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PROVIDER CONNECTIONS

PART C - EARLY INTERVENTION CREDENTIALING AND ENROLLMENT
FUNDED BY THE ILLINOIS DEPARTMENT OF EARLY CHILDHOOD

Please Do Not Double-Side or Duplex

Early Intervention Credential Application

Applicants should use this application packet if applying for a first-time credential or to restore a credential that has lapsed for more than a year. Please review all materials and use the checklist below to determine if you have included all materials required to apply for an Illinois Early Intervention Credential.

	Component Needed	Completion Instructions	Yes	No
1.	Application for Early Intervention Credential **Required**	Applicant completes the demographic section, Part I, and Part II.		
2.	Early Intervention Credential Application documentation **Required** **All application documents must come together.**	Documentation of completion of Online Systems Overview. **AND** A copy of current license from Illinois Department of Financial & Professional Regulation, if eligible; **Official college/university transcripts (not copies), if unlicensed.** **Electronic transcripts can be sent to providerconnections@wiu.edu**		
3.	CFS 689 Authorization For Background Check (CANTS) **Required**	Form must be sent with credential application for processing. You will receive an email from DCFS with instructions for you to authorize this background check process. **Allow 4 weeks for processing the DCFS CANTS (unless there are mitigating circumstances determined by DCFS).**		
4.	Consultation Verification Form **(Required for "first time" credential. Submit as part of this application or send to Provider Connections during the 18-month temporary credential**	Applicant documents **240** hours of consultative experience with infants/ toddlers & their families at time of initial application **or** within the 18-month temporary credential period. Clinical Assessment, Counseling, and other Therapeutic Services; Nutrition; Nursing; Social Services; and Hearing DTs, Vision DTs, or O & M DTs need only document **120** such hours. Please see the Q and A Consultation Experience.		
5.	Early Intervention Ongoing Professional Development Plan Format **(Required—not applicable to Service Coordinators and Parent Liaisons.)**	Applicant agrees to participate in ongoing professional development by signing and returning this document. If a new applicant, leave EI Credential Number blank.		
6.	Central Billing Office Enrollment Application **Required (Not applicable to Assistants.)** IMPACT Enrollment	Applicant will complete and return the appropriate Central Billing Office enrollment application. Payee agreement, if applicable, and Service Matrix. Please see Provider Connections IMPACT page for details. IMPACT Enrollment Guidelines are found under IMPACT resources.		
7.	Early Intervention Program - Acknowledgment of Supervisor (Assistants Only, including CFYs)	Early Intervention Program - Acknowledgment of Supervisor (Assistants Only, including CFYs)		

Return completed applications to:
Please use the appropriate address below based on your shipping method.

USPS Mailing Address

If you are mailing documents or information through USPS, please use the following address:

Center for Best Practices in Early Childhood Education
Western Illinois University
#20 Horrabin Hall
1 University Circle
Macomb, IL 61455

UPS, FedEx, DHL, and Other Shipping Carriers

If you are shipping documents or information through any carrier other than USPS, please use the following address:

Provider Connections
Western Illinois University
950 N Western Ave, Horrabin Hall, Room 20
Macomb, IL 61455

PLEASE DO NOT DUPLEX OR DOUBLE SIDE

FAXED OR EMAILED COPIES NOT ACCEPTED

Forms are fillable, please use this feature or print legibly. Do not get fingerprinted prior to receiving Provider Connections email notification to do so.

Instructions for Completing the Illinois EI Credential Application

1. Enter your full legal name. Make sure this matches your license and IMPACT.
2. A National Provider Identification (NPI) number is required of all specialist level providers (excludes Service Coordinators, Parent Liaisons, and Assistants). If you have one, enter the number on the line following your name. If you do not have one, you will need to apply for one online at https://nppes.cms.hhs.gov.
3. List your complete Social Security Number on the line provided.
4. Home addresses are required on all credential applications. The credential belongs to you rather than your agency. It is important to keep Provider Connections apprised of any home address or email changes.
5. Enter phone numbers as listed.
6. New applicants may leave the line "CFCs Served" blank if they do not know which Child and Family Connections office geographical area they may be serving. A link to the CFC listings can be found at https://providerconnections.org/cfc/
7. List your home county.
8. Providers are now required to have an email address. Provider Connections communicates with providers via email. It is important to keep Provider Connections apprised of any home address or email changes. Please use a personal business email or home email address.

