

CHILD AND FAMILY CONNECTIONS PROVISIONAL PROVIDER REQUEST

Section 1: Provider Information and Certifications

Provider Name _____
 Agency Name (if applicable) _____
 Address _____
 City, State & Zip _____ Phone # _____
 Provider Email Address _____
 Requesting CFC # _____

Provider is (choose one) Evaluating Provider Direct Service Provider

Discipline ST PT OT Other (except Interpreter/Translator) _____

I certify that I will submit the requested Early Intervention (EI) Credential Application and Direct Billing for EI Services Application Packet to the EI Provider Connections office. I certify that I will comply with all requirements of training and credentialing and/or enrollment as quickly as possible and that I will be considered a Provisional Provider only, not to exceed a six (6) month time period from the date of this form.

Signature of Provider _____ Date _____

Provider is an Interpreter and/or Translator

I certify that I will submit the requested Direct Billing for EI Services Application Packet to the EI Provider Connections office. I certify I will comply with all requirements training and competency testing in the language(s) I represent. If there is no current competency test available in my language(s), I agree that when the test is available I will complete the competency testing within 6 months.

Signature of Provider _____ Date _____

Section 2: EI Service Coordinator Information and Certifications

Current Service Coordinator (printed name) _____ Phone # _____

I, the Service Coordinator, certify:

- 1) that the EI service requested is necessary for evaluation or assessment or is on an IFSP functional outcome page;
- 2) that the parents have signed *the Acknowledgement and Notice of Provisional Provider Status* form (not required for Interpreter/Translator); or the provider has completed the Fingerprinting
- 3) that no enrolled provider is available to provide the service(s) requested.

Name of Enrolled EI Provider contacted and reason unavailable (**REQUIRED**)

Date of Contact	Provider Name	Reason

Service Coordinator Signature _____ Date _____

CFC Program Manager Signature _____ Date _____

Section 3: Checklist of Required Attachments

For Direct Service Provider:	For Interpreter/Translator:
<input type="checkbox"/> Copy of qualifying license, certification or credentialing	<input type="checkbox"/> Language _____
<input type="checkbox"/> Signed copy of current W-9 form	<input type="checkbox"/> Signed copy of current W-9 form

****CFC MUST SUBMIT FORM AND ATTACHMENTS TO THE BUREAU'S PROVISIONAL COORDINATOR FOR DECISION****

Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, the Family Educational Rights and Privacy Act, 20 USC 1232g, and the Health Insurance Portability and Accountability Act of 1996, information collected hereunder may not be redisclosed unless the person who consented to this disclosure specifically consents to such redisclosure or the redisclosure is allowed by law.