

**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
* 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
* Copy of Professional License; if applicable
* Copy of Individual National Provider Identification (NPI) number
* Copy of current liability insurance coverage
* 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
* Current malpractice coverage in accordance to your specific Florida Statute Practice Act or bond that complies with the provider’s relevant practice act in the Florida Statutes; if applicable
* 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.
* Documentation of appropriate professional Early Intervention experience
* Documentation of Infant Toddler Developmental Specialist Training Modules completed; if applicable
* Copy of College/University Diploma or Transcript; if applicable
* Documentation of Early Steps Orientation Training Modules completed

 **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 Practice Registered Nurse
* Audiologist
* Board Certified Behavior Analyst (BCBA)
* Board Certified Associate Behavior Analyst (BCABA)
* 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
* School Psychologist
* Speech Language Pathologist (SLP)
* Provisional SLP
* SLP Assistant
* Vision Specialist
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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