Part I

1. Check how you plan to provide services, whether in-person, via live video visit (LVV), or both.
2. New applicants should place a check next to the credential for which they are applying. CFY Speech Pathologists are considered "Assistants" in this program until their full Speech License is issued. At that time, the provider must apply for the Speech Pathologist credential by forwarding the credential application page, a Central Billing Office Enrollment Application, and a photocopy of their state professional license. Applicants for Psychology Assistant, Social Work Assistants, and Counseling Assistants must submit transcripts and a letter from the department stating they are in good standing and where the internship will occur along with the name of the Illinois Early Intervention credentialed supervisor.
3. You may submit a printed copy of the licensee's record from the Illinois Department of Financial and Professional Regulation's website as proof of your current professional license. If your license expires during the month you are applying for the credential, Provider Connections must have verification of the renewed license.

Part II

All providers must complete the Early Intervention Verification section of the application. Provider Connections cannot process an application if this section is not completed and signed by the applicant.

Other Instructions

- The DCFS Authorization for Background Check (CANTS) must be submitted with the application. Wewill not process the CANTS without an application.You will receive an email from DCFS with instructions for you to authorize this background check process. The email subject line will state Account Creation and Authorization Required for a DCFS Background Check Requested by Provider Connections Center for Best Practices in Early Childhood Education.While you are able to reach out to DCFS to have your background check expedited there, it is reviewed by the Provider Connections team with the group that it was sent out with so the process is still 4-6 weeks.
- Applicants need to submit the Ongoing Professional Development PlanFormat.
- Associate-level providers must complete the Early Intervention - Acknowledgment of SupervisorForm.

A complete description of EI Credential Requirements is available in Section 500.60, Provider Qualifications/ Credential and Enrollment at
https://www.ilga.gov/commission/jcar/admincode/089/08900500ZZ9996cR.html

Do Not Email or Fax

APPLICATION FOR ILLINOIS EARLY INTERVENTION CREDENTIAL

Full Legal Name _____
First Middle Last

Individual NPI# (10 digits) _____ SSN _____

Street Address _____

City _____ State _____ Zip +4 Code _____

Phones: Work _____ Home _____ Fax _____

CFCs Served _____ Home County _____

Email (required) _____

Part I: New Applicants

☐ **Check box if reactivating a lapsed credential** **Type of Visit** ☐ **In-Person** ☐ **LVV** ☐ **Both**

Place a ✓check on the credential for which you are applying:

___ Service Coordinator	___ Licensed Speech/Language Pathologist	___ Licensed Speech/Language Assistant (Includes CFYs)
___ Registered Nurse	___ Licensed Occupational Therapist Licensed	___ Certified Occupational Therapy Assistant
___ Parent Liaison	___ Physical Therapist	___ Licensed Physical Therapy Assistant
___ Licensed Behavior Analyst	___ Social Services (LPC, LSW)	___ Social Work Assistant
___ Licensed Dietitian Nutritionist	___ Clinical Assessment & Counseling	___ Psychology Assistant
___ Developmental Therapy	___ Developmental Therapy/Hearing	___ Development Therapy/Vision or O & M

Part II: Early Intervention Verification

To be issued a credential and to maintain a credential, I verify the following by placing an X or a ✓next to the following:

☐ I am not delinquent in paying a child support order as specified in Section 10-65 of the Illinois Administrative Procedure Act [5ILCS 100/10-65];

☐ I am not in default of an educational loan in accordance with Section 2 of the Education Loan Default Act [5ILCS 385/3];

☐ I have not served or completed a sentence for a conviction of any of the felonies set forth in 225ILCS 46/25 (a) and (b) within the preceding 5 years (30ILCS 500/50-10);

☐ I have not been indicated as a perpetrator of child abuse or neglect in an investigation by Illinois or another state for at least the previous 5 years;

☐ I am in compliance with pertinent laws, rules, and government directive regarding the delivery of services for which I seek credentialing.

Signature (required) _____ Date _____

Do Not Duplex or Double Side

CFS 689
Rev 6/2024

State of Illinois
Department of Children and Family Services
AUTHORIZATION FOR BACKGROUND CHECK
Child Abuse and Neglect Tracking System (CANTS)
For Programs NOT Licensed by DCFS

Providers: Please return this form to Provider Connections with your application.

Last Name	First Name	Middle Name	Date of Birth	Gender assigned at birth
				Female

Ethnicity

Not Hispanic (None)

Email

Race Select all that apply

- ☐ AAsian
- ☐ Black/African American
- ☐ Native American/Alaskan (Indian or Eskimo))
- ☐ Native Hawaiian/Pacific Islander
- ☐ Unknown
- ☐ White

Consultation Verification Form

This form must be signed off by a person of the same discipline or Early Intervention service group. Please return Ongoing Professional Development Documention with this form.

