



**SAMPLE**

State of Hawai'i Department of Health  
Early Intervention Section  
1010 Richards Street, #800 • Honolulu • HI • 96813  
**AUTHORIZATION FOR SERVICES**

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex: F  M   
Last First MM/DD/YY

Condition/Diagnosis: \_\_\_\_\_ ICD Code: \_\_\_\_\_ EI-ID #: \_\_\_\_\_

Mileage from Program to Service Location: \_\_\_\_\_ (one way) Audiology Only: Screening Results: \_\_\_\_\_

Type of Service Needed: (Check only <u>one</u> service)		Frequency/Intensity:
<input type="checkbox"/> Audiology	<input type="checkbox"/> Psychology (IBS IC) *	Behavior Strategies: _____
<input type="checkbox"/> Nutrition	<input type="checkbox"/> Psychology (IBS ST)*	Consultation: _____
<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Speech Language Pathology	Evaluation**:
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Transportation	Hearing Aid Related:
<input type="checkbox"/> Psychology (NON IBS)	<input type="checkbox"/> Other: _____	Treatment: _____
*Name of EIS BSS Staff: _____		Meeting***: _____
**Evaluation Consent on file: <input type="checkbox"/> Yes <input type="checkbox"/> No		***Specify Meeting: _____

Service to be provided by: (Use FFS provider list)

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

Attn. (therapist): \_\_\_\_\_

Consent to bill (check all that apply): Private Insurance/Other  Yes  No Medicaid/Quest  Yes  No

Provider to bill: (EIS TO COMPLETE)  Private Insurance/Other  EIS  Medicaid/Quest

Physician: \_\_\_\_\_ Insurance: \_\_\_\_\_

Care Coordinator	Phone	Program Name	Fax #	AFS Request Date
Date and Comments about services/changes in services and/or frequency/intensity: (include effective date)				Auth. Init.

	<u>Authorized Signature</u>	<u>Authorization #</u>	<u>Begin Date</u>	<u>End Date</u>	<u>*Rep.</u>	<u>*Srv. Log</u>
Authorized:	_____	_____	_____	_____		
Re-authorized:	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Re-authorized:	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Re-authorized:	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

\*CC must check off that Quarterly Report AND Service Log have been received prior to Re-Authorization.



(Use Provider's Letterhead with Provider's dba and Remittance Address)

**SAMPLE**

**INVOICE FOR SERVICES**

DATE: August 1, 2017

TO: Early Intervention Section  
1010 Richards Street, Suite 800  
Honolulu, HI 96813  
Attention: AFS Payments

SERVICE: OT, PT, Speech/Language Pathology

RATE: \$ 45 /Hour (rate per contract); or \$11.25 /Unit (1 Unit = 15 Minutes)

ISLAND: Oahu

SERVICE MONTH: July 2017

						Time of Service		
Name of Child	AFS No.	Date	Service Provided	Service Location	Provider Initials	Hours	Hourly Rate	Total Cost Per Child
Kalani North	001200	07-02	PT Eval	H		1.00	\$ 45.00	\$ 45.00
"	002222	07-02	OT Tx	H		.75	\$ 45.00	\$ 33.75
<b>Subtotal:</b>								<b>\$78.75</b>
Susan South	001112	07-02	PT Tx	H		.75	\$ 45.00	\$ 33.75
"	001113	07-16	SLP Tx	H		1.00	\$ 45.00	\$ 45.00
"	001119	07-25	SLP IFSP Mtg	O		.50	\$ 45.00	\$ 22.50
<b>Subtotal:</b>								<b>\$101.25</b>
Amy East	005678	07-02	PT Tx	H		1.00	\$ 45.00	\$ 45.00
<b>Subtotal:</b>								<b>\$45.00</b>
<b>Grand Total:</b>								<b>\$ 225.00</b>

I, the undersigned, am an authorized signatory for the above named provider and certify that this invoice is accurate, complete, and truthful to the best of my knowledge. I hereby certify that this is an original invoice and signature (blue ink).

Original Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Name) (Title)

Notes: Refer to contract for authorized rates and charges.

1. If you are contracted for multiple service disciplines (e.g. OT, PT, SLP), please specify the discipline and activity rendered.
2. Location of Activity – The table below lists the allowable codes:  
H = Home  
C = Community / Child Care Center / Preschool / Community Playgroup  
O = Other place of service (non-natural environment, e.g., at the program office)
3. Provider initials - the rendering provider's initials must be included on the invoice. Please refer to the Personnel List.

