit Corporations , Business Corporations, Professional Services Corporations and Limited Liability Companies must add the names and dates of birth of each member of their Board of Directors.</p>
		<p><b>Select the Agency's Type of Ownership</b>  <i>as reported in the agency's business and taxation documentation</i></p> <p>If <b>Limited Liability Company (LLC)</b>, the following information is required:</p> <ol style="list-style-type: none"> <li>1. The Disclosures tab will need to be completed for           <ol style="list-style-type: none"> <li>1. Each officer</li> <li>2. EI Program Director</li> </ol> </li> <li>2. The Board Members Panel will need to be completed</li> <li>3. A copy of Articles of Organization will need to be uploaded on the Uploads tab</li> </ol> <p>Professional Service Limited Liability Companies, Not-For-Profit Corporations , Business Corporations, Professional Services Corporations and Limited Liability Companies must add the names and dates of birth of each member of their Board of Directors.</p>
		<p><b>(i)</b> <b>The remaining selection appears conditionally based on the type of ownership selected from this drop-down list. The results are as follows:</b></p> <p><b>Select the Agency's Type of Ownership</b>  <i>as reported in the agency's business and taxation documentation</i></p> <p>If <b>Limited Liability Partnership (LLP)</b>, the following information is required:</p> <ol style="list-style-type: none"> <li>1. The Disclosures tab will need to be completed for           <ol style="list-style-type: none"> <li>1. Each partner</li> <li>2. EI Program Director</li> </ol> </li> <li>2. The fully executed Partnership Agreement will need to be uploaded on the Uploads tab</li> <li>3. The fully executed Certificate of Limited Partnership will need to be uploaded on the Uploads tab</li> </ol> <p><b>Select the Agency's Type of Ownership</b>  <i>as reported in the agency's business and taxation documentation</i></p> <p>If <b>Government Subdivision</b>, the following information is required:</p> <ol style="list-style-type: none"> <li>1. The Disclosures tab will need to be completed for           <ol style="list-style-type: none"> <li>1. Authorized individual</li> <li>2. EI Program Director</li> </ol> </li> </ol>

### 9.2.2.1.1 Board Members Grid/Table

Board Members			
First Name	Last Name	Date of Birth	Actions
			<b>Add</b>

FIELD	FIELD TYPE	DESCRIPTION
<b>First Name</b>	Required, Text Field	The first name of the board member.
<b>Middle Name/Initial</b>	Optional, Text Entry	The middle name or initial of the board member.
<b>Last Name</b>	Required, Text Field	The last name of the board member.
<b>Date of Birth</b>	Required, Date/Calendar	The date of birth of the board member.

BUTTON	FIELD TYPE	DESCRIPTION
<b>Add</b>  Use the Add button to display the popup panel.	Conditional Grid	Add a new entry to the grid/table for each board member (shown below).

#### 9.2.2.1.1.1 Board Members Popup Panel

Board Members																																																						
<b>First Name *</b>	<input type="text"/> <small>Please enter the person's full, legal name</small>																																																					
<b>Middle Name/Initial</b>	<input type="text"/> <small>If entering an initial, please do not enter the period ()</small>																																																					
<b>Last Name *</b>	<input type="text"/>																																																					
<b>Date of Birth *</b>	<input type="text"/> mm/dd/yyyy <small>May 2022</small> <table border="1" style="margin-left: 10px;"> <tr><td>«</td><td>May</td><td>2022</td><td>»</td></tr> <tr><td>Su</td><td>Mo</td><td>Tu</td><td>We</td><td>Th</td><td>Fr</td><td>Sa</td></tr> <tr><td>24</td><td>25</td><td>26</td><td>27</td><td>28</td><td>29</td><td>30</td></tr> <tr><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td></tr> <tr><td>8</td><td>9</td><td>10</td><td>11</td><td>12</td><td>13</td><td>14</td></tr> <tr><td>15</td><td>16</td><td>17</td><td>18</td><td>19</td><td>20</td><td>21</td></tr> <tr><td>22</td><td>23</td><td>24</td><td>25</td><td>26</td><td>27</td><td>28</td></tr> <tr><td>29</td><td>30</td><td>31</td><td>1</td><td>2</td><td>3</td><td>4</td></tr> </table>	«	May	2022	»	Su	Mo	Tu	We	Th	Fr	Sa	24	25	26	27	28	29	30	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	1	2	3	4
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29	30	31	1	2	3	4																																																
	<input type="button" value="Close"/> <input type="button" value="Save changes"/>																																																					

### 9.2.2.1.2 Associations Panel



Please complete the following questions regarding the applicant agency's affiliation with other government entities by indicating if they are approved, certified, or licensed by any of the following for services other than early intervention.

Please save your progress often and remember that you can only save if all required fields on the page have been completed and there are no errors to be resolved. The submit application button will systematically review your application and report any errors. Successful submission of the PAT will result in your application being reviewed for approval by the BEI Provider Approval Unit.

**The system has Restrictions and Enforcement Actions grids between Associations and Insurance.**

Associations	
<p>Please complete the following questions regarding the applicant agency's affiliation with other government entities by indicating if currently approved, certified, or licensed by any of the following for services other than early intervention.</p> <p><b>Currently approved, certified, or licensed by the New York State Department of Health *</b></p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p><b>Currently approved, certified, or licensed by the New York State Education Department *</b></p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p><b>Office for People with Developmental Disabilities *</b></p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p><b>Comprehensive Medicaid Case Management</b></p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p><b>Office of Mental Health *</b></p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p><b>Office for Addiction Services and Support *</b></p> <p><input type="radio"/> Yes <input type="radio"/> No</p>	

FIELD	FIELD TYPE	DESCRIPTION
<b>Currently approved, certified, or licensed by the New York State Department of Health *</b>	Required, Yes or No	Select the appropriate radio button.  <b>The following radio buttons appear on the form (example below) when selecting 'Yes.'</b>

FIELD	FIELD TYPE	DESCRIPTION						
		<p><b>Article 28 PHL Diagnostic and Treatment Center *</b> *</p> <input type="radio"/> Yes <input type="radio"/> No						
		<p><b>Article 28 PHL Hospital-based Outpatient Clinic? *</b> *</p> <input type="radio"/> Yes <input type="radio"/> No						
		<p><b>Article 36 Certified Home Health Agency *</b> *</p> <input type="radio"/> Yes <input type="radio"/> No						
		<p><b>Is the agency an approved Medicaid provider? *</b> *</p> <input type="radio"/> Yes <input type="radio"/> No						
<p><b>(i)</b> The following radio buttons appear on the form (example below) when selecting 'Yes' to any of the Articles.</p>								
<table border="1"> <tr> <td><b>License/Certification Control Number *</b></td> <td></td> </tr> <tr> <td><b>Date of last Audit or Program Review *</b></td> <td>mm/dd/yyyy</td> </tr> <tr> <td><b>Office of Mental Health *</b></td> <td></td> </tr> </table>			<b>License/Certification Control Number *</b>		<b>Date of last Audit or Program Review *</b>	mm/dd/yyyy	<b>Office of Mental Health *</b>	
<b>License/Certification Control Number *</b>								
<b>Date of last Audit or Program Review *</b>	mm/dd/yyyy							
<b>Office of Mental Health *</b>								
<p><b>(i)</b> The following text field appears on the form (example below) when selecting 'Yes' to "Is the agency an approved Medicaid provider?"</p>								
<table border="1"> <tr> <td><b>Provider Numbers *</b></td> <td></td> </tr> </table>			<b>Provider Numbers *</b>					
<b>Provider Numbers *</b>								
<b>Currently approved, certified, or licensed by the New York State Education Department *</b>	Required, Yes or No	<p>Select the appropriate radio button.</p> <p><b>(i)</b> The following radio buttons appear on the form (example below) when selecting 'Yes.'</p>						

FIELD	FIELD TYPE	DESCRIPTION
Currently approved, certified, or licensed by the New York State Education Department *	Required, Yes or No	<p>Select the appropriate radio button.</p> <p><b>(i)</b> The following radio buttons appear on the form (example below) when selecting 'Yes.'</p> <div style="border: 1px solid black; padding: 10px;"> <p><b>Section 4410 Education Law *</b></p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p><b>School District/Boards of Cooperative Education Services (BOCES) *</b></p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p><b>Adult Career and Continuing Education Services (ACCESS) *</b></p> <p><input type="radio"/> Yes <input type="radio"/> No</p> </div> <p><b>(i)</b> The following fields appear on the form (example below) when selecting 'Yes.'</p> <div style="border: 1px solid black; padding: 10px;"> <p><b>License/Certification Control Number *</b> <input type="text"/></p> <p><b>Date of last Audit or Program Review *</b> <input type="text"/> mm/dd/yyyy <input type="button" value="Calendar"/></p> </div>
Office for People with Developmental Disabilities *	Required, Yes or No	<p>Select the appropriate radio button.</p> <p><b>(i)</b> The following radio button appears on the form (example below) when selecting 'Yes.'</p> <div style="border: 1px solid black; padding: 10px;"> <p><b>Article 16 OMRDD clinic *</b></p> <p><input type="radio"/> Yes <input type="radio"/> No</p> </div>
Comprehensive Medicaid Case Management	Optional, Yes or No	<p>Select the appropriate radio button.</p> <p><b>(i)</b> The following fields appear on the form (example below) when selecting 'Yes.'</p> <div style="border: 1px solid black; padding: 10px;"> <p><b>License/Certification Control Number *</b> <input type="text"/></p> <p><b>Date of last Audit or Program Review *</b> <input type="text"/> mm/dd/yyyy <input type="button" value="Calendar"/></p> </div>

FIELD	FIELD TYPE	DESCRIPTION
Office of Mental Health*	Required, Yes or No	<p>Select the appropriate radio button.</p> <p><b>(i)</b> The following radio button appears on the form (example below) when selecting 'Yes.'</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> Article 31 MHL clinic * <span style="float: right;">*</span>  <input type="radio"/> Yes  <input type="radio"/> No </div> <p><b>(i)</b> The following fields appear on the form (example below) when selecting 'Yes.'</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> License/Certification Control Number * <input type="text"/>  Date of last Audit or Program Review * <input type="text"/> mm/dd/yyyy <span style="float: right;"></span> </div>
Office for Addiction Services and Support *	Required, Yes or No	<p>Select the appropriate radio button.</p> <p><b>(i)</b> The following radio button appears on the form (example below) when selecting 'Yes.'</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> Article 22 Service Provider * <span style="float: right;">*</span>  <input type="radio"/> Yes  <input type="radio"/> No </div> <p><b>(i)</b> The following fields appear on the form (example below) when selecting 'Yes.'</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> License/Certification Control Number * <input type="text"/>  Date of last Audit or Program Review * <input type="text"/> mm/dd/yyyy <span style="float: right;"></span> </div>

### 9.2.2.1.3 Medicaid Providers Grid/Table

Medicaid Providers		
Medicaid Provider ID	Medicaid Type	Actions
		<b>Add</b>



Use the **Add** button to display the Medical Provider popup panel.

### 9.2.2.1.3.1 Medicaid Providers Pop-up Panel

Medicaid Providers

**Medicaid Provider ID \***

**Medicaid Type \***

**Recertification date \***

mm/dd/yyyy

Close    Save changes

FIELD	FIELD TYPE	DESCRIPTION
Medicaid Provider ID*	Required, Text Entry	Enter the Medical Provider ID
Medicaid Type*	Required, drop-down	Select the Medicaid Type from the list.  El Services Other Services Service Coordination
Recertification date*	Required, Date/Calendar	Manually enter or select the date from the calendar picker.

### 9.2.2.1.4 Restrictions Grid/Table

Restrictions

Agency	Action Date	Reinstatement Date	Actions
--------	-------------	--------------------	---------

Add

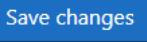
Click the **Add** button, and the 'Restrictions' popup panel appears (shown below).

### 9.2.2.1.4.1 Restrictions Popup Panel

**Restrictions**

<b>Agency *</b>	<input type="text"/>
<b>Action Date *</b>	<input type="text"/> mm/dd/yyyy 
<b>Reason for the Action *</b>	<input type="text"/>
<b>Resolution, Including Corrective Action *</b>	<input type="text"/>
<b>Reinstatement Date *</b>	<input type="text"/> mm/dd/yyyy 
<input type="button" value="Close"/> <input type="button" value="Save changes"/>	

FIELD	FIELD TYPE	DESCRIPTION
<b>Agency *</b>	Required, Drop-Down	Select the appropriate agency that has issued the agency a restriction. <input type="button" value="Department of Health"/> <input type="button" value="State Education Department"/> <input type="button" value="Office of Mental Health"/> <input type="button" value="Office for People with Developmental Disabilities"/> <input type="button" value="Office of Addiction Services and Supports"/> <input type="button" value="Other"/>
<b>Action Date *</b>	Required, Date/ Calendar	Enter the action date manually or use the calendar picker by selecting the calendar icon (  ).
<b>Reason for the Action *</b>	Required, Text Entry	Use the text box and enter the reason for the action against the agency.
<b>Resolution, Including Corrective Action *</b>	Required, Text Entry	Use the text box and enter the resolution, including corrective action on the agency.
<b>Reinstatement Date *</b>	Required, Date/ Calendar	Enter the reinstatement date manually or use the calendar picker by selecting the calendar icon (  ).

BUTTON	DESCRIPTION
<b>Close</b> 	Click this button to close the Restrictions panel; changes do not save.
<b>Save changes</b> 	Click this button to save your changes, and it closes the Restrictions panel.

HYPERLINKS	DESCRIPTION

**Actions**

Actions

Display   Delete   Edit

After adding a record in a grid/table, there are the three (3) hyperlink labels and their descriptions below:

- **Display:** A popup panel appears (read-only) when clicked.
- **Delete:** When clicked, a popup panel appears with two buttons, '**Close**' (gray button) and '**Delete**' (red button).
  - To cancel the deletion, click the **Close** button.
  - To confirm the removal of the record, click the **Delete** button. The record is removed (deleted) from the grid/table when clicked.
- **Edit:** A popup panel appears (edit mode).



**The 'Close' and 'Save Changes' buttons work the same as described above.**

### 9.2.2.1.5 Enforcement Actions Grid/Table



Any Enforcement Actions taken against the agency are reported here.

Enforcement Actions			
Agency	Action Date	Reinstatement Date	Actions
			 Add



Click the **Add** button, and the 'Enforcement Actions' popup panel appears (shown below).

#### 9.2.2.1.5.1 Enforcement Actions Popup Panel

**Enforcement Actions**

**Agency \***

**Action Date \***  mm/dd/yyyy 

**Reason(s) for the Action \***

**Resolution of the Action, (including Corrective Action that was taken and whether approval has been reinstated.) \***

**Reinstatement Date \***  mm/dd/yyyy 

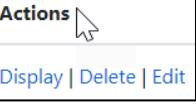
Uploads are limited to 10 MB and must be in one of the following formats only: JPG, PDF, or PNG. Files in other formats and/or larger than 10 MB will not be accepted. **Please ensure the supporting documentation is clear, legible, and oriented correctly.**

**Upload Documentation related to enforcement actions \***

FIELD		DESCRIPTION
<b>Agency *</b>	Required, Drop-Down	Select the appropriate agency to restrict from the list. <input type="button" value="Department of Health"/> <input type="button" value="State Education Department"/> <input type="button" value="Office of Mental Health"/> <input type="button" value="Office for People with Developmental Disabilities"/> <input type="button" value="Office of Addiction Services and Supports"/> <input type="button" value="Other"/>
<b>Action Date *</b>	Required, Date/ Calendar	Enter the action date manually or use the calendar picker by selecting the calendar icon (CALENDAR).
<b>Reason(s) for the Action *</b>	Required, Text Entry	Enter the reason for the action against the agency.
<b>Resolution of the Action (including Corrective Action that was taken and whether approval has been reinstated) *</b>	Required, Text Entry	Enter the resolution, including corrective action on the agency.
<b>Reinstatement Date *</b>	Required, Date/ Calendar	Enter the reinstatement date manually or use the calendar picker by selecting the calendar icon (CALENDAR).

BUTTON	DESCRIPTION
<b>Upload Documentation</b>	Step / Action

<b>related to enforcement actions *</b>	<ol style="list-style-type: none"> <li>To upload documents, click the <b>Browse</b> button adjacent to the appropriate label. When clicked, a dialog window/box appears.           <ul style="list-style-type: none"> <li>Some dialog boxes display 'Choose File to Upload' or 'Open' depending on your browser (MS Edge, Google Chrome).</li> </ul> </li> <li>Search and attach your file by clicking the <b>Open</b> button.</li> </ol>
<b>Close</b>	Click this button to close the Restrictions panel; changes do not save.
<b>Save changes</b>	Click this button to save your changes, and it closes the Restrictions panel.

Hyperlinks	Description
<b>Actions</b>  <a href="#">Display</a>   <a href="#">Delete</a>   <a href="#">Edit</a>	<p>After adding a record in a grid/table, there are the three (3) hyperlink labels and their descriptions below:</p> <ul style="list-style-type: none"> <li><b>Display:</b> A popup panel appears (read-only) when clicked.</li> <li><b>Delete:</b> When clicked, a popup panel appears with two buttons, '<b>Close</b>' (gray button) and '<b>Delete</b>' (red button).           <ul style="list-style-type: none"> <li>To cancel the deletion, click the <b>Close</b> button.</li> <li>To confirm the removal of the record, click the <b>Delete</b> button. The record is removed (deleted) from the grid/table when clicked.</li> </ul> </li> <li><b>Edit:</b> A popup panel appears (edit mode).</li> </ul> <p> <b>The 'Close' and 'Save Changes' buttons work the same as described above.</b></p>

### 9.2.2.1.6 Insurance Grid/Table

 The insurance grid captures the agency's participation agreements with insurance carriers.

Insurance			
Insurance Carrier	Insurance Carrier Provider ID#	In-Network Participation Effective Date	Actions
			<b>Add</b>

 Click the **Add** button, and the 'Insurance' popup panel appears (shown below).

#### 9.2.2.6.1 Insurance Popup Panel

 Identify each Managed Care Organization that recognizes the Agency as an In-Network Provider.

**Insurance** X

Identify each Managed Care Organization that recognizes the Agency as an In-Network Provider

<b>Insurance Carrier</b>	<input type="text"/>
<b>Insurance Carrier Provider ID#</b>	<input type="text"/>
<b>In-Network Participation Effective Date</b>	<input type="text"/> mm/dd/yyyy <input type="button" value="Calendar"/>

**Close** **Save changes**

<b>FIELD</b>	<b>FIELD TYPE</b>	<b>DESCRIPTION</b>
<b>Insurance Carrier</b> <b>Identify each Managed Care Organization that recognizes the Agency as an In-Network Provider</b>	Required, Drop-Down	Select the managed care organization from the list.
<b>Insurance Carrier Provider ID#</b>	Required, Text Entry	Enter the agency's provider identification number for their insurance carrier.
<b>In-Network Participation Effective Date</b>	Required, Date/ Calendar	Manually enter or use the calendar picker and select the 'Effective Date' for the In-Network Participation.

<b>BUTTON</b>	<b>DESCRIPTION</b>
<b>Close</b> <input type="button" value="Close"/>	Click this button to close the Insurance panel; changes do not save.
<b>Save changes</b> <input type="button" value="Save changes"/>	Click this button to save your changes, and it closes the Insurance panel.

Hyperlinks	Description
<b>Actions</b>  <a href="#">Display</a>   <a href="#">Delete</a>   <a href="#">Edit</a>	<p>After adding a record in a grid/table, there are the three (3) hyperlink labels and their descriptions below:</p> <ul style="list-style-type: none"> <li>• <b>Display:</b> A popup panel appears (read-only) when clicked.</li> <li>• <b>Delete:</b> When clicked, a popup panel appears with two buttons, '<b>Close</b>' (gray button) and '<b>Delete</b>' (red button).             <ul style="list-style-type: none"> <li>○ To cancel the deletion, click the <b>Close</b> button.</li> <li>○ To confirm the removal of the record, click the <b>Delete</b> button. The record is removed (deleted) from the grid/table when clicked.</li> </ul> </li> <li>• <b>Edit:</b> A popup panel appears (edit mode).</li> </ul> <p><b>(i)</b> The 'Close' and 'Save Changes' buttons work the same as described above.</p>

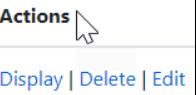
#### 9.2.2.1.7 Medicaid Tracking Panel

If the agency has already applied for a Medicaid Provider ID and the application is still being processed, enter the assigned Medicaid tracking number here. If the agency already has a Medicaid Provider ID, that would be entered under Associations (7.2.4.3 Associations, Medicaid Providers Grid/Table).

Medicaid Tracking Number	<input type="text"/>	
Is the Agency Owned by a Parent Company? *	<input type="radio"/> Yes <input type="radio"/> No	
Does the Agency Own Any Subsidiaries? *	<input type="radio"/> Yes <input type="radio"/> No	

Field	Field Type	Description
<b>Medicaid Tracking Number</b> <div style="background-color: black; color: white; padding: 5px;">                     Medicaid Tracking Number will be required for approval, but is not required for the initial submission (can be added later)                 </div>	Optional, Numeric Entry	Enter the Medicaid Tracking Number.
<b>Is the Agency Owned by a Parent Company? *</b> <div style="background-color: black; color: white; padding: 5px;">                     A subsidiary is a company that belongs to another company, which is usually referred to as the parent company or the holding company.                 </div>	Required, Yes or No	<p>Select the appropriate radio button.</p> <p><b>(i)</b> The Parent Company grid/table appears on the form (example below) when selecting 'Yes.'</p>

FIELD	FIELD TYPE	DESCRIPTION
<b>Does the Agency Own Any Subsidiaries? *</b>	Required, Yes or No	Select the appropriate radio button.  <b>(i)</b> The Subsidiaries grid/table appears on the form (example below) when selecting 'Yes.'

HYPERLINKS	DESCRIPTION
<b>Actions</b>  Display   Delete   Edit	After adding a record in a grid/table, there are the three (3) hyperlink labels and their descriptions below: <ul style="list-style-type: none"><li>• <b>Display:</b> A popup panel appears (read-only) when clicked.</li><li>• <b>Delete:</b> When clicked, a popup panel appears with two buttons, 'Close' (gray button) and 'Delete' (red button).<ul style="list-style-type: none"><li>○ To cancel the deletion, click the <b>Close</b> button.</li><li>○ To confirm the removal of the record, click the <b>Delete</b> button. The record is removed (deleted) from the grid/table when clicked.</li></ul></li><li>• <b>Edit:</b> A popup panel appears (edit mode).</li></ul> <b>(i)</b> The 'Close' and 'Save Changes' buttons work the same as described above.

### 9.2.2.1.8 Parent Company Grid/Table

Parent Company			
Name of Parent Organization	FEIN	NPI	Actions
			<b>Add</b>

 Click the **Add** button, and the 'Parent Company' popup panel appears (shown below).

### 9.2.2.1.8.1 Parent Company Popup Panel

**Parent Company**

<b>Name of Parent Organization *</b>	<input type="text"/>
<b>Address *</b>	<b>Line1</b> <input type="text"/> <b>Line2</b> <input type="text"/> <b>Line3</b> <input type="text"/>
<b>Zip Code</b>	<input type="text"/>
<b>City/Town</b>	<input type="text"/>
<b>State</b>	<input type="button" value="▼"/>
<b>FEIN *</b>	<input type="text"/>
<b>NPI *</b>	<input type="text"/>

**Close** **Save changes**

FIELD	FIELD TYPE	DESCRIPTION
<b>Name of Parent Organization *</b>	Required, Text Entry	Enter the name of the parent organization (parent company).
<b>Address *</b> <small>If entering a PO Box in any of the 3 address fields, please do not enter the periods(.)</small>	Required, Text Entry	<ul style="list-style-type: none"> <li><b>Line1:</b> Enter the address for the parent company.</li> <li><b>Line2:</b> If applicable</li> <li><b>Line3:</b> If applicable</li> <li><b>Zip Code:</b> Enter the Zip +4.</li> <li><b>City/Town:</b> Enter the city/town where the parent company resides.</li> <li><b>State:</b> Use the drop-down and select the state where the parent company resides.</li> </ul>
<b>FEIN *</b>	Required, Numeric Entry	Enter the parent company's Federal Employer Identification Number (FEIN).
<b>NPI *</b>	Required, Numeric Entry	Enter the parent company's National Provider Identifier (NPI) number.

BUTTON	DESCRIPTION
<b>Close</b> <input type="button" value="Close"/>	Click this button to close the Parent Company panel; changes do not save.
<b>Save changes</b> <input type="button" value="Save changes"/>	Click this button to save your changes, and it closes the Parent Company panel.

HYPERLINKS	DESCRIPTION
<b>Actions</b> 	<p>After adding a record in a grid/table, there are the three (3) hyperlink labels and their descriptions below:</p> <ul style="list-style-type: none"> <li>• <b>Display:</b> A popup panel appears (read-only) when clicked.</li> <li>• <b>Delete:</b> When clicked, a popup panel appears with two buttons, '<b>Close</b>' (gray button) and '<b>Delete</b>' (red button).             <ul style="list-style-type: none"> <li>○ To cancel the deletion, click the <b>Close</b> button.</li> <li>○ To confirm the removal of the record, click the <b>Delete</b> button. The record is removed (deleted) from the grid/table when clicked.</li> </ul> </li> <li>• <b>Edit:</b> A popup panel appears (edit mode).</li> </ul> <p> The 'Close' and 'Save Changes' buttons work the same as described above.</p>

### 9.2.2.1.9 Subsidiaries Grid/Table

Subsidiaries	
Subsidiary Name	Actions
	

 Click the **Add** button, and the 'Subsidiaries' popup panel appears (below).

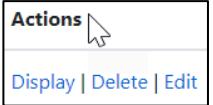
### 9.2.2.1.9.1 Subsidiaries Popup Panel

Subsidiaries ×

<b>Subsidiary Name *</b>	<input type="text"/>
<b>Mailing Address *</b>	<b>Line1</b> <input type="text"/> <span style="float: right;">[</span> <b>Line2</b> <input type="text"/> <b>Line3</b> <input type="text"/> <b>Zip Code</b> <input type="text"/> <b>City/Town</b> <input type="text"/> <b>State</b> <input type="text"/>
<input type="button" value="Close"/> <input type="button" value="Save changes"/>	

FIELD	FIELD TYPE	DESCRIPTION
<b>Subsidiary Name *</b>	Required, Text Entry	Enter the name of the subsidiary.
<b>Mailing Address *</b>  If entering a PO Box in any of the 3 address fields, please do not enter the periods(.)	Required, Text Entry	<ul style="list-style-type: none"> <li>• <b>Line1:</b> Enter the address for the parent company.</li> <li>• <b>Line2:</b> If applicable</li> <li>• <b>Line3:</b> If applicable</li> <li>• <b>Zip Code:</b> Enter the Zip +4.</li> <li>• <b>City/Town:</b> Enter the city/town where the parent company resides.</li> <li>• <b>State:</b> Use the drop-down and select the state where the parent company resides.</li> </ul>

BUTTON	DESCRIPTION
<b>Close</b> 	Click this button to close the Parent Company panel; changes do not save.
<b>Save changes</b> 	Click this button to save your changes, and it closes the Parent Company panel.

HYPERLINKS	DESCRIPTION
<b>Actions</b>  <a href="#">Display</a>   <a href="#">Delete</a>   <a href="#">Edit</a>	<p>After adding a record in a grid/table, there are the three (3) hyperlink labels and their descriptions below:</p> <ul style="list-style-type: none"> <li>• <b>Display:</b> A popup panel appears (read-only) when clicked.</li> <li>• <b>Delete:</b> When clicked, a popup panel appears with two buttons, '<b>Close</b>' (gray button) and '<b>Delete</b>' (red button).             <ul style="list-style-type: none"> <li>○ To cancel the deletion, click the <b>Close</b> button.</li> <li>○ To confirm the removal of the record, click the <b>Delete</b> button. The record is removed (deleted) from the grid/table when clicked.</li> </ul> </li> <li>• <b>Edit:</b> A popup panel appears (edit mode).</li> </ul> <p><b>i</b> The ‘Close’ and ‘Save Changes’ buttons work the same as described above.</p>

### 9.2.3 Disclosures Tab

 The Disclosures tab will need to be completed for the indicated individuals for each type of ownership.

- **Sole Proprietor:** the sole proprietor and the EI Program Director
- **Partnership:** the EI Program Director and each partner
- **Professional Service Limited Liability Company:** the EI Program Director and each officer
- **Limited Liability Partnership:** the EI Program Director and each partner
- **Not-For-Profit Corporation:** the EI Program Director and each officer
- **Business Corporation:** the EI Program Director, each principal stockholder (10% or more), and each officer
- **Professional Services Corporation:** the EI Program Director and each officer
- **Limited Liability Company:** the EI Program Director and each officer
- **Government Subdivision:** Authorized Individual and the EI Program Director

Please save your progress often and remember that you can only save if all required fields on the page have been completed and there are no errors to be resolved. The submit application button will systematically review your application and report any errors. Successful submission of the PAT will result in your application being reviewed for approval by the BEI Provider Approval Unit.

### Agency Application

Basic Information   Director   Agency Background   **Disclosures**   Seeking to Provide   Uploads   Agreements

Instructions:

For each type of ownership, the Disclosures tab will need to be completed for the indicated individuals.

- Sole Proprietor: the sole proprietor and the EI Program Director
- Partnership: the EI Program Director and each partner
- Professional Service Limited Liability Company: the EI Program Director and each officer
- Limited Liability Partnership: the EI Program Director and each partner
- Not-For-Profit Corporation: the EI Program Director and each officer
- Business Corporation: the EI Program Director, each principal stockholder (10% or more), and each officer
- Professional Services Corporation: the EI Program Director and each officer
- Limited Liability Company: the EI Program Director and each officer
- Government Subdivision: Authorized Individual and the EI Program Director

Disclosures

First Name	Last Name	Title	Actions
			<b>Add</b>

Please save your progress often and remember that you can only save if all required fields on the page have been completed and there are no errors to be resolved. The submit application button will initiate a system review of your application and report any errors. Successful submission of the PAT will result in your application being reviewed for approval by the BEI Provider Approval Unit.

**Previous Tab**

**Next Tab**

**Save Progress**

**Submit Application**



Click the **Add** button, and the 'Disclosures' popup panel appears (shown below).

### 9.2.4 Disclosures Popup Panel

**Disclosures**

[Identifying Info](#) [Out of State Addresses](#) [Profession](#) [HHS Offices](#)

[Other Interests/Ownership Entities](#) [Violations](#)

**Is this person the Program Director? \***

Yes  
 No

**Salutation \***

**First Name \***

**Middle Name/Initial**

**Last Name \***

**Suffix**

**Title**

**Personal Phone Number \***

(ddd) ddd-dddd

**Fax Number**

(ddd) ddd-dddd

**Personal Email \***

**Email**

**Email (verify)**

**Home Mailing Address \***

**Line1**

Line 1

**Line2**

Line 2

**Line3**

Line 3

**Zip Code**

ZIP+4

**City/Town**

City/Town

**State**

**Social Security Number \***

ddd dd dddd

**Date of Birth \***

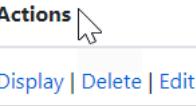
mm/dd/yyyy

**Indicate the percent of interest or voting rights in the applicant agency**

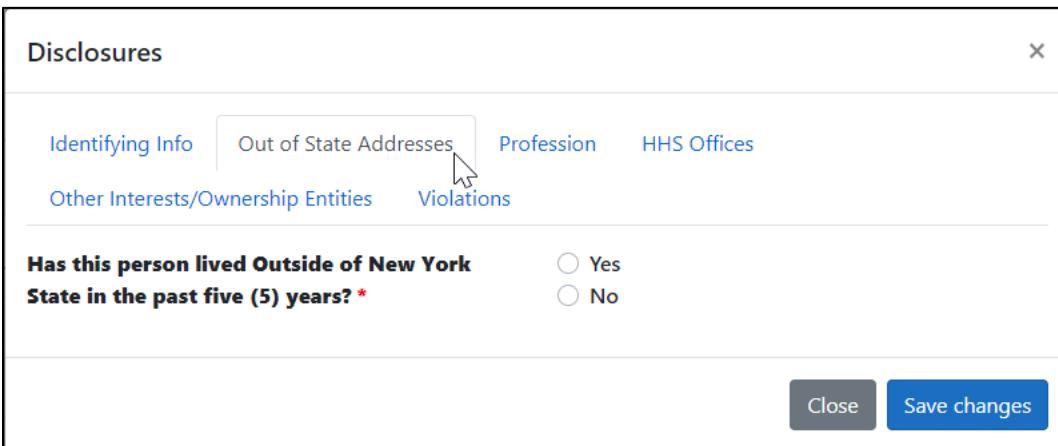
**Close** **Save changes**

FIELD	FIELD TYPE	DESCRIPTION
<b>Is this person the Program Director? *</b>	Required, Yes or No	Select the appropriate radio button. <ul style="list-style-type: none"> <li>○ If 'Yes' is selected, the system auto-populates only the Salutation, First Name, Last Name, and Title fields.</li> <li>○ If 'No' is selected, all the required fields need to be filled out.</li> </ul>
<b>Salutation *</b>	Required, Drop-Down	Select the appropriate salutation from the list.
<b>First Name *</b>	Required, Text Entry	Enter the person's first name in the agency.
<small>The name entered must exactly match the name on all licenses and certifications.</small>		
<b>Middle Name/Initial</b>	Optional, Text Entry	Enter the person's middle name or middle initial in the agency.
<small>If entering an initial, please do not enter the period (.)</small>		
<b>Last Name *</b>	Required, Text Entry	Enter the person's last name in the agency.
<b>Suffix</b>	Optional, Drop-Down	Select the appropriate suffix from the list.
<b>Title</b>	Optional, Text Entry	Enter the person's title in the agency.
<b>Personal Phone Number *</b>	Required, Numeric Entry	Enter the personal phone number (e.g., cell phone).
<b>Fax Number</b>	Optional, Numeric Entry	Enter the person's fax number (at the agency or home office).
<b>Personal Email</b>	Required, Text Entry	Enter the person's email address (e.g., Gmail).
<b>Home Mailing Address *</b>	Required, Text Entry	<ul style="list-style-type: none"> <li>● <b>Line1:</b> Enter the person's home address.</li> <li>● <b>Line2:</b> If applicable</li> <li>● <b>Line3:</b> If applicable</li> <li>● <b>Zip Code:</b> Enter the Zip +4</li> <li>● <b>City/Town:</b> Enter the person's city/town.</li> <li>● <b>State:</b> Use the drop-down and select the state where the person resides.</li> </ul>
<small>If entering a PO Box in any of the 3 address fields, please do not enter the periods(.)</small>		
<b>Social Security Number *</b>	Required, Numeric Entry	Enter the person's social security number (xxx-xx-xxxx).
<b>Date of Birth *</b>	Required, Date/Calendar	Enter the person's date of birth (mm/dd/yyyy).
<b>Indicate the percent of interest or voting rights in the applicant agency</b>	Optional, Numeric Entry	Enter the percentage of interest or voting rights in the applicant agency.

BUTTON	DESCRIPTION
<b>Close</b> 	Click this button to close the Disclosures panel; changes do not save.
<b>Save changes</b> 	Click this button to save your changes, and it closes the Disclosures panel.

Hyperlinks	Description
<b>Actions</b>  Display   Delete   Edit	<p>After adding a record in a grid/table, there are the three (3) hyperlink labels and their descriptions below:</p> <ul style="list-style-type: none"> <li>• <b>Display:</b> A popup panel appears (read-only) when clicked.</li> <li>• <b>Delete:</b> When clicked, a popup panel appears with two buttons, 'Close' (gray button) and 'Delete' (red button).             <ul style="list-style-type: none"> <li>○ To cancel the deletion, click the <b>Close</b> button.</li> <li>○ To confirm the removal of the record, click the <b>Delete</b> button. The record is removed (deleted) from the grid/table when clicked.</li> </ul> </li> <li>• <b>Edit:</b> A popup panel appears (edit mode).</li> </ul> <p> The 'Close' and 'Save Changes' buttons work the same as described above.</p>

#### 9.2.4.1 Out of State Addresses Tab / Panel



The screenshot shows the 'Disclosures' panel with the 'Out of State Addresses' tab selected. The panel contains the following elements:

- Identifying Info
- Out of State Addresses (selected)
- Profession
- HHS Offices
- Other Interests/Ownership Entities
- Violations
- Has this person lived Outside of New York State in the past five (5) years? \* (radio buttons for Yes and No)
- Close button
- Save changes button

FIELD	FIELD TYPE	DESCRIPTION
<b>Has this person lived Outside of New York State in the past five (5) years? *</b>	Required, Yes or No	<p>Select the appropriate response.</p> <ul style="list-style-type: none"> <li>• The 'Out of State Addresses' Grid/Table appears (shown below), selecting 'Yes.'</li> </ul>

### 9.2.4.1.1 Out of State Addresses Grid/Table

Identifying Info    Out of State Addresses    Profession    HHS Offices

Other Interests/Ownership Entities    Violations

**Has this person lived Outside of New York State in the past five (5) years? \***

Yes  
 No

Line1	City/Town	State	ZIP	Actions
				<b>Add</b>

**Close**    **Save changes**

Click the **Add** button, and the 'Out of State Addresses' popup panel appears (shown below).

