



**NASSAU COUNTY DEPARTMENT OF HEALTH  
PRESCHOOL PROVIDER CONTRACT REQUEST DATA SHEET**

The accuracy of the Preschool Special Education Provider List is absolutely essential to the delivery of services. It is important to carefully check off the specific services you or your agency actually provide on page 5. As part of Quality Management, we ask your cooperation in completing the following and returning promptly. Please print the information clearly.

Section A

**Contract type requested** (check off one box only):

- A)  Individual – sole practitioner, will **NOT** have employees and/or sub-contractors
- B)  Agency - Related Service Only– have employees and/or sub-contractors **OR** may have in the future
- C)  Agency - Related Services **and** NYSED approved 4410 (must submit approval letter from NYSED)
- Multidisciplinary Evaluations
- SEIT
- Center Based Program
- Related Services
- D)  NYSED approved 4410 service(s) **only** (must submit approval letter from NYSED)
- Multidisciplinary Evaluations
- SEIT
- Center Based Program

Section B

**Vendor Registration Required**

Registration as County Vendor is required for all individuals and/or agencies wishing to contract with the Nassau County Department of Health. Use the link below to register as a Nassau County Vendor and complete the relevant information and disclosures. There is no fee to register you or your agency as a vendor.

<https://apex5.nassaucountyny.gov/ords/f?p=CEVM:VREG>

Enter your FEIN/TIN/SSN: \_\_\_\_\_

**Notice: If you do not register as a Nassau County Vendor and upload all of the required documents your request for a contract will not be processed!**

Section C

**A Contract Type - Individual Contractor's Name** as it will appear on the contract:

\_\_\_\_\_

NPI # \_\_\_\_\_ New York State License # \_\_\_\_\_

**B, C, or D Contract Type - Agency Contractor's Name:**

\_\_\_\_\_

DBA Name: \_\_\_\_\_

Agency's NPI # \_\_\_\_\_

Agency Owner(s): \_\_\_\_\_

Agency Director: \_\_\_\_\_

#### Section D

Contractor's Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_

Street Address: \_\_\_\_\_  
(Cannot use a PO Box)

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

#### Section E

Please complete all sections below.

● **Entity status:**

- Individual – uses personal social security number for income reporting
- Privately owned corporation – uses TIN (Tax payer ID number) for income reporting
- NY State Not-for-Profit
- Publicly owned corporation
- "S" corporation
- "L" corporation
- PLLC
- Other \_\_\_\_\_

● **Non- Profit Status:**

- Not-for Profit - IRS tax exemption letter required  
     \_\_\_\_\_ NY State  
     \_\_\_\_\_ Out of NY State, \_\_\_\_\_
- For-Profit

#### Section F

**Number of preschool students receiving district authorized services from you, the individual provider or your agency in:**

2016-2017 school year \_\_\_\_\_

2017-2018 school year \_\_\_\_\_

2018-2019 school year \_\_\_\_\_

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 Section G

**Required for Justice Center Clearance**

All individual contractors or agency owner/directors must be cleared through the NYS Justice Center and the NYS Central Registry Database for Child Abuse prior to the contract being sent to you for execution.

**Note: The complete date of birth and social security number must be supplied or the Contract Request Data Sheet cannot be processed.**

Please complete the appropriate information below:

Individual Contractor's

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Or Alien Registration Number \_\_\_\_\_

Agency Owner's (list every owner's information in the blank space below if more than one owner)

Name: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Or Alien Registration Number \_\_\_\_\_

Agency Director's (list every director's information in the blank space below if more than one director)

Name: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Or Alien Registration Number \_\_\_\_\_

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 Section H

**Referral information:**

Accepts e-mail referral \_\_\_\_\_ yes or \_\_\_\_\_ no

E-mail referral address: \_\_\_\_\_

Referral phone number: \_\_\_\_\_

Referral Contact name: \_\_\_\_\_

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 Section I

**Clinical Program Records Location address:**

\_\_\_\_\_  
 \_\_\_\_\_

**Fiscal Records Address (if different from the contractor’s address) where books and records are maintained:**

\_\_\_\_\_

\_\_\_\_\_

Fiscal Contact Name and Title: \_\_\_\_\_

Fiscal Contact phone number: \_\_\_\_\_ Fax: \_\_\_\_\_

Fiscal Contact e-mail: \_\_\_\_\_

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Section J

Please note that the following are some of the conditions that will apply:

- 1) Tax Payer ID Form must be returned with this application.  
<https://www.nassaucountyny.gov/DocumentCenter/View/1272/700W9FORM-Fillable?bidId=>
- 2) Copies of the therapists’ licenses must be submitted with the completed contract for Related Service only providers.
- 3) All therapists must be cleared through The New York State Justice Center. Nassau will clear staff for non-Early Intervention or Related Service Only Providers. The name, date of birth, and social security number or alien registration number will be required to complete this clearance.  
<http://www.justicecenter.ny.gov/investigations-prosecution/sel/management>
- 4) All therapists and the agency owner/directors must be cleared through the NYS Central Registry Database for Child Abuse on or after March 01, 2020. Nassau County will clear the individual/independent contract applicants and agency owners/directors as part of the contracting process. Agencies will clear their staff and sub-contractors.
- 5) All therapists must be cleared (at a minimum) monthly by their agencies through:
  - o The United States Department of Health and Human Service’s Office of the Inspector General’s Lists of Excluded Individuals and Entities or any successor list (or any successor system), [HHS-OIG-Fraud Prevention & Detection - Exclusion Program - Search](https://www.hhs.gov/ohig/fraud-prevention-and-detection-exclusion-program-search)
  - o The New York State Department of Health’s Office of the Medicaid Inspector General’s list of Restricted, Terminated or Excluded Individuals or Entities (or any successor system), <http://www.omig.state.ny.us/fraud/medicaid-terminations-and-exclusions>
- 6) Center based providers must annually supply to the County and the Transportation Management Company the start and end dates of their programs and the start and end times for all classes **prior** to the transportation deadlines. Additionally, the center based providers must attest the start and end dates have been updated on the NYSED website.
- 7) Staff hired for and during the contract period is subject to these conditions.

