TO ENROLL AS A MEDICAID WAIVER PROVIDER IN THE SUNCOAST AREA:

Please complete the Provider Questionnaire on the next page. You must list the Medicaid Waiver services that you would like to provide as well as the education and/or work experience that qualifies you to provide those services. The questionnaire *must* include a complete address, phone number, fax number and email address.

You must have an active email address and access to a computer and printer in order to enroll for required training. Most training materials are sent to participants via email and it is expected that participants print and bring those materials to training.

Questionnaires must be sent to	Agency for Persons with Disabilities		
	Provider Enrollment Unit		
	1201 102 nd Avenue North		
	St. Petersburg, FL 33716		
	Attention: David LePere		

Alternatively, they can be emailed to <u>david_lepere@apd.state.fl.us</u> or faxed to his attention at (727) 217-7044.

Upon receipt, the Provider Enrollment Unit will review your questionnaire to determine if you meet the minimal educational/work experience requirements for the services you requested to provide. If qualified to provide those services, a letter of invitation to attend the *"Phase I - New Provider Orientation"* class will be sent. Invitation letters must be returned to APD to confirm registration for training.

Please do not send in questionnaires requesting to provide services that are not actively being recruited for on our webpage. If a Waiver service is not listed on our webpage, it is because we currently have sufficient provider capacity to meet the needs of the individuals whom we serve.

AGENCY FOR PERSONS WITH DISABILITIES PROVIDER QUESTIONNAIRE (please print clearly)

Name:						
(LAST) Address:	(First)	(Middle)				
City:	State:	Zip Cod	e:			
Phone:	Phone: Cell: (An Email address is mandatory – no action will be taken without one)					
Fax:						
PLEASE LIST THE SERVICE						
(Must be one or more of the services we have enough providers to meet the need	are currently recruiting fo	r – do not list an	-	as we already		
have enough providers to meet the need		le serve)				
PLEASE INDICATE THE EDUCAT FOR THE ABOVE SERVICES. (R "DEVELOPMENTAL SERVICES WAIVED	EQUIREMENTS FOR SE	ERVICE PROVIS	SION ARE LISTE	ED IN THE		
High School Diploma: Yes	Date Received:					
GED: Yes	Date Received:		_			
Associates Degree: Yes	Date Received:		Major:			
Bachelors Degree: Yes	Date Received:		Major:			
Other Training/Education:			Date Rec'd	. / /		
			Date Rec'd			
			Date Rec'd	: / /		
List your last three employers, incl	uding your current er	nployer if still	employed:			
Employer:		From: /	/ To:			
		Hours worked/week				
Job Description:		_				
Employer:		From: /	/ To:	/ /		
		Hours worke	ed/week			
Job Description:						
Employer:		From: /	/ To:	. / /		
		Hours worke	ed/week			
Job Description:		_				

Attach additional sheets if necessary.