#### 9.2.4.1.1.1 Out of State Address Popup Panel

**Home Mailing Address \***

**Line1** Line 1  
**Line2** Line 2  
**Line3** Line 3

**City/Town** City/Town

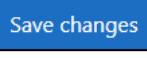
**State** (dropdown menu)

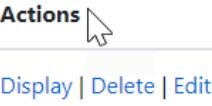
**Zip Code** Zip+4

If entering a PO Box in any of the 3 address fields, please do not enter the periods(.)

**Close**    **Save changes**

FIELD	FIELD TYPE	DESCRIPTION
Home Mailing Address *	Required, Text Field	<ul style="list-style-type: none"> <li>• <b>Line1:</b> Enter the out-of-state address.</li> <li>• <b>Line2:</b> If applicable</li> <li>• <b>Line3:</b> If applicable</li> <li>• <b>City/Town:</b> Enter the city/town.</li> <li>• <b>State:</b> Use the drop-down and select the state.</li> <li>• <b>Zip Code:</b> Enter the Zip +4</li> </ul>

BUTTON	DESCRIPTION
Close 	Click this button to close the Out of State Addresses panel; changes do not save.
Save changes 	Click this button to save your changes, and it closes the Out of State Addresses panel.

Hyperlinks	DESCRIPTION
Actions 	<p>After adding a record in a grid/table, there are the three (3) hyperlink labels and their descriptions below:</p> <ul style="list-style-type: none"> <li>• <b>Display:</b> A popup panel appears (read-only) when clicked.</li> <li>• <b>Delete:</b> When clicked, a popup panel appears with two buttons, '<b>Close</b>' (gray button) and '<b>Delete</b>' (red button). <ul style="list-style-type: none"> <li>○ To cancel the deletion, click the <b>Close</b> button.</li> <li>○ To confirm the removal of the record, click the <b>Delete</b> button. The record is removed (deleted) from the grid/table when clicked.</li> </ul> </li> <li>• <b>Edit:</b> A popup panel appears (edit mode).</li> </ul> <p> The 'Close' and 'Save Changes' buttons work the same as described above.</p>

### 9.2.4.1.2 Profession Tab / Panel

**(i)** When selecting 'Other' in the 'License or Certification type' field, the license number and dates become optional, and the user can skip them.

Disclosures X

[Identifying Info](#)   [Out of State Addresses](#)   **Profession** HHS Offices (Hand icon)

[Other Interests/Ownership Entities](#)   [Violations](#)

**Profession \***

**Will you provide direct service? \***  Yes  
 No

**License or Certification type \***

**License/Certification Control Number \***

**License/Certification Effective Date \*** mm/dd/yyyy (Calendar icon)

**Has your professional license ever been suspended or revoked? \***  Yes  
 No

Close Save changes

**Disclosures**

Identifying Info    Out of State Addresses    Profession    HHS Offices

Other Interests/Ownership Entities    Violations

**Profession \*** Physician

**Physician Specialty \***

**Will you provide direct service? \***

Yes  
 No

**License or Certification type \*** Other

**Other:**

**License/Certification Control Number**

**License/Certification Effective Date**

**License/Certification Expiration Date**

**Has your professional license ever been suspended or revoked? \***

Yes  
 No

**Close**    **Save changes**

FIELD	FIELD TYPE	DESCRIPTION
<b>Profession *</b>	Required, Drop-Down	<p>Select the appropriate profession from the list.</p> <p><b>(i)</b> The 'Profession' listed are the professions recognized as Qualified Personnel in the EIP. You will select "Other" if your profession does not align with the drop-down options and describe in the "Describe Other" field.</p> <p><b>(i)</b> An additional field appears in the Disclosures – Profession tab/form depending on the profession selection. For example, select "Physician," and the 'Physician Specialty' field appears (see example below).</p>

FIELD	FIELD TYPE	DESCRIPTION
		<p><b>Profession *</b> <input type="text" value="Physician"/> </p> <p><b>Physician Specialty *</b> <input type="text"/></p> <p><i>(i) For example, select “Other,” and the ‘Describe Other’ field appears (see example below).</i></p> <p><b>Profession *</b> <input type="text" value="Other"/> </p> <p><b>Describe Other *</b> <input type="text"/></p>
<b>Will you provide direct service? *</b>	Required, Yes or No	<p>Select the appropriate radio button.</p> <ul style="list-style-type: none"> <li>If 'Yes' is selected, the 'NPI' field appears (below). Next, enter the National Provider Identifier (NPI) number.</li> <li>The 'Sex' field also appears (below). Next, enter the person's sex.</li> </ul> <p><b>NPI *</b> <input type="text"/></p> <p><b>Sex *</b> <input type="text"/></p>
<b>License or Certification type *</b>	Required, Drop-Down	<p>Select the appropriate license or certification from the list.</p> <p><i>(i) Individuals who are not delivering EIP services and do not have the license/certification required in EIP select “Other.” Please note that not every agency person who completed disclosures has an EIP-recognized license/certification, and currently, the license number and effective date are required.</i></p> <p><i>(i) Select "Other Under License Type to skip conditional fields.</i></p>
<b>License/Certification Control Number *</b>	Required, Conditional Text	Enter the person's control number (license number).
<b>License/Certification Effective Date *</b>	Required, Conditional Date/ Calendar	Manually enter or use the calendar picker for the person's license/certification effective date.
<b>Has your professional license ever been suspended or revoked? *</b>	Required, Yes or No	<p>Select the appropriate radio button.</p> <ul style="list-style-type: none"> <li>If 'Yes' is selected, the required fields (Date of Action, Reason/s for action, Resolution of Action, including corrective action, and License Reinstatement date) appear (shown below).</li> </ul>

<b>Date of Action *</b>	<input type="text" value="mm/dd/yyyy"/> 
<b>Reason(s) for action *</b>	<input type="text"/>
<b>Resolution of Action, including corrective action *</b>	<input type="text"/>
<b>License Reinstatement date *</b>	<input type="text"/> 

FIELD	FIELD TYPE	DESCRIPTION
<b>Date of Action *</b>	Required, Date/ Calendar	Manually enter or use the calendar picker for the date of action for the person.
<b>Reason(s) for action *</b>	Required, Text Entry	Enter the reason(s) for action for the professional license/cert suspended or revoked for the person.
<b>Resolution of Action, including corrective action *</b>	Required, Text Entry	Enter the resolution of the action, including corrective action for the person.
<b>License Reinstatement date *</b>	Required, Date/ Calendar	Manually enter or use the calendar picker for the reinstatement date for the person.

BUTTON	DESCRIPTION
 Close	Click this button to close the Disclosures panel; changes do not save.
 Save changes	Click this button to save your changes, and it closes the Disclosures panel.

### 9.2.4.1.3 HHS Offices Tab

Disclosures X

[Identifying Info](#)   [Out of State Addresses](#)   [Profession](#)   [HHS Offices](#)    [Other Interests/Ownership Entities](#)   [Violations](#)

**Have you held any offices in Health and Human Services (HHS) agencies/facilities including early intervention, preschool special education programs over the last 10 years? \***

Yes  
 No

[Close](#)   [Save changes](#)

FIELD	FIELD TYPE	DESCRIPTION
<b>Have you held any offices in Health and Human Services (HHS) agencies/facilities, including early intervention, preschool special education programs, over the last 10 years? *</b>	Required, Yes or No	<p>Select the appropriate response.</p> <ul style="list-style-type: none"> <li>The 'HHS Offices Held' panel appears (shown below).</li> </ul>

**Have you held any offices in Health and Human Services (HHS) agencies/facilities including early intervention, preschool special education programs over the last 10 years? \***

- Yes  
 No

HHS Offices Held

Facility Name	Office Held	Held from Date	Held to Date	Actions
---------------	-------------	----------------	--------------	---------

Add

Close

Save changes



Click the **Add** button, and the 'HHS Offices Held' popup panel appears (shown below).

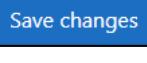
#### 9.2.4.3.1 HHS Offices Held Popup Panel

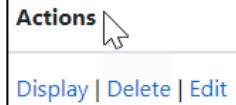
HHS Offices Held

<b>Facility Name *</b>	<input type="text"/>									
<b>Address *</b>	<table> <tr> <td><b>Line1</b></td> <td><input type="text"/> Line 1</td> <td></td> </tr> <tr> <td><b>Line2</b></td> <td><input type="text"/> Line 2</td> <td></td> </tr> <tr> <td><b>Line3</b></td> <td><input type="text"/> Line 3</td> <td></td> </tr> </table>	<b>Line1</b>	<input type="text"/> Line 1		<b>Line2</b>	<input type="text"/> Line 2		<b>Line3</b>	<input type="text"/> Line 3	
<b>Line1</b>	<input type="text"/> Line 1									
<b>Line2</b>	<input type="text"/> Line 2									
<b>Line3</b>	<input type="text"/> Line 3									
<b>Zip Code</b>	<input type="text"/> ZIP+4									
<b>City/Town</b>	<input type="text"/> City/Town									
<b>State</b>	<input type="text"/>									
<b>Phone Number *</b>	<input type="text"/> (ddd) ddd-dddd									
<b>Office Held *</b>	<input type="text"/>									
<b>Held from Date *</b>	<input type="text"/> mm/dd/yyyy									
<b>Held to Date *</b>	<input type="text"/> mm/dd/yyyy									

**Close** **Save changes**

FIELD	FIELD TYPE	DESCRIPTION
Facility Name *	Required, Text Entry	Enter the name of the facility or entity that provides a profession/practice.
Address *	Required, Text Entry	<ul style="list-style-type: none"> <li>• <b>Line1:</b> Enter the person's state address.</li> <li>• <b>Line2:</b> If applicable</li> <li>• <b>Line3:</b> If applicable</li> <li>• <b>Zip Code:</b> Enter the Zip +4</li> <li>• <b>City/Town:</b> Enter the person's city/town.</li> <li>• <b>State:</b> Use the drop-down and select the state where the HHS office resides.</li> </ul>
Phone Number *	Required, Numeric Entry	Enter the facility's phone number.
Office Held *	Required, Text Entry	Enter the name of the Office Held in this text field.
Held from Date *	Required, Date/ Calendar	Manually enter or use the calendar picker for the facility held 'from date.'
Held to Date *	Required, Date/ Calendar	Manually enter or use the calendar picker for the facility held 'to date.'

BUTTON	DESCRIPTION
<b>Close</b> 	Click this button to close the HHS Offices Held panel; changes are not saved.
<b>Save changes</b> 	Click this button to save your changes, and it closes the HHS Offices Held panel.

Hyperlinks	DESCRIPTION
<b>Actions</b> 	<p>After adding a record in a grid/table, there are the three (3) hyperlink labels and their descriptions below:</p> <ul style="list-style-type: none"> <li>• <b>Display:</b> A popup panel appears (read-only) when clicked.</li> <li>• <b>Delete:</b> When clicked, a popup panel appears with two buttons, '<b>Close</b>' (gray button) and '<b>Delete</b>' (red button). <ul style="list-style-type: none"> <li>○ To cancel the deletion, click the <b>Close</b> button.</li> <li>○ To confirm the removal of the record, click the <b>Delete</b> button. The record is removed (deleted) from the grid/table when clicked.</li> </ul> </li> <li>• <b>Edit:</b> A popup panel appears (edit mode).</li> </ul> <p> The 'Close' and 'Save Changes' buttons work the same as described above.</p>

### 9.2.4.2 Other Interests/Ownership Entities Tab

 Provide information on all health or human service agencies or facilities you have owned or controlled interest in over ten (10) years. Include all approved entities to provide early intervention or early childhood services.

Disclosures X

---

Identifying Info    Out of State Addresses    Profession    HHS Offices

---

Other Interests/Ownership Entities ☰

Violations

---

Provide information on all 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.

**Do you own/have interest in another Entity? \***

Yes  
 No

Close Save changes

FIELD	FIELD TYPE	DESCRIPTION
Do you own/have interest in another Entity? *	Required, Yes or No	Select the appropriate response. <ul style="list-style-type: none"> <li>The 'Interest in Other Entities' Grid/Table appears (shown below).</li> </ul>

### 9.2.4.2.1 Interest in Other Entities Popup Panel

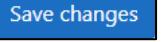
Interest in Other Entities X

<b>Name of Facility/Entity *</b>	<input type="text"/>
<b>Type of Entity *</b>	<input type="text"/>
<b>Address *</b>	<input type="text"/> <b>Line1</b> Line 1
	<input type="text"/> <b>Line2</b> Line 2
	<input type="text"/> <b>Line3</b> Line 3
<b>Zip Code</b>	<input type="text"/> ZIP+4
<b>City/Town</b>	<input type="text"/> City/Town
<b>State</b>	<input type="text"/>
<b>Type of Ownership/Interest *</b>	<input type="text"/>
<b>Indicate % of ownership/interest</b>	<input type="text"/>
<b>Date From *</b>	<input type="text"/> mm/dd/yyyy <span style="float: right;">Calendar icon</span>
<b>Date End *</b>	<input type="text"/> mm/dd/yyyy <span style="float: right;">Calendar icon</span>
<b>Current Status of Entity *</b>	<input type="text"/>
<b>State Agency Approval of Entity *</b>	<input type="text"/>

Close Save changes

FIELD	FIELD TYPE	DESCRIPTION
<b>Name of Facility/Entity *</b>	Required, Text Entry	Enter the name of the facility or entity that provides a profession/practice.
<b>Type of Entity *</b>	Required, Text Entry	Enter the facility or entity profession/practice type
<b>Address *</b> If entering a PO Box in any of the 3 address fields, please do not enter the periods(.)	Required, Text Entry	<ul style="list-style-type: none"> <li>• <b>Line1:</b> Enter the entity address.</li> <li>• <b>Line2:</b> If applicable</li> <li>• <b>Line3:</b> If applicable</li> <li>• <b>Zip Code:</b> Enter the Zip +4</li> <li>• <b>City/Town:</b> Enter the entity city/town.</li> </ul> <b>State:</b> Use the drop-down and select the state where the entity resides.

FIELD	FIELD TYPE	DESCRIPTION
Type of Ownership/Interest *	Required, Text Entry	Enter the stake of a party who owns the property/company.
Indicate % of ownership/interest	Required, Text Entry	Enter the certificate of ownership or security interest in the certificate as the Holder.
Date From *	Required, Date/ Calendar	Manually enter or use the calendar picker for the entity 'from date.'
Date End *	Required, Date/ Calendar	Manually enter or use the calendar picker for the entity' end date.'
Current Status of Entity *	Required, Drop- Down	Select the appropriate item from the list for the entity's current status.  <div style="border: 1px solid #ccc; padding: 5px; text-align: center;"> <span>Open</span>  <span>Closed</span>  <span>Proposed</span> </div>
State Agency Approval of Entity *	Required, Drop- Down	Select the appropriate item from the list for the state agency approval of the entity.  <div style="border: 1px solid #ccc; padding: 5px; text-align: center;"> <span>Department of Health</span>  <span>State Education Department</span>  <span>Office of Mental Health</span>  <span>Office for People with Developmental Disabilities</span>  <span>Office of Addiction Services and Supports</span> </div>

BUTTON	DESCRIPTION
<b>Close</b> 	Click this button to close the Interest in Other Entities panel; changes do not save.
<b>Save changes</b> 	Click this button to save your changes, and it closes the Interest in Other Entities panel.

### 9.2.4.3 Violations Tab / Panel

**Disclosures** X

[Identifying Info](#)   [Out of State Addresses](#)   [Profession](#)   [HHS Offices](#)  
[Other Interests/Ownership Entities](#)   [Violations](#)

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

Yes  
 No

**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? \***

Yes  
 No

**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? \***

Yes  
 No

**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? \***

Yes  
 No

**Has the applicant agency ever been the subject of any childcare 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? \***

Yes  
 No

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

Yes  
 No

**Are there any criminal, civil or administrative charges pending against you? \***

Yes  
 No

Close Save changes

FIELD	FIELD TYPE	DESCRIPTION
<b>Except for minor traffic violations, have you ever been convicted of any violation of the law (e.g., criminal, civil, or administrative charges)? *</b>	Required, Yes or No	Select the appropriate response.
<b>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? *</b>	Required, Yes or No	Select the appropriate response.
<b>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? *</b>	Required, Yes or No	Select the appropriate response.
<b>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? *</b>	Required, Yes or No	Select the appropriate response.
<b>Has the applicant agency ever been the subject of any childcare 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? *</b>	Required, Yes or No	Select the appropriate response.
<b>Have you ever been restricted, suspended, or excluded from participation as a Medicaid provider? *</b>	Required, Yes or No	Select the appropriate response.
<b>Are there any criminal, civil or administrative charges pending against you? *</b>	Required, Yes or No	Select the appropriate response.

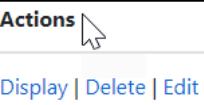


Selecting the 'Yes' radio button to any of the questions above will require additional fields to populate (see below).

<b>Date of Action *</b>	<input type="text" value="mm/dd/yyyy"/> 
<b>Type of Action *</b>	<input type="text"/>
<b>Location *</b>	<input type="text"/> 
<b>Explanation of Violation *</b>	<input type="text"/>
<b>Provide a brief statement of circumstances *</b>	<input type="text"/>
<p>If criminal or civil action was taken against you, attach documents from the court describing the disposition of action.</p> <p>Uploads are limited to 10 MB and must be in one of the following formats only: JPG, PDF, or PNG. Files in other formats and/or larger than 10 MB will not be accepted. <b>Please ensure the supporting documentation is clear, legible, and oriented correctly.</b></p> <p><b>Upload Documentation related to legal actions</b>  *</p>	

FIELD	FIELD TYPE	DESCRIPTION
<b>Date of Action *</b>	Required, Conditional Date/ Calendar	Manually enter or use the calendar picker for the action date (e.g., violations of the law, etc.).
<b>Type of Action *</b>	Required, Conditional Text Entry	Enter the type of action (e.g., criminal, civil, administrative charges).
<b>Location *</b>   	Required, Conditional Text Entry	Enter the city and state where the action took place.
<b>Explanation of the Violation *</b>	Required, Conditional Text Entry	Enter a brief explanation of the violation that occurred.
<b>Provide a brief statement of circumstances *</b>	Required, Conditional Text Entry	Enter a brief statement of the circumstances that occurred.

BUTTON	DESCRIPTION
 Close	Click this button to close the Disclosures panel; changes do not save.
 Save changes	Click this button to save your changes, and it closes the Disclosures panel.

HYPERLINKS	DESCRIPTION
 Actions Display   Delete   Edit	<p>After adding a record in a grid/table, there are the three (3) hyperlink labels and their descriptions below:</p> <ul style="list-style-type: none"> <li><b>Display:</b> A popup panel appears (read-only) when clicked.</li> <li><b>Delete:</b> When clicked, a popup panel appears with two buttons, 'Close' (gray button) and 'Delete' (red button).             <ul style="list-style-type: none"> <li>To cancel the deletion, click the <b>Close</b> button.</li> <li>To confirm the removal of the record, click the <b>Delete</b> button. The record is removed (deleted) from the grid/table when clicked.</li> </ul> </li> <li><b>Edit:</b> A popup panel appears (edit mode).</li> </ul> <p> <b>The 'Close' and 'Save Changes' buttons work the same as described above.</b></p>

## 9.2.5 Seeking to Provide Tab

### Agency Application

Basic Information   Director   Agency Background   Disclosures   Seeking to Provide  Uploads   Agreements

#### 9.2.5.1 Specialty Population Grid/Table

Specialty Populations	
Select populations in which the agency's staff have distinct knowledge, skills, and experience	Actions
	

 Click the **Add** button, and the 'Specialty Populations' popup panel appears (shown below).

### 9.2.5.1.1 Specialty Population Popup Panel

Specialty Populations

Select populations in which the agency's staff have distinct knowledge, skills, and experience

FIELD	FIELD TYPE	DESCRIPTION
Select populations in which the agency's staff have distinct knowledge, skills, and experience.	Optional, Drop Down	Select the appropriate population (e.g., Autism/PDD) from the list.
Specialty Population Other*	Conditional, Text Entry	Enter the specialty population.

BUTTON	DESCRIPTION
<input type="button" value="Close"/>	Click this button to close the Specialty Populations panel; changes do not save.
<input type="button" value="Save changes"/>	Click this button to save your changes, and it closes the Specialty Populations panel.

HYPERLINKS	DESCRIPTION
<b>Actions</b>  <a href="#">Display</a>   <a href="#">Delete</a>   <a href="#">Edit</a>	<p>After adding a record in a grid/table, there are three (3) hyperlink labels and their descriptions below:</p> <ul style="list-style-type: none"> <li><b>Display:</b> A popup panel appears (read-only) when clicked.</li> <li><b>Delete:</b> When clicked, a popup panel appears with two buttons, '<b>Close</b>' (gray button) and '<b>Delete</b>' (red button).             <ul style="list-style-type: none"> <li>To cancel the deletion, click the <b>Close</b> button.</li> <li>To confirm the removal of the record, click the <b>Delete</b> button. The record is removed (deleted) from the grid/table when clicked.</li> </ul> </li> <li><b>Edit:</b> A popup panel appears (edit mode).</li> </ul> <p><b>i</b> The 'Close' and 'Save Changes' buttons work the same as described above.</p>

### 9.2.5.2 Languages Grid/Table

 Indicate all languages and other forms of communication that can be used fluently by agency staff that provide EI services (excluding English). Add each language separately.

Languages	
Language	Actions
	

 Click the **Add** button, and the 'Languages' popup panel appears (shown below).

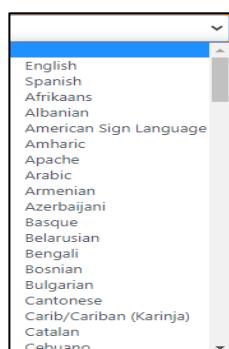
#### 9.2.5.2.1 Languages Popup Panel

Languages X

Indicate all languages and other forms of communication that can be used fluently by agency staff that provide EI services (excluding English). Add each language separately.

Language

Close Save changes

FIELD	FIELD TYPE	DESCRIPTION
Language	Optional, Drop Down	<p>Select the appropriate language (e.g., Spanish.) from the list.</p> <p> If the person speaks multiple languages, use the 'Add' button for each language.</p>  <ul style="list-style-type: none"> <li>English</li> <li>Spanish</li> <li>Afrikaans</li> <li>Albanian</li> <li>American Sign Language</li> <li>Amharic</li> <li>Apache</li> <li>Arabic</li> <li>Armenian</li> <li>Azerbaijani</li> <li>Basque</li> <li>Belarusian</li> <li>Bengali</li> <li>Bosnian</li> <li>Bulgarian</li> <li>Cantonese</li> <li>Carib/Cariban (Karinja)</li> <li>Catalan</li> <li>Cebuano</li> </ul>
Other Language*	Optional, Conditional Text Entry	Enter the appropriate language spoken.

BUTTON	DESCRIPTION
 Close	Click this button to close the Languages panel; changes do not save.
 Save changes	Click this button to save your changes, and it closes the Languages panel.

Hyperlinks	DESCRIPTION
 Actions Display   Delete   Edit	<p>After adding a record in a grid/table, there are the three (3) hyperlink labels and their descriptions below:</p> <ul style="list-style-type: none"> <li><b>Display:</b> A popup panel appears (read-only) when clicked.</li> <li><b>Delete:</b> When clicked, a popup panel appears with two buttons, '<b>Close</b>' (gray button) and '<b>Delete</b>' (red button).             <ul style="list-style-type: none"> <li>To cancel the deletion, click the <b>Close</b> button.</li> <li>To confirm the removal of the record, click the <b>Delete</b> button. The record is removed (deleted) from the grid/table when clicked.</li> </ul> </li> <li><b>Edit:</b> A popup panel appears (edit mode).</li> </ul> <p> The 'Close' and 'Save Changes' buttons work the same as described above.</p>

FIELD	FIELD TYPE	DESCRIPTION
Will services be provided at a site the agency owns, leases, rents, manages, operates from, or otherwise uses on a regular basis? *	Required, Yes or No	<p>Select the appropriate response.</p> <ul style="list-style-type: none"> <li>The 'Service Sites' grid/table appears (shown below), selecting 'Yes.'</li> </ul> <p> If you plan to deliver services in a "community location" like a church, daycare, or library room. In that case, these are considered "service sites" and must be approved by DOH even if you are not paying to use the space.</p>

### 9.2.5.3 Services Site Grid/Table

Service Sites			
Location Name	Classroom Name/Room Number	Last Name	Actions
			

 Click the **Add** button, and the 'Service Sites' popup panel appears (shown below).

### 9.2.5.3.1 Service Sites Popup Panel/ Site Tab

 Complete all four tabs for each agency's physical locations/sites that the agency owns, leases, rents, manages, operates from, or regularly uses to provide services. Enter each site individually, using the **Add** button to include additional sites.

**Service Sites**

×

Site      Service Types      CPR      Upload

Complete all four tabs for each of the agency's physical locations/sites, that the agency owns, leases, rents, manages, operates from, or otherwise uses on a regular basis to provide services. Enter each site individually, using the Add button to include additional sites as appropriate.

<b>Location Name *</b>	<input type="text"/>
<b>Classroom Name/Room Number</b>	
<b>Age Ranges served at this site *</b>	
Age Ranges served at this site <input type="checkbox"/> 6 weeks - 12 months <input type="checkbox"/> 12-24 months <input type="checkbox"/> 24-36 months	
<b>Location Address *</b>	<b>Line1</b> <input type="text"/> <b>Line2</b> <input type="text"/> <b>Line3</b> <input type="text"/>
	<b>Zip Code</b> <input type="text"/> <b>City/Town</b> <input type="text"/> <b>State</b> <input type="text"/>
<b>Is this building used for any other purposes? *</b>	
<input type="radio"/> Yes <input type="radio"/> No	
<b>Is this site ADA compliant? *</b>	
<input type="radio"/> Yes <input type="radio"/> No	
<b>Site Contact Person</b>	
<b>Salutation *</b> <input type="text"/>	
<b>First Name *</b> <input type="text"/>	
<b>Last Name *</b> <input type="text"/>	
<b>Title *</b> <input type="text"/>	
<b>Primary Phone Number *</b> <input type="text"/> (ddd) ddd-dddd	
<b>Primary Email *</b>	<b>Email</b> <input type="text"/>
	<b>Email (verify)</b> <input type="text"/>
<b>Is this Treatment site located outside of NYC?</b>	
<input type="radio"/> Yes <input type="radio"/> No	

FIELD	FIELD TYPE	DESCRIPTION
<b>Location Name *</b>	Required, Text Entry	Enter the name of the location (site).
<b>Classroom Name/Room Number</b>	Required, Text Entry	If applicable, enter the classroom name and room number.
<b>Age Ranges served at this site *</b>  You may select multiple age ranges	Required, Checkboxes	Select all that apply; the age ranges are as follows: <ul style="list-style-type: none"><li>• 6-wks-12 months</li><li>• 12-24 months</li><li>• 24-36 months</li></ul>
<b>Location Address *</b>  This must be the actual physical location of the facility; therefore, PO Boxes will not be accepted.	Required, Text Entry	<ul style="list-style-type: none"><li>• <b>Line1:</b> Enter the site address.</li><li>• <b>Line2:</b> If applicable</li><li>• <b>Line3:</b> If applicable</li><li>• <b>Zip Code:</b> Enter the Zip +4</li><li>• <b>City/Town:</b> Enter the site city/town.</li><li>• <b>State:</b> Use the drop-down and select the state where the site resides.</li></ul>
<b>Is this building used for any other purposes? *</b>	Required, Yes or No	Select the appropriate response. <ul style="list-style-type: none"><li>• Click the <b>Yes</b> radio button; the 'Provide details' field appears (shown below).  <div style="border: 1px solid black; padding: 5px; width: 100%;"><b>Provide details *</b></div> <li>• Please enter a brief description of the site" purpose and its uses.</li></li></ul>
<b>Is this site ADA compliant?</b>	Required, Yes or No	Select the appropriate response if the site is Americans with Disabilities Act compliant.  <b>(i)</b> Please refer to <a href="http://ada.gov">ada.gov</a> for additional information on ADA.

### 9.2.5.3.1.1 Site Contact Person Popup Panel

Site Contact Person

**Salutation \***

**Site Contact Person First Name \***

**Site Contact Person Last Name \***

**Title \***

**Primary Phone Number \***

**Primary Email \***

**Email**

**Email (verify)**

Verify Email

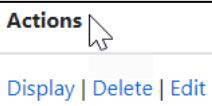
FIELD	FIELD TYPE	DESCRIPTION
<b>Salutation *</b>	Required, Drop-Down	Enter the salutation for the site contact person.
<b>Site Contact Person First Name *</b>	Required, Text Entry	Enter the first name of the site contact person.
<b>Site Contact Person Last Name *</b>	Required, Text Entry	Enter the last name of the site contact person.
<b>Title *</b>	Required, Text Entry	Enter the title of the site contact person.
<b>Primary Phone Number *</b>	Required, Numeric Entry	Enter the primary phone number for the site contact person.
<b>Primary Email *</b>	Required, Text Entry	Enter the primary email address for the site contact person.
<b>Email (verify)</b>	Required, Text Entry	Re-enter the primary email address for the site contact person.

FIELD	FIELD TYPE	DESCRIPTION								
Is this Treatment site located outside of NYC?	Required, Yes or No	<p>Select the appropriate response.</p> <p>Selecting 'Yes'</p> <ul style="list-style-type: none"> <li>Another question with the <b>Yes</b> or <b>No</b> radio buttons appears (shown below).</li> </ul> <div style="border: 1px solid black; padding: 5px;"> <p><b>Will each child's parent or guardian be present * for all sessions? *</b></p> <input type="radio"/> Yes  <input type="radio"/> No       </div> <ul style="list-style-type: none"> <li>Select the appropriate response (<b>Yes</b> or <b>No</b> radio button).           <ul style="list-style-type: none"> <li>Another question with the <b>Yes</b> or <b>No</b> radio buttons appears (shown below).</li> </ul> </li> </ul> <div style="border: 1px solid black; padding: 5px;"> <p><b>Will the agency provide group services to three or more children for three or more hours per day, per child? *</b></p> <input type="radio"/> Yes  <input type="radio"/> No       </div> <p>Selecting 'Yes'</p> <ul style="list-style-type: none"> <li>Another question with the <b>Yes</b> or <b>No</b> radio buttons appears (shown below).</li> </ul> <div style="border: 1px solid black; padding: 5px;"> <p><b>Do you currently hold a NYS Office of Children and Family Services day care permit/license for children ages birth through age 2 at this site? *</b></p> <input type="radio"/> Yes  <input type="radio"/> No       </div> <p>Selecting 'Yes'</p> <ul style="list-style-type: none"> <li>The following fields appear (shown below).</li> </ul> <div style="border: 1px solid black; padding: 5px;"> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;"><b>Name of Day care *</b></td> <td style="width: 70%;"><input style="width: 100%; height: 25px;" type="text"/></td> </tr> <tr> <td><b>License/Permit Number *</b></td> <td><input style="width: 100%; height: 25px;" type="text"/></td> </tr> <tr> <td><b>License Effective Date *</b></td> <td style="text-align: right;"><input style="width: 100px; height: 25px;" type="text"/> mm/dd/yyyy </td> </tr> <tr> <td><b>License Expiration Date *</b></td> <td style="text-align: right;"><input style="width: 100px; height: 25px;" type="text"/> mm/dd/yyyy </td> </tr> </table> </div> <ul style="list-style-type: none"> <li><b>Name of Day Care *:</b> Enter the name of the daycare.</li> <li><b>License/Permit Number *:</b> Enter the professional license/permit number.</li> <li><b>License Effective Date *:</b> Manually enter or use the calendar picker for the person's license effective date.</li> <li><b>License Expiration Date *:</b> Manually enter or use the calendar picker for the person's license expiration date.</li> </ul>	<b>Name of Day care *</b>	<input style="width: 100%; height: 25px;" type="text"/>	<b>License/Permit Number *</b>	<input style="width: 100%; height: 25px;" type="text"/>	<b>License Effective Date *</b>	<input style="width: 100px; height: 25px;" type="text"/> mm/dd/yyyy	<b>License Expiration Date *</b>	<input style="width: 100px; height: 25px;" type="text"/> mm/dd/yyyy
<b>Name of Day care *</b>	<input style="width: 100%; height: 25px;" type="text"/>									
<b>License/Permit Number *</b>	<input style="width: 100%; height: 25px;" type="text"/>									
<b>License Effective Date *</b>	<input style="width: 100px; height: 25px;" type="text"/> mm/dd/yyyy									
<b>License Expiration Date *</b>	<input style="width: 100px; height: 25px;" type="text"/> mm/dd/yyyy									

FIELD	FIELD TYPE	DESCRIPTION								
<b>Is this treatment site located inside of NYC? *</b>	Required, Conditional, Yes, or No	<p>Select the appropriate response.</p> <p>Selecting 'Yes'</p> <ul style="list-style-type: none"> <li>Another question with the <b>Yes</b> or <b>No</b> radio buttons appears (shown below).</li> </ul> <div style="border: 1px solid black; padding: 5px;"> <p><b>Will each child's parent or guardian be present * for all sessions? *</b></p> <input type="radio"/> Yes  <input type="radio"/> No       </div> <p>Select 'Yes' or 'No.'</p> <ul style="list-style-type: none"> <li>Another question with the <b>Yes</b> or <b>No</b> radio buttons appears (shown below).</li> </ul> <div style="border: 1px solid black; padding: 5px;"> <p><b>Will the agency provide group services to three or more children for five or more hours per week, for more than 30 days in a 12-month period? *</b></p> <input type="radio"/> Yes  <input type="radio"/> No       </div> <p>Selecting 'Yes'</p> <ul style="list-style-type: none"> <li>Another question with the <b>Yes</b> or <b>No</b> radio buttons appears (shown below).</li> </ul> <div style="border: 1px solid black; padding: 5px;"> <p><b>Do you currently hold a NYS Office of Children and Family Services day care permit/license for children ages birth through age 2 at this site? *</b></p> <input type="radio"/> Yes  <input type="radio"/> No       </div> <p>Selecting 'Yes'</p> <ul style="list-style-type: none"> <li>The following fields appear (shown below).</li> </ul> <div style="border: 1px solid black; padding: 5px;"> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;"><b>Name of Day care *</b></td> <td style="width: 70%;"><input type="text"/></td> </tr> <tr> <td><b>License/Permit Number *</b></td> <td><input type="text"/></td> </tr> <tr> <td><b>License Effective Date *</b></td> <td><input type="text"/> mm/dd/yyyy </td> </tr> <tr> <td><b>License Expiration Date *</b></td> <td><input type="text"/> mm/dd/yyyy </td> </tr> </table> </div> <ul style="list-style-type: none"> <li><b>Name of Day Care *</b>: Enter the name of the daycare.</li> <li><b>License/Permit Number *</b>: Enter the professional license/permit number.</li> <li><b>License Effective Date *</b>: Manually enter or use the calendar picker for the person's license effective date.</li> <li><b>License Expiration Date *</b>: Manually enter or use the calendar picker for the person's license expiration.</li> </ul>	<b>Name of Day care *</b>	<input type="text"/>	<b>License/Permit Number *</b>	<input type="text"/>	<b>License Effective Date *</b>	<input type="text"/> mm/dd/yyyy	<b>License Expiration Date *</b>	<input type="text"/> mm/dd/yyyy
<b>Name of Day care *</b>	<input type="text"/>									
<b>License/Permit Number *</b>	<input type="text"/>									
<b>License Effective Date *</b>	<input type="text"/> mm/dd/yyyy									
<b>License Expiration Date *</b>	<input type="text"/> mm/dd/yyyy									
<b>Is this service site a NYC DOH Licensed/Permitted Day Care for</b>	Required, Conditional, Yes, or No	Select the appropriate response.								

FIELD	FIELD TYPE	DESCRIPTION
<b>children ages birth through age 2? *</b>		
<b>Will each child" parent or guardian be present for all sessions? *</b>	Required, Conditional, Yes, or No	Select the appropriate response.
<b>Will the agency provide group services to three or more children for three or more hours per day per child?*</b>	Required, Conditional, Yes, or No	Select the appropriate response.
<b>Do you currently hold a NYS Office of Children and Family Services day care permit/license for children ages birth through age 2 at this site?*</b>	Required, Conditional, Yes, or No	Select the appropriate response.
<b>Will the agency provide group services to three or more children for five or more hours per week, for more than 30 days in a 12-month period?*</b>	Required, Conditional, Yes, or No	Select the appropriate response.