Consultation Requirement Either Prior to or During Temporary Credential:
In order to qualify for full credential status, an individual must complete and document **240** hours of professional experience with infants, toddlers and their families. Such experience must be completed while being in consultation with another professional qualified to provide consultative feedback regarding the provision of direct Early Intervention services for which they are being credentialed. The following service categories need to document **120** hours: Clinical Assessment, Counseling, and other Therapeutic Services; Nursing; Nutrition; Social Services; and Development Therapy/Hearing, Developmental Therapy/Vision, Developmental Therapy/O & M. Documentation must show that the individual participated in consultation with an appropriately experienced **individual of the same discipline/Early Intervention service group** who has experience working with children ages birth to three with special needs. The consultation shall be in compliance with the professional standards of the individual seeking the credential as determined and documented by the consultant.

Individuals without the consultative professional experience required above shall complete and document 240/120 hours of such supervised experience **within 18 months of issuance of their temporary credential**. Extensions up to 6 months may be granted upon written request setting forth the facts concerning noncompliance with this requirement. The Department of Human Services credentialing office will consider extreme hardship and other extenuating circumstances and determine if an extension should be granted on an individual basis. **Per IDHS Bureau of Early Intervention policy, if a provider is not able to meet the Consultation requirement within the 18-month period and no extenuating circumstances have been documented, that provider can only finish out open authorizations on Early Intervention children. If the provider is an assistant, services must stop. The provider may reapply after 12 months.**

Applicant Name: _____
First Middle Last

SSN (last 4 digits) _____

Clinical Professional Consultant's Name: _____

Clinical Professional Consultant's Address: _____

☐ By checking the box to the left, the applicant/provider and the Clinical Professional Consultant attest to the completion of the hours of consultative professional experience as required by the Illinois Department of Human Services Rule 500 - Early Intervention **AND** as described above.

_____ hours completed while consulting with Consultant named above from _____ through _____
(mo/yr) **(mo/yr)**

_____ _____
Signature of Clinical Professional Consultant Date

_____ _____
Signature of Credential Applicant/Provider Date

Individuals without the consultative professional experience required above shall complete and document required hours of such consultative experience within 18 months of issuance of their temporary credential.

Early Intervention Ongoing Professional Development Plan Format (Required for all Except Service Coordinators and Parent Liaisons)

I agree to participate in a system of ongoing professional development that includes a once-a-month non-billable meeting held either face-to-face or over the phone with either an **individual specialist-level credentialed provider** of a group, of which **at least one member is a specialist-level credentialed provider** in order to facilitate best practice through case review.

I will submit to the credentialing office complete ongoing professional development documentation forms when moving from a temporary to a full credential status and upon credential renewal. I will make documentation of ongoing professional development meeting available to DHS or its designee upon request.

_____ Leave EI Credential Number blank if you are a new applicant.
Early Intervention Credential Number

_____
Signature

_____
Date

Ongoing Professional Development Documentation Form
(Required for all except Service Coordinators and Parent Liaisons)

A signature from a specialist-level provider is required for each monthly meeting.

Must be completed and submitted to Provider Connections when moving from temporary to full and with credential renewal applications.

This form is required to document Ongoing Professional Development. Substitute forms will not be accepted. Duplicate this form as needed. A copy of this form must be forwarded to Provider Connections when moving from temporary to full and with credential renewal materials documenting ongoing professional development activities for the respective months of the credentialing period. **We accept one (1) meeting per month toward your professional development hours.**

Provider Name_____ **Year** _____
(indicate 1, 2, or 3)

Credential # _____

Date of Meeting	**Location**	**Signature of Credentialed Peer and Peer's Credential #**

Early Intervention Program - Acknowledgement of Supervisor

In order to qualify for an Early Intervention (EI) associate-level credential, an assistant and/or CFY must identify a supervisor who is an active EI-credentialed provider, in the same discipline, prior to receiving or continuing to hold an EI credential. If at any time there is a change in supervisor, this form must be re-submitted so consistent supervision may be confirmed.

This form is required to be completed and kept up to date for EI associate-level providers, including Speech-Language Pathologists (SLP) in their Clinical Fellowship Year (CFY).

