**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 _____ 501 C 3

[ ] Publicly owned corporation

[ ] "S" corporation

[ ] "L" corporation

[ ] PLLC

[ ] Other_____

- **Non- Profit Status:**

[ ] Not-for Profit - IRS tax emption 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:**

2018-2019 school year _____

2019-2020 school year _____

2020-2021 school year _____

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 _____

Section H

**Referral information:**
Accepts e-mail referral _____ yes or _____ no

E-mail referral address: _____

Referral phone number: _____

Referral Contact name: _____

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: _____

---

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:
- 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
- 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)** ***All*** speech therapists and psychologists must be enrolled with Medicaid as an Ordering Referring, Prescribing or Attending (OPRA) provider. Here is the link to enroll: http://support.cpseportal.com/kb/a255/opra-enrollment-information-website.aspx

**8)** Staff hired for and during the contract period is subject to these conditions.

Name: _____ Title: _____

Signature: _____ Date: _____

Section K

## 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:::::

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 one million dollars ($1,000,000) per occurrence and two million dollars ($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 one million dollars ($1,000,000) per occurrence and two million dollars ($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 – <u>Complete if applicable for requested contract type A, B, or C.</u>**

**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 – <u>Complete if applicable for requested contract type A, B, or C.</u> (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 ***<u>all</u>*** 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 - <u>Complete if applicable for requested contract type C or D.</u>**

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: - <u>Complete if applicable for requested contract type C or D.</u>**

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 - <u>Complete if applicable for requested contract type C or D.</u>**

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: _____