Aging and Disability Services Division
Provider Services Application
Nevada Early Intervention Services (NEIS) & Autism Treatment Assistance Program (ATAP)
ATTACHMENT EE

*All questions must be completed by **all providers** unless otherwise marked. **Attach additional sheets** if necessary to answer each question completely. Each additional sheet must display the **relevant question number** from the Application and must be **signed by the provider** or authorized representative.*

Application Type *(Circle one)*: ***New*** ***Renewal/Adding*** *services to an existing agreement* ***Ownership Change*** *(fill out new vendor registration with the* Nevada State Controller's Office *and contact Aging & Disability Services Division for additional "Assignment of Provider Amendment" form*

Indicate below which services you are enrolling to provide for:
Nevada Early Intervention Services (NEIS) or Autism Treatment Assistance Program (ATAP)

☐ Comprehensive Early Intervention Services (For All 16 Services)

For Individual Services, Circle Choices Below

☐ Therapy/Medical Services - Assistive Technology Services/Assistive Technology Devices, Audiology Services, Family Training/Counseling/Home Visits, Health Services, Medical Services *(for diagnostic only)*, Nursing Services, Nutrition Services, Occupational Therapy Services, Physical Therapy Services, Psychological Services, (including Intensive Behavioral Services) Service Coordination Services, Social Work Services, Special Instruction Services, Speech-Language Pathology, Transportation and Related Costs, Vision Services

☐ Medical Transcription Services

☐ Language Interpreter (Speech or Sign)

☐ Autism Treatment Assistance Program (ATAP*)
*ATAP providers *must* have a Board Certified Behavior Analyst or a Licensed Psychologist on staff

Section 1: General Information

1. Business owner (or individual provider) Name:
2. Provider Date of Birth *(for individual providers only)*:
3. Tax Identifier *(Federal Tax ID Number-list last four digits only)*:
4. Check the one box that most closely describes the entity that matches your business license:
   ☐ Individual Provider/Sole Proprietorship ☐ Hospital-based Physician ☐ Provider Group
   ☐ Partnership ☐ Limited Liability Partner ☐ Limited Liability Company ☐ Corporation
   ☐ Non-Profit ☐ Governmental Organization
5. Legal Name as Registered with the Internal Revenue Service (IRS):
6. Doing Business As:
7. Nevada Secretary of State Registered Name:
8. Nevada Secretary of State Issued Business ID :
9. Medicaid Provider Number, if applicable:

10. Physical location of the practice/business/facility. This must be a street address and NOT a post office box.

Address (Line 1):

Address (City, State, Zip and COUNTY):

Office Phone: Extension: E-mail Address:

Fax: TTY Phone:

Mailing Address if different from physical:

Address (Line 1):

Address (City, State, Zip and County):

11. Enter the following information for your professional license (s) that pertains to the service(s) you wish to provide.

Professional License Number:

Name of Issuing Licensing Board, State or Entity:

Professional License Number:

Name of Issuing Licensing Board, State or Entity:

Professional License Number:

Name of Issuing Licensing Board, State or Entity:

Section 2: Background Information and Disclosure

12. Have you or any owner, administrator, manager or employee ever been convicted of a misdemeanor, gross misdemeanor or felony? ☐ Yes ☐ No If yes, provide the following information for each conviction.

Name Used When Convicted: Date of Conviction:

Charges: Disposition:

Conditions of Parole/Probation:

Have you or any owner, administrator, manager or employee ever been placed on the Federal Office of Inspector General, Health and Human Service (OIG/HHS) exclusion list or otherwise been suspended or debarred from participation in Medicare, Medicaid, Title XVIII or Title XIX programs since the inception of these programs?

If yes, provide the following information related to the sanction.

Name Used When Sanctioned:

Provider ID Number(s): Group ID Number(s):

Sanction Effective Date: Reinstatement Date:

13. If you or any owner, administrator, manager or employee has had any professional, business or accreditation license/certificate denied, suspended, restricted or revoked, complete the following for each instance.

Denial/Suspension/Restriction/Revocation From and To Dates:

Explanation:

14. Are you or any owner, administrator, manager or employee, a state current employee or state former employee within the last two years? If yes, complete the following:

Individual's Name: Dates of Employment:

Agency of Employment: Title:

Declaration – For All Providers

I declare under penalty of perjury under the laws of the State of Nevada that the information in **this document and any attachments are true, accurate and complete** to the best of my knowledge and belief. I declare that I have the authority to legally bind the provider(s) listed on this Application. I understand that Aging and Disability Services Division (ADSD) will rely on this information in entering into or continuing a Service Provider Agreement and that this form will be incorporated into and become a part of my ADSD Service Provider Agreement.

I understand that I am required to **notify ADSD within five days** of changes to information on this Application. I understand that **I am responsible for the presentation of true, accurate and complete information on all invoices/claims** submitted. I further understand that payment and satisfaction of these claims will be from Federal and State funds and that false claims, statements, documents or concealment of material facts may be prosecuted under applicable Federal and State laws.

Use dark blue or black ink only. This Application and corresponding contract must be dated within the last 60 days. The person signing below is the *(check all that apply)*: ☐ Provider ☐ Authorized Administrator ☐ Business Owner

Signature: Date:

Print Name:

Return completed agreement to Aging and Disability Services Division located at:

3416 Goni Road, D-132
Carson City, Nevada 89706
Phone: 775-687-4210

Internal Use Only: Status of Approval

Comprehensive Early Intervention Services (All 16 Services) ☐Yes ☐ No

Therapy/Medical Services *(Circle approved services)*
Assistive Technology, Audiology, Family Training/Counseling/home visits, Health, Medical, Nursing, Nutrition, Occupational, Physical, Psychological, Service Coordination, Social Work, Special Instruction, Speech-Language Pathology, Transportation and Related Costs, Vision.

Medical Transcription Services ☐Yes ☐ No Language Interpreter (Speech or Sign) ☐Yes ☐ No

Autism Treatment Assistance Program (ATAP) ☐Yes ☐ No