Supervisors of EI credentialed associate-level providers agree to:

- Follow any and all State licensing requirements and/or supervisory requirements pertinent to the individual's delivery of services
- Follow supervision requirements as listed in *Title 89: Social Services, Chapter IV: Department of Human Services, Subchapter E: Early Childhood Services, Part 500 Early Intervention Program, Section 500. Appendix D - Use of Associate-Level* Providers
- Agree to the policy and procedures of supervision as outlined in the *Illinois Early Intervention Provider Handbook, Chapter 3.*

Assistant's Name: _____ **Discipline:** _____ **Credential #:** _____
(Leave blank if you are a new applicant)

Please list the name of the EI-credentialed provider who will be providing supervision.

Supervisor's Name	Credential #	Payee (Agency/Company)	Email Address	Start Date (MM/DD/YY)	End Date (MM/DD/YY)

_____ _____
Assistant's Signature **Date of Submission**

PLEASE DO NOT DOUBLE-SIDE or DUPLEX

Forms are fillable, please use this feature or print legibly.

Instructions for Completing the Central Billing Office Application

*** Please note that the new HIPAA format requires the use of 9-digit zip codes on all CBO Forms***

A Note about LLCs:

If you are attempting to enroll as a single-member LLC, please view the memo below. A provider should consult a tax accountant to determine the best situation when setting up a business or even as a self-employed individual. Many providers wish to protect their social security number from the public. This is well understood given the times in which we live. However, Early Intervention providers need to understand the payment procedures mandated within the State of Illinois. These facts pertain only to payments from the State of Illinois/Illinois Office of Comptroller. Again, we request a provider to consult a tax accountant for more specific business/tax guidance.

W-9 Questions regarding LLC-Disregarded Entities

The Payee Agreement:

- Only one copy of the Payee Agreement needs to be completed by an agency. All subsequent agency applicants should disregard the Payee Agreement portion of the CBO application.
- Your name must match the name on your state license on all application forms.
- A copy of your marriage license or other court document must be enclosed if your name is different than your license.
- "Payee Name" refers to the individual provider's name or the agency name that is being used to receive payment.
- "Payee Representative Name" is the individual provider or the person acting as the agency representative.
- "Title" refers to the title of the agency representative signing the agreement. Individual providers should write "Individual" on this line.
- The individual provider or agency representative must sign and date this page.
- All six pages must be returned. This is an agreement between you and the Illinois Department of Human Services, so all six pages of the Payee Agreement are required.

The EI Service Matrix:

Provider Connections sends this page to the Central Billing Office.

- List your name as you want it for billing purposes. Fields are available for first, middle, and last names.
- Enter your home address.
- Enter your Social Security Number.
- Indicate your personal National Provider Identification (NPI) number. This does not apply to Assistants, Parent Liaisons, Service Coordinators, Interpreters, and Translators. **Applications missing the NPI number cannot be processed.** You can obtain one by going to https://nppes.cms.hhs.gov.
- List your current e-mail address. Since some providers have more than one employer, an individual e-mail address is preferred. An email address is required.
- List the county or counties you will serve.

- "Payee Name" refers to the individual provider's name or the agency name that is being used to receive payment.
- List the Payee Tax ID Number.
- Enter the CFC or CFCs you will serve.
- Enter the Payee Site Address.
- Enter the Payee Billing Address if different from the Payee Site Address.
- List the Payee Phone and Fax numbers.
- Indicate each type of early intervention service you provide directly with a ✓.
- Check the appropriate box for IMPACT Validation/Enrollment.
- Sign and date the form.

Attach a copy of your current that license to this application. The only exceptions are professions which are not required to have a state license [e.g., Development Therapists].

Important to Note Provider Connections recommends using the most recent applications. It is best to download applications directly form the Provider Connections website and avoid maintaining a stockpile of file copies. Forms change and become obsolete, and obsolete forms are invalid.

Illinois Department of Human Services
Payee Agreement for Authorization to Provide Early Intervention Services

Note: The Payee shall type or print legibly all information except for the signature.

The Payee Agreement is for the sole use of an entity, which either employs or contracts with Early Intervention Providers, to provide Early Intervention Services **or** for the sole use of an entity that enrolls as an Independent with no employees, whichever is applicable.

