RESET

Indiana First Steps
Annual Credential Form

Name:

This form and any required supporting documentation must be emailed, faxed, or mailed to the First Steps Central Reimbursement Office (CRO) at:
Indiana First Steps Provider Enrollment c/o CSC
P.O. Box 29160 | Shawnee Mission, KS 66201-9160
Email: infsenroll@dxc.com | Fax: 913-888-6683 | Phone: 1-866-339-9595 option 2

Annual credential checklist

- ☐ Annual credential form with signed attestation statement (page 3)
- ☐ Signed agreement with the Division of Disability and Rehabilitative Services (12 months current)
- ☐ Current limited criminal history from Indiana State Police (12 months current)
- ☐ National Provider Identifier (NPI) (required for all providers)
- ☐ Copy of license (licensed providers only)
- ☐ Liability insurance certificate (all providers)
- ☐ Copy of certification (if applicable; e.g. SKI-HI)
- ☐ Signed supervision agreement (page 2) (if applicable)

Role

☐ Service or intake coordinator	☐ Service provider	☐ Assessment/evaluation team
☐ Agency director	☐ SPOE director	

Prior Convictions

Have you ever been convicted* of a crime other than a minor traffic violation?

◯ Yes ◯ No

*Convicted means you were declared guilty by a judge or you pleaded guilty in a court of law.
Answering yes to this question does not automatically disqualify an individual from working in First Steps.

Personnel Information
This section is required.

☐ My information has changed since enrollment or initial credential.

Name

Email address

Previous name (if name change)

Phone

Discipline: Select one...

Second discipline*: Select one...

Professional license type*

License number*

License expiration*

Liability insurance agency

Ins. policy number

Ins. expiration

Current criminal history inquiry date

NPI number

*If applicable

Supervision Agreement
Required for COTA and PTA.
The supervising provider must sign this section and attach a copy of their license and First Steps credential.

☐ Supervisor's license attached ☐ Supervisor's First Steps credential attached

Supervisor's name

Supervisor's discipline

Supervisor's phone

Supervisor's email

Supervisor's license number

Supervisor's signature

Date

My Trainings

Duplicate this page as needed. 15 hours of professional development related to early intervention are required. Proof of training completion must be kept on file for a period of 7 years.

	DATE	TYPE OF TRAINING	HOURS	COMPETENCY AREA
1)		Select one...		Select one...
TITLE OF TRAINING:				
2)		Select one...		Select one...
TITLE OF TRAINING:				
3)		Select one...		Select one...
TITLE OF TRAINING:				
4)		Select one...		Select one...
TITLE OF TRAINING:				
5)		Select one...		Select one...
TITLE OF TRAINING:				
6)		Select one...		Select one...
TITLE OF TRAINING:				
7)		Select one...		Select one...
TITLE OF TRAINING:				
8)		Select one...		Select one...
TITLE OF TRAINING:				
9)		Select one...		Select one...
TITLE OF TRAINING:				
10)		Select one...		Select one...
TITLE OF TRAINING:				
		TOTAL HOURS:	0.00	

Attestation Statement: I hereby swear or affirm under penalty of disenrollment from First Steps that I understand and meet the requirements for providing First Steps services and that the information I am submitting is true and correct to the best of my knowledge.

Name (please print)_____

Signature_____ Date_____