



**FIRST STEPS SERVICE PROVIDER INFORMATION FORM**

**CFO Provider Enrollment**  
**P. O. Box 29134**  
**Shawnee Mission, KS 66201-9134**

Phone: 866-711-2573 ext. 2

Fax: 913-888-6683

Email: [mofsenroll@csc.com](mailto:mofsenroll@csc.com)

A completed form is required to enroll in First Steps as a service provider, or to change current enrollment information. If you are enrolled with the CFO, please provide the information currently on file. After completion, please keep a copy for your records, and return the form to the Central Finance Office (CFO) Provider Enrollment.

**PAYEE INFORMATION – PLEASE PRINT**

*If you select a check box, then all fields in this section must be completed.*

**New Information**  **Change Information** (complete this section using the current information on file with the CFO)

Payee Federal Tax ID Number: \_\_\_\_\_ Payee/Agency Name: \_\_\_\_\_

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

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

Phone Number: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Primary Contact for Questions: \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_

**PROVIDER INFORMATION – PLEASE PRINT**

*If you select a check box, then all fields in this section must be completed.*

**New Information**  **Change Information**  **Change Name** Previous name: \_\_\_\_\_

**End Account** Last date of work: \_\_\_\_\_

Provider First Name: \_\_\_\_\_ M: \_\_\_\_\_ Last Name: \_\_\_\_\_

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

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

Work Email Address: \_\_\_\_\_ SSN:\*

Phone: ( ) \_\_\_\_\_ EXT: \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

\*SSN is used for initial identification verification purposes only.

**EARLY INTERVENTION DISCIPLINE – CHECK ALL THAT APPLY**

<input type="checkbox"/>	ABA Consultant	<input type="checkbox"/>	Occupational Therapy Assistant (COTA) Certified	<input type="checkbox"/>	Psychologist
<input type="checkbox"/>	ABA Implementer	<input type="checkbox"/>	Ophthalmologist	<input type="checkbox"/>	Social Worker
<input type="checkbox"/>	Assistive Technology Provider	<input type="checkbox"/>	Optometrist	<input type="checkbox"/>	Special Instructor
<input type="checkbox"/>	Audiologist	<input type="checkbox"/>	Orientation/Mobility Specialist	<input type="checkbox"/>	Special Instructor – Hearing Impairment
<input type="checkbox"/>	Counselor	<input type="checkbox"/>	Para Professional In Early Intervention	<input type="checkbox"/>	Special Instructor – Visual Impairment
<input type="checkbox"/>	Dietitian	<input type="checkbox"/>	Parent Advisor for Hearing Impairments	<input type="checkbox"/>	Speech Language Pathologist
<input type="checkbox"/>	Interpreter for the Deaf	<input type="checkbox"/>	Parent Advisor for Visual Impairments	<input type="checkbox"/>	Speech Language Pathologist Assistant (SLPA)
<input type="checkbox"/>	Nurse (Licensed Practical Nurse)	<input type="checkbox"/>	Physical Therapist	<input type="checkbox"/>	Translator
<input type="checkbox"/>	Nurse (Registered)	<input type="checkbox"/>	Physical Therapy Assistant (PTA)	<input type="checkbox"/>	Transportation Provider
<input type="checkbox"/>	Occupational Therapist	<input type="checkbox"/>	Physician	<input type="checkbox"/>	<b>Other:</b> SPOE as Provider

First Steps services cannot be provided until the provider's name is listed on the Service Matrix at: <http://missouri.eikids.com>. The date enrollment information is received and processed at the CFO will determine the effective date of the provider's status. Status will be updated upon the receipt of completed paperwork. By signing the Provider Information Form, the provider agrees to be enrolled in First Steps and be published on the Service Matrix.

**NOTE 1:** A change in status (i.e. from assistant to specialist level) requires supporting documentation such as transcripts or licensure.

**NOTE 2:** A change in payee name or individual provider name requires an updated W-9 form to be submitted.

**Provider Signature** \_\_\_\_\_ **Date** \_\_\_\_\_