This Early Intervention Payee Agreement is entered into by and between the Illinois Department of Human Services (DHS) as the Lead Agency for the Illinois Early Intervention Services (EI) System and funder of the Early Intervention Program, and

_____
(Payee Name)

Purpose of Agreement: The purpose of this Agreement is to establish the duties, expectations and relationship between DHS and the Payee who is certified by the State of Illinois Comptroller to receive payment from the Central Billing Office (CBO) and who makes service(s) available to eligible children and their families according to the Illinois Early Intervention Services System Act 325 ILCS 20/5 et. seq. (the Act); Part C of the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. Section 1431 et seq.); the Health Insurance Portability and Accountability Act of 1996 (HIPAA); the Family Educational Rights to Privacy Act (FERPA) and its rules, 34 CFR 99; and EI administrative rules, 89 Illinois Administrative Code 500 (Rule 500).

Definition of Payee: The Payee is the entity identified on the W-9 page of the CBO Enrollment Application under Business Name and Taxpayer Identification Number. The Payee may be an entity who employs providers **or** an independent with no employees (Payee as named above).

Definition of Provider: A person that actually provides Early Intervention services to children and families. This includes Physicians, Optometrists, Audiologists, Therapists, Counselors, Parent Liaisons, Deaf Mentors, Interpreters, Nurses, Nutritionists, Transportation and Assistive Technology services.

Definition of Child and Family Connections (CFC): The CFC is the system point of entry in a designated geographic region that is responsible for providing access to the Illinois Part C Early Intervention Services System, for providing service coordination services, and for maintaining the child's permanent EI Record for referred and eligible children.

Definition of Department of Human Services Central Billing Office (CBO): The CBO is an entity designated by DHS for the processing of Early Intervention claims and for data collection.

In consideration of the Authorization to Bill DHS for the Provision of Services, the Payee Shall:

1. Not bill families directly for authorized early intervention services. *(See #s 6 and & 7 for more information).*

2. Provide only those services for which the Payee has a written authorization **in hand.** The exception to this rule is the IFSP meeting. Providers will receive authorization for this meeting based upon actual attendance.

3. Verify insurance company coverage of benefits and comply with insurance company requirements, including network enrollment and documentation requests as outlined in DHS policy, unless insurance use has been waived or exempted by the Department **or** is a service provided at public expense. (See #6 for services provided at public expense).

Bill private insurance before submitting claims to the CBO for covered services for all Early Intervention (EI) children **unless** an insurance exemption or pre-billing waiver has been issued **or** the service is provided at public expense.

Within **ninety (90) calendar days** of receipt of the insurance Explanation of Benefits (EOB), submit claims to the CBO with the EOB attached. The EOB and a completed claim shall be submitted to the CBO for all EI children **even if the entire claim was paid by private insurance**.

Understand that a CFC cannot generate/backdate an insurance waiver or exemption that would apply toward dates of service that have been previously provided to the child/family. Accepting waivers or exemptions post service delivery is not allowed under EI policy.

4. Submit claims to the CBO at the Payee's usual and customary rates.

5. Accept the EI rates as payment in full for covered services provided unless this rate is exceeded by the insurance payment. If the insurance payment is less than the EI rate, then the CBO should be billed for the difference. An Explanation of Benefits from the insurance company shall be submitted with the claim to the CBO.

   Submit legible claims to the CBO on the CMS 1500 form, UB04 form, and for transportation on the CBO Billing Form, or an exact electronic facsimile of one of these forms. Claim information must be **typed or submitted through electronic transfer.**

   Submit claims to the CBO for IFSP Development only as defined in the Provider Handbook entitled *Early Intervention Service Descriptions, Billing Codes and Rates*.

   Not bill or accept reimbursement from the CBO for services in excess of what has been authorized and identified on the child's IFSP. The Payee shall be fully liable for the truth, accuracy and completeness of all claims submitted to the CBO for payment. Any submittals of false or fraudulent claims or concealment of a material fact may be prosecuted under applicable Federal and State laws.

   Submit to the CBO an invoice of charges for services **no later than ninety (90) calendar days** following the service delivery date **or** the receipt of the insurance EOB. Claims **must** indicate the specific individual who actually provided the services or the associate who actually provided the services and his/her credentialed supervisor under whom the authorization was billed against.

   Resubmit a claim no less than **sixty (60) calendar days** from the original submission date of the claim. The resubmitted claim shall be stamped or otherwise marked to delineate that it is a **"RESUBMISSION"** or **"STATEMENT OF ACCOUNT"** and shall include only services documented on the original claim.

6. Not bill the family directly or their insurance for screening, evaluation and assessment services, IFSP development, or implementation of procedural safeguards, as delineated in 34 CFR 303.170 et. seq., since these services must be provided at public expense. However, the Payee may bill the CBO for evaluation and assessment and IFSP development services.