BUTTON	DESCRIPTION
<b>Close</b> 	Click this button to close the Service Sites panel; changes do not save.
<b>Save changes</b> 	Click this button to save your changes, and it closes the Service Sites panel.

HYPERLINKS	DESCRIPTION
<b>Actions</b>  <a href="#">Display</a>   <a href="#">Delete</a>   <a href="#">Edit</a>	<p>After adding a record in a grid/table, there are the three (3) hyperlink labels and their descriptions below:</p> <ul style="list-style-type: none"> <li>• <b>Display:</b> A popup panel appears (read-only) when clicked.</li> <li>• <b>Delete:</b> When clicked, a popup panel appears with two buttons, '<b>Close</b>' (gray button) and '<b>Delete</b>' (red button).             <ul style="list-style-type: none"> <li>○ To cancel the deletion, click the <b>Close</b> button.</li> <li>○ To confirm the removal of the record, click the <b>Delete</b> button. When clicked, the record is removed (deleted) from the grid/table.</li> </ul> </li> <li>• <b>Edit:</b> A popup panel appears (edit mode).</li> </ul> <p><b>(i)</b> The 'Close' and 'Save Changes' buttons work the same as described above.</p>

## Service Types Tab

 This section is to denote all service types for each site. Using the catchment area checkboxes, select all that apply to the early intervention service types requesting approval. Catchment areas are counties where you or employees (for agencies) can actively deliver services. You must be accurate when adding service model and service type combinations. EIP providers can only deliver the services they are authorized to deliver under their license or certification professional scope of practice.

### Service Sites

The agency must employ Quality Assurance (QA) Professionals.

- A QA Professional is a professional employed by the agency whose responsibilities include monitoring and overseeing implementation of the agency's quality assurance plan the agency's quality assurance plan
- The agency must have a QA Professional for each early intervention service/profession the agency will be providing.
- Each QA Professional must hold a license, certification, or registration for each type of early intervention service/profession/service coordination.
- The fully executed Partnership Agreement will need to be uploaded on the Uploads tab
- There does not need to be separate QA Professionals for evaluation and services. For instance, an SLP QA 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.

### Service Types and Models

Service Model	Service Type	Catchment Area	Actions
			<a href="#">Add</a>

[Close](#) [Save changes](#)

Service Sites

[Site](#)   [Service Types](#)   [CPR](#)   [Upload](#)

Service Types and Models

Service Model	Service Type	Catchment Area	Actions
			<a href="#">Display</a>   <a href="#">Delete</a>   <a href="#">Edit</a>
			<a href="#">Add</a>

[Close](#)   [Save changes](#)

**(i)** You must enter service models and service types in appropriate combinations for each catchment area.

**(i)** Providers should only select valid combinations for services they are qualified to apply for at the time of application. When applying to provide a service, providers will need to create a separate entry for each service model, service type, and catchment area combination. This will result in multiple entries for the provider to apply for a service model.

#### 9.2.5.3.2.1 Service Types and Models Grid/Table

Service Types and Models

Service Model	Service Type	Catchment Area	Actions
			<a href="#">Add</a>

 Click the **Add** button, and the ‘Service Type and Models’ popup panel appears (shown below).

##### 9.2.5.3.2.1.1 Service Types and Models Popup Panel

 This section is to denote all service types for each site. Using the catchment area checkboxes, select all that apply to the early intervention service types requesting approval. Catchment areas are counties where you or employees (for agencies) can actively deliver services. You must be accurate when adding service model and service type combinations. EIP providers can only deliver the services they are authorized to deliver under their license or certification professional scope of practice.

 You must enter service models and service types in appropriate combinations for each catchment area. Please refer to *El-HUB RESOURCE: Service Models and Methods for Qualified Professions in the New York State Early Intervention Program* for guidance.

 Providers should only select valid combinations for services they are qualified to apply for at the time of application.

**Service Types and Models** X

Indicate all service types for each site

**Service Model \***

**Service Type \***

*Select the early intervention service types for which you are seeking approval.*

**Catchment Area \***

Catchment Area	
<input type="checkbox"/> Bronx County	<input type="checkbox"/> Kings County
<input type="checkbox"/> New York County	<input type="checkbox"/> Queens County
<input type="checkbox"/> Richmond County	<input type="checkbox"/> Albany County
<input type="checkbox"/> Allegany County	<input type="checkbox"/> Broome County
<input type="checkbox"/> Cattaraugus County	<input type="checkbox"/> Cayuga County
<input type="checkbox"/> Chautauqua County	<input type="checkbox"/> Chemung County
<input type="checkbox"/> Chenango County	<input type="checkbox"/> Clinton County
<input type="checkbox"/> Columbia County	<input type="checkbox"/> Cortland County
<input type="checkbox"/> Delaware County	<input type="checkbox"/> Dutchess County
<input type="checkbox"/> Erie County	<input type="checkbox"/> Essex County
<input type="checkbox"/> Franklin County	<input type="checkbox"/> Fulton County
<input type="checkbox"/> Genesee County	<input type="checkbox"/> Greene County
<input type="checkbox"/> Hamilton County	<input type="checkbox"/> Herkimer County
<input type="checkbox"/> Jefferson County	<input type="checkbox"/> Lewis County
<input type="checkbox"/> Livingston County	<input type="checkbox"/> Madison County
<input type="checkbox"/> Monroe County	<input type="checkbox"/> Montgomery County
<input type="checkbox"/> Nassau County	<input type="checkbox"/> Niagara County
<input type="checkbox"/> Oneida County	<input type="checkbox"/> Onondaga County
<input type="checkbox"/> Ontario County	<input type="checkbox"/> Orange County
<input type="checkbox"/> Orleans County	<input type="checkbox"/> Oswego County
<input type="checkbox"/> Otsego County	<input type="checkbox"/> Putnam County
<input type="checkbox"/> Rensselaer County	<input type="checkbox"/> Rockland County
<input type="checkbox"/> St. Lawrence County	<input type="checkbox"/> Saratoga County
<input type="checkbox"/> Schenectady County	<input type="checkbox"/> Schoharie County
<input type="checkbox"/> Schuyler County	<input type="checkbox"/> Seneca County
<input type="checkbox"/> Steuben County	<input type="checkbox"/> Suffolk County
<input type="checkbox"/> Sullivan County	<input type="checkbox"/> Tioga County
<input type="checkbox"/> Tompkins County	<input type="checkbox"/> Ulster County
<input type="checkbox"/> Warren County	<input type="checkbox"/> Washington County
<input type="checkbox"/> Wayne County	<input type="checkbox"/> Westchester County
<input type="checkbox"/> Wyoming County	<input type="checkbox"/> Yates County

FIELD	FIELD TYPE	DESCRIPTION
<b>Service Model *</b>	Required, Drop-Down	Select the appropriate service model from the list.  A conditional field appears depending on which service model is selected.
		<p><b>Physician's Letter Upload *</b></p> <p><i>The letter must be on the physician's letterhead.</i></p> <p style="text-align: right;"><a href="#">Browse...</a></p>
<b>Service Type *</b>	Required, Drop-Down	Select the appropriate service type from the list.
<b>Catchment Area *</b>	Required, Checkboxes	Select/tick the catchment area for the early intervention service types requesting approval.

**Service Types and Models**

Indicate all service types for each site

**Service Model \***

**Service Type \***

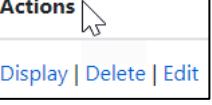
Select the early intervention service types for which you are seeking approval.

**Catchment Area \***

<input type="checkbox"/> Bronx County	<input type="checkbox"/> Kings County
<input type="checkbox"/> New York County	<input type="checkbox"/> Queens County
<input type="checkbox"/> Richmond County	<input type="checkbox"/> Albany County
<input type="checkbox"/> Allegany County	<input type="checkbox"/> Broome County
<input type="checkbox"/> Cattaraugus County	<input type="checkbox"/> Cayuga County
<input type="checkbox"/> Chautauqua County	<input type="checkbox"/> Chemung County
<input type="checkbox"/> Chenango County	<input type="checkbox"/> Clinton County
<input type="checkbox"/> Columbia County	<input type="checkbox"/> Cortland County
<input type="checkbox"/> Delaware County	<input type="checkbox"/> Dutchess County
<input type="checkbox"/> Erie County	<input type="checkbox"/> Essex County
<input type="checkbox"/> Franklin County	<input type="checkbox"/> Fulton County
<input type="checkbox"/> Genesee County	<input type="checkbox"/> Greene County
<input type="checkbox"/> Hamilton County	<input type="checkbox"/> Herkimer County
<input type="checkbox"/> Jefferson County	<input type="checkbox"/> Lewis County
<input type="checkbox"/> Livingston County	<input type="checkbox"/> Madison County
<input type="checkbox"/> Monroe County	<input type="checkbox"/> Montgomery County
<input type="checkbox"/> Nassau County	<input type="checkbox"/> Niagara County
<input type="checkbox"/> Oneida County	<input type="checkbox"/> Onondaga County
<input type="checkbox"/> Ontario County	<input type="checkbox"/> Orange County
<input type="checkbox"/> Orleans County	<input type="checkbox"/> Oswego County
<input type="checkbox"/> Otsego County	<input type="checkbox"/> Putnam County
<input type="checkbox"/> Rensselaer County	<input type="checkbox"/> Rockland County
<input type="checkbox"/> St. Lawrence County	<input type="checkbox"/> Saratoga County
<input type="checkbox"/> Schenectady County	<input type="checkbox"/> Schoharie County
<input type="checkbox"/> Schuyler County	<input type="checkbox"/> Seneca County
<input type="checkbox"/> Steuben County	<input type="checkbox"/> Suffolk County
<input type="checkbox"/> Sullivan County	<input type="checkbox"/> Tioga County
<input type="checkbox"/> Tompkins County	<input type="checkbox"/> Ulster County
<input type="checkbox"/> Warren County	<input type="checkbox"/> Washington County
<input type="checkbox"/> Wayne County	<input type="checkbox"/> Westchester County
<input type="checkbox"/> Wyoming County	<input type="checkbox"/> Yates County

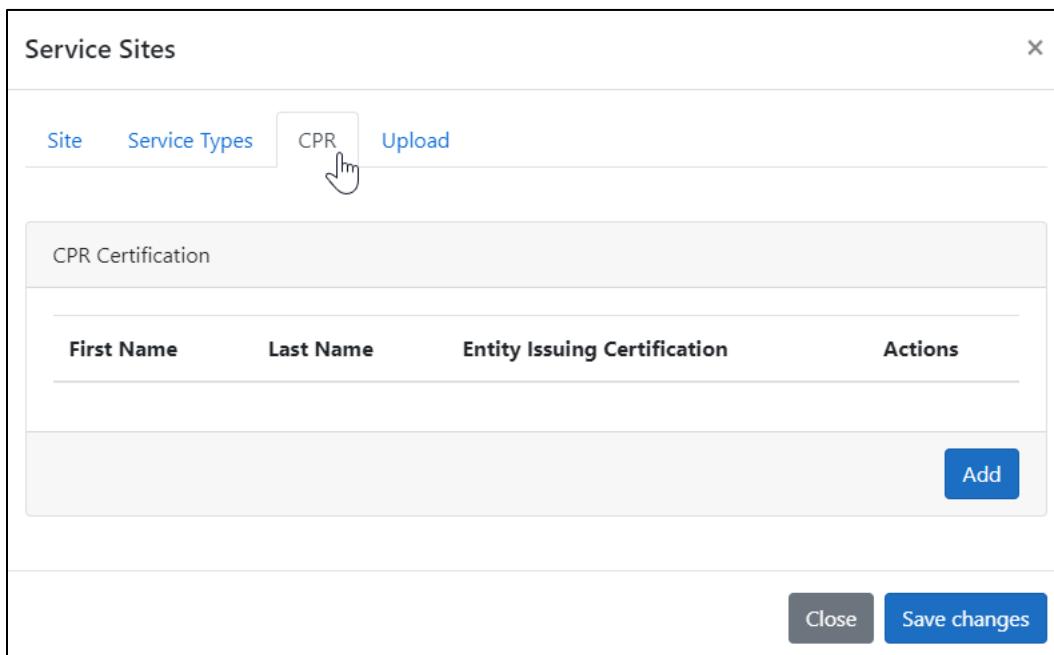
[Close](#) [Save changes](#)

BUTTON	DESCRIPTION
<b>Upload QA plan *</b> 	<p><b>Step / Action</b></p> <ol style="list-style-type: none"> <li>1. To upload documents, click the <b>Browse</b> button adjacent to the appropriate label. When clicked, a dialog window/box appears.           <ul style="list-style-type: none"> <li>• Some dialog boxes display "<b>Choose File to Upload</b>" or "<b>Open</b>" depending on your browser (MS Edge, Google Chrome).</li> </ul> </li> <li>2. Search and attach your file by clicking the <b>Open</b> button.</li> </ol>
<b>Close</b> 	Click this button to close the Service Types and Models panel; changes do not save.
<b>Save changes</b> 	Click this button to save your changes and close the Service Types and Models panel.

HYPERLINKS	DESCRIPTION
<b>Actions</b>  Display   Delete   Edit	<p>After adding a record in a grid/table, there are the three (3) hyperlink labels and their descriptions below:</p> <ul style="list-style-type: none"> <li>• <b>Display:</b> A popup panel appears (read-only) when clicked.</li> <li>• <b>Delete:</b> When clicked, a popup panel appears with two buttons, '<b>Close</b>' (gray button) and '<b>Delete</b>' (red button).           <ul style="list-style-type: none"> <li>○ To cancel the deletion, click the <b>Close</b> button.</li> <li>○ To confirm the removal of the record, click the <b>Delete</b> button. The record is removed (deleted) from the grid/table when clicked.</li> </ul> </li> <li>• <b>Edit:</b> A popup panel appears (edit mode).</li> </ul> <p> The 'Close' and 'Save Changes' buttons work the same as described above.</p>

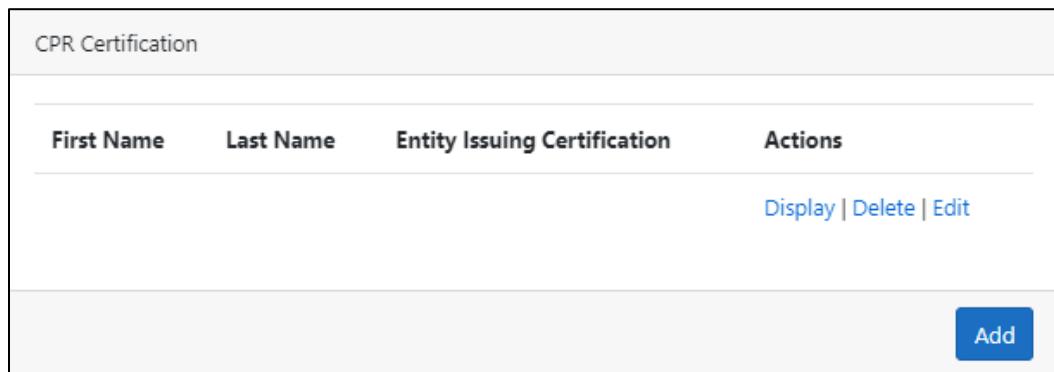
### 9.2.5.3.3 CPR Tab

 Use this section to add service site personnel Cardiopulmonary Resuscitation (CPR) certification.



The screenshot shows a modal window titled 'Service Sites'. At the top, there are tabs: 'Site' (selected), 'Service Types', 'CPR' (which has a hand cursor icon over it), and 'Upload'. Below the tabs is a section labeled 'CPR Certification'. A table grid follows, with columns: 'First Name', 'Last Name', 'Entity Issuing Certification', and 'Actions'. In the 'Actions' column, there is a blue 'Add' button. At the bottom right of the modal are 'Close' and 'Save changes' buttons.

#### 9.5.3.1.1 CPR Certification Grid/Table



CPR Certification			
First Name	Last Name	Entity Issuing Certification	Actions
			<a href="#">Display</a>   <a href="#">Delete</a>   <a href="#">Edit</a>

 Click the **Add** button, and the 'CPR Certification' popup panel appears (shown below).

### 9.5.3.1.1.1 CPR Certification Popup Panel

CPR Certification

<b>First Name *</b>	<input type="text"/>
<b>Last Name *</b>	<input type="text"/>
<b>Entity Issuing Certification *</b>	<input type="text"/>
<b>Certification Number *</b>	<input type="text"/>
<b>Certification Effective Date *</b>	<input type="text"/> mm/dd/yyyy <input type="button" value="Calendar"/>
<b>Certification Expiration Date *</b>	<input type="text"/> mm/dd/yyyy <input type="button" value="Calendar"/>
<input type="button" value="Close"/> <input type="button" value="Save changes"/>	

FIELD	FIELD TYPE	DESCRIPTION
<b>First Name *</b>	Required, Text Entry	Enter the professional person's first name.
<b>Last Name *</b>	Required, Text Entry	Enter the professional person's last name.
<b>Entity Issuing Certification *</b>	Required, Text Entry	Enter the name of the entity issuing the certification.
<b>Certification Number *</b>	Required, Text Entry	Enter the CPR certification number
<b>Certification Effective Date *</b>	Required, Date/Calendar	Enter the CPR effective date (manually typing or using the calendar picker).
<b>Certification Expiration Date *</b>	Required, Date/Calendar	Enter the CPR expiration date (manually typing or using the calendar picker).

HYPERLINKS	DESCRIPTION
<b>Actions</b>  <a href="#">Display</a>   <a href="#">Delete</a>   <a href="#">Edit</a>	<p>After adding a record in a grid/table, there are the three (3) hyperlink labels and their descriptions below:</p> <ul style="list-style-type: none"> <li><b>Display:</b> A popup panel appears (read-only) when clicked.</li> <li><b>Delete:</b> When clicked, a popup panel appears with two buttons, '<b>Close</b>' (gray button) and '<b>Delete</b>' (red button).             <ul style="list-style-type: none"> <li>To cancel the deletion, click the <b>Close</b> button.</li> <li>To confirm the removal of the record, click the <b>Delete</b> button. The record is removed (deleted) from the grid/table when clicked.</li> </ul> </li> <li><b>Edit:</b> A popup panel appears (edit mode).</li> </ul> <p><b>i</b> The 'Close' and 'Save Changes' buttons work the same as described above.</p>

BUTTON	DESCRIPTION
<b>Close</b> 	Click this button to close the CPR Certification Panel; changes do not save.
<b>Save Changes</b> 	Click this button to save your changes, and it closes the CPR Certification Panel.

#### 9.2.5.3.4 Upload Tab

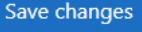
 Uploads are limited to 10 MB and must be in one of the following formats: JPG, PDF, or PNG. The system will not accept files in other formats and/or larger than 10 MB. **Please ensure the supporting documentation is clear, legible, and oriented correctly.**

The agency must provide a written plan to comply with all local fire, health, and safety codes. In addition, it will employ a policy for addressing health, safety, and sanitation issues (including diapering, handwashing, and food preparation) that conform to standards established by the Department and complies with the Americans with Disabilities Act.

Service Sites X

<a href="#">Site</a>	<a href="#">Service Types</a>	<a href="#">CPR</a>	<a href="#">Upload</a> 
<p>Uploads are limited to 10 MB and must be in one of the following formats only: JPG, PDF, or PNG. Files in other formats and/or larger than 10 MB will not be accepted. <b>Please ensure the supporting documentation is clear, legible, and oriented correctly.</b></p> <p><b>Health and Safety Plan *</b> <span style="float: right;"><a href="#">Browse...</a></span></p> <p><i>The agency must provide a written plan 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 (including diapering, handwashing, and food preparation) that conform to standards established by the Department; and is in compliance with the Americans with Disabilities Act.</i></p>			
<a href="#">Close</a> <a href="#">Save changes</a>			

BUTTON	DESCRIPTION
<b>Health and Safety Plan *</b> 	<p><b>Step / Action</b></p> <ol style="list-style-type: none"> <li>3. To upload documents, click the <b>Browse</b> button adjacent to the appropriate label. When clicked, a dialog window/box appears.           <ul style="list-style-type: none"> <li>• Some dialog boxes display "<b>Choose File to Upload</b>" or "<b>Open</b>" depending on your browser (MS Edge, Google Chrome).</li> </ul> </li> <li>4. Search and attach your file by clicking the <b>Open</b> button.</li> </ol>

BUTTON	DESCRIPTION
<b>Close</b> 	Click this button to close the Service Types and Models panel; changes do not save.
<b>Save changes</b> 	Click this button to save your changes and close the Service Types and Models panel.

### 9.2.5.3.5 Services Tab

**Individual Application**

Identifying Information   Professional Experience and Certification   Insurance   Specialty Populations   **Services**   Disclosures

Upload   Appendix 1 Agreement   Provider Agreement

Service Sites

**Will you provide services at a facility you own, lease, rent, manage, operate from, or otherwise use on a regular basis? \***

Yes  
 No

**Are you requesting approval for services that will be provided in other settings (ex. children's homes or a community setting like a child's daycare)? \***

Yes  
 No

Please save your progress often and remember that you can only save if all required fields on the page have been completed and there are no errors to be resolved. The submit application button will initiate a system review of your application and report any errors. Successful submission of the PAT will result in your application being reviewed for approval by the BEI Provider Approval Unit.

[Previous Tab](#)   [Next Tab](#)

[Save Progress](#)   [Submit Application](#)

FIELD	FIELD TYPE	DESCRIPTION
<b>Will you provide services at a facility you own, lease, rent, manage, operate from, or otherwise wise on a regular basis? *</b>	Required, Yes or No	Select the appropriate response.
<b>Are you requesting approval for services that will be provided in other settings (ex. children's homes or a community setting like a child's daycare)? *</b>	Required, Yes or No	Select the appropriate response.  The 'Service Types and Models' grid/table appears (shown below), selecting 'Yes.'

### 9.2.5.3.5.1 Services Types and Models Panel

**Service Types and Models** ×

Indicate all service types for each site

**Service Model \***

**Service Type \***

*Select the early intervention service types for which you are seeking approval.*

**Catchment Area \***

Catchment Area	
<input type="checkbox"/> Bronx County	<input type="checkbox"/> Kings County
<input type="checkbox"/> New York County	<input type="checkbox"/> Queens County
<input type="checkbox"/> Richmond County	<input type="checkbox"/> Albany County
<input type="checkbox"/> Allegany County	<input type="checkbox"/> Broome County
<input type="checkbox"/> Cattaraugus County	<input type="checkbox"/> Cayuga County
<input type="checkbox"/> Chautauqua County	<input type="checkbox"/> Chemung County
<input type="checkbox"/> Chenango County	<input type="checkbox"/> Clinton County
<input type="checkbox"/> Columbia County	<input type="checkbox"/> Cortland County
<input type="checkbox"/> Delaware County	<input type="checkbox"/> Dutchess County
<input type="checkbox"/> Erie County	<input type="checkbox"/> Essex County
<input type="checkbox"/> Franklin County	<input type="checkbox"/> Fulton County
<input type="checkbox"/> Genesee County	<input type="checkbox"/> Greene County
<input type="checkbox"/> Hamilton County	<input type="checkbox"/> Herkimer County
<input type="checkbox"/> Jefferson County	<input type="checkbox"/> Lewis County
<input type="checkbox"/> Livingston County	<input type="checkbox"/> Madison County
<input type="checkbox"/> Monroe County	<input type="checkbox"/> Montgomery County
<input type="checkbox"/> Nassau County	<input type="checkbox"/> Niagara County
<input type="checkbox"/> Oneida County	<input type="checkbox"/> Onondaga County
<input type="checkbox"/> Ontario County	<input type="checkbox"/> Orange County
<input type="checkbox"/> Orleans County	<input type="checkbox"/> Oswego County
<input type="checkbox"/> Otsego County	<input type="checkbox"/> Putnam County
<input type="checkbox"/> Rensselaer County	<input type="checkbox"/> Rockland County
<input type="checkbox"/> St. Lawrence County	<input type="checkbox"/> Saratoga County
<input type="checkbox"/> Schenectady County	<input type="checkbox"/> Schoharie County
<input type="checkbox"/> Schuyler County	<input type="checkbox"/> Seneca County
<input type="checkbox"/> Steuben County	<input type="checkbox"/> Suffolk County
<input type="checkbox"/> Sullivan County	<input type="checkbox"/> Tioga County
<input type="checkbox"/> Tompkins County	<input type="checkbox"/> Ulster County
<input type="checkbox"/> Warren County	<input type="checkbox"/> Washington County
<input type="checkbox"/> Wayne County	<input type="checkbox"/> Westchester County
<input type="checkbox"/> Wyoming County	<input type="checkbox"/> Yates County

FIELD	FIELD TYPE	DESCRIPTION
Service Model *	Required, Drop-Down	Select the appropriate service model from the list.
Service Type *	Required, Drop-Down	Select the appropriate service type from the list.
Catchment Area *	Required, Checkboxes	Select/tick the catchment area(s) that apply to the early intervention service types requesting approval.

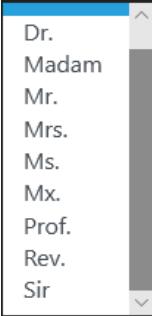
BUTTON	DESCRIPTION
Upload QA plan *	<p><b>Step / Action</b></p> <p>1. To upload documents, click the <b>Browse</b> button adjacent to the appropriate label. When clicked, a dialog window/box appears.</p> <ul style="list-style-type: none"> <li>Some dialog boxes display "<b>Choose File to Upload</b>" or '<b>Open</b>' depending on your browser (MS Edge, Google Chrome).</li> </ul> <p>2. Search and attach your file by clicking the <b>Open</b> button.</p>
Close	Click this button to close the Service Types and Models panel; changes do not save.
Save changes	Click this button to save your changes and close the Service Types and Models panel.

#### 9.2.5.4 Qualified Professional 1 & 2 Grid/Tables

 The field description table below applies to Qualified Professionals 1 & 2. Let's use the 'Qualified Professional 1' table as an example.

 In the table below, the application collects information about the agency's 'Program Director' and two (2) qualified personnel. After an agency is approved, the agency will add (additional) qualified personnel to your agency's roster.

FIELD	FIELD TYPE	DESCRIPTION
Salutation *	Required, Drop-Down	<p>Select the appropriate salutation from the list.</p> <p> All personnel must be certified, licensed, hold a current registration in NYS, or meet the minimum qualifications outlined in EI regulations.</p>

FIELD	FIELD TYPE	DESCRIPTION
		
<b>First Name *</b> <small>The name entered must exactly match the name on all licenses and certifications.</small>	Required, Text Entry	<p>Enter the first name of the agency-qualified professional 1 (QP).</p> <p><b>i</b> The two Qualified Professionals (QP) must provide evaluations, service coordination, or services to individuals with disabilities for a minimum of twenty hours per week.</p>
<b>Middle Name/Initial</b> <small>If entering an initial, please do not enter the period (.)</small>	Optional, Text Entry	<p>Enter the middle name or initial of the QP.</p> <p><b>i</b> If entering an initial, please do not enter a period (.).</p>
<b>Last Name *</b>	Required, Text Entry	Enter the last name or initial of the QP.
<b>Suffix *</b>	Optional, Drop Down	Select the appropriate suffix from the list.
<b>Address *</b> <small>If entering a PO Box in any of the 3 address fields, please do not enter the periods(.)</small>	Required, Text Entry	<ul style="list-style-type: none"> <li><b>Line1:</b> Enter the QP site address.</li> <li><b>Line2:</b> If applicable</li> <li><b>Line3:</b> If applicable</li> <li><b>Zip Code:</b> Enter the Zip +4</li> <li><b>City/Town:</b> Enter the site city/town.</li> <li><b>State:</b> Use the drop-down and select the state where the QP resides.</li> </ul>
<b>Primary Phone Number</b>	Required, Numeric Entry	Enter the primary phone number for the QP.
<b>Primary Email *</b>	Required, Text Entry	<ul style="list-style-type: none"> <li><b>Email:</b> Enter the best email address to reach (e.g., while at work) the Main Contact Person by email.</li> <li><b>Email (verify):</b> Re-enter the same email for verification.</li> </ul>
<b>Social Security Number *</b>	Required, Numeric Entry	Enter the SSN for the QP.
<b>NPI *</b> <small>National Provider Identifier</small>	Required, Text Entry	Enter the National Provider Identifier (NPI) number for the QP.
<b>Sex *</b>	Required, Drop-Down	Enter the sex for the QP.

FIELD	FIELD TYPE	DESCRIPTION
		<div style="border: 1px solid #ccc; padding: 5px; width: fit-content;">           Male            Female            Non-binary            Prefer not to say         </div>
Date of Birth *	Required, Numeric Entry	Enter the date of birth for the QP.
Profession *  <b>(i) Must be a recognized EI profession.</b>	Required, Drop-Down	Select the appropriate profession from the list for the QP.  <b>(i) When selecting “Physician” (QP1 &amp; QP2- Profession = Physician), a specialty field appears (shown below).</b> <div style="border: 1px solid #ccc; padding: 5px; margin-top: 10px;">           Qualified Professional 1 Profession * <input type="text" value="Physician"/> <span style="float: right;">▼</span>            Physician Specialty * <input type="text"/> </div>
License/Certification Type *  <b>*</b>	Required, Drop-Down	Select the appropriate QP license/ certification type.
Licenses/ Certification Control Number *	Required, Text Entry	Enter the license/certification control number for the QP.
License/Certification Effective Date *	Required, Date/ Calendar	Manually enter or use the calendar picker for the license effective date for the person.
License/Certification Expiration Date *	Optional, Date/ Calendar	Manually enter or use the calendar picker for the license expiration date for the person.
Are you the Quality Assurance Professional for this Profession? *	Required, Yes or No	Select the appropriate response.

**(i) Populate the required (\*) fields for the Qualified Professional 2 form (not shown).**

#### 9.2.5.5 Employees and Contractors Grid/Table

Employees and Contractors			
Profession	Number Employed by Profession	Number Contracted by Profession	Actions
			<b>Add</b>

 Click the **Add** button, and the ‘Employees and Contractors’ popup panel appears (shown below).

### 9.2.5.5.1 Employees and Contractors Popup Panel

 Employees' duties are defined, directed, 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)

A contractor does not receive wages and generally receives an IRS form 1099 at the end of the year; this refers to individual qualified personnel available to an agency or municipality through a contractual agreement.

An agency does not employ an individual under contract. Therefore, EI Agencies can only contract with providers who have and maintain individuals or agencies approved by the DOH Bureau of Early Intervention. Maintaining approval means they are approved and have an active agreement (the agreement's expiration date has not passed).

**Employees and Contractors**

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)

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.

<b>Profession *</b>	<input type="text"/>
<b>Number Employed by Profession</b>	<input type="text"/>
<input type="button" value="Close"/> <input type="button" value="Save changes"/>	

FIELD	FIELD TYPE	DESCRIPTION
<b>Profession *</b>   Must be a recognized EI profession.	Required, Drop-Down	Select the appropriate profession (e.g., Nurse Practitioner) from the list.   After populating this drop-down field, the “Number Contracted by Profession” field appears.   When selecting “Physician” (QP1 & QP2- Profession = Physician), a specialty field appears (shown below).
<b>Number Employed by Profession</b>	Optional, Text Entry	Enter the number employed by profession.



Based on the profession selected, the conditional field appears on the screen.

**Employees and Contractors**

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)

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.

<b>Profession *</b>	Nurse Practitioner
<b>Number Employed by Profession</b>	
<b>Number Contracted by Profession</b>	

**Close** **Save changes**

FIELD	FIELD TYPE	DESCRIPTION
<b>Number Employed by Profession</b>	Optional, Text Entry	Enter the number employed by profession.
<b>Number Contracted by Profession</b>	Optional, Conditional Text Entry	Enter the number contracted by profession.  <b>i</b> Not all professions can be contractors.

BUTTON	DESCRIPTION
<b>Close</b> Close	Click this button to close the Employees and Contractors panel; do not save.
<b>Save changes</b> Save changes	Click this button to save your changes, and it closes the Employees and Contractors panel.

Hyperlinks	DESCRIPTION
<b>Actions</b>  <a href="#">Display</a>   <a href="#">Delete</a>   <a href="#">Edit</a>	<p>After adding a record in a grid/table, there are the three (3) hyperlink labels and their descriptions below:</p> <ul style="list-style-type: none"> <li><b>Display:</b> A popup panel appears (read-only) when clicked.</li> <li><b>Delete:</b> When clicked, a popup panel appears with two buttons, '<b>Close</b>' (gray button) and '<b>Delete</b>' (red button).             <ul style="list-style-type: none"> <li>To cancel the deletion, click the <b>Close</b> button.</li> <li>To confirm the removal of the record, click the <b>Delete</b> button. The record is removed (deleted) from the grid/table when clicked.</li> </ul> </li> <li><b>Edit:</b> A popup panel appears (edit mode).</li> </ul> <p><b>i</b> The 'Close' and 'Save Changes' buttons work the same as described above.</p>

## 9.2.6 Uploads Tab

### Agency Application

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Basic Information      Director      Agency Background      Disclosures      Services to Provide      **Uploads**      Agreements

**Upload IRS FEIN Assignment Letter (required) \***  
Include a copy of notice from the IRS confirming your agency's FEIN number.

**Upload Program Standards Table of Contents and Outline (required) \***

*Agencies must have a Program Standards Plan that includes policies and procedures to ensure the following:*

- services delivered by employees and contractors of the agency are delivered in accordance with federal and state laws and regulations and in compliance with the New York State Department of Health Provider Agreement. Please be aware that an approved EI Agency Provider is responsible for and shall ensure that its employees and individual providers under contract with such Agency Provider comply with the provisions of applicable law and regulations, and with the terms of the Provider Agreement with the Department, when delivering evaluations or services on behalf of the Agency Provider;
- compliance with policies, procedures, and guidance issued by the Department that clarify requirements of law and regulation related to the Early Intervention Program;
- 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;
- meeting and communication with parents and other service providers;
- clinical membership 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.

Please submit a summary of the Program Standards Plan and include a table of contents of the completed plan. The entire Program Standards Plan does not need to be submitted, but must be available for review by local or State Early Intervention Program personnel or their designee.

**Upload Statement of Fiscal Viability (required) \***  
Provide information detailing specifically how your agency is "fiscally viable," including how it will maintain existence of external business operations in compliance with federal and state requirements (include an affidavit statement that the applicant is in compliance with state and federal tax and labor laws, regulations and requirements); adequate financial resources to pay any mandatory business fees/expenses including Medicaid enrollment fees; support start-up and support at least a minimum three months of operational business expenses including compliance with labor laws and reimbursement to contractors, any business obligations supporting employees and obligations to any subcontractor, regardless of the volume of EI cases. Your agency is expected to have access to sufficient capital or lines of credit to cover operating expenses. Financial viability may be documented through audit reports and financial statements or other means which demonstrate responsibility and viability.

**Upload SED Corporate Practice Waiver**  
NYS Education Law prohibits some corporations from using licensed professionals. Review on the corporate structure of your agency, and the qualified personnel your agency employs or utilizing you may need to apply to the NYS Education Department (SED) for a waiver to provide these professional services to an EI agency. The instructions and forms to apply for the waiver can be found at <http://www.earlychildhood.ny.gov/waiver-elinfo.htm>. Your waiver application must be under the agency name identified on your EI application and enrolled with the NYS Department of State and include all clients. If your agency requires a waiver, DOH EI will tell you when to apply to SED. Do not start the SED application process before SED tells you to, as this will result in a denial of your waiver application.

**Upload NYSS DMV Driver's License or Non-driver photo ID or other photo identification if outside of NYSS or the Authorized Representative submitting the application \***

Please save your progress often and remember that you can only save if all required fields on the page have been completed and there are no errors to be resolved. The submit application button will initiate a system review of your application and report any errors. Successful submission of the PAT will result in your application being reviewed for approval by the EI Provider Approval Unit.

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[Previous Tab](#)    [Next Tab](#)

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[Save Progress](#)    **Submit Application**

**(i)** The uploads that are required/displayed are dependent on the previous selections made during the application process.

**PAU Please Note:** There is no option to upload “State Department Filing Receipt” as it’s now verified online.

**Uploads are limited to 10 MB and must be in one of the following formats: JPG, PDF, or PNG. The system will not accept files in other formats and/or larger than 10 MB.** Please ensure the supporting documentation is clear, legible, and oriented correctly.



