***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)