7. Not bill the family directly for direct services unless the insurance **payment was paid to the family versus the payee and the payee has a copy of the signed "Child and Family Connections Insurance Affidavit, Assignment and Release" form in hand.** Accept the insurance payment as payment in full unless the payment is less than the EI Rate. (See #5).

8. Participate in evaluation/assessment activities and the development, review and revision of each child's IFSP as set forth in 34 CFR Part 303, and current DHS directives as delineated in writing,

including the “Principles of Early Intervention”. Except for associate level speech language pathologists who are completing a supervised professional experience, associate level providers do not participate in evaluation/assessment activities for review or revision of the IFSP.

9. Provide a report of findings to each child’s service coordinator **in a format designated by DHS** that describes the tests/methods used in evaluation/assessment activities, the results of the test/method including a score and a typed narrative interpretation of the results.

10. Submit all evaluation/assessment reports to the service coordinator within **fourteen (14) calendar days** of receipt of the request to perform evaluation/assessment.

11. Provide a direct service report to each child’s service coordinator **in a format designated by DHS** for each six (6) month IFSP review, or more often if the child’s progress or lack of progress warrants a review.

12. Provide originals of evaluation/assessment reports and documents created on behalf of early intervention such as direct service reports required for the six-month review, discharge reports, written justification of need statements and letters of developmental necessity for Assistive Technology services to the child’s assigned Service Coordinator. The Payee shall also keep copies as part of the child’s record.

13. Provide appropriate service(s) as set forth in the IFSP, to eligible children and their families upon referral and in accordance with pertinent rules, DHS directives, and frequency, intensity and duration timelines identified in the IFSP and on the authorization.

14. Notify the child’s Service Coordinator of any recommended changes in the delivery of services prior to implementation of changes, to ensure that modifications to an existing IFSP are made through the appropriate DHS procedure.

15. Not terminate services for an eligible child without written notification to the child’s service coordinator and family at least **thirty (30) calendar days** prior to the anticipated date of service termination.

16. Meet and maintain all applicable standards and regulations for staff and Payee licensure, certification and credentialing. Hire staff to provide services to children and their families who meet the State’s professional licensing standards and EI credentialing requirements and ensure that all staff performing services under this agreement has the skills to work with the children they serve and hold appropriate EI credentials prior to providing services.

17. Comply with all applicable laws and regulations for physical facilities in which services are made available.

18. Maintain accurate records, including daily documentation of services for each date of service billed, including IFSP development time, for a period of at least six years from the child’s completion of EI services, and permit access to these records by the local CFC, DHS, or if they are Medicaid reimbursable services, the Illinois Department of Healthcare and Family Services (HFS) and the Centers for Medicare/Medicaid Services (CMS), or the United States Department of Education. In the absence of proper and complete documentation, no payments will be made, and payments previously made will be recouped by DHS or HFS.

    If there are outstanding audit exceptions, records shall be retained until such exceptions are closed out to the satisfaction of DHS. If there is active or pending legal action, records shall be retained until a final written resolution is achieved. The Payee/Provider shall also be available, as required, for mediation, impartial administrative proceedings and/or other legal proceedings.

19. Complete the Medicaid enrollment application and bill the CBO for covered services provided to Medicaid eligible children.

20. Provide routine monitoring and supervision activities as set forth by state licensure requirements and delineated in writing by DHS, including self-assessment, on-site monitoring, data collection and reporting obligation, record or chart audits, financial audits, complaint investigation, and consumer satisfaction surveys. Understand that these are administrative functions that are not billable to the CBO.

21. Follow Part C federal laws and regulations and state laws, policies, guidelines, directives and procedures regarding Early Intervention services and other laws and regulations applicable to Payee's and providers hereunder (Example: State licensure laws).

    Provide services and communications to clients in a language or mode of communication understood by the child/family. If the Provider is unable to provide services and communications to the clients in a language or mode of communication understood by the child/family, the Payee shall notify the CFC.

22. Inform eligible families of their rights and procedural safeguards, including mediation and impartial administrative proceedings as delineated in 34 CFR 303.170 et. seq. and in Rule 500, and comply with those rights, and procedural safeguards.

23. Maintain liability insurance sufficient to cover any potential liability such as loss, damage, cost or expenses, including attorney's fees, arising from any act or negligence of the Payee or its employees/contractors.

24. Accept all children eligible for Early Intervention services without discrimination, including but not limited to children with public or private insurance.

25. Provide staff to participate in each EI IFSP Development meeting as a billable activity as specified in Illinois administrative rules for EI and 34 CFR Part 303.343 et. seq. Participation in IFSP meetings and periodic reviews is required.