**Upload IRS FEIN Assignment Letter (required). Include a copy of the notice from the IRS confirming your agency's FEIN number.**



Upload Program Standards Table of Contents and Outline (required): **Agencies must have a Program Standards Plan that includes policies and procedures to ensure the following:**

**Services delivered by employees and contractors of the agency are delivered in accordance with federal and state laws and regulations and compliance with the New York State Department of Health Provider Agreement.**



**Please note the following:**

- An approved EI Agency Provider is responsible for and shall ensure that its employees and Individual Providers are contracted with such Agency Provider.
- Comply with the provisions of applicable law and regulations and with the terms of the Provider Agreement with the Department when delivering evaluations or services on behalf of the Agency Provider.
- Compliance with policies, procedures, and guidance memoranda issued by the Department clarifies requirements of law and regulation related to the Early Intervention Program.
- Provision of services on a twelve-month basis and flexibility in the hours-of-service delivery, including evening and weekend hours.
- Provision of family-centered services.
- Teaming and communicating 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 depend 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



**Please submit a summary of the Program Standards Plan and include a table of contents of the completed plan. Please note that the entire 'Program Standards Plan' is not to be submitted but must be available for review by local or State Early Intervention Program personnel or their designees.**



**Upload Statement of Fiscal Viability (required):** Provide information detailing specifically how your agency is “basically viable,” including how it will maintain (the maintenance of) normal business operations in compliance with federal and state requirements (include an affirmative statement that the applicant complies with state and federal tax and labor rules, regulations and requirements); adequate financial resources to pay any mandatory business fees/expenses including Medicaid enrollment fees; support start-up; and, support at least a minimum three months of operational business expenses including compliance with labor laws and reimbursement to contractors, any business obligations supporting employees and obligations to any subcontractors, regardless of the volume of EI cases. In addition, your agency is expected to have access to sufficient capital or lines of credit to cover operating expenses. You may document financial viability through audit reports, financial statements, or other means demonstrating responsibility and viability.



**Upload SED Corporate Practice Waiver:** NYS Education Law prohibits some corporations from using licensed professionals. Based on the corporate structure of your agency and the qualified personnel your agency intends to utilize, you may need to apply to the NYS Education Department (SED) for a waiver to provide these professional services as an EI agency. You can find the instructions and forms to apply for the waiver at <http://www.op.nysesd.gov/waiver-ei-info.htm>. Your waiver application must be under the agency name identified on your EI application and enrolled with the NYS Department of State, and it must include all site(s) that you own/lease/rent where you will be seeing EI children. If your agency requires a waiver, DOH BEI will tell you when to apply to SED. Do not start the SED application process before BEI tells you to, as this will result in a denial of your waiver application.



**Upload** NYS DMV Driver's license or non-driver photo ID or other photo identification if outside of NYS of the Authorized Representative submitting the application.

### **Upload Quality Assurance Plan (QA Plan):**

- Early Intervention Program agency providers are required to have a comprehensive Quality Assurance (QA) Plan.
- The agency **must** submit its QA Plan to the Department of Health Bureau of Early Intervention (DOH BEI) when the agency is seeking initial approval and amending its approval. Providers may also be asked to submit their QA Plan at the time of re-approval.
- Agencies **must** also produce their QA Plan and evidence of implementation during a monitoring review or any additional time requested by the DOH BEI or the County.
- The comprehensive QA Plan should be individualized to the agency and must include all services offered by the agency, including evaluations, early intervention services, and service coordination.
- The QA Plan should reflect the agency's knowledge and understanding of the Early Intervention Program, each professions' scope of practice, and the services the agency will be providing.
- A QA Plan is a tool for the agency to communicate what quality means to them and set expectations for their employees and contractors.
- The agency program director is responsible for developing a quality assurance plan that is approved by the DOH BEI, implementing the plan, and monitoring that all quality assurance requirements are met.

### **Additional Information about QA Plans:**

- **Service Coordination:** Must include assurance that service coordinators complete introductory service coordination training sponsored or approved by the NYS Department of Health prior to rendering service coordination services—[Early Intervention Program Training - New York State Department of Health \(ny.gov\)](#). Additional information can be found in the Tool Kits for Service Coordinators at [https://www.health.ny.gov/community/infants\\_children/early\\_intervention/memoranda.htm](https://www.health.ny.gov/community/infants_children/early_intervention/memoranda.htm).
- **Evaluations:** The evaluations must include assurance that evaluators complete the DOH-sponsored Evaluation & Eligibility web-based training. [Early Intervention Program Training - New York State Department of Health \(ny.gov\)](#) prior to delivering services. In addition, staff should complete the review of the DOH-issued guidance on Evaluations & Eligibility in the EIP:
  - [Early Intervention Program Memorandum 2005-02 - New York State Department of Health \(ny.gov\)](#)
  - [Addendum to: Early Intervention Guidance Memorandum 2005-2 \(ny.gov\)](#)

### **SUGGESTED CONTENT:**

- Family/Child Confidentiality and Informed Consent
- Ensuring quality of services delivered to children and their families
- Recordkeeping/Documentation
- Ensuring the agency is in compliance with EIP requirements for child records, personnel records, and records to support claiming
- Record Retention (records storage, record access, personnel, employees/contractors)

### **Fiscal Oversight**

- Billing and claiming activities
- Fraud Prevention
- Medicaid compliance
- Recordkeeping/Documentation to support claiming

**Personnel**

- Ensuring qualified personnel have appropriate and current licensure, registration, and certification as applicable
- Ensuring continuing education and training requirements are met
- State Central Register clearance
- Justice Center clearance
- Medicaid Exclusion List clearance

**Training****Supervision**

- Individuals Completing their Experience Requirement/Practicum/Observation
- Employees
- Contractors

**Quality Assurance Activities**

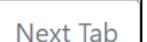
- What activities will be completed?
- How Often will Activities be completed (when)?
- Who will complete activities?
- What will be done if concerns are identified?

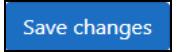
**Ethics Consideration****Scope of Competence**

**Consultation with Other Professionals** (Interaction with other professionals, *Program Director, Other Management*)

**Maintaining Continuing Professional Competence****Maintaining QA Plan:**

- How and when will the QA Plan be reviewed and modified if needed?
- How will updates made to the plan be disseminated?

BUTTON	DESCRIPTION
<b>Browse</b>  Browse...	<p><b>Step / Action</b></p> <ol style="list-style-type: none"> <li>1. To upload documents, click the <b>Browse</b> button adjacent to the appropriate label. When clicked, a dialog window/box appears.           <ul style="list-style-type: none"> <li>• Some dialog boxes display “Choose File to Upload” or “Open” depending on your browser (MS Edge, Google Chrome).</li> <li>• Search and attach your file by clicking the <b>Open</b> button.</li> </ul> </li> </ol> <p> <b>The instruction mentioned above applies to all the upload labels/items in this table.</b></p>
<b>Previous Tab</b>  Previous Tab	<p>To return to the previous tab. Click this button.</p> <p> <b>This button appears in the remaining tabs after advancing to the second tab on the screen.</b></p>
<b>Next Tab</b>  Next Tab	<p>Click this button to advance to the next tab on the screen (panel). Alternatively, click the next tab on the top (below the screen's header name).</p> <p> <b>This button appears in the remaining tabs after advancing to the second tab on the screen.</b></p>

BUTTON	DESCRIPTION
<b>Save changes</b> 	Click this button to save your changes and close the Service Types and Models panel.
<b>Submit Application</b> 	Click this button if you have completed all the tabs and are ready to submit your application.  <b><i>(i)</i> If an error is encountered when completing the PAST, you must clear all errors before the system allows you to submit the application successfully.</b>



Below is an example (snippet) of a partially completed Uploads form.

## Agency Application

Basic Information   Director   Agency Background   Disclosures   Seeking to Provide   **Uploads**   Agreements

Uploads are limited to 10 MB and must be in one of the following formats only: JPG, PDF, or PNG. Files in other formats and/or larger than 10 MB will not be accepted. **Please ensure the supporting documentation is clear, legible, and oriented correctly.**

**Upload IRS FEIN Assignment Letter (required) \***

**Browse...**

*Include a copy of notice from the IRS confirming your agency's FEIN number.*

**Upload Program Standards Table of Contents and Outline (required) \***

**Browse...**

BUTTON	UPLOAD BUTTON
<b>Browse...</b>	<p><b>Step / Action</b></p> <ol style="list-style-type: none"> <li>1. To upload documents, click the <b>Browse</b> button adjacent to the appropriate label. When clicked, a dialog window/box appears.             <ul style="list-style-type: none"> <li>• Some dialog boxes display "<b>Choose File to Upload</b>" or "<b>Open</b>" depending on your browser (MS Edge, Google Chrome).</li> <li>• Search and attach your file by clicking the <b>Open</b> button.</li> </ul> </li> </ol> <p> <b>The instruction mentioned above applies to all the upload labels/items in this table.</b></p>

## 9.2.7 Agreements Tab



Below is an example of the Agreements form.

**Agency Application**

[Basic Information](#) [Director](#) [Agency Background](#) [Disclosures](#) [Seeking to Provide](#) [Uploads](#) [Agreements](#)

Please review the entire Provider Agreement and Appendix 1 thoroughly before proceeding.

Agency providers must agree to both the Provider Agreement and Appendix 1 to be approved.

Yes  
 No

Does the applicant wish to enter into an Provider Agreement? \*

Yes  
 No

Does the applicant wish to enter into an Appendix 1 Agreement? \*

Yes  
 No

Does the applicant attest to the following?

The applicant assures that the agency will abide by department policies as stated in guidelines issued by the Department that clarify requirements of law and regulation related to the Early Intervention Program. \*

Yes  
 No

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 these personnel. \*

Yes  
 No

The applicant assures that agency personnel have access to, and provide for, ongoing training relating to the delivery of early intervention services. \*

Yes  
 No

The applicant assures that the agency has the capacity to and will provide services to children in accordance with IEPs and in natural settings to the maximum extent appropriate. \*

Yes  
 No

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. \*

Yes  
 No

The applicant assures that the agency has the capacity to deliver all required services model system adopted for in this application. \*

Yes  
 No

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 accordance with the Standards for Childcare. \*

Yes  
 No

The applicant assures that agency personnel will immediately notify the Early Intervention Office if the licensee issue of any license or authority issued in community-based settings where the is providing personnel child groups, family support groups, or group developmental interventions. \*

Yes  
 No

The applicant assures that it will comply with the confidentiality requirements as set forth in federal and state statute and regulation. \*

Yes  
 No

The applicant assures that it will respond, in writing, approved from the State Agency granting approval, if the agency wishes to make any changes to its provider agreement to include additional services or to change the location of the agency or to change the mode of providing an alternative agreement to one or more of the other than our present or an increase or change rights of the agency, other than those set forth herein. \*

Yes  
 No

Please note that following prior to signing this application:

I agree and it is my intent, to sign this application. I understand that I am committing myself to the terms and conditions of this application. I understand that my signature on this application is an agreement that my organization will submit to the Department and early intervention office additional written notice of such intention and a plan for transition of children less than 180 days prior to the intended date of such action.

I Agree

**Below the Check Box:**

Name of Applicant or Authorized Representative:  Director Workphone:   
Title of Applicant or Authorized Representative:  Email:   
Date:

Please use your program code and organization that you can only view all required fields on this page have been completed and there are no errors. If you are unable to complete this application, please contact your regional office and request an extension. Unsuccessful submission of this application will result in your application being reviewed for approval by the BIP Provider Approval Unit.

[Previous Tab](#) [Save Progress](#) [Submit Application](#)

**(i)** Please review the entire Provider Agreement and Appendix 1 thoroughly before proceeding.

## Agency Application

[Basic Information](#) [Director](#) [Agency Background](#) [Disclosures](#) [Seeking to Provide](#) [Uploads](#) [Agreements](#)

Please review the entire Provider Agreement and Appendix 1 thoroughly before proceeding.

Agency providers must agree to both the Provider Agreement and Appendix 1 to be approved.

**Does the applicant wish to enter into an Provider Agreement? \***

- Yes
- No

**Does the applicant wish to enter into an Appendix 1 Agreement? \***

- Yes
- No

### 9.2.7.1 Provider and Appendix 1 Agreement Section

**(i)** Agency providers must review the Provider Agreement and Appendix 1. Review the information carefully and maintain a copy for your records.

LABEL	FIELD TYPE	DESCRIPTION
Does the applicant wish to enter into a Provider Agreement? *	Required, Yes or No	<p>Select the appropriate response.</p> <ul style="list-style-type: none"> <li>The following agreement appears in the panel/screen when clicking the Yes radio button.</li> <li>When clicked (<b>Yes</b> radio button), the following fields appear beneath the Appendix 1 Agreement verbatim:</li> </ul> <ul style="list-style-type: none"> <li><b>Select the Check Box *</b>  <input type="checkbox"/> I Read The Entire Appendix 1 Agreement</li> <li><b>Does the applicant agree to the terms and conditions of the Provider Agreement? *</b>  <input type="radio"/> Yes  <input type="radio"/> No</li> <li><b>Does the applicant wish to enter into an Appendix 1 Agreement? *</b></li> </ul>
Does the applicant wish to enter into an Appendix 1 Agreement? *	Required, Yes or No	<p>Select the appropriate response.</p> <ul style="list-style-type: none"> <li>The following agreement appears in the panel/screen when clicking the Yes radio button.</li> <li>When clicked (<b>Yes</b> radio button), the following fields appear beneath the Appendix 1 Agreement verbatim:</li> </ul> <ul style="list-style-type: none"> <li><b>Select the Check Box *</b>  <input type="checkbox"/> I Read The Entire Appendix 1 Agreement</li> <li><b>Does the applicant agree to the terms and conditions of the Appendix 1 Agreement? *</b>  <input type="radio"/> Yes  <input type="radio"/> No</li> </ul>

### 9.2.7.2 Applicant Attest Section

**Does the applicant attest to the following?**

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.\*

Yes  
 No

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.\*

Yes  
 No

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

Yes  
 No

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.\*

Yes  
 No

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.\*

Yes  
 No

The applicant assures that the agency has the capacity to deliver all approved service model options applied for in this application.\*

Yes  
 No

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.\*

Yes  
 No

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.\*

Yes  
 No

The applicant assures that it will comply with the confidentiality requirements as set forth in federal and state statute and regulation.\*

Yes  
 No

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 qualified personnel available to deliver services or service models provided or transferred, assignments, or other dispositions of less than ten percent of an interest or voting rights of the agency.\*

Yes  
 No

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.\*

Yes  
 No

Please note the following prior to signing the application.  
I agree, and it is my intent, to sign this record/document by checking this box and clicking the "Submit" button, and thereby electronically submitting this record/document to the New York State Department of Health. I understand that my signing and submitting of this record/document in this fashion is the legal equivalent of having placed my handwritten signature on both the submitted record/document and this attestation. I do hereby certify under penalty of perjury, that I am duly authorized to subscribe and submit this application, enter into agreement with the New York State Department of Health, and request modifications to such agreement with the New York State Department of Health. I further affirm under penalty of perjury that all information contained herein and uploaded 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 thereunder.

Select the Check Box \*

I Agree

Name of Applicant or Authorized Representative \*

Title of Applicant or Authorized Representative \*

Date \*

6/30/2023

Please save your progress often and remember that you can only save if all required fields on the page have been completed and there are no errors to be resolved. The submit application button will initiate a system review of your application and report any errors. Successful submission of the PAT will result in your application being reviewed for approval by the EI Provider Approval Unit.

[Previous Tab](#)

[Save Progress](#) [Submit Application](#)

**i Does the applicant attest to the following questions below?**

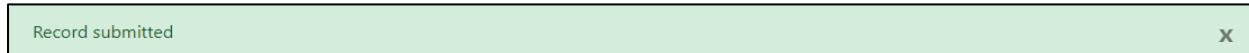
FIELD	FIELD TYPE	DESCRIPTION
<b>The applicant assures that the agency will abide by department policies as stated in guidance issued by the Department that clarifies requirements of law and regulation related to the Early Intervention Program.*</b>	Required, Yes or No	Select the appropriate response.

FIELD	FIELD TYPE	DESCRIPTION
<b>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. *</b>	Required, Yes or No	Select the appropriate response.
<b>The applicant assures that agency personnel have access to and participate in ongoing in-service training on the delivery of early intervention services. *</b>	Required, Yes or No	Select the appropriate response.
<b>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. *</b>	Required, Yes or No	Select the appropriate response.
<b>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. *</b>	Required, Yes or No	Select the appropriate response.
<b>The applicant assures that the agency has the capacity to deliver all approved service model options applied for in this application. *</b>	Required, Yes or No	Select the appropriate response.
<b>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. *</b>	Required, Yes or No	Select the appropriate response.
<b>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 Grid/Tables, family support Grid/Tables, or Grid/Table developmental interventions. *</b>	Required, Yes or No	Select the appropriate response.
<b>The applicant assures that it will comply with the confidentiality requirements as set forth in federal and state statutes and regulations. *</b>	Required, Yes or No	Select the appropriate response.

FIELD	FIELD TYPE	DESCRIPTION
<b>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 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. *</b>	Required, Yes or No	Select the appropriate response.
<b>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 the transition of children not less than 90 days prior to the intended effective date of such Action. *</b>	Required, Yes or No	Select the appropriate response.
<b>Please note the following prior to signing the application. 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 uploaded 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.</b>	Required, Checkbox	Select/tick the checkbox to agree with the terms.   <b>I Agree</b>
<b>Select the Check Box *</b>		
<b>Name of Applicant or Authorized Representative *</b>	Auto-Generated, Text Entry	This field is prefilled with the name of an applicant or authorized representative.
<b>Title of Applicant or Authorized Representative *</b>	Auto-Generated, Text Entry	Enter your title as an applicant or authorized representative.
<b>Date *</b>	Auto-Generated, Date	The system defaults to the current date when signing the electronic signature box.

BUTTON	DESCRIPTION
<b>Next Tab</b> 	Click this button to advance to the next tab on the screen (panel). Alternatively, click the next tab on the top (below the screen's header name).  <b>i</b> This button appears in the remaining tabs after advancing to the second tab on the screen.
<b>Previous Tab</b> 	To return to the previous tab, click this button.  <b>i</b> This button appears in the remaining tabs after advancing to the second tab on the screen.
<b>Save Progress</b> 	Click this button to save your data entry progress before submitting your application.
<b>Submit Application</b> 	Click this button if you have completed all the tabs and are ready to submit your application.

**i**When successfully submitted/validated by the system, the following message pad (shown below) appears on top of your screen, showing your 'Record Submitted.'



Click the 'Print' button on the panel's bottom/screen and save it for your records.



This section concludes the PAT Agency Application(s).

## Unit 10. PAT Individual Applications

### PAT Individual Applications

Created Date	Last Modified Date	Status	Actions
1/8/2021	1/8/2021	Active	<a href="#">Edit</a>

Once your application appears in the 'PAT Individual Applications' (example above) history panel, completing the Individual Provider application is next. Then, click the 'Edit' hyperlink (image shown above) and review the following tabs below for new required information.

#### 10.1 Identifying Information Tab

Congratulations on the successful submission of your PAST. The system transferred the information entered in the PAST to the PAT. Hence eliminating the need to reenter the same information. Please review each tab and panel and complete all appropriate fields, including the required fields. Screen navigation is the same as in the PAST.

Please save your progress often and remember that you can only save if all required fields on the page have been completed and there are no errors to be resolved. The submit application button will systematically review your application and report any errors. Successful submission of the PAT will result in your application being reviewed for approval by the BEI Provider Approval Unit.

### Individual Application

Identifying Information      Professional Experience and Certification      Insurance      Specialty Populations      Services      Disclosures  
[Upload](#)      [Appendix 1 Agreement](#)      [Provider Agreement](#)

Congratulations on the successful submission of your PAST. The information you entered in the PAST has been transferred to the PAT, eliminating the need to reenter the same information. Please review each tab and panel, completing all appropriate fields, including all required fields. Screen navigation is the same as in the PAST.

**Applicant ID**

1017

**Salutation \***

Mr.

**Applicant First Name \***

Buck

**Applicant Middle Name/Initial**

**Applicant Last Name \***

Rogers

**Applicant Suffix**

**AKA Name/Maiden Name**

**Individual Provider Type \***

- I am interested in becoming an early intervention provider using my legal name and Social Security number
- I am interested in becoming an early intervention provider using a business name and a Federal Employer Identification number (FEIN)

**(i)** The Individual Provider PAST application process populates the fields below. You may edit where the areas are allowed. Remember, a required field (\* bold red Asterix) means you must enter an answer or populate data in the area to submit your application successfully.

FIELD	FIELD TYPE	DESCRIPTION
Applicant ID	System Generated, Numeric Entry	Pre-filled system-generated Applicant ID.
Salutation *	Required, Drop-Down	To edit, Select the appropriate salutation.
Applicant First Name *	Required, Text Entry	To edit, re-enter the applicant's first name.
Applicant Middle Name/Initial	Optional, Text Entry	To edit, re-enter the applicant's middle name (optional).
Applicant Last Name *	Required, Text Entry	To edit, re-enter the applicant's last name.
Applicant Suffix	Optional, Drop-Down	Select the appropriate applicant's suffix to edit.
AKA Name/Maiden Name	Optional, Text Entry	To edit, enter the names of others associated with the applicant if they are different from the applicant's first name, or record the applicant's former name here (e.g., maiden name).
Individual Provider Type *	Required, Radio Button Options	<p>To edit, select the appropriate radio button to change your option.</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <input type="radio"/> I am interested in becoming an early intervention provider using my legal name and Social Security number  <input type="radio"/> I am interested in becoming an early intervention provider using a business name and a Federal Employer Identification number (FEIN)         </div> <p><b>(i)</b> Selecting “I am interested in becoming an early intervention provider using a business name and a Federal Employer Identification Number (FEIN)” radio button, the following fields:</p> <ul style="list-style-type: none"> <li>• Doing Business As (DBA)</li> <li>• Federal Employer Identification Number (FEIN)</li> <li>• Organization National Provider Identifier (NPI)</li> </ul>



The identifying **Information Tab** continues.

<b>Doing Business As (DBA) *</b>			
<b>Federal Employer Identification Number (FEIN) *</b>	dd-dddddddd		
<b>Organization National Provider Identifier (NPI) *</b>			
<b>Social Security Number *</b>	ddd	dd	ddd
<b>Date of Birth *</b>	mm/dd/yyyy		
<b>Individual National Provider Identifier (NPI) *</b>			
<b>Health Commerce System (HCS) username</b>			
<b>Alternate ID</b>			
<b>Primary Email Address *</b>	<b>Email</b>	Email	
	<b>Email (verify)</b>	Verify Email	
<b>Mailing Address *</b>	<b>Line1</b>	Line 1	
	<b>Line2</b>	Line 2	
	<b>Line3</b>	Line 3	
	<b>Zip Code</b>	ZIP+4	
	<b>City/Town</b>	City/Town	
	<b>State</b>		

FIELD	FIELD TYPE	DESCRIPTION
<b>Doing Business As (DBA) *</b>	Required, Text Entry	To edit, enter the business name under a different identity from the applicant's or the applicant's formal business entity name.
<b>Federal Employer Identification Number (FEIN) *</b>	Required, Numeric Entry	To edit, enter the applicant's FEIN.
<b>Organization National Provider Identifier (NPI) *</b>	Required, Numeric Entry	To edit, enter the applicant's organization NPI.
<b>Social Security Number * (SS#)</b>	Required, Numeric Entry	You need to tab through each formatted field and enter the applicant's SS# to edit.
<b>Date of Birth *</b>	Required, Date/Calendar	To edit, enter the applicant's date of birth.
<b>Individual National Provider Identifier (NPI) *</b>	Required, Text Entry	To edit, enter the applicant's individual NPI.
<b>Health Commerce System (HCS) username</b>	Optional, Text Entry	To edit, enter the applicant's HCS Username (if applicable).

FIELD	FIELD TYPE	DESCRIPTION
Alternate ID	Optional, Text Entry	To edit, enter the applicant's alternate identification number.
Primary Email Address *	Required, Text Entry	Enter the applicant's email address and the email verified field to edit.
Mailing Address *	Required, Text Entry	To edit, enter the applicant's mailing address for the adjacent fields: Line 1, Line 2, Line 3, Zip Code, City/Town, and State.



The identifying **Information Tab** continues below.

**Are your mailing and physical location addresses the same? \***

Yes  
 No

**Physical Location Address**

**Line1** 
  
**Line2** 
  
**Line3** 
  
**Zip Code** 
  
**City/Town** 
  
**State**

**Does your Billing/Claiming address match one of the addresses previously entered? \***

**Billing Address \***  
*Address to which all claims payments are to be sent*

**Line1** 
  
**Line2** 
  
**Line3** 
  
**Zip Code** 
  
**City/Town** 
  
**State**

**Primary Phone Number \***

**Additional Phone - Office**

**Additional Phone - Mobile**

**Additional Phone - Pager**

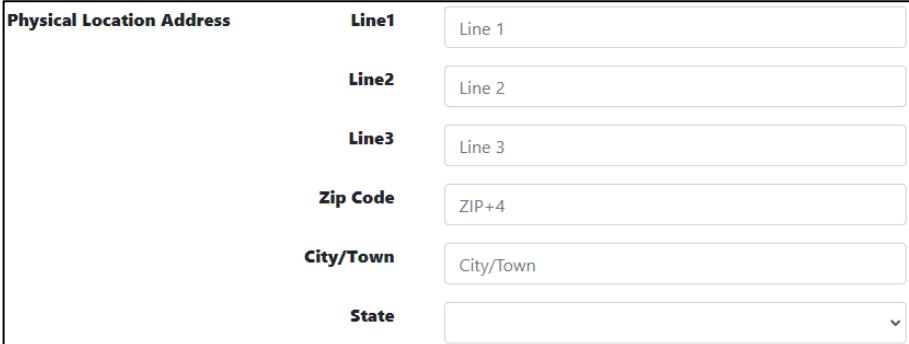
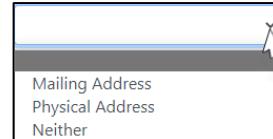
**Additional Phone - Home**

**Additional Phone - Fax**

Please save your progress often and remember that you can only save if all required fields on the page have been completed and there are no errors to be resolved. The submit application button will initiate a system review of your application and report any errors. Successful submission of the PAT will result in your application being reviewed for approval by the BEI Provider Approval Unit.

[Next Tab](#)

[Save Progress](#)
|
[Submit Application](#)

FIELD	FIELD TYPE	DESCRIPTION
<b>Are your mailing and physical location addresses the same? *</b>	Required, Yes or No	<p>To edit, select the appropriate radio button.</p> <p><b>(i)</b> Selecting ‘No,’ the application adds a ‘Physical Location Address’ with the required data entry fields: Line 1, Line 2, Line 3, Zip Code, City/Town, and State.</p> 
<b>County/Borough*</b>	Required, Drop- Down	<p>Select the appropriate County/Borough from the list to edit.</p> <p>Please note the county/borough is not a validated field. Users should verify the county/borough selected is accurate.</p>
<b>Does your Billing/Claiming address match one of the addresses previously entered? *</b>	Required, Drop-Down	<p>To edit, select the appropriate address that matches the address entered.</p>  <p>Selecting the appropriate indicator from the list populates the “Billing Address” fields.</p>
<b>Billing Address *</b>	Required, Text Entry	The billing address is the address location for all claims payments to be sent. To edit, enter the address, and re-enter the following: Line 1, 2 (optional), 3 (optional), Zip Code, City/Town, and State.
<b>Primary Phone Number *</b>	Required, Numeric Entry	To edit, enter the applicant's primary phone number.
<b>Additional Phone – Office</b>	Optional, Numeric Entry	To edit, enter the applicant's office phone number.
<b>Additional Phone – Mobile</b>	Optional, Numeric Entry	To edit, enter the applicant's mobile phone number.
<b>Additional Phone – Pager</b>	Optional, Numeric Entry	To edit, enter the applicant's pager phone number.
<b>Additional Phone – Home</b>	Optional, Numeric Entry	To edit, enter the applicant's home phone number.

FIELD	FIELD TYPE	DESCRIPTION
<b>Additional Phone – Fax</b>	Optional, Numeric Entry	To edit, enter the applicant's fax phone number.

## 10.2 Professional Experience and Certification Tab

 There are three (3) Grid/Tables (Panels) you can edit/add professional experience and certification; we will break them down as follows:

- Profession Panel
- Employment History Panel
- Continuing Education Panel

### Individual Application

Identifying Information      Professional Experience and Certification      Insurance      Specialty Populations      Services      Disclosures

Upload      Appendix 1 Agreement      Provider Agreement

Profession Panel					
Profession	License/Certification Control Number	License/Certification Type	Actions		
			<a href="#">Add</a>		

Employment History Panel					
Employer Name	Type of Employment	Employment Setting	Hours per Week	Hours Employed	Actions
					<a href="#">Add</a>

**Total hours of all Employers combined:**

Please provide information about 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.

Continuing Education Panel					
Title of Training	Date of Training	Actions			
		<a href="#">Add Training/Education</a>			

Please save your progress often and remember that you can only save if all required fields on the page have been completed and there are no errors to be resolved. The submit application button will initiate a system review of your application and report any errors. Successful submission of the PAT will result in your application being reviewed for approval by the BEI Provider Approval Unit.

[Previous Tab](#) [Next Tab](#)

[Save Progress](#) [Submit Application](#)

### 10.2.1 Profession Panel Grid/Table

 Use this grid/table to **add** the applicant's profession.

Profession Panel			
Profession	License/Certification Control Number	License/Certification Type	Actions
Audiologist	1999	Certification	<a href="#">Display</a>   <a href="#">Delete</a>   <a href="#">Edit</a>
<a href="#">Add</a>			

FIELD	DESCRIPTION
<b>Profession</b>	After adding a profession, this column displays the profession type (e.g., Audiologist).
<b>License/Certification Control Number</b>	After adding a profession, this column displays the license/certification control number.  The New York State Education Department assigns the license/certification number. This number must match exactly and be active. It will be verified with the Office of Professions or TEACH.
<b>License/Certification Type</b> *	Select the appropriate license/certification type from the list using the drop-down.   <b>The type determines the expiration is needed.</b>
<b>Actions</b>	After adding a profession, this column displays <b>Display</b>   <b>Delete</b>   <b>Edit</b> hyperlinks.   <a href="#">Display</a>   <a href="#">Delete</a>   <a href="#">Edit</a>

BUTTON	DESCRIPTION
<b>Add</b>	To add a Profession to the Professions Panel, click this button. When clicked, a popup panel appears (example below).

### 10.2.1.1 Professional Panel Popup Panel

Profession Panel

<b>Profession *</b>	<input type="text"/>
<b>License/Certification Control Number *</b>	<input type="text"/>
<b>License/Certification Type *</b>	<input type="text"/>
<b>License Effective Date *</b>	<input type="text"/> mm/dd/yyyy <input type="button" value="Calendar"/>
<input type="button" value="Close"/> <input type="button" value="Save changes"/>	

Profession Panel

<b>Profession *</b>	<input type="text" value="Physician"/>
<b>Profession Specialty *</b>	<input type="text"/>
<b>License/Certification Control Number *</b>	<input type="text"/>
<b>License/Certification Type *</b>	<input type="text" value="Professional License"/>
<b>License/Certification Effective Date *</b>	<input type="text"/> mm/dd/yyyy <input type="button" value="Calendar"/>
<b>License/Certification Expiration Date *</b>	<input type="text"/> mm/dd/yyyy <input type="button" value="Calendar"/>
<input type="button" value="Close"/> <input type="button" value="Save changes"/>	

FIELD	FIELD TYPE	DESCRIPTION
<b>Profession *</b> <i>(i)</i> Must be a recognized EI profession.	Required, Drop-Down	Select the appropriate profession from the list. <i>(i)</i> When selecting “Physician” (QP1 & QP2- Profession = Physician), a specialty field appears. <div style="border: 1px solid #ccc; padding: 5px; margin-top: 10px;"> <div style="display: flex; justify-content: space-between;"> <span>Qualified Professional 1 Profession *</span> <input type="text" value="Physician"/> </div> <div style="margin-top: 5px;"> <b>Physician Specialty *</b> <input type="text"/> </div> </div>
<b>License/Certification Control Number *</b>	Required, Text Entry	Enter your license/certification control number. This number must match exactly with the number the New York State

FIELD	FIELD TYPE	DESCRIPTION
		Education Department assigned to you and will be verified with the Office of Professions or TEACH.
<b>License/Certification Type *</b>	Required, Text Entry	Select the appropriate license/certification type from the list using the drop-down.   <b>The type determines the expiration is needed.</b>
<b>License Effective Date *</b>	Required, Date/ Calendar	Enter the license effective date (manually typing or using the calendar picker).

BUTTON	DESCRIPTION
 Close	No changes do not save when clicked, and it closes the popup panel.
 Save changes	To save your data entry, click this button. When clicked, the system saves the popup panel changes.

HYPERLINKS	DESCRIPTION
 Actions Display   Delete   Edit	After adding a record in a grid/table, there are the three (3) hyperlink labels and their descriptions below: <ul style="list-style-type: none"> <li><b>Display:</b> A popup panel appears (read-only) when clicked.</li> <li><b>Delete:</b> When clicked, a popup panel appears with two buttons, 'Close' (gray button) and 'Delete' (red button). <ul style="list-style-type: none"> <li>To cancel the deletion, click the <b>Close</b> button.</li> <li>To confirm the removal of the record, click the <b>Delete</b> button. When clicked, the record is removed (deleted) from the grid/table.</li> </ul> </li> <li><b>Edit:</b> A popup panel appears (edit mode).</li> </ul>  <b>The 'Close' and 'Save Changes' buttons work the same as described above.</b>

### 10.2.2 Employment History Panel – Grid/Table

- ☞ Use this panel to **add** information about the applicant's employment history.
- ☞ The following experience requirements apply to all individuals seeking approval to provide early intervention services as an individual professional provider:
  1. A minimum of 1000 clock hours of experience in a clinical pediatric, early intervention, or early childhood program delivering services to children under five years old, including children with disabilities and their families.
  2. Supervised experience required for licensure or certification may be counted toward this requirement, such as clinical experience in a clinical pediatric, early intervention, or early childhood education program that delivers services to children aged birth to five years,

including children with disabilities. Indicate a minimum of 1000 clock hours/clinical experience (listing the most recent experience first).

- a. You provided direct therapeutic/clinical services in your discipline to infants and young children (aged birth to 5 years) and their families in the settings described above. Also, it 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.
  - b. This information may be verified as part of the Bureau of Early Intervention provider application process.
3. Please enter each employer separately.

Employment History Panel					
Employer Name	Type of Employment	Employment Setting	Hours per Week	Hours Employed	Actions
Space ABC	Employed	Clinic	1600	7085	<a href="#">Display</a>   <a href="#">Delete</a>   <a href="#">Edit</a>
<a href="#">Add</a>					
<b>Total hours of all Employers combined:</b>		7085			

FIELD	DESCRIPTION
<b>Employer Name</b>	This column displays the employer's name.
<b>Type of Employment</b>	This column displays the type of employment (Employed, Contract).
<b>Employment Setting</b>	This column displays the employment setting (e.g., Clinic).
<b>Hours per Week</b>	This column displays the hours per week the Provider works.
<b>Hours Employed</b>	This column displays the total hours the Provider worked.
<b>Actions</b>	After adding a profession, this column displays <b>Display</b>   <b>Delete</b>   <b>Edit</b> hyperlinks.

BUTTON	DESCRIPTION
<b>Add</b> 	To add details to the Employment History Panel, click this button. When clicked, a popup panel appears (example below).

### 10.2.2.1 Employment History Panel

Employment History Panel

<b>Employer Name *</b>	<input type="text"/>
<b>Employer Address *</b>	<b>Line1</b> <input type="text"/> <b>Line2</b> <input type="text"/> <b>Line3</b> <input type="text"/>
<b>Zip Code</b>	<input type="text"/>
<b>City/Town</b>	<input type="text"/>
<b>State</b>	<input type="text"/>
<b>Phone Number *</b>	<input type="text"/>
<b>Type of Employment *</b>	<input type="text"/>
<b>Employment Setting *</b>	<input type="text"/>
<b>Employment Start Date *</b>	<input type="text"/> mm/dd/yyyy <input type="button" value="Calendar"/>
<b>Employment End Date</b>	<input type="text"/> mm/dd/yyyy <input type="button" value="Calendar"/>
<b>Hours per Week *</b>	<input type="text"/>
<b>Hours Employed</b>	<input type="text"/>

**Close** **Save changes**

FIELD	FIELD TYPE	DESCRIPTION
<b>Employer Name *</b>	Required, Text Entry	Enter the name of the employer for the Individual Provider.
<b>Employer Address *</b>	Required, Text Entry	<ul style="list-style-type: none"> <li><b>Line1:</b> Enter the address where mail is physically delivered.</li> <li><b>Line2:</b> If applicable, Enter the address line two (2).</li> <li><b>Line3:</b> If applicable.: Enter the address line three (3).</li> <li><b>Zip Code:</b> Enter the Zip +4</li> <li><b>City/Town:</b> Enter the city/town where mail is physically delivered.</li> <li><b>State:</b> Use the drop-down and select the state where mail is physically delivered.</li> </ul>
<b>Phone Number *</b>	Required, Numeric Entry	Enter the best phone number to reach the employer.

