



**Terms and Conditions of Approval as a Provider in the
CMS/Early Steps Provider Management System**

I agree to the following terms and condition:

1. Once I am an approved provider in the CMS/Early Steps Provider Management system, I am eligible to provide services in the Early Steps system through a provider agreement with a Local Early Steps (LES).
2. A Local Early Steps is under no obligation to employ or contract with me based solely on the fact that I am approved in the CMS/Early Steps Provider Management System.
3. I am required to immediately notify the Early Steps Provider Enrollment Specialist of any changes in my application

As an approved provider, that is employed or contracted with a Local Early Steps, I am required to:

1. Be knowledgeable of and abide by all applicable federal, state, and local laws, rules, regulations, and policies as set forth in the Early Steps Policy and Guidance documents.
2. Maintain accurate clinical records for a period of at least five years from discharge from services, and to make available to Early Steps all records and information necessary to assure the appropriateness of payments and to assure the proper administration of Early Steps and to assure compliance with all applicable statutes and regulations.
3. Continually meet and maintain all applicable and necessary standards and regulations for licensing, credentialing, program licensure, and funding requirements for services provided.
4. Provide services to eligible children and their families as set forth in the IFSP.
5. Participate in IFSP face-to-face meetings and conference calls and communicate on a frequent basis with families and other team members.
6. Make records available, as requested, for local and state quality assurance activities.
7. Ensure services are family centered, inclusive, culturally competent, and that family members are an integral part of the service planning, implementation and on-going assessment.

I agree with these terms and conditions and certify that the documentation/records that I have mailed are accurate. I further understand that falsification of any documentation/records can result in immediate termination of my application.

Please print your name: _____

Signature: _____ Date: _____

Please print your Email Address: _____

The following information is required to process your application:

Your Social Security # ___ - ___ - ___

Employer/ Agency Name: _____

Employer/ Agency Address: _____