**SAMPLE**

(Use Letterhead with Provider's dba and Remittance Address)

**INVOICE FOR  
MILEAGE CHARGES**

DATE: August 1, 2017

TO: Early Intervention Section  
1010 Richards Street, Suite 800  
Honolulu, HI 96813  
Attention: AFS Payments

MILEAGE RATE: \$ 0.50 /Mile (rate per contract)

ISLAND: Oahu

SERVICE MONTH: July 2017

				Authorized Mileage			
Name of Child	AFS No.	Date	Activity	From Program Name/ Previous Address	To (Address)	Miles	Cost
Kalani North	001200	7-2	PT Eval	East Sultan	1234 Kapahulu	1.5	\$ 0.75
"	002222	7-2	OT Tx	East Sultan	1234 Kapahulu	1.5	\$ 0.75
"	002222	7-2	Return	1234 Kapahulu	East Sultan	1.5	\$ 0.75
<b>Subtotal:</b>							<b>\$ 2.25</b>
Susan South	001112	7-2	PT Tx	Lanakila ECSP	444 Ala Mahamoe	4.0	\$ 2.00
"	001113	7-16	SLP Tx	Lanakila	444 Ala Mahamoe	4.0	\$ 2.00
"	001113	7-16	Return	444 Ala Mahamoe	Lanakila	4.0	\$ 2.00
<b>Subtotal:</b>							<b>\$ 6.00</b>
Amy East	005678	7-2	PT Tx	444 Ala Mahamoe	1111 Likini	3.0	\$ 1.50
"	005678	7-2	return	1111 Likini	UCP	5.	\$ 2.50
<b>Subtotal:</b>							<b>\$ 4.00</b>
<b>Total Mileage Cost:</b>							<b>\$ 12.25</b>

I, the undersigned, am an authorized signatory for the above named provider and certify that this invoice is accurate, complete, and truthful to the best of my knowledge. I hereby certify that this is an original invoice and signature (blue ink).

Original Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Name) (Title)

**SAMPLE**

**Notes:**

1. Provider is contracted for the Honolulu area.
2. On 7-2, provider (PT) has back-to-back appointments. Provider goes to 1<sup>st</sup> appt. at 1234 Kapahulu Ave (mileage from East Sultan), then to 2<sup>nd</sup> appt. at 444 Ala Mahamoe (mileage from Lanakila ECSP), then to 3<sup>rd</sup> appt. at 1111 Likini (mileage from 2<sup>nd</sup> appt. closer than from requesting program - UCP), and finally the return mileage at the end of the day. See Table 1 below for further edification on back-to-back appointments.
3. Authorized mileage shall be from the requesting program's location (refer to Mileage from Program to Service Location on AFS form) or last treatment location (whichever is the closest) to the next treatment location. After your last appt, you are allowed mileage back to the requesting program of your last appt.
4. If appointments are spread out during the day, and not back-to-back, or if there is only a single appointment, authorized mileage shall be from the requesting program's location to the next treatment location and the return back to requesting program prior to next appointment. For example, on 7-2, provider (OT) has only one appointment for the day so return mileage is listed.
5. If appointment is at the program, no mileage is authorized and therefore is not invoiced. For example, on 7- 25, IFSP meeting was at the program so no mileage is reported.

**TABLE 1**  
**Schedule for 07-01-17**

	<b>Location</b>	<b>Authorized Mileage per AFS</b>	<b>Invoiced Mileage</b>	<b>Notes</b>
1	1234 Kapahulu	1.5	1.5	From requesting program's location to treatment location
2	444 Ala Mahamoe	4.0	4.0	From requesting program's location to treatment location – closer than from <i>last treatment location</i>
3	1111 Likini	5.0	3.0	From last treatment location to next appt – closer than from <i>requesting program's location</i>
4	UCP	5.0	5.0	From last treatment location back to requesting program's location – <i>end of day</i>

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# Department of Health Early Intervention

## FEE-FOR-SERVICE PROVIDER QUARTERLY PROGRESS REPORT

IFSP Date: \_\_\_\_\_ Reporting Period (Months/Year): \_\_\_\_\_

The reporting period is according to the AFS quarters (i.e., Authorization period Jan. - March; Reporting Period is Dec - Feb; Report due Mar 15<sup>th</sup>; Subsequent Reporting Periods: Mar - May; Jun - Aug; Sept - Nov). Submit completed Progress Report to the Care Coordinator two weeks after the end of the quarter. Authorization for the next quarter will not be submitted until the Progress Report has been received by the Care Coordinator.