FIELD	FIELD TYPE	DESCRIPTION
Type of Employment *	Required, Drop-Down	Use the drop-down and select the appropriate type of employment from the list.
Employment Setting *	Required, Drop-Down	Use the drop-down and select the appropriate employment setting for the employer.
Employment Start Date *	Required, Date/ Calendar	Manually enter or use the calendar picker for the start date for the individual provider working for the employer.
Employment End Date	Required, Date/ Calendar	Manually enter or use the calendar picker for the end date for the individual provider working for the employer.
Hours per Week *	Required, Text Entry	Enter the work hours per week to identify the most typical weekly working schedule over a person" (individual provider) selected period in employment.
Hours Employs	Required, Text Entry	Based on the Employment Start Date, Employment End Date (if applicable), and Hours per Week (worked), the system uses the date duration built-in calculator to determine the number of days and hours between the times on two different dates.

BUTTON / HYPERLINK	DESCRIPTION												
<b>Close</b> 	When clicked, changes do not save, and it closes the popup panel.												
<b>Save changes</b> 	<p>To save your data entry, click this button. When clicked, the system saves the popup panel changes, closes it, and displays the listings you made (an example below).</p> <div style="border: 1px solid #ccc; padding: 10px; margin-top: 10px;"> <p>Employment History Panel</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Employer Name</th> <th>Type of Employment</th> <th>Employment Setting</th> <th>Hours per Week</th> <th>Hours Employed</th> <th>Actions</th> </tr> </thead> <tbody> <tr> <td>Space ABC</td> <td>Employed</td> <td>Clinic</td> <td>1600</td> <td>7085</td> <td><a href="#">Display</a>   <a href="#">Delete</a>   <a href="#">Edit</a></td> </tr> </tbody> </table> <p>Total hours of all Employers combined: <span style="float: right;">7085</span></p> <p style="text-align: right;"><a href="#">Add</a></p> </div> <p><b>Note</b> the three (3) hyperlink labels and their descriptions below:</p> <ul style="list-style-type: none"> <li>• <b>Display:</b> The Employment History popup panel appears (read-only) when clicked.</li> <li>• <b>Delete:</b> When clicked, the Employment History popup panel appears with two buttons, 'Close' (gray) and 'Delete' (red). <ul style="list-style-type: none"> <li>○ To cancel the deletion, click the <b>Close</b> button.</li> <li>○ To confirm the removal of the record, click the <b>Delete</b> button. The record is removed (deleted) from the Professions Panel when clicked.</li> </ul> </li> </ul>	Employer Name	Type of Employment	Employment Setting	Hours per Week	Hours Employed	Actions	Space ABC	Employed	Clinic	1600	7085	<a href="#">Display</a>   <a href="#">Delete</a>   <a href="#">Edit</a>
Employer Name	Type of Employment	Employment Setting	Hours per Week	Hours Employed	Actions								
Space ABC	Employed	Clinic	1600	7085	<a href="#">Display</a>   <a href="#">Delete</a>   <a href="#">Edit</a>								

BUTTON / HYPERLINK	DESCRIPTION
	<ul style="list-style-type: none"><li>• <b>Edit:</b> When clicked, the Employment History popup panel appears (edit mode).</li></ul> <p> The ‘Close’ and ‘Save Changes’ buttons work the same as described above.</p>

FIELD	DESCRIPTION
Total hours of all Employers combined:	This column displays the total hours of all Employers combined.

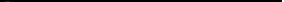
### **10.2.3 Continuing Education Panel – Grid/Table**



 Use this panel to **add** the applicant's information about continuing education programs related to professional development, learning experiences, and in-services attended during the previous five years that focused on providing services for infants and toddlers with disabilities.

Continuing Education Panel		
Title of Training	Date of Training	Actions
<a href="#">Add Training/Education</a>		

COLUMN	DESCRIPTION
<b>Title of Training</b>	This column displays the name of the training.
<b>Date of Training</b>	This column displays the training date.
<b>Actions</b>	After adding a profession, this column displays <b>Display   Delete   Edit</b> hyperlinks.

BUTTON	DESCRIPTION
<b>Add Training/Education</b> 	Click this button to add training/education to the Continuing Education Panel. When clicked, a popup panel appears (example below).

#### **10.1.2.3.1 Continuing Education Panel**

**Continuing Education Panel**

**Title of Training**

**Date of Training**  mm/dd/yyyy

**Training focused on infants/toddlers w/ disabilities?**  Yes  No

**Who provided the training?**

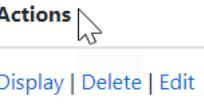
**Brief Summary of Training**

---

FIELD	FIELD TYPE	DESCRIPTION
Title of Training	Optional, Text Entry	Enter the name of the training.

FIELD	FIELD TYPE	DESCRIPTION
Date of Training	Optional, Date/Calendar	Enter the training date (manually typing or using the calendar picker).
Training focused on infants/ toddlers w/ disabilities?	Optional, Yes or No	Select/click the appropriate radio button.
Who provided the training?  Name of individual and/or organization	Optional, Yes or No	Enter the name of the organization or individual who provided the training.
Brief Summary of Training	Optional, Text Entry	Enter a brief description (e.g., focus, outcomes) of the training.

BUTTON	DESCRIPTION
Close 	No changes do not save when clicked, and it closes the popup panel.
Save changes 	To save your data entry, click this button. When clicked, the system saves the popup panel changes.

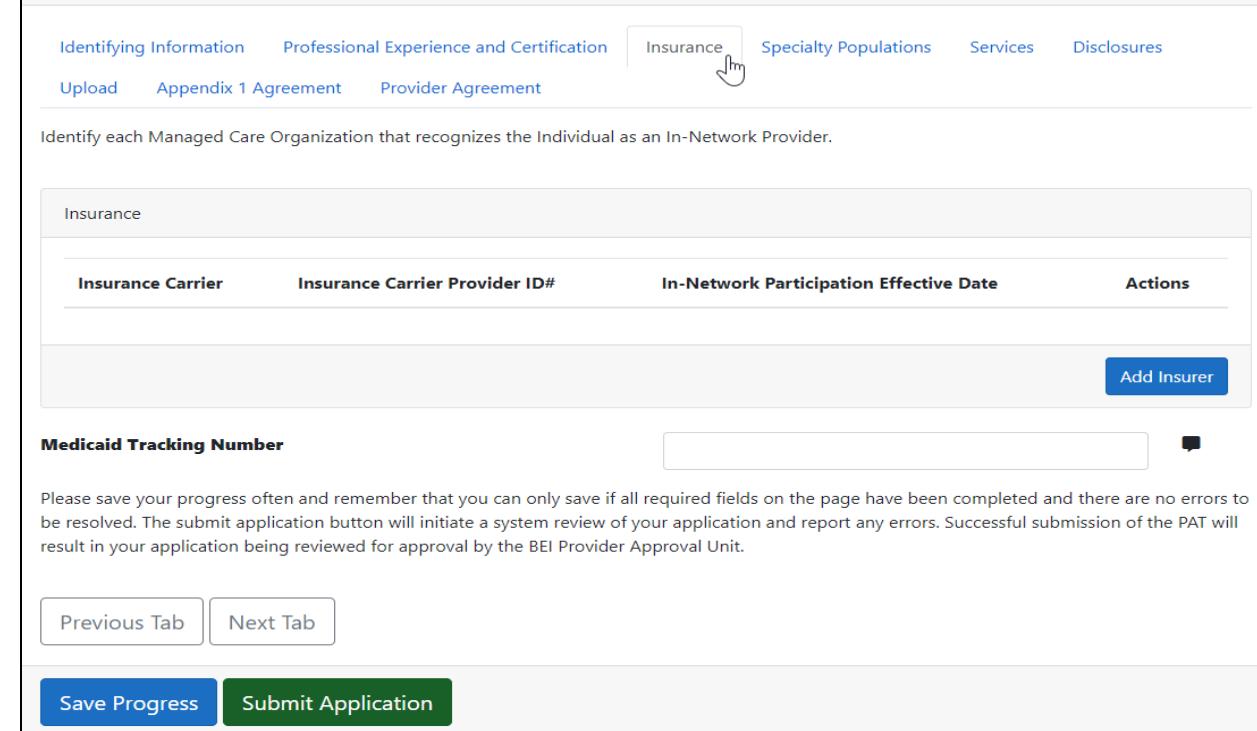
HYPERLINKS	DESCRIPTION
Actions  Display   Delete   Edit	<p>After adding a record in a grid/table, there are the three (3) hyperlink labels and their descriptions below:</p> <ul style="list-style-type: none"> <li>• <b>Display:</b> A popup panel appears (read-only) when clicked.</li> <li>• <b>Delete:</b> When clicked, a popup panel appears with two buttons, '<b>Close</b>' (gray button) and '<b>Delete</b>' (red button). <ul style="list-style-type: none"> <li>○ To cancel the deletion, click the <b>Close</b> button.</li> <li>○ To confirm the removal of the record, click the <b>Delete</b> button. When clicked, the record is removed (deleted) from the grid/table.</li> </ul> </li> <li>• <b>Edit:</b> A popup panel appears (edit mode).</li> </ul> <p> The 'Close' and 'Save Changes' buttons work the same as described above.</p>

## 10.3 Insurance Tab

 Identify each Managed Care Organization that recognizes the Individual as an In-Network Provider.

Please save your progress often and remember that you can only save if all required fields on the page have been completed and there are no errors to be resolved. The submit application button will systematically review your application and report any errors. Successful submission of the PAT will result in your application being reviewed for approval by the BEI Provider Approval Unit.

### Individual Application



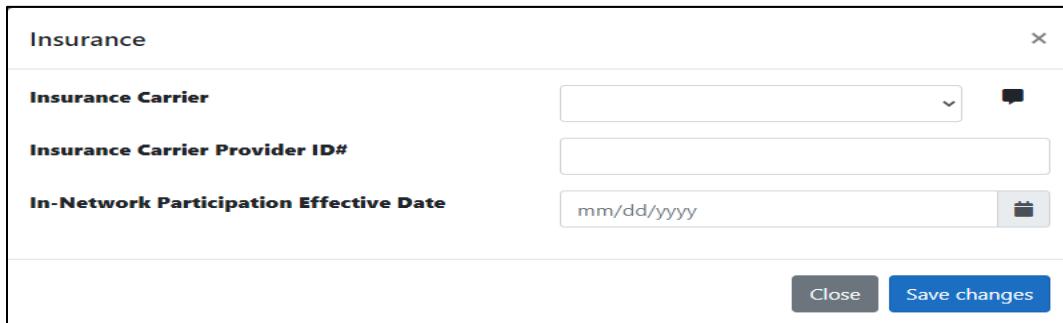
The screenshot shows the 'Individual Application' form with the 'Insurance' tab selected. The top navigation bar includes tabs for Identifying Information, Professional Experience and Certification, Insurance (selected), Specialty Populations, Services, and Disclosures. Sub-tabs under Insurance include Upload, Appendix 1 Agreement, and Provider Agreement. A note below the tabs states: 'Identify each Managed Care Organization that recognizes the Individual as an In-Network Provider.' The main content area is titled 'Insurance' and contains a table with columns for Insurance Carrier, Insurance Carrier Provider ID#, In-Network Participation Effective Date, and Actions. A blue 'Add Insurer' button is located at the bottom right of the table. Below the table is a 'Medicaid Tracking Number' input field with a small info icon. A note at the bottom of the form area states: 'Please save your progress often and remember that you can only save if all required fields on the page have been completed and there are no errors to be resolved. The submit application button will initiate a system review of your application and report any errors. Successful submission of the PAT will result in your application being reviewed for approval by the BEI Provider Approval Unit.' At the bottom are buttons for Previous Tab, Next Tab, Save Progress (blue), and Submit Application (green).

COLUMN	DESCRIPTION
Insurance Carrier	This column displays the name of the insurance carrier.
Insurance Carrier Provider ID#	This column displays the insurance carrier provider number.
In-Network Participation Effective Date	This column displays the In-Network Participation effective date.
Actions	After adding a profession, this column displays <b>Display</b>   <b>Delete</b>   <b>Edit</b> hyperlinks.

FIELD	DESCRIPTION
Medicaid Tracking Number <small>Medicaid Tracking Number will be required for approval, but is not required for the initial submission (can be added later)</small>	Enter the agency's Medicaid Tracking Number.

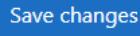
BUTTON	DESCRIPTION
Add Insurer 	To add an Insurer to the Insurance Panel, click this button. When clicked, a popup panel appears (example below).

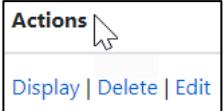
### 10.3.1 Insurance Popup Panel



The screenshot shows a modal dialog titled "Insurance". It contains three input fields: "Insurance Carrier" (a dropdown menu), "Insurance Carrier Provider ID#" (a text input field), and "In-Network Participation Effective Date" (a date picker). At the bottom are two buttons: "Close" and "Save changes".

FIELD	FIELD TYPE	DESCRIPTION
Insurance Carrier	Optional, Drop-Down	A participating provider agreement is currently in place. Select the appropriate insurance carrier name from the list.
Insurance Carrier Provider ID#	Optional, Text Entry	Enter the insurance carrier provider number.
In-Network Participation Effective Date	Optional, Date/Calendar	Enter the effective date for In-Network Participation (manually typing or using the calendar picker).

BUTTON	DESCRIPTION
Close 	When clicked, nothing is saved, and it closes the popup panel.
Save changes 	To save your data entry, click this button. When clicked, the system saves the popup panel changes.

Hyperlinks	Description
<b>Actions</b>  <a href="#">Display</a>   <a href="#">Delete</a>   <a href="#">Edit</a>	<p>After adding a record in a grid/table, there are the three (3) hyperlink labels and their descriptions below:</p> <ul style="list-style-type: none"> <li>• <b>Display:</b> A popup panel appears (read-only) when clicked.</li> <li>• <b>Delete:</b> When clicked, a popup panel appears with two buttons, 'Close' (gray button) and 'Delete' (red button).             <ul style="list-style-type: none"> <li>○ To cancel the deletion, click the <b>Close</b> button.</li> <li>○ To confirm the removal of the record, click the <b>Delete</b> button.</li> </ul> <p>When clicked, the record is removed (deleted) from the grid/table.</p> </li> <li>• <b>Edit:</b> A popup panel appears (edit mode).</li> </ul> <p> <b>The 'Close' and 'Save Changes' buttons work the same as described above.</b></p>

## 10.4 Specialty Population Tab

 Please save your progress often, and remember that you can only save if all required fields on the page have been completed and no errors are to be resolved. The submit application button will systematically review your application and report any errors. Successful submission of the PAT will result in your application being reviewed for approval by the BEI Provider Approval Unit.

 Add or edit the Specialty Populations in which the Provider has distinct knowledge, skills, and abilities.

### Individual Application

[Identifying Information](#)    [Professional Experience and Certification](#)    [Insurance](#)    [Specialty Populations](#)    [Services](#)    [Disclosures](#)  
[Upload](#)    [Appendix 1 Agreement](#)    [Provider Agreement](#)



### 10.4.1 Languages Grid/Table

 Add or edit the language(s), including English and other communication forms in which the Provider is fluent.

Languages	
Language	Actions
Spanish	<a href="#">Display</a>   <a href="#">Delete</a>   <a href="#">Edit</a>

[Add](#)

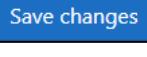
COLUMN	DESCRIPTION
<b>Language</b>	This column displays additional languages in which the Provider is fluent.
<b>Actions</b>	After adding a language, this column displays <b>Display</b>   <b>Delete</b>   <b>Edit</b> hyperlinks.
BUTTON	DESCRIPTION
<a href="#">Add</a>	To add a language to the Languages Panel, click this button. When clicked, a popup panel appears (example below).

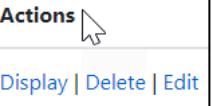
#### 10.4.1.1 Languages Panel

 Indicate the language(s), including English and other forms of communication in which you are fluent. Add each language separately.

Languages	
Indicate the language(s), other than English, and other forms of communication in which you are fluent. Add each language separately.	
Language	<input type="text"/> <span style="float: right;">▼</span>
<a href="#">Close</a> <a href="#">Save changes</a>	

FIELD	FIELD TYPE	DESCRIPTION
<b>Language</b>	Optional, Drop-Down	Select a language, including English and other forms of communication, from which the Provider is fluent.

BUTTON	DESCRIPTION
<b>Close</b> 	No changes do not save when clicked, and it closes the popup panel.
<b>Save changes</b> 	To save your data entry, click this button. When clicked, the system saves the popup panel changes.

Hyperlinks	Description
<b>Actions</b> 	<p>After adding a record in a grid/table, there are the three (3) hyperlink labels and their descriptions below:</p> <ul style="list-style-type: none"> <li>• <b>Display:</b> A popup panel appears (read-only) when clicked.</li> <li>• <b>Delete:</b> When clicked, a popup panel appears with two buttons, 'Close' (gray button) and 'Delete' (red button). <ul style="list-style-type: none"> <li>○ To cancel the deletion, click the <b>Close</b> button.</li> <li>○ To confirm the removal of the record, click the <b>Delete</b> button. When clicked, the record is removed (deleted) from the grid/table.</li> </ul> </li> <li>• <b>Edit:</b> A popup panel appears (edit mode).</li> </ul> <p> The 'Close' and 'Save Changes' buttons work the same as described above.</p>

### 10.4.1.2 Specialty Populations Section

 Using the radio buttons in this panel, select (**Yes** or **No**) population(s) in which the Provider has specific knowledge, skills, and experience.

Specialty Populations

Select population(s) in which you have distinct knowledge, skills, and experience.

<b>Apraxia</b>	<input type="radio"/> Yes <input type="radio"/> No
<b>Auditory Processing Disorder</b>	<input type="radio"/> Yes <input type="radio"/> No
<b>Autism/PDD</b>	<input type="radio"/> Yes <input type="radio"/> No
<b>Cerebral Palsy</b>	<input type="radio"/> Yes <input type="radio"/> No
<b>Communication Disorders</b>	<input type="radio"/> Yes <input type="radio"/> No
<b>Down Syndrome</b>	<input type="radio"/> Yes <input type="radio"/> No
<b>Dyspraxia</b>	<input type="radio"/> Yes <input type="radio"/> No
<b>Feeding/Swallowing Disorders</b>	<input type="radio"/> Yes <input type="radio"/> No
<b>Fetal Alcohol Syndrome</b>	<input type="radio"/> Yes <input type="radio"/> No
<b>Hearing Loss</b>	<input type="radio"/> Yes <input type="radio"/> No
<b>Medically Complex</b>	<input type="radio"/> Yes <input type="radio"/> No
<b>Intellectual Disability</b>	<input type="radio"/> Yes <input type="radio"/> No
<b>Motor Disorders</b>	<input type="radio"/> Yes <input type="radio"/> No
<b>Oral Motor Disorders</b>	<input type="radio"/> Yes <input type="radio"/> No
<b>Prematurity</b>	<input type="radio"/> Yes <input type="radio"/> No
<b>Psychiatric/Behavioral/Emotional Disorders</b>	<input type="radio"/> Yes <input type="radio"/> No
<b>Seizure Disorders</b>	<input type="radio"/> Yes <input type="radio"/> No
<b>Sensory Integration Disorders</b>	<input type="radio"/> Yes <input type="radio"/> No
<b>Traumatic Brain Injury</b>	<input type="radio"/> Yes <input type="radio"/> No
<b>Vision Impairments</b>	<input type="radio"/> Yes <input type="radio"/> No
<b>Other</b>	<input type="radio"/> Yes <input type="radio"/> No

Please save your progress often and remember that you can only save if all required fields on the page have been completed and there are no errors to be resolved. The submit application button will initiate a system review of your application and report any errors. Successful submission of the PAT will result in your application being reviewed for approval by the BEI Provider Approval Unit.

Previous Tab Next Tab
  
Save Progress Submit Application

FIELD	FIELD TYPE	DESCRIPTION
<b>Apraxia</b>	Optional, Yes or No	Edit/select the appropriate radio button.
<b>Auditory Processing Disorder</b>	Optional, Yes or No	Edit/select the appropriate radio button.
<b>Autism/PDD</b>	Optional, Yes or No	Edit/select the appropriate radio button.
<b>Cerebral Palsy</b>	Optional, Yes or No	Edit/select the appropriate radio button.
<b>Communication Disorders</b>	Optional, Yes or No	Edit/select the appropriate radio button.
<b>Down Syndrome</b>	Optional, Yes or No	Edit/select the appropriate radio button.
<b>Dyspraxia</b>	Optional, Yes or No	Edit/select the appropriate radio button.
<b>Feeding/Swallowing Disorders</b>	Optional, Yes or No	Edit/select the appropriate radio button.
<b>Fetal Alcohol Syndrome</b>	Optional, Yes or No	Edit/select the appropriate radio button.
<b>Hearing Loss</b>	Optional, Yes or No	Edit/select the appropriate radio button.
<b>Medically Complex</b>	Optional, Yes or No	Edit/select the appropriate radio button.
<b>Intellectual Disability</b>	Optional, Yes or No	Edit/select the appropriate radio button.
<b>Motor Disorders</b>	Optional, Yes or No	Edit/select the appropriate radio button.
<b>Oral Motor Disorders</b>	Optional, Yes or No	Edit/select the appropriate radio button.
<b>Prematurity</b>	Optional, Yes or No	Edit/select the appropriate radio button.
<b>Psychiatric/Behavioral/Emotional Disorders</b>	Optional, Yes or No	Edit/select the appropriate radio button.
<b>Seizure Disorders</b>	Optional, Yes or No	Edit/select the appropriate radio button.
<b>Sensory Integration Disorders</b>	Optional, Yes or No	Edit/select the appropriate radio button.
<b>Traumatic Brain Injury</b>	Optional, Yes or No	Edit/select the appropriate radio button.
<b>Vision Impairments</b>	Optional, Yes or No	Edit/select the appropriate radio button.
<b>Other</b>	Optional, Yes or No	<p>Edit/select the appropriate radio button.</p> <p>Selecting the 'Yes' radio button, the "Explanation of Other" field appears (shown below)</p> <div style="border: 1px solid black; padding: 5px; width: fit-content;"> <p>Other</p> <p><input checked="" type="radio"/> Yes <input type="radio"/> No</p> <p>Explanation of Other *</p> <input type="text"/> </div>

## 10.4.2 Services Tab

 Select the service you are seeking approval to provide. For each service model, indicate the catchment area(s) you can deliver services to.

 You must enter service models and service types in appropriate combinations for each catchment area. Please refer to the *EI-Hub Resource: Service Models and Methods for Qualified Professions in the New York State Early Intervention Program*.

Providers must only select valid combinations of services for which they are qualified to apply at the time of application.

Please save your progress often and remember that you can only save if all required fields on the page have been completed and there are no errors to be resolved. The submit application button will systematically review your application and report any errors. Successful submission of the PAT will result in your application being reviewed for approval by the BEI Provider Approval Unit.

### Individual Application

Identifying Information    Professional Experience and Certification    Insurance    Specialty Populations    **Services**    Disclosures

Upload    Appendix 1 Agreement    Provider Agreement

Service Sites -

**Will you provide services at a facility you own, lease, rent, manage, operate from, or otherwise use on a regular basis? \***

- Yes  
 No

**Are you requesting approval for services that will be provided in other settings (ex. children's homes or a community setting like a child's daycare)? \***

- Yes  
 No

Please save your progress often and remember that you can only save if all required fields on the page have been completed and there are no errors to be resolved. The submit application button will initiate a system review of your application and report any errors. Successful submission of the PAT will result in your application being reviewed for approval by the BEI Provider Approval Unit.

[Previous Tab](#)

[Next Tab](#)

[Save Progress](#)

[Submit Application](#)

LABEL	FIELD TYPE	RADIO BUTTON (YES or NO)
Will you provide services at a facility you own, lease, rent, manage, operate from, or otherwise use on a regular basis? *	Required, Yes or No	<p>Edit/select the appropriate radio button.</p> <p>Selecting the 'Yes' radio button, the Service Sites and CPR Certification Panel appear (shown below).</p> <p>"Community Sites" such as churches, libraries, and rooms in daycare buildings that the provider will use to deliver EIP services to children are considered "sites" and must be approved by DOH prior to use. However, if a provider goes to a child's childcare setting to deliver EIP services to that child per the IFSP, then that is considered a Home/Community-based setting and does not require DOH approval.</p>
Are you requesting approval for services that will be provided in other settings (e.g., Children's homes or a community setting like a child's daycare)? *	Required, Yes or No	<p>Edit/select the appropriate radio button.</p> <p>If you are not requesting site approval (above), you must select 'Yes' for this question.</p>

#### 10.4.2.1 Service Sites Grid/Table

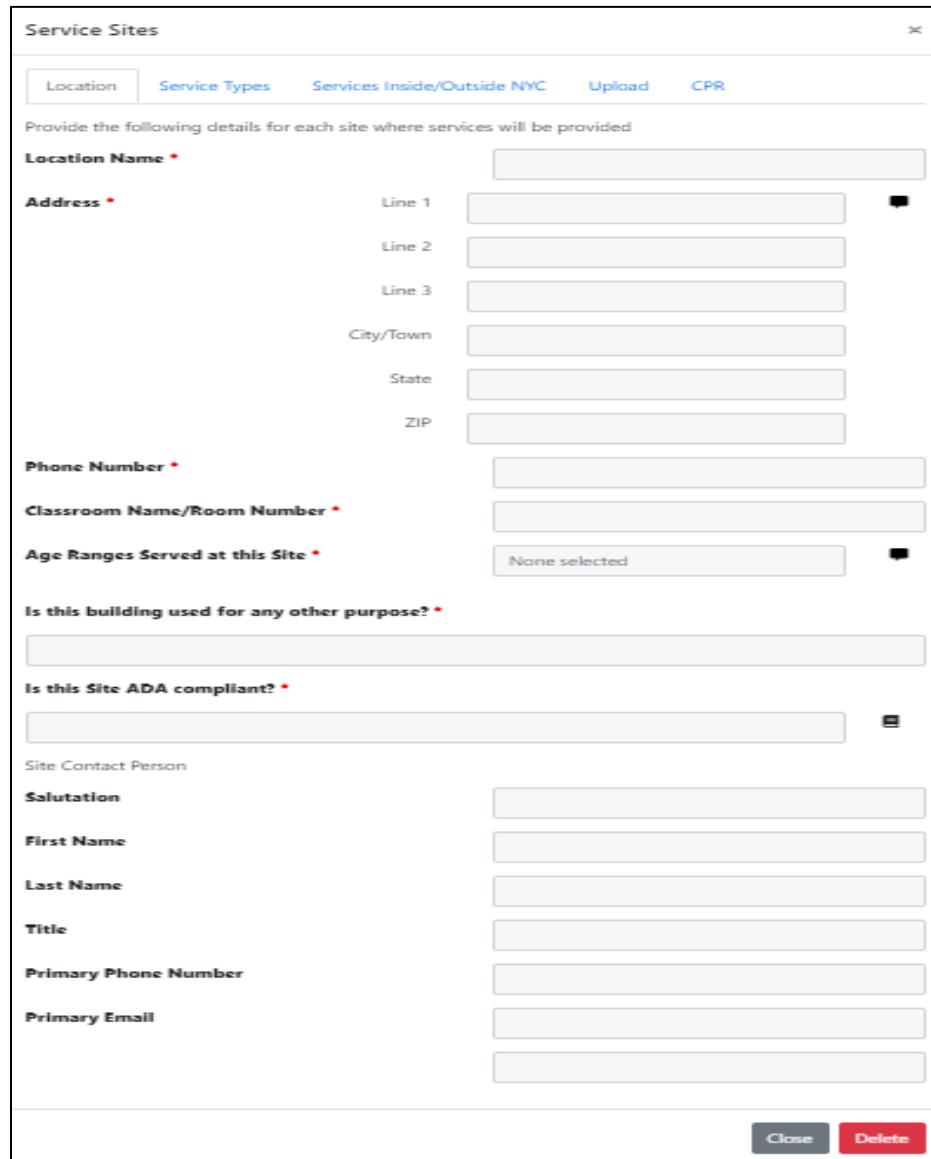
Service Sites	
Location Name	Actions
	Add Service Site



Click the **Add Service Site** button, and the 'Service Sites' popup tab/panel appears (shown below).

### 10.4.2.1.1 Service Sites Location Tab

 Use the fields below and provide the following details for each site where services will occur.



The screenshot shows a form titled "Service Sites" with a tab bar at the top: Location (selected), Service Types, Services Inside/Outside NYC, Upload, and CPR. Below the tabs, a note says "Provide the following details for each site where services will be provided". The main area contains the following fields:

- Location Name \***: Text input field.
- Address \***: Group of fields for Line 1, Line 2, Line 3, City/Town, State, and ZIP.
- Phone Number \***: Text input field.
- Classroom Name/Room Number \***: Text input field.
- Age Ranges Served at this Site \***: Drop-down menu showing "None selected".
- Is this building used for any other purpose? \***: Text input field.
- Is this Site ADA compliant? \***: Text input field.
- Site Contact Person** section:
  - Salutation**: Text input field.
  - First Name**: Text input field.
  - Last Name**: Text input field.
  - Title**: Text input field.
  - Primary Phone Number**: Text input field.
  - Primary Email**: Text input field.

At the bottom right are "Close" and "Delete" buttons.

FIELD	FIELD TYPE	DESCRIPTION
<b>Location Name *</b>	Required, Text Entry	Enter the name of the location (site).
<b>Location Address *</b>	Required, Text Entry	<ul style="list-style-type: none"> <li><b>Line1</b>: Enter the site address.</li> <li><b>Line2</b>: If applicable</li> <li><b>Line3</b>: If applicable</li> <li><b>Zip Code</b>: Enter the Zip +4</li> <li><b>City/Town</b>: Enter the site city/town.</li> <li><b>State</b>: Use the drop-down and select the state where the site resides.</li> </ul>
<b>Phone Number *</b>	Required, Numeric Entry	Enter the phone number for the location.

FIELD	FIELD TYPE	DESCRIPTION																
<b>Classroom Name/Room Number *</b>	Required, Text Entry	If applicable, enter the classroom name and room number.																
<b>Age Ranges served at this site *</b>  You may select multiple age ranges.	Required, Checkboxes	Select all that apply; the age ranges serviced are as follows: <ul style="list-style-type: none"><li>• 6-wks-12 months</li><li>• 12-24 months</li><li>• 24-36 months</li></ul>																
<b>Is this building used for any other purposes? *</b>	Required, Yes or No	<ul style="list-style-type: none"> <li>• Edit/select the appropriate radio button.</li> </ul> <p>Click the <b>Yes</b> radio button; the ‘Provide details’ field appears (shown below).</p> <div style="border: 1px solid #ccc; padding: 5px; margin-top: 10px;"> <b>Provide details *</b> </div> <ul style="list-style-type: none"> <li>• Please enter a brief description of the site's purpose and its uses.</li> </ul>																
<b>Is this site ADA compliant? *</b>  Click <a href="#">ada.gov</a> for additional information.	Required, Yes or No	Select the appropriate response if the site is compliant with the Americans with Disabilities Act. <ul style="list-style-type: none"> <li>• Click the <b>Yes</b> radio button; the “Site Contact Person” text field appears and must be populated (shown below).</li> </ul> <div style="border: 1px solid #ccc; padding: 5px; margin-top: 10px;"> <b>Site Contact Person</b> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;"><b>Salutation</b></td> <td style="width: 85%;"><input type="text"/></td> </tr> <tr> <td><b>First Name</b></td> <td><input type="text"/></td> </tr> <tr> <td><b>Last Name</b></td> <td><input type="text"/></td> </tr> <tr> <td><b>Title</b></td> <td><input type="text"/></td> </tr> <tr> <td><b>Primary Phone Number</b></td> <td>(ddd) ddd-dddd <input type="text"/></td> </tr> <tr> <td><b>Primary Email</b></td> <td><b>Email</b> <input type="text"/></td> </tr> <tr> <td></td> <td><b>Email (verify)</b> <input type="text"/></td> </tr> <tr> <td></td> <td><b>Verify Email</b> <input type="button" value="Verify Email"/></td> </tr> </table> </div>	<b>Salutation</b>	<input type="text"/>	<b>First Name</b>	<input type="text"/>	<b>Last Name</b>	<input type="text"/>	<b>Title</b>	<input type="text"/>	<b>Primary Phone Number</b>	(ddd) ddd-dddd <input type="text"/>	<b>Primary Email</b>	<b>Email</b> <input type="text"/>		<b>Email (verify)</b> <input type="text"/>		<b>Verify Email</b> <input type="button" value="Verify Email"/>
<b>Salutation</b>	<input type="text"/>																	
<b>First Name</b>	<input type="text"/>																	
<b>Last Name</b>	<input type="text"/>																	
<b>Title</b>	<input type="text"/>																	
<b>Primary Phone Number</b>	(ddd) ddd-dddd <input type="text"/>																	
<b>Primary Email</b>	<b>Email</b> <input type="text"/>																	
	<b>Email (verify)</b> <input type="text"/>																	
	<b>Verify Email</b> <input type="button" value="Verify Email"/>																	
<b>Site Person Salutation</b>	Optional, Drop-Down	Select the appropriate salutation for the site person from the list.																
<b>First Name</b>	Optional, Text Entry	Enter the site person’s first name.																
<b>Last Name</b>	Optional, Text Entry	Enter the site person’s last name.																
<b>Title</b>	Optional, Text Entry	Enter the site person’s title.																
<b>Primary Phone Number</b>	Optional, Numeric Entry	Enter the primary phone number for the site contact person.																
<b>Primary Email</b>	Optional, Text Entry	<b>Email:</b> Enter the best email address to reach (e.g., while at work) the Main Contact Person by email. <b>Email (verify):</b> Re-enter the same email for verification																

#### 10.4.2.1.2 Service Types Tab

Service Sites

Location    Service Types    Services Inside/Outside NYC    Upload    CPR

Service Types			
Service Model	Service Type	Catchment Area	Actions
			Add

**Close**    **Save changes**

#### 10.4.2.1.3 Service Types Grid/Table

Service Types

Service Model	Service Type	Catchment Area	Actions
			Add



Click the **Add** button, and the 'Service Sites' popup tab/panel appears (shown below).

#### 10.4.3.1.4 Service Type Popup Panel

 Indicate all service types for each site, and using the catchment area checkboxes (shown below), select all that apply to the early intervention service types requesting approval. You are selecting the service model and service type combinations that you will deliver at the identified site or from this identified site (e.g., Home/Community-Based Individual/Collateral services are provided in the child's home or childcare). The catchment areas are the counties where you can provide services or authorize children to receive services at the identified site. You must be accurate when adding service model and service type combinations. EIP providers can only deliver the services they are authorized to deliver under their license or certification professional scope of practice.

 You must enter service models and service types in appropriate combinations for each catchment area. Please refer to the *EI-Hub Resource: Service Models and Methods for Qualified Professions in the New York State Early Intervention Program*. For each service model (ex., Physical Therapy), you may need to create multiple entries into the Service Types Grid/Table to ensure you are approved to provide all appropriate service types (Extended, Basic, Facility-Based).

If a provider is applying to deliver home and community-based services, providers must add entries for basic and extended service types.

 Providers should only select valid combinations for services they are qualified to apply for at the time of application.

**Service Types**

Indicate all service types for each site

**Service Model \***

**Service Type \***

Select the early intervention service types for which you are seeking approval.

