



Missouri First Steps Service Provider Enrollment Checklist

PLEASE WRITE LEGIBLY, IN BLACK OR BLUE INK, AND DO NOT USE HIGHLIGHTER.

✓ Indicate with a check on the line provided if item is included in the packet.

Part I: Payee Checklist. (Applicable to individual providers and agencies)

NOTE: Individuals who work for an agency do not need to submit these items. The agency will complete these forms. If you are an independent provider, you need to submit these items upon enrollment.

- ___ Completed and signed First Steps Service Provider Agreement (*one per payee*)
- ___ W-9 Request for Taxpayer Identification Number and Certification (*one per payee*)
- ___ Proof of professional liability (copy of insurance certificate) for each payee AND/OR for each employee if professional liability is not covered by the payee. Not applicable for ABA implementers.
- ___ EFT/Direct Deposit form and voided or cancelled check (*This cannot be faxed, original signature needed.*)

Part II: Provider Checklist. (Applicable to every provider, including individuals who work as private providers and individuals who work for a provider agency)

- ___ Completed and signed First Steps Service Provider Agreement for each individual provider
- ___ Completed and signed Provider Information Form for each individual provider
- ___ Applicable License, Transcript, High School Diploma or equivalent to assure minimum entry level standard according to the credential requirement
- ___ Module I: Orientation completed. Please print final score and send with packet and/or send the date completed.
- ___ Certification regarding Lobbying, Debarment, Suspension and Other Responsibility Matters and Drug-Free Workplace
- ___ Family Care Safety Registry – Worker Registration for each provider
- ___ Criminal Background Check/Fingerprinting submitted to DESE/Educator Certification/Conduct and Investigations Background Check
- ___ Online Access Forms (*cannot be faxed, original signature needed*)
 - ___ Certification for Online Claims
 - ___ Electronic Signature
 - ___ User Online Access Request
- ___ Medicaid / Medicare Provider Information Form **only for Assistive Technology, Audiologist, Counselor, Dietician, Nurse (RN and LPN), OT, PT, SLP, Optometrist, Ophthalmologist, Physician, Psychologist, and Social Worker.**

PLEASE SUBMIT ALL APPLICABLE ITEMS LISTED ABOVE ALONG WITH A COPY OF THIS COMPLETED CHECKLIST TO:

Provider Enrollment/CSC Attn: Missouri Provider Enrollment
PO Box 29134
Shawnee Mission, KS 66201-9134

**For questions please contact Provider Enrollment at 1-866-711-2573 ext. 2
or email at: mofsenroll@csc.com**