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Care Coordinator: \_\_\_\_\_ Program: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Service Provider: \_\_\_\_\_ Fax: \_\_\_\_\_

Agency/Program: \_\_\_\_\_ Phone: \_\_\_\_\_

NOTE:  CC has consent on file to send/receive via:  email  fax  
 CC does not have consent to e-mail/fax on file, send response via mail to Agency/Program address listed above.

Summarize progress during this reporting period: (copy the 3 lines and paste it as many times as needed. When typing, hit enter at the end of the line, it doesn't automatically wrap)

Obj. #: \_\_\_\_\_ Objective: \_\_\_\_\_  
Progress: \_\_\_\_\_

New issues and/or concerns: (e.g., attendance, change in family dynamics, illness)

**SAMPLE**

## Early Intervention Section Fee-for-Service Personnel List

ASO LOG No.: \_\_\_\_\_

Contractor: \_\_\_\_\_

The following is a list of those persons who will be rendering activities/services under the current contract with the State's Department of Health (DOH) Early Intervention Section (EIS).

#	Name	Discipline	Initials	License#/Certification#/Registration#
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

I, the undersigned, certify this information to be accurate, complete, and truthful to the best of my knowledge.

**Original Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### NOTES:

Name: Rendering direct services (provider's first and last name)

Discipline: OT = Occupational Therapist  
PT = Physical Therapist  
SLP = Speech Language Pathologist  
SPED = Special Educator  
GE = General Educator  
IC = Instructional Consultant  
ST = Skills Trainer  
Psy = Psychologist  
Other = Other (please specify)

**Initials: Please do not use duplicates**

License#/Certification: List **State (DCCA)** license #/Certification #/Registration #

- If **State (DCCA)** licensure/certification/registration exists and provider is not licensed/certified/registered, designate with "**None.**"
- If there is no State or national license/certification/registration for the discipline, designate with "**N/A.**"

**SAMPLE**

## VTM New Vendor Information Letter

*(Provider's ENTIRE LEGAL NAME, including dba)*  
*(Business Address, matching the address on the Certificate of Liability Insurance)*  
*(City, State, Zip Code)*

*(Date)*

Mae Braceros  
Early Intervention Section  
1010 Richards Street, Suite 800  
Honolulu, Hawaii 96813

RE: NEW VENDOR INFORMATION

Aloha Mae:

Here is the information you requested to set up my vendor code on FAMIS, for payment of my invoices for *(type of service providing)* services.

My SSN: *(###-##-####)*

Sincerely,

*(Provider's Signature)*

# **Attachment C**

## **Credentialing and Supervision Guidelines for Providers of Intensive Behavioral Support Services**

**CREDENTIALING AND SUPERVISION GUIDELINES FOR PROVIDERS OF INTENSIVE BEHAVIORAL SUPPORT SERVICES**

I. **Instructional Consultant:**

The Instructional Consultant (IC) is responsible for writing the Behavior Strategies Guide (BSG) (i.e., behavior plan) and ensuring its proper implementation by the Skills Trainer (ST), family and other members of the Individualized Family Support Plan (IFSP) team.

The IC shall be periodically observed by the EIS Behavior Support Service (BSS) staff and will engage in ongoing collaboration to confirm that methods of treatment, understanding of early childhood development, support and oversight of the ST, and collaboration with the team are appropriately demonstrated. If concerns with regard to the IC skills and abilities are identified, the BSS or the EIS Supervisor may request that the IC receive additional agency training and/or supervisory supports (at the provider's expense) until the concerns are rectified. Any concerns that cannot be rectified will result in removal of the IC from the case.

**Experience:** Unless otherwise indicated, the IC shall have direct or educational (e.g., practicum, student teaching, or similar hands-on) experience in the treatment of children (preferably ages one-to-five) with Autism Spectrum Disorders (ASD), or with significant impairments in communicating and relating, and/or social-emotional-behavioral functioning. The amount of experience required for each degree level is specified below. Exceptions can be considered on a case-by-case basis.