26. Have access to the Internet and monitor the Early Intervention/Provider Connections websites on a **weekly** basis for changes and/or updates that affect the functions of the Early Intervention system.

27. Comply with all applicable Federal and State laws, including the American Recovery and Reinvestment Act of 2009 and its reporting requirements.

28. Comply with HIPAA Standards 45 CFR Parts 160, 162 and 164 and any additional parts that may be finalized in the future, where applicable.

29. Not use or disclose protected health information except as allowed by the HIPAA Standard 45 CFR Parts 160 and 164 and not use of disclose EI records except as allowed by FERPA.

30. By signing this agreement, the Payee certifies that each employee providing EI services has:
    1. not been delinquent in paying a child support order as specified in Section 10-65 of the Illinois Administrative Procedure Act [5 ILCS 100/10-65];
    2. not been in default of an educational loan in accordance with Section 2 of the Education Loan Default Act [5 ILCS 385/2];
    3. not served or completed a sentence for a conviction of any of the felonies set forth in 225 ILCS 46/25(a) and (b) within the preceding five years (see 30 ILCS 500/50-10);
    4. not been indicated as a perpetrator of child abuse or neglect in an investigation by Illinois or another state for at least the previous five years; and
    5. been in compliance with pertinent laws, rules, and government directives regarding the delivery of services for which they seek credentialing.

In consideration of the performance of this Agreement, DHS shall:

1. Produce authorizations in the name of the Payee only and not in the name of any individual staff employed or contracted by the Payee for services to be performed by the Payee.
2. Notify the Payee, a reasonable time in advance of implementation of any changes in rules regulations, procedures, policies, directives and any other program guidelines that affect the Payee's performance of this Agreement. This notification may be via the DHS Early Intervention/Provider Connections Websites. Copies of DHS rules, policies, guidelines, directives, etc., can be obtained from the DHS Early Intervention Website (www.dhs.state.il.us/ei) or the Provider Connections Website (www.providerconnections.org).
3. Reimburse the Payee for services rendered under this Agreement pursuant to the rates established for the covered services provided and only for those services pre-authorized in the IFSP. DHS shall adjust future payment to a Payee that has been underpaid or offset payment to a Payee that has been overpaid.
4. Comply with HIPAA Standards 45 CFR Parts 160, 162 and 164 and any additional parts that may be finalized in the future, where applicable.

Termination of this Agreement: This agreement may be terminated by either party, in writing, without cause, with at least **thirty (30) calendar days** prior written notice. This Agreement may be terminated by DHS at any time for failure by the Payee to perform any of the obligations and provisions set forth in this Agreement. This termination will be in writing, by DHS, and will specify the termination date.

Confidentiality: All records and other information obtained by the Payee concerning persons served under this Agreement are confidential pursuant to State and Federal statutes, Federal regulations and DHS administrative rules and shall be protected by the Payee and employees of the Payee from unauthorized disclosure.

Liability: DHS assumes no liability for actions of the Payee or its employees under this Agreement. The Payee agrees to indemnify, hold harmless and defend DHS against any and all liability, loss, damage, costs or expenses including attorney's fees arising from intentional torts or any act or negligence of the Payee or its employees, with the exception of acts performed in conformance with an explicit, written directive of DHS. The Payee agrees to maintain liability insurance sufficient to cover any potential liability.

Right of Audit and Monitoring: DHS maintains the right to inspect and audit any or all information or records in possession of the Payee/Provider that pertain to this Agreement. This right to audit extends to pertinent State and Federal officials, including the Department of Human Services, the Department of Healthcare and Family Services, federal auditors and the Office of the Auditor General of Illinois.

Void: This Agreement shall become null and void on the date that the Payee/Provider ceases to participate in the Department of Healthcare and Family Services Medicaid vendor program or provides at least a **thirty (30) calendar days** prior written notice to terminate.

Miscellaneous: This Agreement may be executed in any number of counterparts, each of which shall be deemed an original. All paragraph headings are for referral purposes only and shall not in any way affect the meaning or interpretation of this Agreement. Failure of DHS to enforce any provision of this Agreement shall not constitute a waiver of that provision by DHS.

Entire Agreement: DHS and the Payee understand and agree that this Agreement constitutes the entire agreement between them and that no promises, terms, or conditions not recited herein or incorporated herein or referenced herein, including prior agreements or oral discussions, shall be binding upon either the Payee or DHS.

