Agency for Persons with Disabilities
Provider Enrollment Application

Instructions

SECTION A – ALL PROVIDERS
ALL providers are to complete **SECTION A** of the APD Provider Enrollment Application to provide waiver services under iBudget Florida. Submit the completed application to the local APD area office. To provide services in multiple areas, submit an APD Provider Enrollment Application to each area where you intend to provide services.

SECTION B – NEW PROVIDERS or PROVIDERS EXPANDING SERVICES
- **a)** NEW applicants wishing to enroll as providers for iBudget Florida services are to complete **SECTION B**.
- **b)** CURRENT providers wishing to enroll in services for which they are not presently enrolled are to complete **SECTION B.**

NOTES
- Life Skills Development – Level 1 *(formerly Companion)*, Life Skills Development – Level 2 *(formerly Supported Employment)* and Life Skills Development – Level 3 *(formerly Adult Day Training)* are **NOT** new services; therefore, providers who currently provide these services do **NOT** need to complete **SECTION B**.

- Personal Supports is a **NEW** service that combines Personal Care Assistance (PCA), In-Home Supports, Respite and Companion for individuals age 21 or older, living in their own home or family home, **and** also for those at least age 18 but under age 21 living independently. If you are currently enrolled in any of the four services (PCA, In-Home Supports, Respite, and Companion), you are qualified for Personal Supports in iBudget and do **NOT** need to complete **SECTION B** to enroll in Personal Supports.

SECTION A – ALL PROVIDERS

1. Geographical Limitation
In what counties do you intend to provide services? (Please list):

2. Contact Information	
For iBudget Florida enrollment purposes, please provide the name and contact information of the person designated as the official representative for your business:	
Name:	Telephone No.:
Address:	Cell Phone No.:
City/State/Zip:	Email Address:

3. Provider Application Designation	
☐ **SOLO Provider** (Applicant alone will be providing services)	☐ **AGENCY Provider** (Applicant will be hiring others to perform services)
NOTE: *The provider and employees of a provider agency must meet qualifications required to perform the specified services.*	
Business Name:	
FEIN / SSN:	Treating Provider ID (WSC only): ____________________ Provider Number (List both if applicable): ____________

4. Check All iBudget Florida Waiver Services for Which You Are Requesting Enrollment		
*Agencies or individuals applying for **Support Coordination** shall not apply to provide any other waiver service. (For more information on the new and renamed services, please see page 5.)*		
Support Coordination	**Residential Services**	**Therapeutic Supports and Wellness**
☐ Support Coordination (Limited - Full - Enhanced)	☐ Residential Habilitation (Standard)	☐ Behavior Analysis Services
Dental Services	☐ Residential Habilitation (Behavior-Focused)	☐ Behavior Assistant Services
☐ Adult Dental Services	☐ Residential Habilitation (Intensive Behavior)	☐ Dietician Services
Life Skills Development	☐ Residential Habilitation (Live-In)	☐ Occupational Therapy
☐ Life Skills Development 1 (Companion)	☐ Specialized Medical Home Care	☐ Physical Therapy
☐ Life Skills Development 2 (Supported Employment)	☐ Supported Living Coaching	☐ Private Duty Nursing
☐ Life Skills Development 3 (Adult Day Training)	**Supplies and Equipment**	☐ Residential Nursing
Personal Supports	☐ Consumable Medical Supplies	☐ Respiratory Therapy
☐ Personal Supports	☐ Durable Medical Equipment and Supplies	☐ Skilled Nursing
☐ Respite – Under 21	☐ Environmental Accessibility Adaptations	☐ Specialized Mental Health Counseling
Transportation	☐ Personal Emergency Response Systems	☐ Speech Therapy
☐ Transportation		

SECTION A – CERTIFICATION

I certify that all licenses, insurance policies, certificates, etc., are current and all future changes will be submitted to the APD area office(s) where I initially enrolled.

Print Name	**Signature**	**Date**

~ END OF SECTION A ~

SECTION B – NEW APPLICANTS OR CURRENT PROVIDERS REQUESTING EXPANSION OF SERVICES

1. Education Information

List educational experiences below and the date completed. Please submit a copy of your high school or college diploma. Waiver Support Coordinators are required to submit original transcripts.

Degree Obtained	School/College/University	Date Completed

2. Other Qualifications

List other qualifications, licenses, and certificates that make the applicant qualified to perform each iBudget Florida service checked in SECTION A, #3 of this application.

☐ **Attachments** You *must attach a resume or employment history*. *All gaps in employment must be explained.*

1.

2.

3.

4.

