



**ILLINOIS DEPARTMENT OF HUMAN SERVICES BUREAU  
OF EARLY INTERVENTION**

**EVALUATION/ASSESSMENT  
PORTFOLIO APPLICATION**

Name:	
Address:	
City:	
State:	Zip Code:
Phone #:	Fax #:
CFCs Serving:	Credential:

***Where should I send my portfolio?***

Send **TWO COPIES** of the following: this cover sheet and application packet components to:

**Provider Connections  
Western Illinois University  
1 University Circle  
Macomb, IL 61455**

**FAXES WILL NOT BE ACCEPTED**

Revised 2/2009

## EVALUATION/ASSESSMENT PORTFOLIO APPLICATION PACKAGE INSTRUCTIONS/CHECKLIST

In order to receive an Evaluation/Assessment credential you must (1) hold a current Illinois Early Intervention Credential, and (2) have attended the required Evaluation/Assessment for Early Intervention Training. Documentation of these two items should be included with this application.

Please identify application packet components by checking one or more in each category.

- 1) **Credential:** Copy of current Early Intervention Credential
  
- 2) **Evaluation/Assessment Provider Agreement:** All portfolio applications must include a signed agreement. The provider information requested in the form should be that of the applicant, unless a provider agency completes the form and includes the applicant's name on the form. If you provide services both for an agency and as an independent provider, you are only required to submit one Evaluation/Assessment Provider Agreement.
  
- 3) **Six months of pediatric (birth to age 18) post degree supervision:**  
Complete the Evaluation/Assessment Credential Experience Verification form, with the supervisor/program director verifying the number of months of pediatric post degree supervision. Documentation of six months experience is required. (The applicant may not sign the form for the supervisor/program director.) **OR**  
If a supervisor/program director is not available to sign the Evaluation/Assessment Credential Experience Verification form, the applicant must verify his/her pediatric post degree supervision, including the name of the supervising agency and the duration of the supervision, and the reason why a verification form cannot be signed by this agency (i.e., agency closed, agency no longer providing Early Intervention services, etc.).
  
- 4) **Experience within your credentialed discipline related to infants and toddlers between birth and three years of age:** Evaluation/Assessment Credential  
Complete the Experience Verification Form(s), for each place of employment where you provide(d) early intervention services, verifying the number of years of pediatric experience and experience related to infants and toddlers between birth and three years of age. Documentation of a minimum of three years (full time equivalent) pediatric experience within your credentialed discipline is required with no less than 20% of that experience related to infants and toddlers between birth and three years of age or the equivalent, with a minimum of one year (full time equivalent) pediatric experience within your credentialed discipline with no less than 60% related to infants and toddlers. **OR**  
A letter from a CFC manager that verifies the number of years (full time equivalent) experience you have in providing early intervention services within your credentialed discipline to families who live within the CFC agency's service area.

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- 5) **Documentation of the required Evaluation/Assessment Training** as offered through the Illinois Early Intervention Training Program. This training can be fulfilled by completion of the online & follow-up EI Systems Overview Training or Day 2 of the three-day EI Systems Overview Training.
- 6) **Three sample evaluation/assessment reports using the required Evaluation/Assessment Report Format.** These can be either initial or annual evaluation/assessment reports chosen by you and **conducted within the last six months.** All identifying information on the child should be marked out on the reports sent in with the portfolio.

Indicate in the following chart that you have or have not met all of the requirements of this application. **If required information is not included in the packet, the application will be automatically denied.**

Component		Criteria for Review	Yes	No
1	Current credential	Provided current Illinois EI Credential.		
2	Evaluation/Assessment Provider Agreement	Provided signed agreement		
3	Pediatric post degree supervised employment.	Documented at least six months pediatric post degree supervision		
4	Pediatric experience and experience related to infants and toddlers between birth and three years of age.	Documented a minimum of three years (full time equivalent) pediatric experience within your credentialed discipline related to infants and toddlers birth to three with no less than 20% of that experience related to infants and toddlers between birth and three years of age or the equivalent with a minimum of one year (full time equivalent) pediatric experience within your credentialed discipline, with no less than 60% related to infants and toddlers <b>OR</b> Provided a letter from the CFC Manager verifying number of years (full time equivalent) of experience within your credentialed discipline in providing services related to birth to three		
5	Documented required Eval/Assment Tng (All)	Provided documentation of completion of Systems Overview Day 2 or the Online and Follow-up Sessions of Systems Overview Training		
6	Samples of reports	Provided three evaluation/assessment reports		

