

**EARLY STEPS PROVIDER ATTESTATION CHECKLIST**

 Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail Address/Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Medicaid Number or Medicaid Application Tracking Number (ATN): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Solo Y/N: \_\_\_\_\_\_\_\_ Agency Y/N\_\_\_\_\_\_\_\_\_\_

* [Copy of current Form W9](BlankW9.pdf)
* Resume; Work History, documenting in a month/year timeline for last five (5) years, *with explanation of any gaps longer than 90 days in employment*
* Copy of Social Security card & driver’s license
* Copy of Professional License; if applicable
* [Copy of Individual National Provider Identification (NPI) number](https://npiregistry.cms.hhs.gov/)
* [Copy of current liability insurance coverage- agency: letter on letterhead stating individual is covered under agency policy.](insurance.docx)
* Summary of professional liability claim(s) pending or filed against you within the past five (5) years
* Summary of Medicaid and Medicare sanctions within the past five (5) years. Provide date of occurrence, amount paid and brief summary of events for each sanction
* [Level II Security Background Screen. Active/eligible Medicaid providers are exempt from submitting a Level II Security Background Screen if an eligible screen has been conducted within the past 5 years as evidenced by AHCA.](BACKGROUND%20SCREENING%20INFORMATION.docx)
* [Documentation of appropriate professional Early Intervention experience (Certificate of Experience form or Mentorship form – top of page 1 filled out completely) (an ITDS cannot complete a mentorship in lieu of experience)](10_Certif_of_Experience.docx)
* [Documentation of Infant Toddler Developmental Specialist Training Modules completed (ITDS ONLY)](http://www.floridahealth.gov/alternatesites/cms-kids/providers/early_steps/training/itds/itds.html)
* [Documentation of Early Steps Orientation Training Modules completed](http://www.floridahealth.gov/alternatesites/cms-kids/providers/early_steps/training/orientation/orientation.html)
* Copy of College/University Diploma or Transcript
* [**EARLY STEPS APPLICATION**](application.docx)

**This attestation checklist verifies that the provider named above is qualified and approved as the following provider type to participate in the Early Steps program:**

* Advanced Registered Nurse Practitioner
* Audiologist
* Board Certified Behavior Analyst (BCBA)
* Board Certified Associate Behavior Analyst (BCaBA)
* Clinical Social Worker
* Dietician
* Marriage & Family Therapist
* Mental Health Counselor
* Occupational Therapist
* Occupational Therapy Assistant
* Optometrist
* Physical Therapist
* Physical Therapy Assistant
* Physician
* Psychologist
* Registered Nurse
* Registered Respiratory Therapist
* School Psychologist
* Speech Language Pathologist (SLP)
* Provisional SLP
* SLP Assistant
* Vision Specialist
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Infant Toddler Developmental Specialist

Early Steps Program Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Attestation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Early Steps Program Director Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Early Steps Program Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_