**Catchment Area \***

<b>Catchment Area</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Bronx County</li> <li><input type="checkbox"/> New York County</li> <li><input type="checkbox"/> Richmond County</li> <li><input type="checkbox"/> Allegany County</li> <li><input type="checkbox"/> Cattaraugus County</li> <li><input type="checkbox"/> Chautauqua County</li> <li><input type="checkbox"/> Chenango County</li> <li><input type="checkbox"/> Columbia County</li> <li><input type="checkbox"/> Delaware County</li> <li><input type="checkbox"/> Erie County</li> <li><input type="checkbox"/> Franklin County</li> <li><input type="checkbox"/> Genesee County</li> <li><input type="checkbox"/> Hamilton County</li> <li><input type="checkbox"/> Jefferson County</li> <li><input type="checkbox"/> Livingston County</li> <li><input type="checkbox"/> Monroe County</li>   <li><input type="checkbox"/> Nassau County</li> <li><input type="checkbox"/> Oneida County</li> <li><input type="checkbox"/> Ontario County</li> <li><input type="checkbox"/> Orleans County</li> <li><input type="checkbox"/> Otsego County</li> <li><input type="checkbox"/> Rensselaer County</li> <li><input type="checkbox"/> St. Lawrence County</li> <li><input type="checkbox"/> Schenectady County</li> <li><input type="checkbox"/> Schuyler County</li> <li><input type="checkbox"/> Steuben County</li> <li><input type="checkbox"/> Sullivan County</li> <li><input type="checkbox"/> Tompkins County</li> <li><input type="checkbox"/> Warren County</li> <li><input type="checkbox"/> Wayne County</li> <li><input type="checkbox"/> Wyoming County</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Kings County</li> <li><input type="checkbox"/> Queens County</li> <li><input type="checkbox"/> Albany County</li> <li><input type="checkbox"/> Broome County</li> <li><input type="checkbox"/> Cayuga County</li> <li><input type="checkbox"/> Chemung County</li> <li><input type="checkbox"/> Clinton County</li> <li><input type="checkbox"/> Cortland County</li> <li><input type="checkbox"/> Dutchess County</li> <li><input type="checkbox"/> Essex County</li> <li><input type="checkbox"/> Fulton County</li> <li><input type="checkbox"/> Greene County</li> <li><input type="checkbox"/> Herkimer County</li> <li><input type="checkbox"/> Lewis County</li> <li><input type="checkbox"/> Madison County</li> <li><input type="checkbox"/> Montgomery County</li> <li><input type="checkbox"/> Niagara County</li> <li><input type="checkbox"/> Onondaga County</li> <li><input type="checkbox"/> Orange County</li> <li><input type="checkbox"/> Oswego County</li> <li><input type="checkbox"/> Putnam County</li> <li><input type="checkbox"/> Rockland County</li> <li><input type="checkbox"/> Saratoga County</li>   <li><input type="checkbox"/> Schoharie County</li>   <li><input type="checkbox"/> Seneca County</li> <li><input type="checkbox"/> Suffolk County</li> <li><input type="checkbox"/> Tioga County</li> <li><input type="checkbox"/> Ulster County</li> <li><input type="checkbox"/> Washington County</li> <li><input type="checkbox"/> Westchester County</li> <li><input type="checkbox"/> Yates County</li> </ul>
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FIELD	FIELD TYPE	DESCRIPTION
<b>Service Model *</b>	Required, Drop-Down	Select the appropriate service model from the list.
<b>Service Type *</b>	Required, Drop-Down	Select the appropriate service type from the list.
<b>Catchment Area *</b>	Required, Checkboxes	Select/tick the checkboxes that apply to the early intervention service types requesting approval.

BUTTON	DESCRIPTION
<b>Close</b> 	Click this button to close the Service Types panel; changes do not save.
<b>Save changes</b> 	Click this button to save your changes, and it closes the Service Types panel.

### 10.4.3 Services Inside/Outside NYC Tab

Service Sites

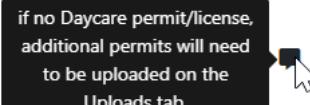
Location   Service Types   **Services Inside/Outside NYC**   Upload   CPR

**Is this service site located outside of NYC? \***

Yes  
 No

**Close**   **Save changes**

FIELD	FIELD TYPE	DESCRIPTION
<b>Is this service site located outside of NYC? *</b>	Required, Yes or No	<p>Select the appropriate radio button.</p> <p><b>(i)</b> If you select the ‘Yes’ radio button, two (2) additional labels/radio buttons appear (shown below).</p> <div style="border: 1px solid black; padding: 10px;"> <p><b>Is this service site located outside of NYC?</b></p> <p><input checked="" type="radio"/> Yes <input type="radio"/> No</p> <p><b>Will each child’s parent or guardian be present for all sessions? *</b></p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p><b>Will the agency provide group services to three or more children for three or more hours per day, per child? *</b></p> <p><input type="radio"/> Yes <input type="radio"/> No</p> </div> <ul style="list-style-type: none"> <li>• <b>Will each child’s parent or guardian be present for all sessions? *</b> <ul style="list-style-type: none"> <li>○ Select the appropriate radio button (<b>Yes</b> or <b>No</b>).</li> </ul> </li> <li>• <b>Will the agency provide group services be provided to three or more children, operating a total of five hours or more per week for more than 30 days in a 12-month period? *</b> <ul style="list-style-type: none"> <li>○ Select the appropriate radio button (<b>Yes</b> or <b>No</b>). If ‘Yes,’ additional labels/fields appear (shown below).</li> </ul> </li> </ul> <div style="border: 1px solid black; padding: 10px; margin-top: 10px;"> <p><b>Do you currently hold a NYS Office of Children and Family Services day care permit/license for children ages birth through age 2 at this site? *</b></p> <p><input type="radio"/> Yes <input type="radio"/> No</p> </div>

FIELD	FIELD TYPE	DESCRIPTION																						
		<p>if no Daycare permit/license, additional permits will need to be uploaded on the Uploads tab.</p>  <ul style="list-style-type: none"> <li>• Do you currently hold a NYC Office of Children and Family Services day care permit/license for children ages birth through age 2 at this site? *</li> </ul> <ul style="list-style-type: none"> <li>○ Select the appropriate radio button (Yes or No). <ul style="list-style-type: none"> <li>▪ If 'Yes,' additional labels/fields appear for you to populate (shown below).</li> </ul> </li> </ul> <div style="border: 1px solid #ccc; padding: 10px; margin-top: 10px;"> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 5px;"><b>Name of Day Care *</b></td> <td style="padding: 5px;"><input type="text"/></td> </tr> <tr> <td style="padding: 5px;"><b>License/Permit Number *</b></td> <td style="padding: 5px;"><input type="text"/></td> </tr> <tr> <td style="padding: 5px;"><b>License/Permit Effective Date *</b></td> <td style="padding: 5px;"><input type="text"/> mm/dd/yyyy </td> </tr> <tr> <td style="padding: 5px;"><b>License/Permit Expiration Date *</b></td> <td style="padding: 5px;"><input type="text"/> mm/dd/yyyy </td> </tr> <tr> <td style="padding: 5px;"><b>Entity which issued license *</b></td> <td style="padding: 5px;"><input type="text"/></td> </tr> </table> </div> <div style="border: 1px solid #ccc; padding: 10px; margin-top: 10px;"> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>FIELD</th><th>DESCRIPTION</th></tr> </thead> <tbody> <tr> <td style="padding: 5px;"><b>Name of Day Care *</b></td><td style="padding: 5px;">Enter the name of the day care.</td></tr> <tr> <td style="padding: 5px;"><b>License/Permit Number *</b></td><td style="padding: 5px;">Enter the day care license/permit number.</td></tr> <tr> <td style="padding: 5px;"><b>License/Permit Effective Date *</b></td><td style="padding: 5px;">Enter the license/permit effective date (manually typing or using the calendar picker).</td></tr> <tr> <td style="padding: 5px;"><b>License/Permit Expiration Date *</b></td><td style="padding: 5px;">Enter the license/permit expiration date (manually typing or using the calendar picker).</td></tr> <tr> <td style="padding: 5px;"><b>Entity which issued license *</b></td><td style="padding: 5px;">Enter the name of the entity that issued the day care license/permit.</td></tr> </tbody> </table> </div>	<b>Name of Day Care *</b>	<input type="text"/>	<b>License/Permit Number *</b>	<input type="text"/>	<b>License/Permit Effective Date *</b>	<input type="text"/> mm/dd/yyyy 	<b>License/Permit Expiration Date *</b>	<input type="text"/> mm/dd/yyyy 	<b>Entity which issued license *</b>	<input type="text"/>	FIELD	DESCRIPTION	<b>Name of Day Care *</b>	Enter the name of the day care.	<b>License/Permit Number *</b>	Enter the day care license/permit number.	<b>License/Permit Effective Date *</b>	Enter the license/permit effective date (manually typing or using the calendar picker).	<b>License/Permit Expiration Date *</b>	Enter the license/permit expiration date (manually typing or using the calendar picker).	<b>Entity which issued license *</b>	Enter the name of the entity that issued the day care license/permit.
<b>Name of Day Care *</b>	<input type="text"/>																							
<b>License/Permit Number *</b>	<input type="text"/>																							
<b>License/Permit Effective Date *</b>	<input type="text"/> mm/dd/yyyy 																							
<b>License/Permit Expiration Date *</b>	<input type="text"/> mm/dd/yyyy 																							
<b>Entity which issued license *</b>	<input type="text"/>																							
FIELD	DESCRIPTION																							
<b>Name of Day Care *</b>	Enter the name of the day care.																							
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<b>License/Permit Effective Date *</b>	Enter the license/permit effective date (manually typing or using the calendar picker).																							
<b>License/Permit Expiration Date *</b>	Enter the license/permit expiration date (manually typing or using the calendar picker).																							
<b>Entity which issued license *</b>	Enter the name of the entity that issued the day care license/permit.																							
<b>Is this service site located outside of NYC? *</b>	Required, Yes or No	<p>Select the appropriate radio button.</p> <p> If you select the 'No' radio button, two (2) additional labels/radio buttons appear (shown below).</p>																						

FIELD	FIELD TYPE	DESCRIPTION
		<p>Service Sites</p> <p>Location    Service Types    Services Inside/Outside NYC    Upload</p> <p>Is this service site located outside of NYC?</p> <p><input type="radio"/> Yes  <input checked="" type="radio"/> No</p> <p>Is this Service Site located inside of NYC? *</p> <p><input type="radio"/> Yes  <input type="radio"/> No</p> <p><b>Close</b> <b>Save changes</b></p> <ul style="list-style-type: none"> <li>• <b>Is this Service Site located inside of NYC? *</b> <ul style="list-style-type: none"> <li>○ Select the appropriate radio button (<b>Yes</b> or <b>No</b>).           <ul style="list-style-type: none"> <li>▪ If the answer is '<b>Yes</b>,' additional labels/fields appear (shown below).</li> </ul> </li> </ul> </li> </ul> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p><b>Will each child's parent or guardian be present for all sessions? *</b></p> <p><input type="radio"/> Yes  <input type="radio"/> No</p> <p><b>Will group services be provided to three or more children, operating a total of five hours or more per week, for more than 30 days in a 12-month period? *</b></p> <p><input type="radio"/> Yes  <input type="radio"/> No</p> </div> <ul style="list-style-type: none"> <li>• <b>Will each child's parent or guardian be present for all sessions? *</b> <ul style="list-style-type: none"> <li>○ Select the appropriate radio button (<b>Yes</b> or <b>No</b>).</li> </ul> </li> <li>• <b>Will group services be provided to three or more children, operating a total of five hours or more per week, for more than 30 days in a 12-month period? *</b> <ul style="list-style-type: none"> <li>○ Select the appropriate radio button (<b>Yes</b> or <b>No</b>).           <ul style="list-style-type: none"> <li>▪ If '<b>Yes</b>,' additional labels/fields appear (shown below).</li> </ul> </li> </ul> </li> </ul> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p><b>Do you currently hold a NYC DOH and Mental Hygiene day care permit/license for children ages birth through age 2 at this site? *</b></p> <p><input type="radio"/> Yes  <input type="radio"/> No</p> </div> <div style="background-color: black; color: white; padding: 5px; margin-top: 10px;"> <p>if no Daycare permit/license, additional permits will need to be uploaded on the <a href="#">Uploads tab</a>.</p>  </div>

FIELD	FIELD TYPE	DESCRIPTION
		<ul style="list-style-type: none"> <li>• Do you currently hold a NYC DOH and Mental Hygiene day care permit/license for children ages birth through age 2 at this site? *</li> <li>○ Select the appropriate radio button (Yes or No). <ul style="list-style-type: none"> <li>▪ If 'Yes,' additional labels/fields appear for you to populate (shown below).</li> </ul> </li> </ul> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Name of Day Care *</p> <input type="text"/>  <p>License/Permit Number *</p> <input type="text"/>  <p>License/Permit Effective Date *</p> <input type="text"/> mm/dd/yyyy <input type="button" value="Calendar"/> <p>License/Permit Expiration Date *</p> <input type="text"/> mm/dd/yyyy <input type="button" value="Calendar"/> <p>Entity which issued license *</p> <input type="text"/> </div>

BUTTON	DESCRIPTION
<b>Close</b> 	Click this button to close the Services Inside/Outside NYC panel; changes do not save.
<b>Save Changes</b> 	Click this button to save your changes and close the Services Inside/Outside NYC panel.

HYPERLINKS	DESCRIPTION
<b>Actions</b>  Display   Delete   Edit	<p>After adding a record in a grid/table, there are the three (3) hyperlink labels and their descriptions below:</p> <ul style="list-style-type: none"> <li>• <b>Display:</b> A popup panel appears (read-only) when clicked.</li> <li>• <b>Delete:</b> When clicked, a popup panel appears with two buttons, 'Close' (gray button) and 'Delete' (red button). <ul style="list-style-type: none"> <li>○ To cancel the deletion, click the <b>Close</b> button.</li> <li>○ To confirm the removal of the record, click the <b>Delete</b> button. The record is removed (deleted) from the grid/table when clicked.</li> </ul> </li> <li>• <b>Edit:</b> A popup panel appears (edit mode).</li> </ul> <p> The <b>Close</b> and <b>Save Changes</b> buttons work the same as described above</p>

#### 10.4.4 Upload Tab

 Uploads are limited to 10 MB and must be in one of the following formats: JPG, PDF, or PNG. The system will not accept files in other formats and/or larger than 10 MB. **Please ensure the supporting documentation is clear, legible, and oriented correctly.**

**Health and Safety Plan:** The agency must provide a written plan that it will comply with all local fire, health, and safety codes; will employ a policy for addressing health, safety, and sanitation issues (including diapering, handwashing, and food preparation) that conform to standards established by the Department; and complies with the Americans with Disabilities Act.

Service Sites X

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Location
Service Types
Services Inside/Outside NYC
Upload
CPR

---

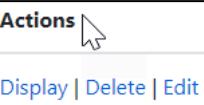
Uploads are limited to 10 MB and must be in one of the following formats only: JPG, PDF, or PNG. Files in other formats and/or larger than 10 MB will not be accepted. **Please ensure the supporting documentation is clear, legible, and oriented correctly.**

**Health and Safety Plan \*** Browse...

*The agency must provide a written plan 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 (including diapering, handwashing, and food preparation) that conform to standards established by the Department; and is in compliance with the Americans with Disabilities Act.*

Close
Save changes

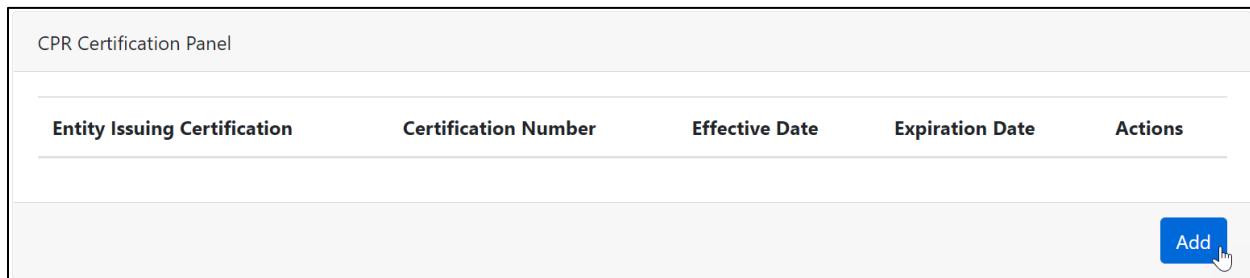
BUTTON	DESCRIPTION
<b>Health and Safety Plan *</b> <span style="border: 1px solid #ccc; padding: 2px;">Browse...</span>	<b>Step / Action</b> <ol style="list-style-type: none"> <li>1. To upload documents, click the <b>Browse</b> button adjacent to the appropriate label. When clicked, a dialog window/box appears.           <ul style="list-style-type: none"> <li>• Some dialog boxes display "<b>Choose File to Upload</b>" or "<b>Open</b>" depending on your browser (MS Edge, Google Chrome).</li> </ul> </li> <li>2. Search and attach your file by clicking the <b>Open</b> button.</li> </ol>
<b>Close</b> <span style="border: 1px solid #ccc; padding: 2px;">Close</span>	Click this button to close the Service Sites panel; changes do not save.
<b>Save Changes</b> <span style="background-color: #0070C0; color: white; border: 1px solid #0070C0; padding: 2px;">Save changes</span>	Click this button to save your changes, and it closes the Service Sites panel.

HYPERLINKS	DESCRIPTION
<b>Actions</b>  <a href="#">Display</a>   <a href="#">Delete</a>   <a href="#">Edit</a>	<p>After adding a record in a grid/table, there are the three (3) hyperlink labels and their descriptions below:</p> <ul style="list-style-type: none"> <li>• <b>Display:</b> A popup panel appears (read-only) when clicked.</li> <li>• <b>Delete:</b> When clicked, a popup panel appears with two buttons, 'Close' (gray button) and 'Delete' (red button).             <ul style="list-style-type: none"> <li>○ To cancel the deletion, click the <b>Close</b> button.</li> <li>○ To confirm the removal of the record, click the <b>Delete</b> button. When clicked, the record is removed (deleted) from the grid/table.</li> </ul> </li> <li>• <b>Edit:</b> A popup panel appears (edit mode).</li> </ul> <p> <b>The Close and Save Changes buttons work the same as described above.</b></p>

## 10.4.5 CPR Tab

 Add notes and text to introduce this tab.

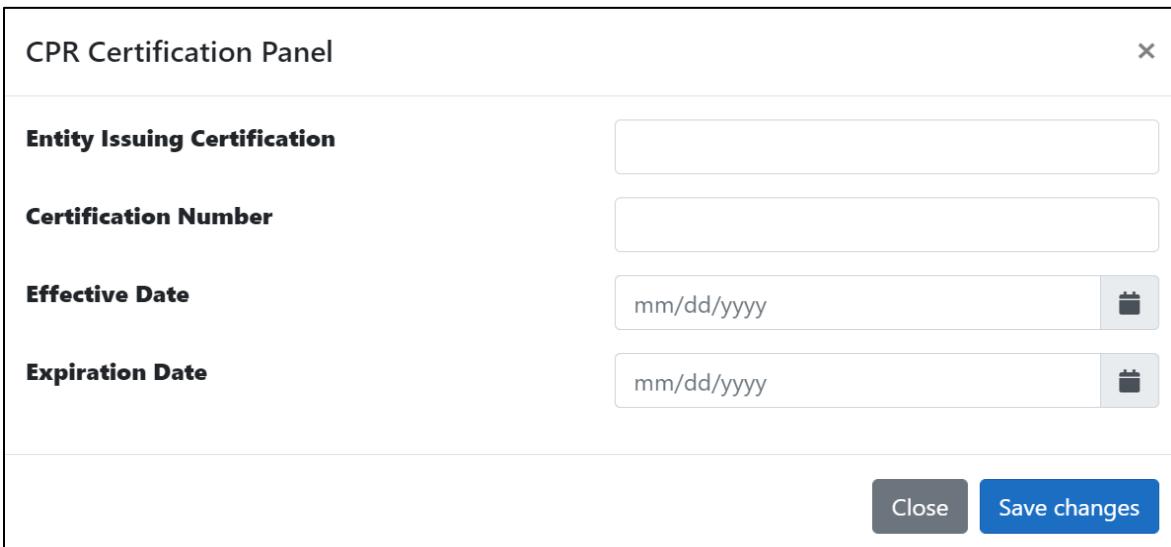
### 10.4.5.1 CPR Certification Panel (Grid/Table)



CPR Certification Panel

Entity Issuing Certification	Certification Number	Effective Date	Expiration Date	Actions
				<b>Add</b> 

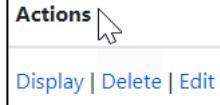
 Click the **Add** button, and the 'CPR Certification' popup panel appears (shown below).

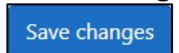


CPR Certification Panel

<b>Entity Issuing Certification</b>	<input type="text"/>	
<b>Certification Number</b>	<input type="text"/>	
<b>Effective Date</b>	<input type="text"/> mm/dd/yyyy 	
<b>Expiration Date</b>	<input type="text"/> mm/dd/yyyy 	
		<input type="button" value="Close"/> <input style="background-color: #0070C0; color: white;" type="button" value="Save changes"/>

FIELD	FIELD TYPE	DESCRIPTION
Entity Issuing Certification *	Optional, Text Entry	Enter the name of the entity issuing the certification.
Certification Number *	Optional, Text Entry	Enter the CPR certification number
Certification Effective Date *	Optional, Date/Calendar	Enter the CPR effective date (manually typing or using the calendar picker).
Certification Expiration Date *	Optional, Date/Calendar	Enter the CPR expiration date (manually typing or using the calendar picker).

HYPERLINKS	DESCRIPTION
<b>Actions</b>  <a href="#">Display</a>   <a href="#">Delete</a>   <a href="#">Edit</a>	<p>After adding a record in a grid/table, there are the three (3) hyperlink labels and their descriptions below:</p> <ul style="list-style-type: none"> <li><b>Display:</b> A popup panel appears (read-only) when clicked.</li> <li><b>Delete:</b> When clicked, a popup panel appears with two buttons, 'Close' (gray button) and 'Delete' (red button).             <ul style="list-style-type: none"> <li>To cancel the deletion, click the <b>Close</b> button.</li> <li>To confirm the removal of the record, click the <b>Delete</b> button. When clicked, the record is removed (deleted) from the grid/table.</li> </ul> </li> <li><b>Edit:</b> A popup panel appears (edit mode).</li> </ul> <p> <b>The 'Close' and 'Save Changes' buttons work the same as described above.</b></p>

BUTTON	DESCRIPTION
<b>Close</b> 	Click this button to close the CPR Certification Panel; changes do not save.
<b>Save Changes</b> 	Click this button to save your changes, and it closes the CPR Certification Panel.

## 10.5 Disclosures Tab



Answer the following question by selecting the appropriate radio buttons (**Yes** or **No**).

Please save your progress often and remember that you can only save if all required fields on the page have been completed and no errors are to be resolved. The submit application button will systematically review your application and report any errors. Successful submission of the PAT will result in your application being reviewed for approval by the BEI Provider Approval Unit.

### Individual Application

Identifying Information      Professional Experience and Certification      Insurance      Specialty Populations      Services      Disclosures

**Have you lived outside of New York State within the past 5 years? \***

- Yes  
 No

**Have you held any offices in any health or human services or facilities, including early intervention or preschool special education programs, within the past (5) years? (Example: Director, CEO, Board of Director, etc.) \***

- Yes  
 No

**Have you had (or do you currently have) a fiscal or operating interest in any health or human service agencies or facilities within the past five (5) years? Include all entities that were approved to provide early intervention or preschool special education programs. \***

- Yes  
 No

**Has your License/Certification ever been Suspended or Revoked? \***

- Yes  
 No

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

- Yes  
 No

**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? \***

- Yes  
 No

**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? \***

- Yes  
 No

**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? \***

- Yes  
 No

**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? \***

- Yes  
 No

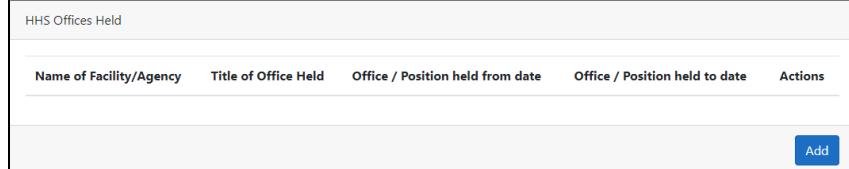
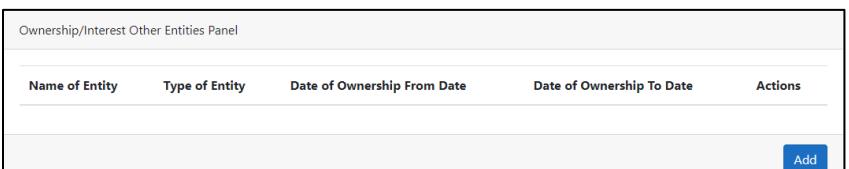
Please save your progress often and remember that you can only save if all required fields on the page have been completed and there are no errors to be resolved. The submit application button will initiate a system review of your application and report any errors. Successful submission of the PAT will result in your application being reviewed for approval by the BEI Provider Approval Unit.

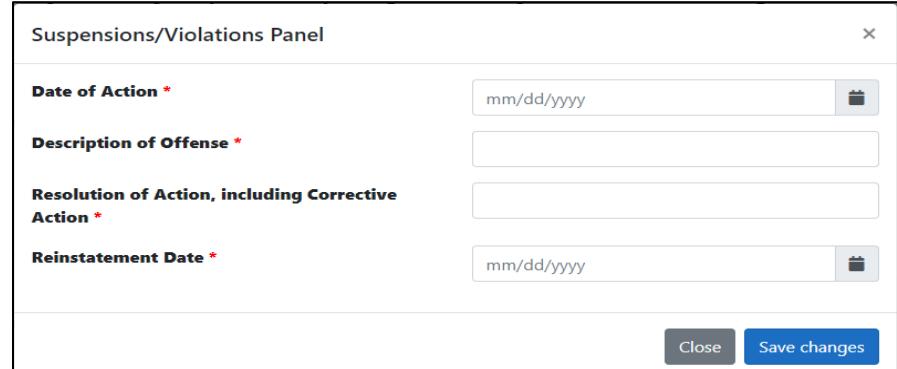
[Previous Tab](#)

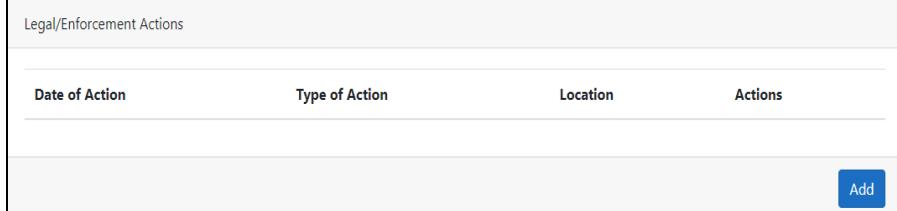
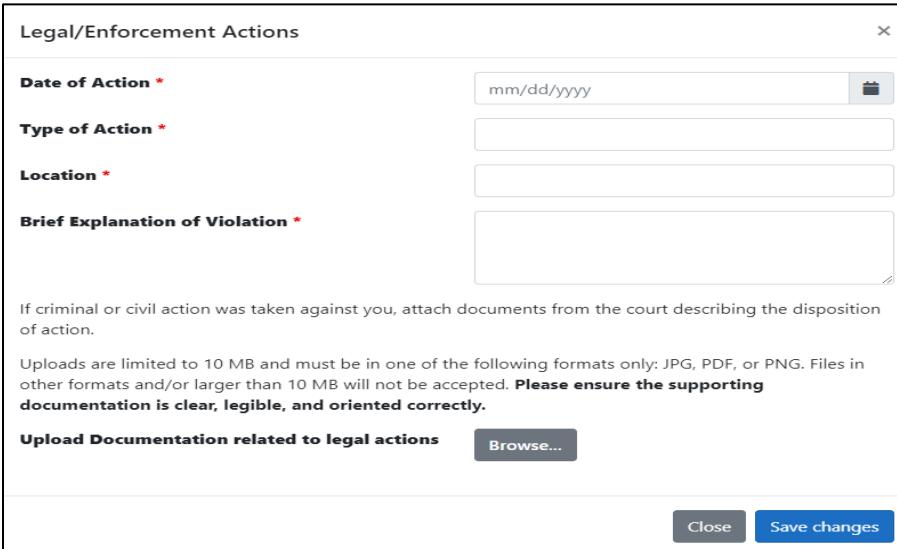
[Next Tab](#)

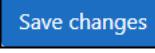
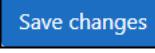
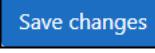
[Save Progress](#)

[Submit Application](#)

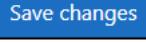
FIELD	FIELD TYPE	DESCRIPTION
<b>Have you lived outside of New York State within the past 5 years? *</b>	Required, Yes or No	<p>Edit/select the appropriate radio button.</p> <p><b>(i)</b> If you choose the 'Yes' radio button, the Out of State Addresses panel appears (shown below).</p>  <p><b>(i)</b> For fields and action buttons, please refer to the '<a href="#">Out of State Addresses Tab.</a>'</p>
<b>Have you held any offices in any health or human services or facilities, including early intervention or preschool special education programs, within the past (5) years? (Example: Director, CEO, Board of Directors, etc.) *</b>	Required, Yes or No	<p>Edit/select the appropriate radio button.</p> <p><b>(i)</b> If you choose the 'Yes' radio button, the HHS Offices Held panel appears (shown below).</p>  <p><b>(i)</b> For fields and action buttons, please refer to the '<a href="#">HHS Offices Tab.</a>'</p>
<b>Have you had (or do you currently have) a fiscal or operating interest in any health or human service agencies or facilities within the past five (5) years? Include all entities that were approved to provide early intervention or preschool special education programs. *</b>	Required, Yes or No	<p>Edit/select the appropriate radio button.</p> <p><b>(i)</b> If you choose the 'Yes' radio button, the Ownership/Interest Other Entities Panel appears (shown below).</p>  <p><b>(i)</b> For fields and action buttons, please refer to the '<a href="#">Other Interests/Ownership Entities Tab.</a>'</p>

FIELD	FIELD TYPE	DESCRIPTION
Has your License/Certification ever been Suspended or Revoked? *	Required, Yes or No	<p>Edit/select the appropriate radio button.</p> <p><b>(i)</b> If you choose the 'Yes' radio button, the Suspension/Violations Panel appears (shown below).</p> 
FIELD	DESCRIPTION	
Add	<p>To add a suspension/violation, click this button. The Suspensions/Violations popup panel appears (shown below) when clicked.</p> 	
FIELD	DESCRIPTION	
Date of Action *	Manually enter or use the calendar picker for the action date (e.g., violations of the law).	
Description of Offense *	Enter the type of offense (e.g., criminal, civil, administrative charges).	
Resolution of Action, including Corrective Action *	Enter a brief explanation of the resolution for the offense.	
Reinstatement Date *	Manually enter or use the calendar picker for the reinstatement date (e.g., violations of the law).	

FIELD	FIELD TYPE	DESCRIPTION
<b>Except for minor traffic violations, were you ever convicted of any violation of the law (e.g., criminal, civil, or administrative charges)? *</b>	Required, Yes or No	<p>Edit/select the appropriate radio button.</p> <p><b>(i)</b> If you choose the 'Yes' radio button, the Legal/Enforcement Actions panel appears (shown below).</p> 
<b>FIELD</b> <b>DESCRIPTION</b>		
<b>Add</b> 		
<p>To add a legal/enforcement action, click this button. When clicked, the Legal/Enforcement Actions popup panel appears (shown below).</p> 		
<b>FIELD</b> <b>DESCRIPTION</b>		
<b>Date of Action *</b>		Manually enter or use the calendar picker for the action date (e.g., legal/enforcement).
<b>Type of Action *</b>		Enter the type of action (e.g., criminal, civil, administrative charges).
<b>Location *</b>		Enter the location where the legal/enforcement took place.

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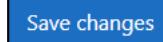
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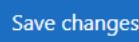
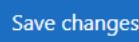
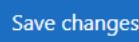
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		<b>Save Changes</b>  	Click this button to save your changes and close the 'Office or position ever had a contract terminated, suspended, or restricted for failure to perform or for any other reason?' panel.

FIELD	FIELD TYPE	DESCRIPTION									
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 licenses restricted, revoked, or suspended by the Office of Children and Family Services OR New York City Department of Health and Mental Hygiene? *	Required, Yes or No	<p>Edit/select the appropriate radio button.</p> <p><b>(i)</b> If you select the 'Yes' radio button, the Childcare-related enforcement actions panel appears (shown below).</p> <div style="border: 1px solid #ccc; padding: 10px; margin-top: 10px;"> <p>Childcare-related enforcement actions</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Date of Action</th> <th>Type of Action</th> <th>Location</th> <th>Actions</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td style="text-align: right;"><a href="#">Add</a></td> </tr> </tbody> </table> </div>	Date of Action	Type of Action	Location	Actions				<a href="#">Add</a>	
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BUTTON	DESCRIPTION
<b>Close</b>  	Click this button to close the CPR Certification Panel; changes do not save.
<b>Save Changes</b>  	Click this button to save your changes, and it closes the CPR Certification Panel.
<b>Next Tab</b>  	Click this button to advance to the next tab on the screen (panel). Alternatively, click the next tab on the top (below the screen's header name).

BUTTON	DESCRIPTION
	<b>(i)</b> This button appears in the remaining tabs after advancing to the second tab on the screen.
<b>Previous Tab</b> 	To return to the previous tab. Click this button.  <b>(i)</b> This button appears in the remaining tabs after advancing to the second tab on the screen.
<b>Save Progress</b> 	Click this button to save your data entry progress before submitting your application.
<b>Submit Application</b> 	Click this button if you have completed all the tabs and are ready to submit your application.  <b>(i)</b> Applicant - Individual PAST > 'SSN' field: If you submit the PAST without this required field, the box is red, but the error message appears on top of the NPI field below. This functionality is because the NPI field behaves differently due to the new NPI process.

## 10.6 Upload Tab

 Verify if all the uploaded required accompanying documentation files appear. If edits are needed, use the **Browse** button adjacent to each label to replace an existing one or add a blank section that the system requires (\*).

Please save your progress often and remember that you can only save if all required fields on the page have been completed and there are no errors to be resolved. The submit application button will systematically review your application and report any errors. Successful submission of the PAT will result in your application being reviewed for approval by the BEI Provider Approval Unit.

### Individual Application

Identifying Information    Professional Experience and Certification    Insurance    Specialty Populations    Services    Disclosures

Upload    Appendix 1 Agreement    Provider Agreement

Uploads are limited to 10 MB and must be in one of the following formats only: JPG, PDF, or PNG. Files in other formats and/or larger than 10 MB will not be accepted. Please ensure the supporting documentation is clear, legible, and oriented correctly.

**Upload Business Association Agreement (Health Homes)**

*Only needed if associated with Medicaid Health Homes*

**Browse...**

**Upload Attestation (Health Homes)**

*Only needed if associated with Medicaid Health Homes*

**Browse...**

**Upload NYS DMV Driver's License or Non-driver photo ID or other photo identification if outside of NYS \***

**Browse...**

Please save your progress often and remember that you can only save if all required fields on the page have been completed and there are no errors to be resolved. The submit application button will initiate a system review of your application and report any errors. Successful submission of the PAT will result in your application being reviewed for approval by the BEI Provider Approval Unit.

**Previous Tab**

**Next Tab**

**Save Progress**

**Submit Application**

BUTTON	DESCRIPTION
<b>Browse</b>  <b>Browse...</b>	<p><b>Step / Action</b></p> <ol style="list-style-type: none"> <li>To upload documents, click the <b>Browse</b> button adjacent to the appropriate label. When clicked, a dialog window/box appears.           <ul style="list-style-type: none"> <li>Some dialog boxes display 'Choose File to Upload' or 'Open' depending on your browser (MS Edge, Google Chrome).</li> </ul> </li> <li>Search and attach your file by clicking the <b>Open</b> button.</li> </ol>

## Unit 11. Appendix 1 Agreement Tab

 Individual Providers can only bill independently with a valid **Appendix 1 agreement**. Without Appendix 1 participation, Individual Providers must be employed or contracted by an approved Agency Provider. Individuals must have prior billing experience in order to be approved for an Appendix 1 Agreement. BEI Provider Approval Unit may request additional information from you related to this experience.

Please save your progress often and remember that you can only save if all required fields on the page have been completed and there are no errors to be resolved. The submit application button will systematically review your application and report any errors. Successful submission of the PAT will result in your application being reviewed for approval by the BEI Provider Approval Unit.

### Individual Application

Identifying Information    Professional Experience and Certification    Insurance    Specialty Populations    Services    Disclosures

Upload    Appendix 1 Agreement    Provider Agreement

**Are you interested in the Appendix 1 Agreement? \***

- Yes  
 No



Please save your progress often and remember that you can only save if all required fields on the page have been completed and there are no errors to be resolved. The submit application button will initiate a system review of your application and report any errors. Successful submission of the PAT will result in your application being reviewed for approval by the BEI Provider Approval Unit.

Previous Tab

Next Tab

Save Progress

Submit Application

FIELD	FIELD TYPE	DESCRIPTION
<b>Are you interested in the Appendix 1 Agreement? *</b>  <div style="border: 1px solid black; padding: 5px;">                     Individual Providers can only bill independently with a valid Appendix 1 agreement in place. Without Appendix 1 participation, individual providers must be employed or contracted by an approved agency provider.                      </div>	Required, Yes or No	<ul style="list-style-type: none"> <li>The following agreement appears in the panel/screen when clicking the <b>Yes</b> radio button.</li> <li>When clicked (<b>Yes</b> radio button), the following fields appear beneath the Appendix 1 Agreement verbatim (Not shown due to the length of this form.):                             <ul style="list-style-type: none"> <li><b>Select the Check Box *</b>  <input type="checkbox"/> I Read The Entire Appendix 1 Agreement</li> <li><b>Would you like to enter into the Appendix 1 Agreement? *</b>  <input type="radio"/> Yes  <input type="radio"/> No                             </li> </ul> </li> </ul>

## Unit 12. Provider Agreement Tab

 This Agreement aims to set forth the terms and conditions for participation in the Early Intervention Program (EIP) and establish the obligations, expectations, and relationships between the Department, municipalities within the State, and the Provider.