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**EVALUATION/ASSESSMENT CREDENTIAL EXPERIENCE VERIFICATION FORM**

To document for evaluation/assessment early intervention credential:

- I) Number of months of pediatric (birth to age 18) post degree supervision **and**
- II) Pediatric experience and experience related to infants and toddlers between birth and three years of age within the applicant's credentialed discipline

**Please complete this form and have it signed by a supervisor or director of the agency where you have been employed or contracted with to provide early intervention services.**

Applicant Name:		SSN (last 4 only):
Employer Name:		Position:
Employer Address:		
City:	State:	Zip:

**Section I. Please provide a number of months of pediatric (birth to age 18) post degree supervision**

**(see instructions):**

\_\_\_\_ Number of **months** of pediatric post degree supervision. (The minimum to be documented is six months)

Supervised by: \_\_\_\_\_ Month/Yr Supervised: \_\_\_\_\_ - \_\_\_\_\_ Location: \_\_\_\_\_

**Section II. Please provide a number of years (full time equivalent) of pediatric & birth to three experience within the credential applicant's credentialed discipline (see instructions):**

\_\_\_\_ Number of **years** (full time equivalent) of pediatric experience within the applicant's credentialed discipline **and** \_\_\_\_\_% experience related to infants and toddlers between birth and three years of age

Supervised by: \_\_\_\_\_ Month/Yr Supervised: \_\_\_\_\_ - \_\_\_\_\_ Location: \_\_\_\_\_

**By signing below I hereby verify, based upon my personal knowledge, that the applicant completed the above required experience.**

\_\_\_\_\_  
Signature of Supervisor/Program Director

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Credential Applicant

\_\_\_\_\_  
Date

**Use a separate sheet to provide verification from each supervisor/program being used to document the required supervision verification components cited above**

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## **ADDITIONAL EVALUATOR/ASSESSMENT CREDENTIAL INFORMATION**

If you have attended the evaluation training and meet all of the defined qualifications, including evaluations that demonstrate sufficient quality and are consistent with Department guidelines, you will be issued a temporary Evaluator/Assessment credential for six months. (Applications for an Evaluator/Assessment credential will either be approved for a temporary credential or denied. No provisional credentials will be awarded.) With a temporary Evaluation Assessment credential, you may provide initial evaluations/assessments. To qualify for a full credential, you must submit for approval three initial evaluations that were completed after the date the temporary credential was issued.

The approved period for a provider's full evaluation/assessment credential will coincide with his/her discipline-specific credential. This ensures that individuals are not providing evaluations without a current discipline-specific credential.

**THE FOLLOWING ILLINOIS DEPARTMENT OF HUMAN SERVICES  
PROVIDER AGREEMENT FOR AUTHORIZATION TO PROVIDE  
EARLY INTERVENTION EVALUATIONS/ASSESSMENTS MUST BE  
COMPLETED AND RETURNED IN ITS ENTIRETY WITH  
THEEVALUATOR PORTFOLIO APPLICATION.**

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Revised 2/2009

**Illinois Department of Human Services  
Agreement for Authorization to Provide Early Intervention Evaluations/Assessments**

**Note:** The Payee shall type or print legibly all information except for the signature.

This Early Intervention Service Provider Agreement is entered into by and between the Illinois Department of Human Services (DHS) as the Lead Agency for the Illinois Early Intervention Services System and funder of the Early Intervention Program (EI) and.

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**Evaluator Name (required)**

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**Payee Name (required)**

**Purpose of Agreement:** The purpose of this Agreement is to establish the duties, expectations and relationship between DHS and the Provider who is credentialed to complete evaluations and assessments to eligible children and their families, and the Payee who is certified by the State of Illinois Comptroller to receive payment from the DHSCBO and who makes service(s) available to eligible children and their families and their families according to the Illinois Early Intervention Services System Act, 325 ILCS 20/5 et. seq. (the Act); Part C of the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. Section 1431 et seq.); the Health Insurance Portability and Accountability Act of 1996 (HIPAA); the Family Educational Rights to Privacy Act (FERPA) and its rules; and EI administrative rules, 89 Illinois Administrative Code 500 (Rule 500).

**Definition of Payee:** The Payee is the entity identified on the W-9 page of the Central Billing Office Enrollment Application under Business Name and Taxpayer Identification Number. The Payee may be an entity who employs providers or an independent with no employees (Payee as named above).

