Kentucky Early Intervention System
Enrollment Application

General Information

A. Agency Identification (Please print)

Agency Name	**Agency Administrator Name**	
Agency Administrator Email	**Agency Administrator Provide Services? Y/N** (If yes, please list on page 3)	
Billing Contact Name and Email (if different from above)	**Billing Contact Provide Services? Y/N** (If yes, please list on page 3)	
Mailing Address		
Physical Address (If different from Mailing Address)		
City	**State**	**Zip** (Must include the 4 digit extension)
Telephone ( )	**Referral Number** ( )	**Fax Number** ( )
Agency Federal Tax ID #	**Agency NPI #:** (this is the number associated with your Federal Tax ID#)	
Tax Status (Check One) __Individual __Sole Proprietorship __Partnership __Estate/Trust __Corporation __Public Service Corp. __Government/Not for Profit		

B. Subcontracting

Do you intend to subcontract any part of the early intervention services the agency will provide?
___ Yes ___ No

If "Yes", a copy of the subcontract must be submitted with the signed application for prior approval.

C. Insurance

Please list all insurance companies with whom the agency is in-network

Insurance Company	

Are you enrolled in TIBS? ___ Yes ___ No

Certification

I, the undersigned, hereby certify under penalty of perjury that I am duly authorized to subscribe and submit this application and that the information contained herein and attached hereto is accurate, true and complete. I further acknowledge that the application will be processed pursuant to the provisions of 902 KAR 30.150.

Per 34 C.F.R. §303.415 (d) Each participating early intervention service provider or agency must maintain, for public inspection, a current listing of the names and positions of those employees within the agency who may have access to personally identifiable information.

_____	_____
Signature	Date
_____	_____
Print or Type Name	Title

Please mail completed forms to:
Provider Enrollment Coordinator, Kentucky Early Intervention System, 275 East Main Street, HS2W-C, Frankfort, KY 40621.

Agency Name: _____ **Date: _____**

(This list must include all individuals who have access to TOTS)

Employee or Subcontractor (E or S)	**Name**	**Email Address** All individuals must have a separate, functional email address listed	**Individual Provider NPI#**	**Service Provider Type** (ex: SLP, OT, PT, DI, PLE)	**Cell Phone** (Optional)

This form must be attached with the agency application.