Providers intending to receive service authorizations for early intervention services directly from a Municipality **and** payment from the Municipality for such services rendered must complete and comply with the attached **Appendix 1- Payee Provider Agreement/Service Authorizations and Payment**. Appendix 1 sets forth the terms and conditions for such authorizations and payments.

Providers who want to work under an approved EIP agency and bill for services through the agency **do not** need an Appendix 1 Agreement. The Basic Provider Agreement is sufficient.

### Individual Application

Identifying Information    Professional Experience and Certification    Insurance    Specialty Populations    Services    Disclosures

Upload    Appendix 1 Agreement

Provider Agreement



#### Purpose of Agreement

The purpose of this Agreement is to set forth the terms and conditions for participation in the Early Intervention Program (EIP) and to establish the obligations, expectations and relationship between the Department, municipalities within the State and the Provider.

Providers intending to receive service authorizations for early intervention services directly from a Municipality **and** payment from the Municipality for such services rendered must complete and comply with the attached **Appendix 1- Payee Provider Agreement/Service Authorizations and Payment**. Appendix 1 sets forth the terms and conditions for such authorizations and payment.

# Individual Application

Identifying Information    Professional Experience and Certification    Insurance    Specialty Populations    Services    Disclosures  
 Upload    Appendix 1 Agreement    **Provider Agreement**

New York State Department of Health  
 Bureau of Early Intervention

**Early Intervention Provider Agreement (effective 2018)**

This Provider Agreement is entered into by and between the New York State Department of Health (hereinafter referred to as the "Department"), and ASHLEY ANDINO (hereinafter referred to as the "Provider"). Provider acknowledges that this agreement is made by and between the Department and Provider, as Provider is currently organized and constituted or presented. The Department reserves the right to terminate this agreement should the Provider reorganize or otherwise substantially change the character of its corporate or other business structure or presentation.

**Purpose of Agreement**

The purpose of this Agreement is to set forth the terms and conditions for participation in the Early Intervention Program (EIP) and to establish the obligations, expectations and relationship between the Department, municipalities within the State and the Provider.

Providers intending to receive service authorizations for early intervention services directly from a Municipality and payment from the Municipality for such services rendered must complete and comply with the attached **Appendix 1- Payee Provider Agreement/Service Authorizations and Payment**. Appendix 1 sets forth the terms and conditions for such authorizations and payment.

**Definitions**

When used herein, the following terms shall have the following meanings:

- Applied behavior analysis or "ABA" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.
- "Early Intervention Official" or "EIO" shall mean an appropriate municipal official designated by the chief executive officer of a municipality and an appropriate designee of such official.
- "Early Intervention Program" or "EIP" means the program established pursuant to Title II-A of Article 25 of the Public Health Law.
- "Family/Caregiver Support Group" is the provision of early intervention services to a group of parents, caregivers (foster parents, day care staff, etc.) and/or siblings of eligible children for the purposes of enhancing their capacity to care for and/or enhance the development of the eligible child and providing support, education, and guidance to such individuals relative to the child's unique developmental needs.
- "Group Developmental Intervention Visit" shall mean the provision of early intervention services by appropriate qualified personnel to eligible children in a group which may also include children without disabilities, at an approved Provider's site or in a community-based setting.
- "Home and Community Based Individual/Collateral Visits" shall mean the provision by appropriate qualified personnel of services to an eligible child and/or parent or other designated caregiver at the child's home or any other natural environment in which children under three years of age are typically found (including day care centers other than those located at the same premises as the Provider, and family day care homes).
- "Municipality" shall mean a county outside of the City of New York or in the case of a county located within the City of New York. For purposes of this agreement, "Municipality" shall further mean the Municipality in which the Provider renders evaluations, service coordination or early intervention services to children residing in such Municipality.
- "Office/Facility-Based Individual/Collateral Visits" shall mean the provision by appropriate qualified personnel of services to an eligible child and/or parent or other designated caregiver at an approved Provider's site (including day care centers located at the same premises as the Provider).
- "Parent-Child Group" is 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 a community-based site (e.g., day care center, family day care, or other community settings).

- "Provider" shall mean an agency or individual approved in accordance with 10 NYCRR § 69-4.5 to deliver service coordination, evaluations and screenings and/or services in the EIP.
  - "Agency Provider" shall mean an entity which employs qualified personnel as defined in 10 NYCRR § 69-4.1(ak), and may contract with individual providers or other agency providers which are approved by the Department, for the provision of early intervention program evaluations and screenings, service coordination, and/or early intervention services.
  - "Individual Provider" shall mean a person who holds a state-approved or recognized certificate, license or registration in one of the disciplines set forth in 10 NYCRR § 69-4.1(ak) and who either receive service authorizations for early intervention services from a Municipality and/or are under contract with an agency provider.
- "Services" shall mean those early intervention services as defined in 10 NYCRR 69-4.1(l) that the Provider identified in the Provider's application to the Department as being able to provide, either directly or for Agency Providers through employees and/or contracts with Individual Providers or other Agency Providers.
- "Service authorization" shall mean approval by a municipality relating to specific services contained in a child's Individualized Family Service Plan (IFSP) and includes the following details: the provider of record; the type of service; whether it is a facility based or home and community based service; whether it is a basic or extended service; how many times per week the service can be provided; the rendering provider; and the diagnosis for the child.
- "Service Coordination Services" shall mean assistance 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 to be provided under the EIP.
- "State" shall mean the State of New York.

**Now, therefore, the Department and Provider agree as follows:**

**I. Appendix**

The Provider cannot receive service authorizations from a Municipality and claim for early intervention services rendered unless requested by the provider and approved by the Department in this agreement. The following appendix, when checked, shall be incorporated and made a part of this agreement as if fully set forth herein:

Appendix 1- Payee Provider Agreement/Service Authorizations and Payment

**II. Role of Department, Municipalities and Providers in the Early Intervention Program**

Pursuant to Public Health Law (PHL) § 2550, the Department is the lead agency responsible for the administration of the Early Intervention Program in this State. Each individual Municipality and the city of New York is responsible for the local administration of the program, which includes but is not limited to, accepting referrals of children potentially eligible for program services, assigning initial service coordinators, participating in IFSP meetings, ensuring that early intervention (EI) services contained in an IFSP are appropriately delivered, and reimbursing providers for services not covered by Medicaid or commercial insurance according to rates set by the Department pursuant to regulations. PHL authorizes the Department to contract with a fiscal agent that will handle provider claiming and payment. The Provider hereby understands and agrees that the claims submitted shall be accurate and complete, and shall reflect the actual service rendered. The Provider further understands and agrees that, pursuant to PHL § 2557(3) and (3-a), PHL § 2552(1) and 10 NYCRR § 69-4.12, both the Department and the Municipality are authorized to monitor and audit evaluators, service coordinators and Providers of services within the Municipality. Provider understands and agrees that certain provisions within this Agreement that require notice to the Municipality or includes the Municipality with respect to obligations or requirements, are designed to acknowledge the Municipality's role in the local administration of the Early Intervention Program and in the oversight of Providers in the delivery and payment for evaluations and services provided to children within such Municipality.

**III. Provider Responsibilities**

- A. Provider shall comply with all applicable provisions of law, rule and regulation when participating in the Early Intervention Program, including but not limited to PHL § 2550 et seq, 10 NYCRR SubPart 69-4, Part C of the Individuals with Disabilities Education Act and its regulations at 34 CFR Part 303, and the Family Educational Rights and Privacy Act (FERPA) and its regulations at 34 CFR Part 99.
- B. Agency Provider understands and hereby agrees that it is responsible for and shall ensure that its employees and Individual Providers under contract with such Agency Provider comply with the provisions of applicable law and regulations, and with the terms of this Agreement when delivering evaluations or services on behalf of the Agency Provider.
- C. Provider hereby agrees that Provider can and shall deliver services in the areas of the State identified by the Provider to the Department as part of this agreement but the Provider is not prohibited from providing services in additional areas of the State. Provider shall only conduct evaluations and deliver the services for which Provider is approved by the Department to deliver.

- D. Provider understands and hereby agrees that nothing in this Agreement or Appendix 1 of this Agreement shall be deemed to require or otherwise hold the Department responsible for making payment to the Provider for evaluations or services rendered under the EIP. Provider understands and agrees that reimbursement for evaluations and services is governed by PHL §2557 and §2559. In accordance with those sections, Providers who receive direct service authorizations from a Municipality shall, in the first instance and where applicable, seek reimbursement under a health insurance policy, plan or contract, including under the medical assistance program or the child health insurance program, prior to seeking reimbursement from a Municipality for services rendered to a child who has health insurer or health maintenance organization coverage. Payments will be made by insurers and the Medicaid Program directly to the Provider and remittance advices will be submitted by the third-party payors to the Department's state fiscal agent (SFA) with claims adjudication information. The SFA will inform the Provider of denied claims and will work with the Provider to address any denials resulting from inaccurate or incomplete information required for payment (for example, missing diagnostic or procedural codes.) Pursuant to PHL §2557, approved costs, other than those reimbursable under a health insurance policy, plan or contract, including under the medical assistance program or the child health insurance program, for evaluations and services shall be a charge upon the Municipality wherein an eligible child resides. Provider shall not seek or be entitled to reimbursement directly from the Department for evaluations or services rendered to eligible children under the EIP.
- E. Provider understands and hereby agrees that the Provider cannot be involved in any activity relating to the provision of evaluations or services rendered under the EIP if the Provider is excluded from Medicaid or Medicare.
- F. Agency Provider understands and hereby agrees that the Agency Provider must verify that a person is not excluded from Medicaid or Medicare at the time of hire or upon entering into contract and at least verify every thirty (30) days that current employees and contractors used by the Agency Provider have not been excluded.
- G. Provider understands and hereby agrees that nothing in this Agreement shall be construed as guaranteeing to Provider a specific number of evaluation assignments or service authorizations. Provider understands and agrees that the Provider may not be assigned any evaluations or provided with any service authorizations in the EIP, and/or that service authorizations may be modified at any time in accordance with PHL, for reasons including but not limited to the eligible child has progressed under the EIP and the IFSP team determines that a service should be reduced or is no longer needed. Provider further understands that payment for evaluations and services under the EIP is subject to funds being appropriated and made available therefor.
- H. Provider understands and hereby agrees that all sites are under the control of the Provider and will be maintained in compliance with all applicable laws and regulations and implement a policy for addressing health, safety and sanitation issues that conforms with standards established by the Department and where applicable, in conformance with the American with Disabilities Act. Provider further understands that all sites under the control of the Provider must be approved by the Department prior to rendering EIP services at each site.

#### **IV. Personnel**

- A. Provider hereby affirms that Provider can deliver services on a twelve-month basis and provides flexibility in hours of service delivery, which includes but is not limited to, rendering services outside of standard business and/or operating hours. This includes but is not limited to service delivery on weekend and evening hours in accordance with eligible children's IFSPs.
- B. Provider shall maintain a statement from a health care provider which documents that the Provider, and employees and Individual Providers under contract with an Agency Provider, has no diagnosed disorder or condition that would preclude him/her from providing services. Such statement shall be obtained prior to the provision of services and updated on an annual basis thereafter.
- C. Provider shall maintain proof from a health care provider that the Provider, and/or employees and Individual Providers under contract with an Agency Provider, meet the following requirements, prior to provision of services:
- measles, mumps, and rubella titer and/or vaccine; and annual Mantoux/PPD or chest X-ray with the exception of EI Providers who are also licensed day care providers by the NYC Bureau of Day Care. NYC Bureau of Day Care Providers must demonstrate that upon commencement of work, a record of testing performed for tuberculosis infection, and further testing at any time, if required by the NYC Bureau of Day Care.
  - have the following recommended vaccines or has documented refusal, prior to the provision of EI Provider services: Hepatitis B vaccine, Tetanus immunization within the past 10 years, Diphtheria, Pertussis, Varicella, and Influenza.
- D. In accordance with Social Services Law (SSL) §424-a and §495, Agency Provider shall conduct a Staff Exclusion List (SEL) check of potential hires through the New York State Justice Center for the Protection of People with Special Needs (Justice Center) prior to conducting a Statewide Central Registry (SCR) of Child Abuse and Maltreatment check. The Agency Provider is responsible for initiating this process with the state's Justice Center.

## EI-Hub Provider Enrollment Management (PEM) User Guide v1.5.1

- E. Providers shall, in accordance with Social Services Law (SSL) § 424-a, ensure that Statewide Central Register Database Check Form LDSS-3370 is completed and submitted to the SCR for: (i) any person who is being actively considered for employment, and who will have the potential for regular and substantial contact with children who receive early intervention services; and (ii) any prospective Individual Provider providing goods and services who will have the potential for regular and substantial contact with children who receive services. Agency Provider shall complete the SCR database check and must receive an acceptable response from the SCR prior to authorizing or allowing any person or Individual Provider to have any unsupervised contact with a child receiving early intervention services. If any person about whom the Agency Provider has made an inquiry is found to be the subject of an indicated report of child abuse or maltreatment, such Agency Provider must, in accordance with SSL § 424-a, determine, on the basis of information it has available and in accordance with guidelines developed and disseminated by the NYS Office of Children and Family Services for child care services, whether to hire, retain or use the person as an employee, volunteer or contractor or to permit the person providing goods or services to have access to children being served by the Agency Provider. Whenever such person is hired, retained, used or given access to children in the EIP, such Agency Provider must maintain a written record, as part of the application file or employment or other personnel record of such person, of the specific reason(s) why such person was determined to be appropriate and acceptable as an employee, volunteer, contractor or provider of goods or services with access to children being served the Agency Provider.
- F. If Agency Provider denies employment or determines not to retain or utilize such person, Agency Provider shall comply with the requirements contained in SSL § 424-a.
- G. Provider shall review and become familiar with the Department's guidance and written policies and procedures for the provision of EI services, including but not limited to guidance regarding referral, eligibility, evaluations, provision of services, record keeping and claiming. Agency Providers shall ensure that its employees and Individual Providers under contract with such Agency Providers are familiar with such guidance, policies and procedures.
- H. Agency Providers shall only utilize qualified personnel as defined in 10 NYCRR §69-4.1 as appropriate for the provision of authorized services, and shall ensure that such qualified personnel maintain current registration, certification or licensure in the area for which they are providing services on behalf of the agency.
- I. Individual Providers shall demonstrate proficiency in early childhood development and only render services within the scope of practice for which they are licensed and currently registered, or certified, as applicable, and within the areas in which the Individual Provider has been trained and educated, and with which he or she is familiar and competent.
- J. Agency Providers shall assign a speech language pathologist to provide services to a child when a speech service is authorized in a child's IFSP; the Agency Provider shall not assign a certified teacher when speech services are authorized in the child's IFSP and requested by the service coordinator.
- K. Provider, employees and independent contractors (including Service Coordinators) utilized by a Provider Agency to deliver services shall demonstrate continued professional development related to their professional field of practice, including but not limited to family-centered services, child outcomes, quality improvement and on state and municipal policies and procedures of the early intervention program, including participation in Department-sponsored training. Provider shall participate in a minimum of ten clock (10) hours of professional development activities per year. Such professional development activities are not restricted to Department sponsored training and may include other professional activities necessary for licensure and activities identified by the Provider to increase the Provider's professional skills and knowledge. Activities may include but are not limited to formal continuing education courses/workshops, formal academic study, independent study, mentoring, and in-service training programs. Activities may also include Department sponsored training, Municipal sponsored training, webcasts, and webinars which may be provided particularly during periods of introduction of a new policy and procedure. Provider will maintain documentation of professional development activities and make such documentation available upon request to the Department and/or Municipality.
- L. Agency Providers will, before utilizing a student/intern, a physical therapy assistant or an occupational therapy assistant for the provision of EI provider services, notify the Municipality, service coordinator and parent that the Agency Provider intends to have a student/intern, a physical therapy assistant or an occupational therapy assistant provide services under the supervision of a licensed practitioner; provide the Municipality, service coordinator and parent a written plan for how the supervising practitioner will assume professional responsibility for the services provided under his or her direction and how the need for continued services will be monitored; and have agreement from the Municipality, service coordinator and parent prior to the provision of services by a student/intern, a physical therapy assistant or an occupational therapy assistant.
- M. Agency Providers shall maintain, using the Department's electronic database, a contemporaneous list of their employees and Individual Providers under contract with such Agency Provider which reflects the current staff available to provide EI services.

## EI-Hub Provider Enrollment Management (PEM) User Guide v1.5.1

- N. Provider shall be familiar with and comply with all applicable Medicaid rules and regulations. Provider shall not engage in any act which constitutes an unacceptable practice under the Medical Assistance Program as enumerated in Title 18 of the New York Code of Rules and Regulations Section 515.2(a) and (b) (1) through (b) (15), (17) and (18). Agency Providers shall not utilize employees or Individual Providers or vendors, who have been excluded from participation in the Medical Assistance Program. Agency Providers shall ensure that they do not employ, or are affiliated with, any individual or agency, which has been excluded from either the Medicare or the Medicaid program. Providers shall routinely but no less than every thirty (30) days review federal and state databases to determine if employees, prospective employees, and contractors (Individuals and other Agency Providers), have been excluded or terminated from participation in the Medical Assistance Program.
- O. Provider shall provide their own equipment and supplies including toys necessary to conduct their business. Provider understands that it is not the responsibility of the Department or Municipalities to supply such equipment, supplies or toys. Provider shall comply with applicable health and safety standards, including those related to use of toys, equipment and supplies.
- P. Provider shall obtain access to the Department's electronic database for at least one person for the purpose of managing EI information necessary to conduct business utilizing the electronic database.

### **V. Services**

- A. Provider shall use informed clinical opinion, observation and ongoing assessment in collaboration with the family/caregiver and additional team members to prioritize identified family/caregiver areas of concern. Provider shall be an active participant in the development of integrated family & child focused goals and outcomes for the IFSP. As a licensed and/or certified professional focused on their field of practice, Provider shall encourage families and caregivers to collaboratively identify priorities as they relate to a child's participation in everyday activities; observe families/caregivers and their children to engage in activities when clinically appropriate; collaboratively document child and family strengths, accomplishments, interests and needs which will assist a family to be an informed advocate for their child/children and active member of the IFSP team; and inform an IFSP team, if the provider is unable to attend an IFSP meeting.
- B. Provider shall render services in conformance with the child's and family's IFSP, including but not limited to functional outcomes, the duration specified, location and frequency of such service.
- C. Provider understands and agrees that the use of aversive intervention in any form is strictly prohibited when providing EIP services. Aversive intervention is defined in 10 NYCRR § 69-4.9 to mean an intervention that is intended to induce extreme or excessive and/or non-therapeutic pain or discomfort to a child for the purpose of modifying or changing a child's behavior, limiting a child's free range of movement, or eliminating or reducing maladaptive behaviors, including but not limited to the following: contingent application of noxious, painful, intrusive stimuli or activities; any form of noxious, painful, or intrusive spray (including water or other mists), inhalant, or tastes; contingent food programs that include the denial or delay of the provision of meals or intentionally altering staple food or drink to make it distasteful; movement limitation used as punishment, including but not limited to helmets and mechanical restraint devices; physical restraints; blindfolds; and white noise helmets and electric shock.
- D. Provider shall work collaboratively with the family to identify strategies/activities and the necessary services and supports to achieve IFSP outcomes including but not limited to developing and enhancing the family's capacity to support their child's learning and development between visits; building on the interests and strengths of the child and family; and determining the intensity, and method for each service to be reasonable and not burdensome to the family.
- E. Provider shall use a child developmental approach in intervention strategies, incorporating evidence-based child development practices with necessary adaptations to foster and promote age appropriate development.
- F. Provider shall use an individualized approach, including consideration and respect for cultural and religious, lifestyle, ethnic, and other individual and family characteristics.
- G. Provider shall be an active participant in the development and implementation of a transition plan for a child transitioning from the EIP.

### **VI. Documentation and Recordkeeping**

- A. When required by the Department, Provider shall utilize a standardized reporting format when reporting on services delivered in the EIP.
- B. Provider shall maintain documentation necessary to support claiming to third party payors (Medicaid and commercial insurers), the Municipality and State. In instances where corrections are made to documentation required to support claiming, the rendering provider shall leave his or her original writing intact, strike through the mistake with a single line, make a legible correction and clearly write his or her initials and date correction was made next to the correction. Provider shall not use white-out in an EI record.
- C. Provider shall maintain contemporaneous session notes, utilizing a Department standardized form when required by the Department, following each child and family contact, which shall include the information required in 10 NYCRR 69-4.26(c) including: the recipient's name, date of service, type of service provided, time the Provider began delivering therapy to child and end time, brief description of the recipient's progress made during the session as related to the outcome contained in the IFSP, name, title, and signature of the person rendering the service, date the session note was created, and signature of the parent or caregiver which documents that the service was received by the child on the date and during the period of time as recorded by the Provider.

- D. Provider understands and hereby agrees that all 'make-up' sessions must be consistent with Department regulations and guidance, occur in conformance with the IFSP and session notes created for 'make-up' sessions must accurately state that the session is in place of a previously scheduled session, and reflect the date/time that the 'make-up' session occurred. Provider further understands and hereby agrees that Provider risks non-payment for inaccurate claims.
- E. Original session notes must be maintained in accordance with the requirements of 10 NYCRR § 69-4.26. In situations where an Individual Provider is rendering services to a child and family under an authorization to such Provider by a Municipality or when the Individual Provider is rendering services as a contractor to an Agency Provider, the Individual Provider shall maintain the original session notes. A Municipality or Agency Provider may request or require submission of copies of such Individual Provider's session notes. Original EI records generated by qualified personnel who are employees of a Municipality or Agency Provider shall be retained by the respective Municipality or Agency Provider.
- F. Provider shall make periodic progress notes summarizing the effectiveness of the service and the progress being made toward outcomes included in the child's and family's IFSP. Progress notes shall be made at a minimum frequency of twice during the IFSP yearly cycle - for six-month IFSP reviews and for the annual IFSP review. The Department may direct that the progress notes be made in a certain format or manner. Progress notes shall be included in the child's record and shall be available upon request by the service coordinator, Municipality, or Department.
- G. Provider shall maintain records that document the performance of services required to be completed by Provider on behalf of eligible children and their families, including but not limited to: parental consents for provision of evaluations and services; reports, session notes, progress notes, and other documentation related to evaluations or service delivery; a copy of the IFSP; service authorizations; physicians orders and/or prescriptions for services provided and other documents as may be required in regulation.
- H. Provider shall maintain accurate and complete records that support claiming for actual services rendered. Provider shall only submit claims for payment that accurately reflect the service provided by qualified personnel authorized to provide the service on the date such service is provided and which shall be consistent with the child's IFSP.
- I. Provider shall maintain complete records and data that support information necessary for the Department to report annually through the Part C Annual Performance Report (Part C- APR). Information/data will include but is not limited to timely IFSP, timely services, and transition steps and services. The Department may direct that information be made in a certain format or manner.
- J. Provider shall retain EI records pertaining to a child and family for a minimum of six years from the date that care, services, or supplies were provided to the child and family. Individual Providers who are licensed, registered, or certified under state education law must retain child and family records for the period of time set forth in the laws and regulation that apply to their profession.

### **VII. Notifications**

- A. Provider shall make reasonable efforts to notify the child's parent/family/caregiver prior to the date and/or within one hour prior to the time on which a EI provider service is to be delivered, of any temporary inability to deliver such service due to circumstances such as illness, emergencies, hazardous weather, or other circumstances which impede the provider's ability to deliver the service. If circumstances prevent such notification prior to a visit, notification should be provided as soon as possible following the missed visit. Provider shall also make reasonable efforts to notify the child's parent/family/caregiver if the Provider will be more than fifteen (15) minutes late for a scheduled session, due to uncontrollable circumstances.
- B. Provider shall make reasonable efforts to notify the Department and municipality (s) within five (5) business days of any prolonged closure or unavailability to provide EI services to children located in a specific municipality.
- C. Provider shall notify the child's parent and service coordinator at least five (5) business days prior to any scheduled absences due to vacation, professional activities, or other circumstances, including the dates for which the Provider will be unable to deliver services to the child and family in conformance with the IFSP and the date on which services will be resumed by such Provider. Missed visits may be rescheduled and delivered to the child and family by such Provider, as clinically appropriate, agreed upon by the parent and in conformance with the child's and family's IFSP.
- D. Provider shall notify the child's service coordinator and early intervention official (EIO) of the intent to permanently terminate the delivery of early intervention program services to a child and the child's family, for any reason, at least thirty (30) calendar days prior to the date on which the Provider intends to cease providing services.
- E. Provider shall notify the child's service coordinator within twenty-four (24) hours of the child's absence from more than three (3) consecutive scheduled sessions for the delivery of services, indicating the reason for said absence, if known.
- F. Provider shall notify the service coordinator and the Municipality within two (2) business days, when a parent voluntarily withdraws their child from early intervention services with a Provider, for any reason.
- G. Provider shall notify the Department, in writing, within five (5) calendar days, in the event Provider becomes a party to any litigation, investigation or transaction that may reasonably be considered to have a material impact on Provider's ability to perform under this Agreement.

H. Individual Providers shall notify the Department within two (2) business days if their license is suspended, revoked, limited or annulled, regardless of whether the suspension or limitation is stayed.

I. Provider shall notify the Department immediately upon becoming aware that the, Medicare or Medicaid certification of Provider, or any employee or Individual Provider under contract with the Agency Provider is restricted, suspended or temporarily and/or permanently revoked by any regulatory authority.

### **VIII. Mandated Reporting**

A. Providers shall report or cause to be reported suspected cases of child abuse and/or maltreatment to the SCR whenever they believe that there is reasonable cause to suspect that a child, made known to them in their official capacity as a Provider under the EIP, is or has been abused or maltreated.

B. Provider shall develop and maintain policies and procedures regarding the reporting of suspected child abuse and/or maltreatment. Agency Providers shall ensure that its employees and Individual Providers under contract with such Agency Provider are aware of the Agency Provider's policies and procedures in this regard.

### **IX. Confidentiality**

A. Provider shall preserve the confidentiality of all electronic and/or hard-copy data and information, both historical and current data, that is shared, received, collected, or obtained in relation to services provided in the EIP, in accordance with applicable law and regulations, including but not limited to FERPA and 10 NYCRR § 69-4.17.

B. Provider shall keep child records secure, whether records are stored in a business location, an Individual Provider's home or at a secure location outside the Provider's home. Provider shall have a written policy on confidentiality and meet all confidentiality requirements of the EIP, including physical security.

C. Provider shall prevent the disclosure, redisclosure or release of such data or information, except as expressly authorized by law. Provider shall not use such data or information for personal benefit.

D. Provider agrees to develop and maintain specific procedures ensuring the protection of health history information related to an individual who has been diagnosed as having AIDS or HIV-related illness or HIV infection or laboratory tests performed on an individual for HIV-related illness.

E. Agency Provider agrees to comply with the confidentiality and disclosure requirements set forth in and in Part 403 of New York State Social Service Law and Section 2782 of Public Health Law, and ensure that staff, to whom confidential HIV-related information is disclosed as a necessity for providing services, are fully informed of the penalties and fines for redisclosure in violation of State law and regulations.

F. The Provider fully agrees that any disclosure of confidential HIV-related information shall be accompanied by a written statement as follows:

- This information has been disclosed to you from confidential records, which are protected by State law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of State law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient authorization for further disclosure.

### **X. Marketing**

A. Provider shall comply with the provisions of 10 NYCRR § 69-4.5(e).

B. Provider shall not represent themselves as, or claim to be, an officer or employee of the State or Municipality by reason of this Agreement.

C. Provider shall ensure that marketing and advertising materials adhere to the Department's Marketing Standards for Early Intervention Service Providers and adequately inform parents or guardians of children less than three years of age who are suspected of having a disability or are at risk of disability about the EIP.

### **XI. Auditing, Monitoring, Due Process**

A. Provider shall cooperate with any announced or unannounced fiscal audit, programmatic monitoring and/or quality improvement monitoring by the Department, Municipality or its respective designee. Provider shall maintain and make available to the Department and Municipality upon request, complete financial records and clinical documentation related to the provision of services to permit a full fiscal audit by appropriate State and municipal authorities.

B. Provider shall make available such records or documents that are requested on the date and time of the visit, and shall provide access to the facility for facility based Providers.

C. Provider shall render diligently to the Department and the Municipality any and all cooperation, without additional compensation, that may be required as part of an investigation, mediation, or hearing.

D. Provider shall demonstrate full and faithful cooperation with any investigation, audit or inquiry conducted by the Department, Municipality or State or Federal governmental agency or authority that is empowered directly or by designation to compel attendance of witnesses and to examine witnesses under oath, or conducted by a governmental agency that is a party in interest to the transaction, that is subject of the investigation, audit or inquiry.

E. Provider shall render diligently to the Municipality and Department any and all cooperation, without additional compensation, that may be required to defend the Municipality and/or Department against any claims, demand, or action that pertain to Provider that may be brought against the Municipality and/or the Department in connection with services rendered by or on behalf of Provider to children under the Early Intervention Program and/or the terms and provisions of this Agreement.

F. Provider shall implement to the satisfaction of the Department, corrective actions deemed necessary by the Department or its designee to bring the Provider into compliance with applicable State and Federal statutes and regulations governing the EIP. Provider shall further implement, to the satisfaction of the Municipality, any corrective actions as may be required by Municipality after an audit or monitoring of the Provider by the Municipality in accordance with PHL § 2557(3-a), PHL § 2552(1) and 10 NYCRR § 69-4.12.

G. Provider understands and hereby agrees that payment by the Municipality may be withheld or suspended if upon audit or monitoring by the Department or Municipality it is found that the Provider, and/or employees or Individual Providers under contract with an Agency Provider, did not provide the services claimed for, the services were not provided in conformance with a child's IFSP, the rendering provider was not qualified by licensure, certification or registration to deliver the services, and/or the services were not provided in conformance with law or regulation or this Agreement.

### **XII. EI Model Specific Responsibilities**

#### **A. Service Coordination**

A1. Provider, and employees and Individual Providers under contract with an Agency Provider, who deliver service coordination services, shall, in accordance with 10 NYCRR §§ 69-4.4 and 69-4.5(xi) demonstrate continued professional development on state and local policies and procedures of the EIP, including participation in Department-sponsored training. Provider shall maintain documentation of continuing education/training and make such documentation available upon request to the Department and Municipality.

A2. Provider shall ensure that they, their employees and independent contractors utilized by the Provider Agency demonstrate participation in on-going training including but not limited to introductory service coordination, advanced service coordination, evaluation, and IFSP training sponsored or approved by the Department of Health, when Provider is approved for service coordination services.

A3. Provider, and employees and Individual Providers utilized by an Agency Provider who deliver service coordination services on behalf of the Agency Provider shall complete introductory service coordination training sponsored or approved by the Department of Health prior to rendering service coordination services and participate in a minimum of one (1) professional development activity totaling a minimum of 1 1/2 clock hours directly related to service coordination per calendar year. Such activity is not limited to Department sponsored training but can include other professional development activities which focus on enhancing skills necessary for service coordinators to increase their competency to provide service coordination activities.

A4. Provider shall render all service coordination activities as set forth in applicable law and regulations and as specified in the child's IFSP.

A5. Provider of initial and/or ongoing service coordination services shall document all activities (billable and non-billable) related to the performance of their duties which includes the following information: recipient's name; date of service; a description of the specific service coordination activity performed; name, date of contact, and purpose of contact for providers or others contacted on behalf of the child and family as necessary to implement the IFSP; start and end time for each contact; and name, title and signature of the service coordinator, as applicable. The Department may require that the Provider document such activities using a standard form or format.

A6. Provider shall provide Service Coordination as authorized by the Municipality when authorized for initial service coordination, and when authorized for on-going service coordination for a child/family, up to the limit of units of service coordination prescribed in the IFSP and indicated on the service authorization. Provider shall provide additional units of service only if authorized in accordance with a fully executed amendment to the IFSP, which shall include signatures of the Parent(s) and EIO/designee and IFSP team members.

A7. Provider shall prepare and submit reports and/or data regarding Service Coordination activities as requested by the Department or Municipality in a manner and format as may be requested by the Department or Municipality.

A8. Provider shall be reasonably accessible to the child's evaluator, other Providers of EI services, the Department and the Municipality during standard business hours.

A9. The Provider shall be reasonably available to the parent in a manner that does not limit service access to daytime and/or weekday hours and does not limit access to a specific location. The Provider shall ensure that accessibility for service coordination are available to families in non-traditional schedules and through a variety of methods and locations. Provider shall be responsible for informing families of changes to their contact number, email address, and the specific times and places of their accessibility.

A10. Provider shall communicate with the family about the purpose of Early Intervention, provide all information to the family in the family's dominant language or other mode of communication unless clearly not feasible to do so, and shall ensure that the family has received or has access to the current version of [Early Intervention Steps: A Parent's Basic Guide to the Early Intervention Program](#), the parent's handbook that provides information about the program upon referral to the EIP.

A11. Provider shall describe the rationale for services in natural environments. Provider shall describe each step of the IFSP process, including its purpose, and what service delivery might look like.

- A12. Provider shall collaboratively balance listening to the family with sharing information and shall use open-ended questions that encourage the family to share their thoughts and concerns. Provider shall discover family preferences for sharing and receiving information as well as the family's teaching and learning strategies they prefer to use with their child.
- A13. Provider shall review with the EI family the EIP procedural safeguards/due process rights upon initial contact with the family and whenever the family may disagree with an eligibility decision or with the early intervention official/designee decision regarding services for their child/family.
- A14. Provider shall assist families to obtain the services and/or assistance they need.
- A15. Provider shall inform the family that services must be at no cost to families, use of Medicaid and/or third party insurance for payment of services is required under the EIP, that any deductible or co- payments is not the responsibility of the family; the use of third party insurance for payment of early intervention services will not be applied against lifetime or annual limits specified in their insurance policy, if such policy is subject to New York State law and regulation; and that the Municipality/Department/service coordinator will not obtain payment from their insurer, if such policy is not subject to New York State law and regulation and if the insurer is therefore not prohibited from and will apply payment for early intervention services to the annual and lifetime limits specified in their insurance policy. Provider shall collect, from the family, information on any insurance policy, plan or contract under which an eligible child has coverage.
- A16. Provider shall review all options for evaluation and screening with the family from the list of approved evaluators including location, types of evaluations performed, and settings for evaluations (e.g., home vs. at the evaluation agency). Upon selection of an evaluator by the family, the Provider shall ascertain from the family any needs the family may have in accessing the evaluation. Provider shall at the family's request, assist the family in arranging of the evaluation after the family selects from the list of approved evaluators.
- A17. Provider shall contact the family to ensure that the family has received information concerning alternative approved evaluators and ascertain from the family any needs the family may have in accessing the evaluation, if the family has accessed an approved evaluator prior to contact by the initial service coordinator.
- A18. Provider, upon receipt of the results of the evaluation, may with parental consent and the approval of the early intervention official, require additional diagnostic information regarding the condition of the child, provided that such information is not unnecessarily duplicative or invasive to the child according to guidelines of the Department of Health. One such example is that such information may assist the IFSP team to determine the appropriate type, location, frequency or duration of the EI provider service.
- A19. Provider shall prior to obtaining written parental consent for additional diagnostic information, provide the family with a written explanation which shall include: diagnostic information requested; reasons for obtaining the information, and use of the information; location of diagnostic testing; source of payment and that no costs shall be incurred by the parent; a statement that the information shall not be used to refute eligibility; and a statement that the meeting to formulate the Individualized Family Service Plan shall be held within the 45 day time limit.
- A20. The Provider shall, with parent consent, notify the Office for People with Developmental Disabilities' regional developmental disabilities services office of the potential eligibility of a child for programs or services available under that Office, if the Provider, in consultation with the evaluator, identifies the child as potentially eligible for programs or services offered by or under such office.
- A21. Provider shall, upon the determination of a child as ineligible for EIP services, inform the family of the right to due process procedures as set forth in 10 NYCRR § 69-4.17 and shall inform the family of other services which the family may choose to access and for which the child may be eligible and offer assistance with appropriate referrals.
- A22. Provider shall collect from the family a written referral from a primary care provider as documentation, for eligible children, of the medical necessity of EIP services in order to support private insurance claiming.
- A23. Provider shall assist the family in preparing for the meeting to develop the IFSP, including facilitating their understanding of the child's multidisciplinary evaluation and identifying their resources, priorities, and concerns related to their child's development.
- A24. Provider shall inform the family of the opportunity to select an ongoing service coordinator, who may be different from the initial service coordinator, at the Individualized Family Service Plan meeting or at any other time after the formulation of the IFSP.
- A25. Provider shall ensure that the IFSP, including any amendments thereto, is implemented in a timely manner within thirty (30) days of parent consent to the IFSP, or if the projected date for the initiation of a service is greater than thirty (30) days of parent consent to the IFSP, not later than thirty (30) calendar days after the projected date for initiation of the service.
- A26. Provider shall in consultation with the service Provider and the family/caregiver continuously seek the appropriate services and situations necessary to benefit the development of the child for the duration of the child's EIP eligibility, including providing appropriate referrals for families to access social and mental health services.
- A27. When notified by a Provider or by otherwise becoming aware of a child's absence from more than three (3) scheduled sessions for the delivery of services, Provider shall contact the child's parent/family to ascertain the reason for any absences and immediately notify the EIO regarding the absences, reason for such absences and whether there is a need to modify an existing IFSP.
- A28. Provider shall early in the relationship with the family, have conversations about what they want for their child's future once they transition from the EIP.