**Definition of Provider:** A person that actually completes evaluations and assessments to children and families on behalf of the Early Intervention Services System.

**Definition of Child and Family Connections (CFC):** The CFC is the system point of entry in a designated geographic region that is responsible for providing access to the Illinois Early Intervention Services System, for providing service coordination services, and for maintaining the child's permanent Early Intervention Record for referred and eligible children.

**Definition of Department of Human Services Central Billing Office (DHSCBO):** The DHSCBO is an entity designated by DHS for the processing of Early Intervention claims and for data collection.

In consideration of the Authorization to Bill DHS for the Provision of Services, the Payee and Provider Shall:

1. Not bill families directly for authorized early intervention evaluation/assessment services or for IFSP meetings.
2. Provide only those services for which the Payee/Provider has a written authorization in hand. The exception to this rule is the IFSP meeting. Providers will receive authorization for this meeting based upon attendance.
3. Not bill a family's insurance directly for authorized evaluation/assessment services, IFSP development, or implementation of procedural safeguards as delineated in 34 CFR 303.170

et.seq. as these services **must** be provided at public expense. The Payee may bill the DHSCBO for evaluation/assessment and IFSP development services.

4. Submit claims to the DHSCBO for IFSP Development only as defined in the Provider Handbook entitled *Early Intervention Service Description, Billing Codes and Rates*.
5. Submit claims to the DHSCBO at the Payee's usual and customary rates.
6. Submit legible claims to the DHSCBO on the CMS 1500 form or the UB04 form or an exact electronic facsimile of either form. Claim information must be **typed or submitted through electronic transfer**.
7. Not bill or accept reimbursement from the DHSCBO for services in excess of what has been authorized and identified on the child's IFSP. The Payee shall be fully liable for the truth, accuracy and completeness of all claims submitted to the DHSCBO for payment. Any submittals of false or fraudulent claims or concealment of a material fact may be prosecuted under applicable Federal and State laws.

Submit to the DHSCBO an invoice of charges for services no later than 90 days following the service delivery date. Claims **must** indicate the Provider who actually provided the services.

Resubmit a claim no less than sixty (60) calendar days from the original submission date of the claim. The resubmitted claim shall be stamped or otherwise marked to delineate that it is a **"RESUBMISSION"** or **"STATEMENT OF ACCOUNT"** and shall include only services documented on the original claim.

8. Participate in initial evaluation/assessment activities and the development of each child's IFSP for whom the Provider has completed initial evaluation/assessment activities as set forth in 34 CFR Part 303 and current DHS directives as delineated in writing. Associate level providers, including speech language pathologists who are completing their supervised professional experience, do not participate in the initial evaluation/assessment activities or the initial development of a child's IFSP.
9. Perform evaluation/assessments and present recommendations thereon, consistent with the "Principals of Early Intervention" and the early intervention philosophy, and provide adequate justification for service recommendations.
10. Understand that recommendations for goals, outcomes and strategies for services, with frequency, intensity and duration will be determined at the IFSP meeting in collaboration with each child's family based on their identified priorities. It is inappropriate for Providers to approach a child's family to discuss EI eligibility and/or recommendations for services prior to the IFSP meeting. Providers may discuss the results of evaluations/assessments only with families prior to the meeting.
11. Provide a report of findings to each child's service coordinator **in a format designated by DHS** that describes the tests/methods used in evaluation/assessment activities, the results of the test/method including a score and a typed narrative interpretation of the results.
12. Submit all evaluation/assessment reports to the service coordinator **within 14 calendar days of receipt of the request to perform evaluation/assessment**. The Payee shall also keep copies as part of the child's record.

