***EARLY STEPS PROGRAM***





WESTERN PANHANDLE

SACRED HEART HOSPITAL

***PROVIDER ENROLLMENT APPLICATION***

|  |
| --- |
| NAME |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| FIRST | MIDDLE | LAST | MAIDEN/OTHER | SUFFIX |
|  |  |  |  |  |

|  |
| --- |
| HOME ADDRESS |
| Address 1 | Address 2 |
|  |  |
| CITY | STATE | ZIP + 4 | COUNTY | TELEPHONE |
|  |  |  |  |  |

|  |
| --- |
| EMAIL ADDRESS |
| Primary email address | Secondary email address |
|  |  |

|  |
| --- |
| PERSONAL  |
| SSN | DOB | GENDER | ETHNICITY | PRIMARY LANGUAGE SPOKEN |
|  |  |  |  |  |
| SECONDARY LANGUAGE SPOKEN |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| COUNTIES WILLING TO SERVE |  YES | NO | AS NEEDED |

|  |
| --- |
| **OKALOOSA** |[ ] [ ] [ ]
| **WALTON** |[ ] [ ] [ ]
| **ESCAMBIA** |  [ ]  |[ ] [ ]
| **SANTA ROSA** |[ ] [ ] [ ]

|  |
| --- |
| OTHER – MEDICAID/NPI  |
| MEDICAID THERAPY # | EFFECTIVE DATE |
|  |  |
| MEDICAID ATN (application tracking number) | DATE APPLICATION SUBMITTED |
|  |  |
| NPI # (national provider identifier) | DATE OF LAST UPDATE |
|  |  |

|  |
| --- |
| GROUP INFORMATION- IF APPLICABLE |

|  |  |
| --- | --- |
| AGENCY NAME |  |
| ADDRESS |  |
| PHONE  |  |
| MEDICAID THERAPY # |  |
| MEDICAID EI #  |  |
| NPI # |  |

|  |
| --- |
| PROVIDER TYPE |

[ ] **Advanced Registered Nurse Practitioner**

[ ] **Audiologist**

[ ] **Board Certified Behavior Analyst**

[ ] **Clinical Social Worker**

[ ] **Dietician**

[ ] **Infant Toddler Developmental Specialist**

[ ] **Marriage & Family Therapist**

[ ] **Mental Health Counselor**

[ ] **Occupational Therapist**

[ ] **Occupational Therapy Assistant**

[ ] **Optometrist**

[ ] **Physical Therapist**

[ ] **Physical Therapy Assistant**

[ ] **Physician**

[ ] **Psychologist**

[ ] **Registered Nurse**

[ ] **Registered Respiratory Therapist**

[ ] **Psychologist**

[ ] **Registered Nurse**

[ ] **Registered Respiratory Therapist**

[ ] **School Psychologist**

[ ] **Speech Language Pathologist (SLP)**

[ ] **Provisional SLP**

[ ] **SLP Assistant**

|  |
| --- |
| LICENSES |
| LICENSE TYPE | NUMBER | EXPIRATION DATE | STATE |
|  |  |  |  |
|  |  |  |  |

|  |  |
| --- | --- |
| THREE PROFESSIONAL REFERENCES  |  |
| NAME | CONTACT INFORMATION |
|  |  |
|  |  |
|  |  |

|  |  |  |
| --- | --- | --- |
| HANDS ON PROFESSIONAL SERVICES |  YES |  NO |
| Have you provided **one year** of hands-on services within your scope of practice to children birth through four years of age? |[ ] [ ]
| Were children with special needs/developmental delays represented within your client base? |[ ] [ ]
| Was it paid experience? |[ ] [ ]
| Was it post degree? |[ ] [ ]

|  |  |  |
| --- | --- | --- |
| HEALTH STATUS | YES | NO |
| Health Issues |[ ] [ ]
| If yes, I will provide this information to you via | [ ] **FAX** | [ ] **MAIL** |

|  |  |  |
| --- | --- | --- |
| DISCIPLINARY ACTIONS | YES | NO |
| Healthcare Practitioner License |[ ] [ ]
| Convicted of Criminal Activity |[ ] [ ]
| Medicaid or Other Professional Registration |[ ] [ ]
| Healthcare Facility or Affiliation  |[ ] [ ]
| Subject to Federal Investigation |[ ] [ ]
| If yes, I will provide information via | [ ] **FAX** | [ ] **MAIL** |

|  |  |  |
| --- | --- | --- |
| MALPRACTICE ACTIONS | YES | NO |
| Files Professional Liability Suits |[ ] [ ]
| Liability Judgments or Settlements  |[ ] [ ]
| Pending Professional Liability Suits |[ ] [ ]
| If yes, I will provide information to you via  | [ ] **FAX** | [ ] **MAIL** |

 Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 AGENCY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (if applicable)