Service Provider Rider

This document is attached to and incorporated into the Provider Agreement which is active and in force at the time of execution of this agreement for:

Individual Provider Name	Agency Name

Provider Services: The Provider has represented to the Department of Health and Hospitals (DHH) he/she possesses the ability to provide specific service(s) other than FSC services as defined in federal and state regulations, and the current LA Part C Federal Application ,certifying that he/she meets all current state credentialing and/or licensure requirements established as of the effective date of this Agreement.

1. The Provider will be held accountable for the following performance indicators.

Service Provider Performance Indicators

Number	Responsibility	Performance Indicators
1	Participate in the multidisciplinary team's assessment of a child and a child's family and in the development of strategies and outcomes for the IFSP and participate in the 6 month and annual IFSP.	Documentation on IFSP to verify participation.
2	Provide training to parents/caregivers on how to incorporate interventions into family routines.	Documentation to support parent/caregiver participation in the delivery of services on the monthly report
3	Consult with parents, service coordinators, other service providers, and representatives of appropriate community agencies to ensure the effective provision of services.	Documentation to support consultation with IFSP team members and others in delivery of services to individual children.
4	Delivery of services in accordance with the IFSP in a timely manner.	Percent of services delivered in accordance to IFSP as documented In monthly report in a timely manner.
5	Continuously collect data to determine child's developmental progress.	Documentation of child specific data regarding developmental Progress on the monthly report.
6	Provide appropriate levels of service based on child's developmental level, best practice guidelines and family concerns.	Average cost of services per child within acceptable range.

____Date: _____________________
Signature of Individual Provider

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Provider Name (Printed)

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Organization/Payee Name (Printed)