13. Meet and maintain all applicable standards and regulations for staff and Provider licensure, certification and credentialing. Ensure that the Provider performing services under this agreement will have the skills to work with the children served and holds the appropriate EI credential prior to providing services.
14. Comply with all applicable laws and regulations for physical facilities in which services are made available.
15. Maintain accurate records, including daily documentation of services as required by the lead agency for a period of at least six years from the child's completion of EI services for each date of service billed, including IFSP time, and permit access to these records by the local CFC, DHS, or if they are Medicaid reimbursable services, the Illinois Department of Healthcare and Family Services (HFS) and the Centers for Medicare/Medicaid Services (CMS), or the United States Department of Education. In the absence of proper and complete documentation, no payments will be made and payments previously made will be recouped by DHS or HFS.
16. If there are outstanding audit exceptions, records shall be retained until such exceptions are closed out to the satisfaction of DHS. If there is active or pending legal action, records shall be retained until a written resolution is achieved. The Payee/Provider shall also be available, as required, for mediation, impartial administrative proceedings and/or other legal proceedings.
17. Complete the Medicaid enrollment application and bill the DHSCBO for covered services provided to Medicaid eligible children.
18. Provide routine monitoring and supervision activities as set forth by state licensure requirements and delineated in writing by DHS, including self-assessment, on-site monitoring, data collection and reporting obligation, record or chart audits, financial audits, complaint investigation, and consumer satisfaction surveys. Understand that these are administrative functions that are not billable to the DHSCBO.
19. Follow federal laws and regulations and state laws, policies, guidelines, directives and procedures regarding Early Intervention and services and other laws and regulations applicable to service providers hereunder (Example: State licensure laws).
20. Provide evaluations/assessments and communications regarding the evaluation/assessments to clients in a language or mode of communication understood by the child/family. If the Provider is unable to provide services and communications to the clients in a language or mode of communication understood by the child/family, the Payee shall notify the CFC and request an Interpreter.
21. Inform eligible families of their rights and procedural safeguards, including mediation and impartial administrative proceedings as delineated in 34 CFR 303.170 et. seq. and in Rule 500, and comply with those rights, and procedural safeguards.
22. Maintain liability insurance sufficient to cover any potential liability such as loss, damage, cost or expenses, including attorney's fees, arising from any act or negligence of the Payee or its employees/contractors.

23. Accept all children referred for evaluation/assessment without discrimination, including but not limited to children with public or private insurance coverage.
24. Participate in each IFSP Development meeting as a billable activity as specified in Rule 500 and 34 CFR Part 303.343 et. Seq. Participation in IFSP meetings is required.
25. Comply with HIPAA Standards 45 CFR Parts 160, 162 and 164 and any additional parts that may be finalized in the future, where applicable.
26. Not use or disclose protected health information except as allowed by the HIPAA Standards 45 CFR Parts 160 and 164, and not use or disclose EI records except as allowed by FERPA.
27. Comply with all applicable Federal and State laws, including the American Recovery and Reinvestment Act of 2009 and its reporting requirements.
28. Have access to the Internet, and monitor the Early Intervention/Provider Connections websites on a **weekly** basis for changes and/or updates that affect the functions of the Early Intervention Services System.

By signing this agreement the Payee certifies that each named evaluator/assessor:

1. Has a minimum of three years pediatric experience with no less than 20% of that experience related to infants and toddlers between birth and five years of age (or the equivalent).
2. Is not delinquent in paying a child support order as specified in Section 10-65 of the Illinois Administrative Procedure Act [5 ILCS 100/10-65];
3. Is not in default of an educational loan in accordance with Section 2 of the Education Loan Default Act [5 ILCS 385/2];
4. Has not served or completed a sentence for a conviction of any of the felonies set forth in 225 ILCS 46/25(a) and (b) within the preceding five years (see 30 ILCS 500/50-10);
5. Has not been indicated as a perpetrator of child abuse or neglect in an investigation by Illinois or another state for at least the previous five years;
6. Has competency in using and interpreting a variety of Department approved assessment tools related to their discipline; and
7. Has demonstrated past work as a team member and agrees to work with other evaluators.

In consideration of the performance of this Agreement, DHS shall:

1. Notify the Payee, a reasonable time in advance of implementation, of any changes in rules regulations, procedures, policies, directives and any other program guidelines that affect the Payee's performance of this Agreement. This notification may be via the DHS Early Intervention/Provider Connections Websites. Copies of DHS rules, policies, guidelines, directives, etc., can be obtained from the DHS Early Intervention Website ([www.dhs.state.il.us/ei](http://www.dhs.state.il.us/ei)) or the Provider Connections Website ([www.wiu.edu/providerconnections](http://www.wiu.edu/providerconnections)).

2. Reimburse the Payee for services rendered under this Agreement pursuant to the rates established for the covered services and only for those services pre-authorized in the Service Plan. DHS shall adjust future payment to a Payee who has been underpaid or offset payments to a Payee who has been overpaid.
3. Comply with HIPAA Standards 45 CFR Parts 160, 162 and 164 and any additional parts that may be finalized in the future, where applicable.