Laws of Illinois: This Agreement shall be governed and construed in accordance with the laws of the State of Illinois and all subsequent amendments.

Notice: Notices under this Agreement regarding termination will be in writing and will be deemed to have been given when delivered by hand, U.S. Postal Service, messenger service, or overnight delivery service to the address listed on the following page or such other address as DHS shall specify in a written notice to the Payee or post on the DHS Website (www.dhs.state.il.us/ei).

DEPARTMENT OF HUMAN SERVICES:

Name: Bureau of Early Intervention

Address: 823 East Monroe Street

Springfield, IL 62701

Please **mail** your completed application/agreement to:

Provider Connections

Center for Best Practices in Early Childhood Education
950 N Western Ave, Horrabin Hall, Room 20
Macomb IL 61455

PAYEE INFORMATION: (Please mail your completed application/agreement to Provider Connections.)

Payee Name: _____

Payee Rep. Name: _____

Title: _____

Address: _____

City: _____

State, Zip Code: _____

Phone #: _____

Payee Tax ID #: _____

Taxpayer Certification: Under penalties of perjury, the Payee representative certifies that the Payee's Social Security Number or Federal Taxpayer Identification Number (FEIN) is correct. The entity identified as the "Payee" is doing business as:

- ☐ Individual
- ☐ Owner of Sole Proprietorship
- ☐ Partnership
- ☐ Tax-exempt hospital or extended care facility or trust
- ☐ Government Entity
- ☐ Corporation providing or billing medical and/or health care services
- ☐ Corporation NOT providing or billing medical and/or health care services
- ☐ Trust or Estate
- ☐ Foreign corporation, partnership or estate
- ☐ Not-for-Profit Corporation
- ☐ Other: _____

Severability: If any provision of this Agreement is declared invalid, its other provisions shall not be affected thereby.

Signature Authority/Execution: The signature of all who sign this Agreement on behalf of the Payee and DHS are required for Execution of this Agreement. Each signature has been made with complete and full authority to commit the party to all terms and conditions of this Agreement, including each and every representation, certification and warranty contained herein. This Agreement becomes effective the date the Secretary's signature is affixed to this Agreement.

Printed Name of Payee: _____

Printed Name of Payee Representative: _____

Payee Representative Signature: **X** _____ Date: _____

Illinois Department of Human Services

Printed Name: **Dulce M. Quintero ,** *Secretary*

Signature: **X** _____ Date: _____

*****FOR IDHS USE ONLY*****

Do Not Email Due to Sensitive Information

EI Service Matrix

Individual Provider Name _____
First Middle Last

Home Address _____
Street City State Zip+4 Code

Individual Phone Number _____ SSN _____ Individual NPI # _____
National Provider ID

Email (required) _____ County/Counties Served _____

Payee Name _____

Payee Tax Identification Number _____ CFCs Served _____

Payee Site Address _____
Street City State Zip+4 Code

Payee Billing Address _____
Street City State Zip+4 Code

Payee Phone Number _____ Fax Number _____

If you have been previously enrolled with Provider Connections, please list the name you used: _____

Type of Visit ☐ In-Person ☐ LVV ☐ Both

Early Intervention Services

☐ Assistive Technology
☐ Audiology
☐ Aural Rehabilitation
☐ Developmental Evaluation (physicians only)
☐ Nursing
☐ Nutrition
☐ Consultation (physicians only)
☐ Licensed Occupational Therapist
☐ Licensed Physical Therapist
☐ Board Certified Behavioral Analyst
☐ Licensed Professional Counselor
☐ Licensed Clinical Professional Counselor
☐ Transportation
  ☐ Parent Transportation Provider

☐ Licensed Clinical Psychologist
☐ Licensed Social Worker
☐ Licensed Clinical Social Worker
☐ Licensed Marriage/Family Therapist
☐ Licensed Regional Optometrist
☐ Developmental Therapist ☐ Hearing ☐ Vision ☐ O & M
☐ Service Coordinator (list CFC #)_____
☐ Licensed Speech/Language Pathologist
☐ Deaf Interpreter (certification and SO Training required)
☐ Parent Liaison (list CFC #) _____
☐ Bi-Lingual Interpreter (Proficiency Test & SO for Bi-Lingual Interpreter required)
_____ (Language)
  ☐ Writing Proficient (Proficiency Exam Required)
  ☐ Speaking Proficient (Proficiency Exam Required)

Are you enrolled/validated in the IMPACT System? ☐Yes ☐No

_____ _____
Signature (Required) Date