**Licensure and credentialing requirements:**

1. *Board Certified Behavior Analyst-Doctorate* (BCBA-D); or
2. *Board Certified Behavior Analyst* (BCBA); or
3. *Board Certified Assistant Behavior Analyst* (BCaBA).

II. **Skills Trainer:**

The ST is responsible for implementing direct treatment services under the direction of the IC.

**Credentialing requirements:**

1. *Registered Behavior Technician* (RBT); or
2. *Board Certified Assistant Behavior Analyst* (BCaBA).

# **Attachment D**

## **Guidelines for: Certificate of Insurance, Tax Clearance Certificate, and Notary**

## **Guidelines for Name, Certificate of Insurance, Tax Clearance Certificate, and Notary Public**

### **Name**

The name you choose to do business under must be consistent with **any and all required supporting documentation.**

**If your legal business name (vendor name) is “XYZ, Inc.”, then your application/proposal, liability insurance certificate/policies (including auto), tax clearance, etc., etc. must all be under the exact same name “XYZ, Inc.”**

**If your legal business name is “XYZ, Inc.” and you have a DBA (doing business as), then that must also be reflected on any and all documents.**

### **Certificate of Insurance (COI)– General Liability/Professional Liability and Auto Liability**

The policy amounts for the minimum coverage is as stated in the RFP. Currently, for general/professional liability it is ONE MILLION AND NO/100 DOLLARS (\$1,000,000.00) for bodily injury and property damage liability arising out of each occurrence and TWO MILLION AND NO/100 DOLLARS (\$2,000,000.00) aggregate. For auto liability, it is currently ONE MILLION DOLLARS AND NO/100 DOLLARS (\$1,000,000.00) per occurrence. **Do not forget the auto liability coverage as it is a recent requirement.**

The insurance shall be obtained from a company authorized by the law to issue such insurance in the State of Hawaii (or meet Section 431: 8-301, Hawaii Revised Statutes, if utilizing an insurance company not licensed by the State of Hawaii - see item 2. below).

The insurance coverage shall be primary and shall cover the insured for all work to be performed under the Contract, including changes, and all work performed incidental thereto or directly or indirectly connected therewith. The contractor shall maintain in effect this liability insurance until the State certifies that the contractor’s work under the contract has been completed satisfactorily.

Any insurance maintained by the State of Hawaii will apply in excess of, and not contribute with, insurance provided by the Contractor’s policy

#### **A. General Liability – additional requirements**

##### **1. Additional Insured**

- i. The certificate must have a Special Provision naming “Additional Insured” as per the following: “The State of Hawaii and its officers and employees are additional insured with respect to operations performed for the State of Hawaii.”**

B. Certificate/Memorandum Holder

1. **DOES NOT** refer to “Certificate Holder” or “Memorandum Holder” when describing the additional insured **unless** the Certificate Holder is identified as the State of Hawaii only, and not a subdivision thereof.
  - i. The certificate or memorandum holder shall be:

State of Hawaii Department of Health  
Administrative Services Office  
P.O. Box 3378  
Honolulu, HI 96801-3378

- C. The company issuing the policy **must** be licensed by the State of Hawaii. **If not**, then pursuant to HRS §431:8-301, the following must be stated on the certificate: “This insurance contract is issued by an insurer which is not licensed by the State of Hawaii and is not subject to its regulation or examination. If the insurer is found insolvent, claims under this contract are not covered by any guaranty fund of the State of Hawaii.”

D. Cancellation Provisions

1. The Contractor shall immediately provide written notice to the contracting department or agency should any of the insurance policies evidenced on its certificate of insurance forms be cancelled, limited in scope, or not renewed upon expiration.
2. If the scheduled expiration date of the insurance policy is earlier than the expiration date of the time of performance under the Contract, the Contractor, upon renewal of the policy, shall promptly cause to be provided to the State an updated certificate of insurance.

**Tax Clearance Certificate (TCC)**

- A. The form is available at: <http://www.hawaii.gov/tax/a6.pdf>. The document **MUST** have the **GREEN** Certified Copy Stamp, and have a State approval stamp and IRS approval stamp not more than 6 months from the effective date of agreement.
- B. If the provider is registered with **Hawaii Compliance Express (HCE)**, and current status is compliant, this **DOES NOT** apply.

**Notary Public**

There are new requirements that your Notary Public should already be aware of, but if not, please refer to the following Provider’s Acknowledgement page of a contract. The additional information required is highlighted in yellow.