**Termination of this Agreement:** This agreement may be terminated by either party, in writing, without cause, with at least thirty (30) calendar days' prior written notice. This Agreement may be terminated by DHS at any time for failure by the Payee/Provider to perform any of the obligations and provisions set forth in this Agreement. This termination will be in writing, by DHS, and will specify the termination date.

**Confidentiality:** All records and other information obtained by the Payee/Provider concerning persons served under this Agreement are confidential pursuant to State and Federal statutes, Federal regulations and DHS administrative rules and shall be protected by the Payee/Provider from unauthorized disclosure.

**Liability:** DHS assumes no liability for actions of the Payee or its agents, employees or contractors under this Agreement. The Payee agrees to indemnify, hold harmless and defend DHS against any and all liability, loss, damage, costs or expenses including attorney's fees arising from intentional torts or any act or negligence of the Payee or its agents, employees or contractors, with the exception of acts performed in conformance with an explicit, written directive of DHS. The Payee agrees to maintain liability insurance sufficient to cover any potential liability.

**Right of Audit and Monitoring:** DHS maintains the right to inspect and audit any or all information or records in possession of the Payee/Provider that pertain to this Agreement. This right to audit extends to pertinent State and Federal officials, including the Department of Human Services, the Department of Healthcare and Family Services, federal auditors and the Office of the Auditor General of Illinois.

**Void:** This Agreement shall become null and void on the date that the Provider is no longer licensed to practice by the Illinois Department of Professional Regulation under the licensure upon which their credential was based, and/or on the date upon which the Provider ceases to participate in the Department of Healthcare and Family Services Medicaid vendor program.

**Miscellaneous:** This Agreement may be executed in any number of counterparts, each of which shall be deemed an original. All paragraph headings are for referral purposes only and shall not in any way affect the meaning or interpretation of this Agreement. Failure of DHS to enforce any provision of this Agreement shall not constitute a waiver of that provision by DHS.

**Entire Agreement:** DHS and the Payee understand and agree that this Agreement constitutes the entire agreement between them and that no promises, terms, or conditions not recited herein or incorporated herein or referenced herein, including prior agreements or oral discussions, shall be binding upon either the Payee or DHS.

**Laws of Illinois:** This Agreement shall be governed and construed in accordance with the laws of the State of Illinois and all subsequent amendments.

**Notice:** Notices under this Agreement regarding termination will be in writing and will be deemed to have been given when delivered by hand, U.S. Postal Service, messenger service, or overnight delivery service to the address below or such other address as DHS shall specify in a written notice to the Payee/Provider or post on the DHS Website ([www.dhs.state.il.us/ei](http://www.dhs.state.il.us/ei))

**DEPARTMENT OF HUMAN SERVICES:**

**PAYEE INFORMATION:**

**(Please, mail your completed application to Provider Connections)**

Name: Janet D. Gully  
Title: Chief, Bureau of Early Intervention  
Address: 222 S. College, 2<sup>nd</sup> Floor  
Springfield, IL 62704

Payee Name: \_\_\_\_\_  
Payee Representative Name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Phone #: \_\_\_\_\_  
Payee Tax ID #: \_\_\_\_\_

**Taxpayer Certification:** Under penalties of perjury, the Payee representative certifies that the Social Security Number or Federal Taxpayer Identification Number (FEIN) is correct. The entity identified as the "Payee" is doing business as:

- Individual
- Owner of Sole Proprietorship
- Partnership
- Tax-exempt hospital or extended care facility or trust
- Government Entity
- Corporation providing or billing medical and/or health care services
- Corporation NOT providing or billing medical and/or health care services
- Trust or Estate
- Foreign corporation, partnership or estate
- Not-for-Profit Corporation
- Other: \_\_\_\_\_

**Severability:** If any provision of this Agreement is declared invalid, its other provisions shall not be affected thereby.

**Signature Authority/Execution:** The signature of all who sign this Agreement on behalf of the Payee and DHS are required for Execution of this Agreement. Each signature has been made with complete and full authority to commit the party to all terms and conditions of this Agreement, including each and every representation, certification and warranty contained herein. This Agreement becomes effective on the date the Secretary's signature is affixed to the Agreement.

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

Name of Payee Representative: \_\_\_\_\_

Payee Representative Signature: X \_\_\_\_\_ Date: \_\_\_\_\_

**Illinois Department of Human Services**

Printed Name: Michelle R.B. Saddler, Secretary

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