A29. Provider shall identify transition issues and discuss steps to prepare the family for choices/options at different transition points and to prepare the child for participating in the new setting when transition occurs. Provider shall ensure that the family understands the timeframe for transition from the EIP and when transition planning should occur.

A30. Provider shall, together with the IFSP team, develop a transition plan as part of the IFSP process which includes the outcomes and activities to prepare the child and family for success after early intervention.

A31. When applicable, Provider shall notify the local Committee on Preschool Special Education (CPSE) of a child's potential transition to CPSE services utilizing Department-standardized forms, procedures, and timelines in accordance with applicable law and regulations.

A32. Provider understands and agrees that, in accordance with PHL § 2552, a Municipality may request that the parent/family select a new service coordinator or require that the service coordinator select a new Provider of services if the Municipality finds that the service coordinator or Provider, as applicable, has not been performing his or her responsibilities as required or that services have not been provided in accordance with the child's IFSP.

**B. Evaluations & Screenings**

B1. Provider shall only provide evaluation and screening services as authorized in accordance with their licensure, registration or certification. Agency Providers shall only use qualified personnel who are licensed, certified or registered in the area for which they are providing evaluation services for the provision of core/multidisciplinary evaluations and/or supplemental evaluations.

B2. Provider shall provide evaluations in accordance with a service authorization issued by the Municipality or service coordinator. If the parent selects an approved Provider to conduct the evaluation prior to the designation of an initial service coordinator, the Provider shall immediately notify the EIO of such selection and shall begin the evaluation no sooner than four (4) business days of the EIO's receipt of written notice from the Provider. The Provider shall obtain parental consent to conduct the evaluation prior to the initiation of the evaluation.

B3. Provider shall when conducting a multidisciplinary evaluation include qualified personnel who have sufficient expertise in child development, and include at least one qualified personnel in the area of the child's suspected delay or disability. The primary area of concern must be included as part of the core evaluation. No evaluation may be performed by telephone, in whole or in part.

B4. Provider shall when conducting a family assessment include qualified personnel who are trained in the use of professionally accepted methods and procedures to assist the family in identifying their concerns, priorities, and resources related to the development of their child.

B5. Provider shall ensure that they and, if applicable, their employees who provide Evaluation & Screening services complete continuing professional and clinical education relevant to early intervention services, and in-service training sponsored by the Department regarding evaluation and eligibility, within six (6) months of becoming an employee of the Agency Provider or within six (6) months of the start date of the Agreement, whichever is later. Provider or employees of an Agency Provider who render evaluations and screenings shall also participate in a minimum of one (1) professional development activity totaling a minimum of 1 1/2 clock hours per year related to the provision of evaluation & assessments to children under the age of 5 years old. Such activity is not limited to Department sponsored training but can include other professional development activities which focus on enhancing skills necessary for evaluators to increase their competency to provide evaluation activities. Provider shall have the training and competency to administer a particular evaluation tool prior to conducting an EI evaluation utilizing such tool. Agency Providers shall ensure that its employees who conduct evaluations have the training and competency to administer a particular evaluation tool prior to conduct an unsupervised evaluation.

B6. Provider shall ensure that they and, if applicable, all employees and Individual Providers under contract to provide evaluations for an Agency Provider, have access to the Department's guidance regarding evaluations and eligibility criteria for the early intervention program, prior to conducting an evaluation or screening and that it is implemented appropriately.

B7. Provider shall have availability and competency to screen, evaluate, and assess infant and toddler development using appropriate methods and procedures, both formal and informal.

B8. Provider shall utilize evaluation and assessment procedures that are responsive to the cultural, ethnic, religious and linguistic background of the family. Tests and other evaluation materials and procedures shall be administered in the dominant language or other mode of communication of the child, unless it is clearly not feasible to do so. If such an evaluation is not possible, Provider should not accept the evaluation assignment or must document the attempts to locate a bilingual evaluator and notify the service coordinator of their inability to provide the evaluation in the dominant language or other mode of communication of the child and receive further direction from the service coordinator before proceeding with the evaluation. The service coordinator may, after discussion with and consent by the parent, request that the evaluation be reassigned to another Provider or Provider Agency.

B9. Agency providers shall only use qualified personnel who are licensed, certified or registered in the area for which they are providing evaluation services for the provision of core/multidisciplinary evaluations and/or supplemental evaluations.

- B10. Provider shall adhere to recognized standards of practice for their respective disciplines when conducting evaluations and utilizing and scoring standardized assessment instruments.
- B11. Provider shall, when conducting a multidisciplinary evaluation include the core components of a developmental assessment of all domains (physical development, cognitive development, communication development, social or emotional development, and adaptive development); a review of pertinent records, parent interview, and, at the option of the family, a family assessment.
- B12. Provider shall use the most recent edition of a standardized test instrument as soon as practicable (e.g., when the standardized instrument has become widely available, including the availability of training, if required by test developers) when conducting evaluations for the purpose of determining a child's initial or ongoing eligibility for the EIP. Standardized test instruments must be administered, scored and interpreted according to the tool's manual.
- B13. Provider understands that no single procedure or instrument may be used as the sole criterion or indicator of eligibility. Provider shall utilize information from a variety of appropriate sources, including but not limited to standardized instruments and procedures, when appropriate or possible; observations of the child; parent interviews; informed clinical opinion; and any other sources of information about the child's developmental status available to the team conducting the child's evaluation.
- B14. Provider shall consider the parent's input regarding the preferred natural environment/setting for the evaluation and should conduct an evaluation in a setting conducive to ensuring accurate results. After the evaluation, the family should be asked whether they believe their child's response was optimal, and the family's response shall be included in the evaluation summary and report.
- B15. Provider shall immediately notify the Parent, the Service Coordinator and EIO/M, prior to initiation of the Evaluation if the Provider reasonably believes that the Provider cannot provide an evaluation within a sufficient time frame so that it can be accomplished within forty-five (45) days necessary to schedule an IFSP (due to workload or scheduling issues).
- B16. Provider shall provide the family a single point of contact and phone number for the evaluation process.
- B17. Provider shall describe to the family each step of the evaluation process, including its purpose, and what the evaluation might look like, including process, rules and procedures that Providers must follow.
- B18. Provider shall discuss how information gathered from the family is used in planning and conducting the evaluation. Provider shall help the family decide how they want to participate in their child's evaluation. The child's parent shall have the opportunity to be present and participate in the performance of evaluation and assessments, unless the parent's circumstances prevent the parent's presence.
- B19. Provider shall provide evaluation results in layman's terms/user friendly language in a manner which is understandable to family and caregivers. Provider shall discuss screening, evaluation, and assessment information with families in understandable language and in the context of the child's strengths. Provider shall ensure that parents are afforded the opportunity to discuss the evaluation results with evaluators, including any concerns they have with the evaluation process.
- B20. Provider shall ensure that when conducting a multidisciplinary evaluation, the Evaluator prepares an evaluation report and written summary and submits the summary, and upon request the report, to the following individuals within sufficient time to ensure completion of the IFSP within forty-five (45) days of a child's referral to the EIP: the child's parent(s); the EIO; and the initial service coordinator. Provider shall ensure that the multidisciplinary report is coordinated by qualified personnel who conducted the child's evaluation.
- B21. Provider shall ensure that Provider creates one integrated multidisciplinary report according to a state-standardized form and that the evaluation report and summary include the names, titles, and qualifications of the persons performing the evaluation and assessment; a description of the assessment process; the child's responses to the procedures and instruments used as part of the evaluation process; the family's belief about whether the responses were optimal; the developmental status of the child in each of the five developmental domains, including the unique strengths and needs in each area; documentation of how clinical opinion was used by the persons performing the evaluation and assessing the child's developmental status and potential eligibility for the EIP; and measures and/or scores that were used, if any; and an explanation of these measures or scores. The evaluation report shall also include diagnostic information and the International Classification of Disease (ICD) codes related to the child's eligibility, where appropriate.
- B22. Provider shall ensure that when a diagnosis is made during the evaluation, one or more persons who conducted the evaluation are qualified under the NYS Education Law to render the diagnosis. A diagnosis shall not be rendered by an evaluation team member unless they are qualified by their profession to render such diagnosis.
- B23. Provider shall fully document the basis for Provider's eligibility determination and provide such information and documentation that may be requested by the Municipality or the Department within the timeframes specified.
- B24. Provider shall ensure that if the results of the multidisciplinary evaluation indicate the child is not eligible for the EIP, the team's evaluation report will clearly document reasons why the child is not eligible. If a child is not eligible for the EIP but has a developmental delay and the evaluation team believes the child should receive services or supports outside of the EIP, the evaluation team should inform the family of options for services and community resources that will promote the child's development.
- B25. Provider shall submit any additional documentation or explanation requested by the Municipality, service coordinator or Department regarding any evaluation, within five (5) business days of the request.
- B26. Provider understands and agrees that all evaluations must be completed in accordance with applicable law and regulations in order to receive payment for the same.

## EI-Hub Provider Enrollment Management (PEM) User Guide v1.5.1

B27. Provider shall participate in IFSP meetings in accordance with the requirements of 10 NYCRR § 69-4.11.  
B28. Provider understands and agrees that if the EIO determines that the Provider has not complied with PHL and/or regulations pertaining to an evaluation, the EIO may require that the Provider immediately submit additional documentation to support the eligibility determination and no later than five (5) business days, or if the documentation provided continues to be inconsistent with PHL or regulations, the EIO can require that the parent select another Provider to conduct a multidisciplinary evaluation to determine whether the child meets eligibility for EIP services.

**C. Home/Community-Based and Office/Facility-Based Individual/Collateral Visits**

C1. Provider shall provide home/community-based individual/collateral services in accordance with a service authorization issued by the Municipality or service coordinator.  
C2. Provider shall assist families in learning ways that the family can report more effectively on their observations and understanding (assessment) of their child's skills, behaviors and interests. Provider shall document a family's observations and assessments into the child's session notes. Family observations and assessments should be encouraged but not required.  
C3. Provider shall apply knowledge of current research and evidenced based practices to the development and implementation of strategies, therapy and interventions with the child and family.  
C4. Provider shall work collaboratively with family/caregivers to seek opportunities to adapt learning experiences and therapeutic strategies to reflect individual characteristics of the child and family, and to identify and implement, as appropriate, strategies that enhance and promote the child's participation in natural learning opportunities across both child and family routines and community settings.  
C5. Provider and family/caregivers shall collaboratively identify toys, materials, interactions and locations that are available, of interest to, and motivating for the child and family.  
C6. Provider and family/caregivers shall collaboratively identify and incorporate family identified resources, concerns and priorities which shall result in individualized strategies promoting the outcomes identified by the family, therapeutic outcomes and outcomes identified in an IFSP. Provider shall be aware of and acknowledge new family concerns or interests.  
C7. Provider shall assist the family in learning how to communicate with their child.

**D. Group Developmental Intervention**

D1. Provider shall provide group developmental intervention services in accordance with a service authorization issued by the Municipality or service coordinator.  
D2. Provider shall only utilize qualified personnel as defined by 10 NYCRR § 69-4.1(ak) when assigning a substitute in situations where the usual group leader is absent.  
D3. Provider shall provide EI services in a safe, developmentally appropriate environment which has adequate space for the group-size, a physical environment and facilities conducive to learning and reflective of the different stages of development of each child. Providers should incorporate, when possible, Universal Design for Learning principles into the creation of learning environments that support all children, including children with disabilities, when designing a learning environment. Provider agrees that it shall only provide Group developmental services in a location that has been included in Provider's application to the Department.  
D4. Provider shall support a child's positive behavior through well-organized classrooms, consistent schedules, well-designed learning areas, established routines, and sensitive and appropriate guidance strategies.  
D5. Provider shall engage in ongoing adaptations of the environment to meet the needs of individual children, including varying teaching strategies which can influence a child's ability to participate.  
D6. Provider shall have clear curricular goals and learning outcomes and where appropriate individualized learning objectives for children and modification of instructional materials as indicated on the child's IFSP.  
D7. Provider shall promote supportive interventions within the classroom which minimize the need for a child to be pulled out of the group for an individualized intervention.  
D8. Provider shall foster a collaborative partnership with all persons involved with the child including the child's family, caregivers and other Providers and will create an individualized learning experience reflective of the individual child's social and cultural experience, child's interests, abilities, and developmental progress. Provider shall inform the child's family on a regular basis about their child's progress and experience in the group developmental setting.

**E. Parent-Child Groups and Family/Caregiver Support Groups**

E1. Provider shall provide parent-child groups and family/caregiver support group services in accordance with a service authorization issued by the Municipality or service coordinator.  
E2. Provider shall assist parents to understand their child's needs and identify community resources to meet family and child needs and to understand the emotional impact of having a child with disabilities.  
E3. Provider shall assist the family to learn multiple strategies for communicating with their child.  
E4. Provider shall assist the family to be confident in their parental skills and in their ability to care for a child with disabilities.  
E5. Provider shall assist the family to communicate with the team who works with his/her child and family and to develop skills as an advocate for the child.

E7. Provider shall assist the family to learn how to communicate with their child.  
E8. Provider shall assist the family to learn how to understand and manage their child's behavior.  
E9. Provider shall assist the family to develop skills to cope with stressful situations.  
E10. Provider shall assist the family to enhance their own ability to modify family routines, such as mealtimes or bedtime, bathing and dressing to accommodate the family needs as well as the developmental and emotional needs of their child and to improve the family's quality of life.

F. Providers Using Applied Behavior Analysis (ABA) in the Delivery of ABA Early Intervention Provider Services

F1. Provider understands and hereby agrees that "Applied behavior analysis" or "ABA" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

F2. Agency Provider understands and hereby agrees to only utilize qualified personnel as defined in 10 NYCRR §69-4.1 as appropriate for the provision of early childhood ABA services and such employees and Individual Provider have been trained, educated, and are familiar with and competent in the delivery of such services.

F3. Provider understands and hereby agrees that Provider shall maintain and implement written policies and procedures for the delivery of ABA services which are in conformance with nationally recognized, evidence-based practices for the delivery of such services. Such written policies and procedures shall be: reviewed at least annually by the Provider and updated as necessary to maintain conformance with evidence-based practices for delivery of ABA services; and made available for review for monitoring purposes and upon request by the Department and/or its agent and the Municipality.

F4. Provider shall be responsible for developing individual child ABA plans in collaboration with the child's family and Agency Provider, as appropriate, qualified personnel; directing the implementation of individual child ABA plans and the ongoing monitoring, systematic measurement, data collection, and documentation of child progress; modifying individual child ABA services as necessary to promote progress towards goals, generalization of learning; and, where applicable, transitioning of the child from receiving services in home- and facility-based settings to receiving services and participating in other community settings.

F5. Provider shall provide assistance, training, and support as needed by parents/caregivers to assist them in follow-through activities specified in the child's ABA plan to enhance child development, behavior, and functioning.

**XIII. Additional Provider Responsibilities**

- A. Provider understands and agrees that nothing herein shall be deemed to create an "employee" and "employer" relationship between the Department and the Provider, or between the Municipality and the Provider. The relationship of the Provider to the Department or Municipality shall be that of an Independent Contractor for whom no federal or state income tax will be deducted by the Municipality in payment for services provided, and for whom no retirement benefits, workers' compensation protection, survivor benefit insurance, group life insurance, vacation and sick leave, liability protection, and similar benefits available to the State or Municipal employees will accrue.
- B. Provider shall be responsible for the services for which Provider is approved to deliver and, with respect to Agency Providers, shall only utilize employees and/or Individual Providers and/or another Agency Provider when approved by the Department as an Agency Provider. Agency Provider understands and agrees that when utilizing Individual Providers or another Agency Provider to deliver authorized services, the Agency Provider may only utilize Individuals and Agencies approved by the Department and shall remain responsible for the services for which it is authorized to deliver that were rendered by the Individual Provider and/or the other Agency Provider, including but not limited to all claims for payment related to such services, and in ensuring that the Individual Provider and/or the other Agency Provider complied with all applicable rules and regulations in relation to such services.
- C. Agency Provider shall be responsible for the acts and omissions of Individual Providers and/or other Provider Agencies utilized by the Provider Agency for the provision of services as it is for the acts and omissions of persons directly employed by it.
- D. Provider shall maintain continued compliance with all applicable provisions of the Federal and State Labor Standards.
- E. Provider shall maintain continued compliance with all applicable provisions of the Federal Internal Revenue Code, 20 NYCRR-Taxation and Finance, and all rules promulgated there under, including withholding provisions and timely deposits of employee taxes and unemployment insurance taxes, as applicable.
- F. Provider shall operate and provide services in compliance with the provisions of the Civil Rights Act of 1964, as amended; with 44 CFR Part 7, entitled "Nondiscrimination in Federally Administered Programs"; and with 45 CFR Parts 84 and 85, entitled "Non-Discrimination on the Basis of Handicap in Program Activities Receiving or Benefiting from Federal Financial Assistance".
- G. Provider shall operate, hire, subcontract and provide services without regard to race, creed, color, national origin, sex, age, disability, sexual orientation, genetic predisposition or carrier status or marital status.
- H. Provider shall not have religious worship, instruction, or proselytizing as part of or in connection with the provision of early intervention Provider services, nor shall any of the funds provided under this Agreement be used for such purposes.
- I. Provider shall operate, hire and subcontract in compliance with the provisions of Article 15 of the New York State Executive Law (also known as the Human Rights Law) and all other State and Federal statutory and constitutional non-discrimination provisions.

J. Agency Provider shall, in the event that the Agency Provider files for bankruptcy or reorganization under Chapter seven or Chapter Eleven of the United States Bankruptcy Code, disclose such action to the Department within (7) seven days of filing. This Agreement shall not be assigned by the Provider or its right, title or interest therein assigned, transferred, conveyed, sublet or otherwise disposed of and attempts to do so are null and void.

K. Indemnification:

i. Provider shall be solely responsible and answerable in damages for any and all accidents and/or injuries to persons (including death) or property arising out of or related to the services to be rendered by the Provider or its employees or Individual Providers under contract, pursuant to this AGREEMENT. The Provider shall indemnify and hold harmless the Department and its officers and employees and Municipalities and its officers and employees from claims, suits, actions, damages and costs of every nature arising out of the provision of services pursuant to this AGREEMENT and under the EIP.

ii. The Provider is an independent contractor and may neither hold itself out nor claim to be an officer, employee or subdivision of the Department or Municipality nor make any claims, demand or application to or for any right based upon any different status.

This provision shall survive the termination of this Agreement. This Agreement shall be deemed terminated immediately upon the Provider's failure to comply.

**XIV. Terms and Termination**

This Agreement shall be effective for a five (5) year term, unless terminated pursuant to the terms hereof. Provider shall not provide services, nor hold itself out as authorized to provide such services on and after the date upon which this Agreement shall be deemed terminated.

If the Provider wishes to continue participating the EIP after the expiration of this Agreement, Provider shall notify the Department at least ninety (90) days prior to the expiration date and request that the Department enter into a new agreement with the Provider.

Amendments to this agreement may be made by the Department and shall be sent to the Provider via mail or electronically utilizing the Provider's email address. The Provider shall notify the Department within thirty (30) calendar days of the date the Provider receives the proposed Amendment of whether it accepts the terms contained in the proposed Amendment. The Department reserves the right to terminate this Agreement if a proposed Amendment is not accepted. Oral modifications to this Agreement are prohibited.

**1. Termination for Convenience by the Department:**

This Agreement may be cancelled at any time by the Department giving to the Provider not less than ninety (90) days written notice that on or after a date therein specified this Agreement shall be deemed terminated and cancelled. Provider shall not render services in the EIP on and after the date specified in such notice and shall not claim for any services rendered after such termination date.

**2. Termination for Convenience by Provider:**

This Agreement may be cancelled at any time by the Provider, giving to the Department not less than ninety (90) days written notice that on or after a date therein specified this Agreement shall be deemed terminated and cancelled. In the event the Provider terminates the Agreement in accordance with this paragraph, Provider shall, together with any notice of termination, provide each child's Service Coordinator and the corresponding Municipality of residency of the children served with a Plan and Timetable for the orderly transition of services, and a copy of any proposed notification to parents, transporters, employees and Individual Providers utilized by an Agency Provider who deliver services. The plan and timetable for orderly transition of services must be developed in conjunction with affected municipalities and in accordance with municipal procedures. Notification to parents, transporters, employees and Individual Providers utilized by an Agency Provider shall be disseminated by the Provider upon approval by the Municipality and the Department of the proposed Plan and Timetable. The notice of termination and transition plan shall be submitted to the service coordinator(s), affected Municipalities and the Department not less than ninety (90) calendar days prior to the intended termination date of the Agreement.

Provider also understands and agrees that the Provider will supply, to the best of the Provider's ability, any outstanding child/family information necessary for the Department's Part C Annual Performance Report, prior to terminating this agreement.

### **3. Termination for Cause:**

The Department or the Provider may terminate this agreement, prior to the end of term by giving thirty (30) calendar days written notice to the other party of its intention and reason for termination. The non-terminating party may be given an opportunity to cure the reason for termination within the 30-day period. If the non-terminating party does not cure the reason for termination to the satisfaction of the terminating party, this Agreement shall terminate at the end of such 30-day period. Cause for termination may include but shall not be limited to: (a) failure to comply with the terms and conditions of this Agreement; (b) § 69-4.12 and (c) any violation of applicable laws or regulations, including an unacceptable practice under the Medical Assistance Program as enumerated in Title 18 NYCRR §515.2. Provider shall immediately provide each child's individual Service Coordinator and the corresponding Municipality of residency of the children served, with a Plan and Timetable for the orderly transition of Services, and a copy of any proposed notification to Parents, transporters, employees and independent contractors utilized by a provider agency who deliver EI provider services. The plan and timeline for orderly transition of services must be developed in conjunction with municipalities and in accordance with municipal procedures. Notification to parents, transporters, employees and independent contractors utilized by a Provider Agency shall be disseminated by the Provider Agency upon approval by the affected Municipalities and the Department of the proposed Plan and Timetable. Provider also understands and agrees that the Provider will supply, to the best of the Provider's ability, any outstanding child/family information necessary for the Department's Part C Annual Performance Report for services furnished, prior to terminating this agreement.

### **4. Immediate Termination by the Department:**

The Department shall have the right to terminate this Agreement, in whole or with respect to any identifiable part of the Program, effective immediately in cases of imminent danger to the health and safety of Eligible Children, Parents and/or staff, or upon the filing of a petition in bankruptcy or insolvency, by or against the Provider. Such termination shall be immediate and complete, without termination costs or further obligations by the Department or Municipality to the Provider.

### **5. Compliance Involving Health & Safety Issues:**

If the Department finds that the health or safety of a child, the child's parents or staff of the Agency Provider or Municipality is in imminent risk of danger or there exists any condition or practice or a continuing pattern of conditions or practices which poses imminent danger to the health or safety of such child, parents or staff of the Agency Provider or Municipality, in addition to any other remedies available to it, the Department may:

- a. terminate this Agreement;
- b. terminate one or more of the service models the Provider is authorized to deliver in the EIP;
- c. terminate one or more service delivery methods/settings;
- d. direct that the Municipality prohibit or limit the assignment of children to the Provider;
- e. direct that the Municipality remove or cause to be removed some or all of the children the Provider currently serves;
- f. direct that the Municipality suspend or limit or cause to be suspended or limited payment for services to the Provider.

### **6. Compliance proceedings involving approval of an individual or agency:**

In accordance with 10 NYCRR § 69-4.24, the Department may, in addition to any other remedies available to it, revoke, suspend, limit this agreement and approval.

### **7. Notices:**

All notices shall be sent by mail or email to the Provider listed within the electronic data system (currently NYEIS or any successor data system as required by the Department) as the Program Director or in the case or to an Individual Provider. The Provider is responsible for notifying the Department of any change in contact information including mailing and email addresses. All notices of termination will contain the specific date on which the Provider must cease providing Early Intervention Services.

All notices from the Provider must be sent to the Department at the following address:

New York State Department of Health  
Bureau of Early Intervention Provider Approval & Due Process Unit  
ESP, Corning Tower, Room 287  
Albany, New York 12237-0660

### **8. Severability:**

It is expressly agreed that if any term or provision of this Agreement, or the application thereof to any person or circumstance, shall, to any extent, be held invalid or unenforceable, the remainder of this Agreement, or the application of such term or provision to persons or circumstances other than those as to which it is held invalid or unenforceable, shall not be affected thereby; and every other term and provision of this Agreement shall be valid and shall be enforced to the fullest extent permitted by law.

<p><b>Select the Check Box *</b></p> <p>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. *</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>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. *</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>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. *</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>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. *</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>The applicant assures that s/he will participate in in-service training in the delivery of early intervention services. *</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>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. *</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>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. *</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>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. *</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>The applicant assures s/he will comply with the confidentiality requirements set forth in federal and state statute and regulation. *</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>The applicant assures that s/he will conform with health, safety and sanitation standards established by the Department; *</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>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. *</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>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 target population or qualifications to deliver services. *</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>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. *</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>	<p><input type="checkbox"/> I Read The Entire Provider Agreement</p>
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## EI-Hub Provider Enrollment Management (PEM) User Guide v1.5.1

I agree, and it is my intent, to sign this record/document by checking this box and clicking the "Submit" button, and thereby electronically submitting this record/document to the New York State Department of Health. I understand that my signing and submitting of this record/document in this fashion is the legal equivalent of having placed my handwritten signature on both the submitted record/document and this attestation. I do hereby certify under penalty of perjury, that I am duly authorized to subscribe and submit this application, enter into agreement with the New York State Department of Health, and request modifications to such agreement with the New York State Department of Health. I further affirm under penalty of perjury that all information contained herein and uploaded 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.

**Select the Check Box \***

I Agree

**First Name \***

**Middle Name/Initial**

**Last Name \***

**Date \***

7/5/2023

The following field is not considered when determining eligibility for participation in the program, but is required of all rendering providers.

**Sex \***

Please save your progress often and remember that you can only save if all required fields on the page have been completed and there are no errors to be resolved. The submit application button will initiate a system review of your application and report any errors. Successful submission of the PAT will result in your application being reviewed for approval by the BEI Provider Approval Unit.

[Previous Tab](#)

[Save Progress](#) [Submit Application](#)



The following agreement appears in the panel/screen.

FIELD	DESCRIPTION
Select the Check Box *	<input checked="" type="checkbox"/> I Read The Entire Provider Agreement

FIELD	FIELD TYPE	DESCRIPTION
<b>The applicant assures the maintenance of current state licensure and/or certification and demonstrated proficiency in early childhood development, e.g., previous experience in the delivery of services to infants and toddlers with developmental delay or disability. *</b>	Required, Yes or No	Edit/select the appropriate radio button.
<b>The applicant assures that s/he will notify the Department within two working days of suspension, expiration, revocation, limitation, or annulment of licensure, certification, or registration, regardless of whether the suspension or limitation is stayed. *</b>	Required, Yes or No	Edit/select the appropriate radio button.
<b>The applicant assures that s/he has the ability to and will provide</b>	Required, Yes or No	Edit/select the appropriate radio button.

FIELD	FIELD TYPE	DESCRIPTION
<b>services to children in accordance with IFSPs and in natural settings to the maximum extent appropriate.*</b>		
<b>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 Grid/Tables, family support Grid/Tables, or Grid/Table developmental interventions.*</b>	Required, Yes or No	Edit/select the appropriate radio button.
<b>The applicant assures that s/he will participate in in-service training in the delivery of early intervention services.*</b>	Required, Yes or No	Edit/select the appropriate radio button.
<b>The applicant agrees to enter into an approved Medicaid Provider Agreement and to reassign Medicaid benefits to the local county early intervention program or City of New York early intervention program.*</b>	Required, Yes or No	Edit/select the appropriate radio button.
<b>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.*</b>	Required, Yes or No	Edit/select the appropriate radio button.
<b>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.*</b>	Required, Yes or No	Edit/select the appropriate radio button.
<b>The applicant assures s/he will comply with the confidentiality requirements set forth in federal and state statute and regulation.*</b>	Required, Yes or No	Edit/select the appropriate radio button.
<b>The applicant assures that s/he will conform with health, safety, and sanitation standards established by the Department.*</b>	Required, Yes or No	Edit/select the appropriate radio button.
<b>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.*</b>	Required, Yes or No	Edit/select the appropriate radio button.

FIELD	FIELD TYPE	DESCRIPTION
<b>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 target population or qualifications to deliver services. *</b>	Required, Yes or No	Edit/select the appropriate radio button.
<b>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. *</b>	Required, Yes or No	Edit/select the appropriate radio button.

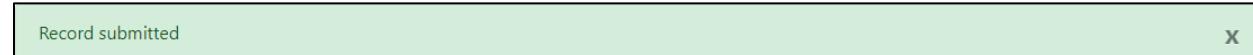
"I agree, and it is my intent, to sign this record/document by checking this box and clicking the "Submit" button, and thereby electronically submitting this record/document to the New York State Department of Health. I understand that my signing and submitting of this record/document in this fashion is the legal equivalent of having placed my handwritten signature on both the submitted record/document and this attestation. I do hereby certify under penalty of perjury that I am duly authorized to subscribe and submit this application, enter into an agreement with the New York State Department of Health, and request modifications to such agreement with the New York State Department of Health. I further affirm under penalty of perjury that all information contained herein and uploaded 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."

FIELD	FIELD TYPE	DESCRIPTION
<b>Select the Check Box *</b>	Required, Check box	Select/tick the 'I Agree' checkbox (shown below) to agree to all terms.  <div style="border: 1px solid black; padding: 5px; text-align: center;"><input type="checkbox"/> I Agree</div>
<b>First Name *</b>	Optional, Auto-populated, Read-Only	This field displays the Provider's first name.
<b>Middle Name/Initial</b>	Optional, Auto-populated, Read-Only	This field displays the Provider's first name, if applicable.
<b>Last Name *</b>	Required, Auto-populated, Read-Only	This field displays the Provider's last name.
<b>Date *</b>	Required, Auto-populated, Read-Only	This field displays the application date.

FIELD	FIELD TYPE	DESCRIPTION
Sex	Required, Drop-Down	This field is not required when determining program participation eligibility, but all rendering providers need it. Select the appropriate gender or prefer not to say from the list.

BUTTON	DESCRIPTION
Save Progress 	Click this button to save your data entry progress before submitting your application.
Submit Application 	Click this button if you have completed all the tabs and are ready to submit your application.

 When successfully submitted/validated by the system, the following message pad (shown below) appears on your top screen, showing your 'Record Submitted.'



Click the 'Print' button on the panel's bottom/screen and save it for your records.



## PAT Individual Applications

Created Date	Last Modified Date	Status	Actions
1/8/2021	1/8/2021	Rejected	<a href="#">View</a>
1/8/2021	2/23/2021	Submitted for review by PCG Team	<a href="#">View</a>

## Unit 13. Appendix A

### 13.1 Application Document Upload Table

 PAU should utilize the Submitted Approval Requests Dashboard to access documents uploaded as part of the provider's re-approval or amendment submitted through provider management. PAU should search for the provider on the dashboard and select the "View" button associated with the pending, approved, or denied re-approval or amendment submissions. This button will bring the user to the submission, where the uploaded documents will be available on the **Documents Tab**. Staff may need to search each amendment or re-approval request to locate the documents they are searching for.

Required Documentation	Description	Agency	Individual
<b>Articles of Organization</b>	<ul style="list-style-type: none"> <li>Required if the Agency is for Professional Service Limited Liability Company or Limited Liability Company.</li> </ul>	X	
<b>Attestation (Health Homes)</b>	<ul style="list-style-type: none"> <li>Required If associated with Medicaid Health Homes.</li> </ul>	X	
<b>Authority to Do Business in NY</b>	<ul style="list-style-type: none"> <li>Required for those doing business under a business name and that business is a foreign entity (business created outside of NYS).</li> </ul>	X	X
<b>Authorization to File Application</b>	<ul style="list-style-type: none"> <li>Required for Not-for-Profit Corporations, Business Corporations, Professional Services Corporations, and Government Subdivisions</li> <li>Corporations need a Board Resolution authorizing the agency to submit an application.</li> <li>Public applicants must attach a resolution from the legislature, board of supervisors, or other governing body.</li> </ul>	X	
<b>Building Inspection</b>	<ul style="list-style-type: none"> <li>Required for service sites without NYS childcare license/permit.</li> </ul>	X	X
<b>Business Association Agreement (Health Homes)</b>	<ul style="list-style-type: none"> <li>If associated with Medicaid Health Homes.</li> </ul>	X	
<b>Certificate of Assumed Name</b>	<ul style="list-style-type: none"> <li>Required for a DBA.</li> </ul>	X	X
<b>Certificate of Incorporation</b>	<ul style="list-style-type: none"> <li>Required for agencies with the following Types of Ownership: Professional Services Corporations, Business Corporations, or Not for not-for-profit corporations.</li> </ul>	X	
<b>Certificate of Limited Partnership</b>	<ul style="list-style-type: none"> <li>Required for agencies with a Limited Liability Partnership.</li> </ul>	X	
<b>Certificate of Occupancy</b>	<ul style="list-style-type: none"> <li>Required for service sites without NYS childcare license/permit.</li> </ul>	X	X

Required Documentation	Description	Agency	Individual
<b>Documentation Related to Enforcement Actions</b>	<ul style="list-style-type: none"> <li>Required for those who disclose enforcement action(s).</li> </ul>	X	X
<b>Documentation Related to Legal Actions</b>	<ul style="list-style-type: none"> <li>Required for those who disclose legal action(s).</li> </ul>	X	X
<b>Driver's License</b>	<ul style="list-style-type: none"> <li>Individual providers must submit a picture ID (e.g., Driver's license).</li> <li>Agencies must submit the driver's license of the individual serving as the Authorized Representative for the EIP application.</li> </ul>	X	X
<b>FEIN Assignment Letter (IRS)</b>	<ul style="list-style-type: none"> <li>Required for all agencies and individuals with a business name associated with their approval (DBA).</li> </ul>	X	X
<b>Fire/Disaster Evacuation Plan</b>	<ul style="list-style-type: none"> <li>Required for service sites without NYS childcare license/permit.</li> </ul>	X	X
<b>Fire Inspection</b>	<ul style="list-style-type: none"> <li>Required for service sites without NYS childcare license/permit.</li> </ul>	X	X
<b>Health and Safety Plan</b>	<ul style="list-style-type: none"> <li>Required when requesting approval for a site (licensed or unlicensed).</li> </ul>	X	X
<b>Partnership Agreements</b>	<ul style="list-style-type: none"> <li>Required for Partnership or Limited Liability Partnership.</li> </ul>	X	
<b>Physician's Letter</b>	<ul style="list-style-type: none"> <li>Required if requesting to provide multidisciplinary evaluations (must be on physician's letterhead).</li> </ul>	X	
<b>Program Standards Table of Contents Outline</b>	<ul style="list-style-type: none"> <li>Required of all agencies.</li> </ul>	X	
<b>Quality Assurance Plan</b>	<ul style="list-style-type: none"> <li>Required for <b>each</b> service type/profession, including service coordination and evaluations offered by an agency.</li> </ul>	X	

Required Documentation	Description	Agency	Individual
<b>SED Corporate Practice Waiver</b>	<ul style="list-style-type: none"> <li>NYS Education Law prohibits some corporations from using licensed professionals. Therefore, based on the corporate structure of your agency and the qualified personnel your agency intends to utilize, you may need to apply to the NYS Education Department (SED) for a waiver to provide these professional services as an EI agency.</li> <li>NYS DOH will inform you if you must apply for a SED Waiver.</li> <li>Your waiver application must be under the agency name identified on your EI application, enrolled with the NYS Department of State, and include all site(s) you own/lease/rent where you will see EI children.</li> <li>For additional information, refer to <a href="http://www.op.nysesd.gov/waiver-ei-info.htm">http://www.op.nysesd.gov/waiver-ei-info.htm</a>.</li> </ul>	X	
<b>Site Diagram</b>	<ul style="list-style-type: none"> <li>Required for service sites without NYS childcare license/permit.</li> </ul>	X	X
<b>Statement of Fiscal Viability</b>	<ul style="list-style-type: none"> <li>The agency submits verification of funds to cover its expenses for a three-month start-up period through financial statements or other means demonstrating responsibility and viability.</li> </ul>	X	



This section concludes the PAT Individual Application(s).