License, Registration, or Certification	Number	Effective Date	Expiration Date	State Licensing Agency

3. Current or Past Service Provision

List all current or past services actually provided by the applicant to individuals who are customers of the Agency for Persons with Disabilities, including type of service, dates (range), and APD area where provided.

Service	Dates (Range)	Areas

4. Disenrollment

Have you ever been disenrolled from any other APD area **or** disenrolled from Medicaid or another Medicaid waiver program? ☐ **NO** ☐ **YES** If YES, provide details below.

APD Areas	Dates	Other Programs	Dates

5. New Agency or Group Provider

If the applicant is a new agency or new group provider, attach a current table of organization that contains (as appropriate to the organization) the board of directors, directors, supervisors, support staff, and all other employees (the number and type of staff available).

☐ **Attachment(s)**

6. Special Requirements – Part A

All new applicants or existing providers wishing to expand enrollment to one or more of the iBudget Florida services listed below, please provide as attachments:

- A detailed description of how you will implement each service for which you are applying. Include in the description how services being provided will meet the needs and/or support the individual (person-centered).
- Explain how you will assess customer needs and how you will train or implement changes to better meet customer needs.
- Explain how you will measure success and identify additional changes needed in training and/or services.

☐ **Attachment(s)**

iBudget Florida services requiring documentation:	Residential Habilitation (Four Types)
Life Skills Development - Level 2	Support Coordination (Limited, Full, Enhanced)
Life Skills Development - Level 3	Supported Living Coaching

7. Special Requirements – Part B

All new applicants or existing providers wishing to expand enrollment in Residential Habilitation, Support Coordination, or Supported Living Coaching, please provide:

- A detailed description of your plan for 24-hour/7-days-a-week service
- Appropriate qualified back-up documentation

☐ **Attachment(s)**

SECTION B CERTIFICATION

I certify that all licenses, insurance policies, certificates, etc., are current and all future changes will be submitted to the APD area office(s) where I initially enrolled.

Print Name	Signature	Date

EXHIBIT A – PROVIDER EXPERIENCE

Describe your work experience in detail, beginning with your **current** or **most recent job**. Use a separate block to describe each position. Include military service (indicate rank) and job-related volunteer work, if applicable. Indicate number of employees supervised. Provide an explanation of any gaps in employment. If needed, attach additional sheets, using the same format as this sheet. **Resumes are acceptable for the description of duties and responsibilities only**. All other information in this section must be completed.

Name of Present or Last Employer:							
Address:					Phone number:		
Job Title:					Supervisor's Name:		
Months/Years of employment:	*From:*		*To:*		Hours Per Week:		
Your name, if different during employment:							
Duties and responsibilities:							
Reason(s) for leaving:							

Name of Present or Last Employer:							
Address:					Phone number:		
Job Title:					Supervisor's Name:		
Months/Years of employment:	*From:*		*To:*		Hours Per Week:		
Your name, if different during employment:							
Duties and responsibilities:							
Reason(s) for leaving:							

Name of Present or Last Employer:							
Address:					Phone number:		
Job Title:					Supervisor's Name:		
Months/Years of employment:	*From:*		*To:*		Hours Per Week:		
Your name, if different during employment:							
Duties and responsibilities:							
Reason(s) for leaving:							

iBudget Florida Services

Service Family	iBudget Services
Life Skills Development	Life Skills Development Level 1 *(formerly known as Companion Services)*
	Life Skills Development Level 2 (*formerly known as Supported Employment*)
	Life Skills Development – Level 3 *(formerly known as Adult Day Training)*
	Family and Legal Representative Training *(not available yet)*
Supplies and Equipment	Consumable Medical Supplies
	Durable Medical Equipment and Supplies
	Environmental Accessibility Adaptations
	Personal Emergency Response Systems *(unit and services)*
Personal Supports	Personal Supports *(includes services formerly known as In-Home Supports, Respite, Personal Care and Companion; for individuals age 21 or older, living in their own home or family home; also for those at least 18 but under 21 living in their own home)*
	Respite *(for individuals under 21 living in their family home)*
Residential Services	Standard Residential Habilitation
	Behavior-Focused Residential Habilitation
	Intensive-Behavior Residential Habilitation
	Live-In Residential Habilitation
	Specialized Medical Home Care
	Supported Living Coaching
Support Coordination	Limited Support Coordination
	Full Support Coordination
	Enhanced Support Coordination
Therapeutic Supports and Wellness	Private Duty Nursing
	Residential Nursing
	Skilled Nursing
	Dietician Services
	Respiratory Therapy
	Speech Therapy
	Occupational Therapy
	Physical Therapy
	Specialized Mental Health Counseling
	Behavior Analysis Services
	Behavior Assistant Services
Transportation	Transportation
Dental Services	Adult Dental Services