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**INSURANCE REQUIREMENTS**

**The following three insurance requirements must be satisfied and uploaded to the Nassau County Vendor Portal prior to the County sending you a contract for execution.**

[https://apex5.nassaucountyny.gov/ords/f?p=312:LOGIN\\_DESKTOP:7193858574357::::](https://apex5.nassaucountyny.gov/ords/f?p=312:LOGIN_DESKTOP:7193858574357::::)

Please provide this information to your insurance agent.

- 1) **Commercial General Liability Insurance**, which policy shall name “Nassau County” as an additional insured and have a minimum single combined limit of liability of not less than \$1,000,000 per occurrence and \$2,000,000 aggregate coverage.

Certificate of Insurance must include the following in regard to General Liability:

- Description: The County of Nassau is named as an Additional Insured.
  - Certificate Holder: County of Nassau, 200 County Seat Drive, Mineola, NY 11501
- 2) **Professional Liability Insurance**, which policy shall have a minimum single combined limit liability of not less than \$1,000,000 per occurrence and \$2,000,000 aggregate coverage.
  - 3) **Workers’ Compensation Insurance**, compensation insurance for the benefit of the Contractor’s employees, which insurance is in compliance with the New York State Workers’ Compensation Law. In the event that the Contractor does not have any employees, a signed letter attesting to this must be provided to the County.

Failure to maintain current certificates of insurance on file with the County could result in the contract being terminated or delays in payment. Updated certificates should be mailed to the Department of Health, 200 County Seat Drive, Mineola, NY 11501 or faxed to (516) 227-7079.

## Section L

**Related Services Provided outside of a Center Based Program**

**Preschool Related Services at non-center based location – Complete if applicable for requested contract type A, B, or C.**

**Please indicate all services that will be provided during the contract period:**

- 1:1 Aide (non-Center Based)
- Certified Teacher Assistant
- Teacher Aide
- Audiology
- Coordination of Services -as a related service
- Occupational Therapy
- Orientation and Mobility
- Parent Counseling and Training (any Therapist)
- Physical Therapy
- Psychological Counseling Services (Social Work, Psychologist, Psychiatrist)
- School Health Service/ Nurse
  - Nurse RN
  - Nurse LPN
- School Social Work
- Speech Therapy
- Teacher of the Hearing Impaired
- Teacher of the Visually Impaired
- Assistive Technology Services

Section M

**Related Services – Complete if applicable for requested contract type A, B, or C. (continued)**

**Related Services Location of Service Provision:**

Check of all the locations at which services will be provided.

Child’s Preschool Setting

Child’s Home

Community Setting

Provider Office

**Related Service Providers requesting a contract must list *all* sites other than student’s home, regular education preschool or other community setting at which the provider, their employees and/or sub-contractors will provide preschool special education district authorized services.**

Office

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Attach an additional page if necessary.

Therapist’s Home Office (*Must submit Fire Marshal’s Certificate of Inspection and a Certificate of Occupancy for the home office.*)

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Specialties (please list)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Languages other than English (please specify by discipline)

\_\_\_\_\_  
\_\_\_\_\_

## Section N

**[ ] 4410 Multidisciplinary Evaluation Services - Complete if applicable for requested contract type C or D.**

Note: All NYSED approved 4410 agencies must submit their most current SED approval letters with this data sheet.

Please indicate all services which will be provided during the contract period:

**[ ] Specialty Evaluations in addition to the Multidisciplinary Evaluations (please specify)****[ ] Assistive Technology****[ ] Orientation and Mobility****[ ] Neurological****[ ] Neuropsychological****[ ] Psychiatric****[ ] Optometric****[ ] Other \_\_\_\_\_ See pages 8-11 of the link below:**

<http://www.oms.nysed.gov/stac/preschool/policy/eval3-4yr803.pdf>

List all Multidisciplinary Evaluation Site location(s) which will service Nassau County children below. Attach additional page if necessary.

This information must match your NYSED Approval Letter.

Location Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_

Contact Number: \_\_\_\_\_ FAX: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Languages other than English: \_\_\_\_\_



[ ] **4410 SEIT Services - Complete if applicable for requested contract type C or D.**

Note: All NYSED approved 4410 agencies must submit their most current SED approval letters with this data sheet.

List all SEIT Administration Site Location(s) which will service Nassau County children below. Attach additional page if necessary.

This information must agree with NYSED Approval Letter.

Location Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_

Contact Number: \_\_\_\_\_ FAX: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Languages other than English: \_\_\_\_\_

Center Based - **Complete if applicable for requested contract type C or D.**

Note: All NYSED approved 4410 agencies must submit their most current SED approval letters with this data sheet.

List all center based locations which will service Nassau County children below. Attach additional page if necessary.

This information must match your NYSED Approval Letter.

Special Class (SC)

Half Day  Full Day

Special Integrated Class (SCIS)

Half Day  Full Day

Other - Describe \_\_\_\_\_

Half Day  Full Day

Location Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_

Contact Number: \_\_\_\_\_ FAX: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Languages other than English: \_\_\_\_\_