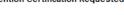
Enter your first, m	niddle, and last names as they appear on	your license/certification		
First Name		Primary Phone		
Middle Name		Alternate Phone		
Last Name		Confidential Fax		
Preferred Name		Email		
Mailing Address				
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			Save Cancel	
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Disciplines (🕂)				
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Occupational The	erapist Qualifications Delete			
Qualifications (+)		No. 1 . 1 . 1 . 1 . 1 . 1 . 1 . 1 . 1 . 1		
Qualification	Licensure as Occupational Therapist by th Licensure as Occupational Therapist by th	ne Virginia Board of Medicine		
License Number				
Expiration Date				
		Save Qualification Cancel		
ARLY INTERVENT	TION CERTIFICATION APPLICATION	_		
arly Intervention Cer	tification Requested ()			
Certification Type	,,]		
	Select a Certification Type Early Intervention Professional			
		_		
	Next Cancel]		
		~		

Early Intervention Certification Requested (+)



Certification Type

Initial Early Intervention Professional 1 Requirements Delete

Required Continued Education Activities

	Training	Date Competency Test Passed
Edit	Child Development	01/01/2009
Edit	Family Centered Services	01/01/2009
Edit	Service Pathway	01/01/2009
Edit	Practitioner Requirements	01/01/2009

Next Cancel

Assurances

	No Y	/es
I have read, understand and agree to abide by Part C Regulations and Virginia Part C requirements including the Infant & Toddler Connection of Virginia Practice Manual.	0	0
I understand that I may not, and agree that I will not provide early intervention services in Virginia until I have been notified that my application for certification has been approved by the Infant & Toddler Connection of Virginia.		0
understand that I must coordinate early intervention services I provide with each child's service coordinator/IFSP team.	0	
understand that I must establish a contract or otherwise arrange for services with a local lead agency if necessary to allow for exchange of Part C funds, unless I am an employee or contractor with a provider agency that contracts with or otherwise arranges for services with a local lead agency as necessary for exchange of Part C Funds.	•	(
understand that I must provide to the Part C System (Local Lead Agency or State Lead Agency) revenue information and other data required by he Part C System for children within the Part C system for whom I provide services (unless I am an employee or contracted with a provider agency hat provides this information for me to the Part C System).	0	(
understand that Part C funds are used only as "payor of last resort" and to meet this requirement, services must be provided by providers in the family's payor network unless there are no available providers in their network.		(
The information I have provided is complete and accurate.		((

Acknowledgements

I understand that I must retain documentation of my successful completion of the training requirements for this certification until the issuance of my renewal certification.

I understand that in order to bill Medicaid and other third party payors I must complete the application process required by Medicaid and other third party payors or establish a relationship with an agency that will do the billing for my services.

I understand that once I am certified as a practitioner for the Infant & Toddler Connection of Virginia, my name, credentials, business contact information, locations served, general work schedule, and professional areas of interest and expertise will be made public.

I understand the early intervention rate incorporates the total cost of providing the face-to-face service including travel time and costs, documentation, supervision, training, billing, and support staff time, in addition to the personnel costs for the individual providing the direct service.

Practitioner Signature Signature Signature Signature

A typed signature serves as an electronic signature and will be accepted as a valid and binding signature.

Previous

Submit

Cancel