

## Louisiana Early Steps Online Access Enrollment Form

*Please keep a copy for your records*

Agency/Billing Entity Information				
If you are an enrolled provider with the CFO or have current online access, please provide the Billing Entity Information currently on file with the CFO. Sign and mail the completed form to: <b>Central Finance Office c/o CSC, P.O. Box 29134, Shawnee Mission, KS 66201-9134</b>				
Tax ID Number Agency/Billing Entity:			Agency Name:	
<b>Agency Administrator, SPOE Personnel or Independent Provider Information:</b>				
First Name:		Last Name:		Email:
Address:		City:	State:	Zip:
Phone:			Ext.	
<b>Primary Contact for Questions:</b>				
User Information				
<input type="checkbox"/> <b>New User Information:</b> Select One: <input type="checkbox"/> <b>Currently Enrolled EarlySteps Provider</b> <input type="checkbox"/> <b>Other User</b> <input type="checkbox"/> <b>New Enrollment</b>				
<input type="checkbox"/> <b>Change of Information:</b> Please indicate the type of change: <input type="checkbox"/> <b>Delete Online Access</b> <input type="checkbox"/> <b>Modify Online Access</b>				
User First and Last Name:			Email: Must be unique to user.	
Social Security Number (last 4 digits):		Phone:		Ext.
<b>User ID Selection:</b> Please submit two selections in case your first choice is not available.				
User ID: #1 _____ #2 _____				
For EIDS Access (skip if only seeking EarlySteps Online access)				
<b>Security Word:</b>				
<b>User Access Description</b> (Please select <u>one</u> of the following types):				
<input type="checkbox"/> Independent Provider/Provider Administrator <input type="checkbox"/> Agency Administrator <input type="checkbox"/> Agency Provider – Non-Billing Provider		<input type="checkbox"/> SPOE Office User for Region # _____ <input type="checkbox"/> Agency Claims and Billing <input type="checkbox"/> Agency Provider - Billing		<input type="checkbox"/> Not Applicable
For EarlySteps Online Access (skip if only seeking EIDS access)				
<b>Security Question:</b>				
<b>Answer to Security Question:</b>				
<b>User Access Description</b> (Please select <u>one</u> of the following types):				
<input type="checkbox"/> State Administrator <input type="checkbox"/> Intake Coordinator for Region # _____ <input type="checkbox"/> Agency Provider		<input type="checkbox"/> SPOE User for Region # _____ <input type="checkbox"/> Family Support Coordinator Agency Administrator		<input type="checkbox"/> Not Applicable

Signing this document legally obligates you to the information entered on this form.

Signature:

Date:

Administrator Signature:

Date:

The date the information is received and processed at the CFO office will determine the effective date of online access. An email will be sent to the user's email address with further directions on how to access the online system. Please keep a copy of this form for your records.