AGENCY FOR PERSONS WITH DISABILITIES
PROVIDER SUPPLEMENT TO HCBS WAIVER APPLICATION TO PROVIDE iBUDGET FLORIDA SERVICES

Instructions:
If you are a current provider wishing to be enrolled in the same services in which you are presently enrolled, fill out ***Section A*** *ONLY.*

If you are a current provider wishing to enroll for a service you are not presently enrolled in, fill out ***Section A and Section B.***

Note: *You do* ***not*** *have to fill out* ***Section B*** *if only the name of the service you provide has changed. See the attached sheet for more detailed information about new or renamed iBudget Florida services.*

SECTION A:

GEOGRAPHIC LIMITATION
Unless you indicate limits of geographic areas of interest below, your services will be available statewide. In what counties are you willing to provide services? _____

1. Please provide the name and contact information of the person designated as the official representative for your business for iBudget Florida initial enrollment purposes and general liaison functions:

Name: _____ Phone No. ( ) _____
Address: _____ Email Address: _____
_____

2. Applicant is applying as:

_____**SOLO** (Applicant alone will be providing services.)

_____**AGENCY** (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.

Applicant Name: _____

3. Check all iBudget services for which you are requesting enrollment. For service descriptions and provider qualifications, see the *Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook,* available at http://apd.myflorida.com/ibudget/**.**

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Please note: *Life Skills Development I, II, and III are not new services; the names have been changed in accordance with the waiver. You do **not** have to fill out **Section B** if only the name of the service you provide has changed.

*Personal Supports is a new service for persons over 21 and it is a combination of the following former services: In-Home Supports, Personal Care Assistance, Respite and Companion. If you are a provider wishing to provide personal supports, you must meet the qualifications for Personal Supports, as listed in the *Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook*. Providers wishing to provide personal supports need to complete **Sections A and B** of this supplement if you did not provide all of the following services: In-Home Supports, Personal Care Assistance, Respite and Companion.

*Person Centered Planning and Family and Guardian Training are new iBudget services and persons wishing to provide these services, must meet the qualifications listed in the *Developmental Disabilities Individual Budgeting Waiver Services Coverage and Limitations Handbook*. Providers wishing to provide Person Centered Planning and/or Family and Guardian Training need to complete **Sections A and B** of this supplement.

For more detailed information on the new services and those that have been renamed, see the attached table.

____Life Skills Development Level I
(Formerly Companion)

____Life Skills Development Level II
(Formerly Supported Employment)

____Life Skills Development Level III
(Formerly Adult Day Training)

____Person Centered Planning
(New iBudget Florida Service)

____Family and Guardian Training
(New iBudget Florida Service)

____Consumable Medical Supplies

____Durable Medical Equipment

____Environmental Accessibility Adaptations

____Personal Emergency Response Systems

____Personal Supports (for persons over 21 years of age)
(Formerly In-Home Supports, Personal Care, Respite [persons over 21 years of age] and Companion)

____Respite for Persons Under 21 years of Age

____Residential Habilitation (Standard)

____Residential Habilitation (Intensive Behavior)

____Specialized Medical Home Care

____Supported Living Coaching

____Support Coordination (Limited)

____Support Coordination (Full)

____Support Coordination (Enhanced)

____Private Duty Nursing

____Residential Nursing

____Skilled Nursing

____Dietician Services

____Respiratory Therapy

____Speech Therapy

____Occupational Therapy

____Physical Therapy

____Specialized Mental Health Counseling

____Behavior Analysis Services

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____Residential Habilitation (Behavior Focused)	____Behavior Assistive Services
____Transportation	____Adult Dental Services

Agencies or individuals applying for support coordination shall not apply to provide any other DD waiver services.

I certify that all licenses, insurances, certificates, etc. are current and any changes will be submitted to the APD Area office where I initially enrolled.

_____ _____

Signature Date

SECTION B:

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

DEGREE OBTAINED	SCHOOL/COLLEGE/UNIVERSITY	DATE COMPLETED

2. 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 and area(s) where provided.

SERVICE	DATE(S)	AREA(S)

3. List other qualifications, licenses and certificates that make the applicant qualified to perform each iBudget Florida service checked in Section A, #3 of this supplement. **(You must attach a resume or employment history).**

_____
_____
_____
_____

LICENSE, REGISTRATION OR CERTIFICATION:	NUMBER	EFFECTIVE DATE	EXPIRATION DATE	STATE LICENSING AGENCY

4. Have you ever been disenrolled in any other area or disenrolled from Medicaid or a Medicaid Waiver program? ___Yes ___ No

If yes, what date(s) and area(s)?

Date(s):_____ Area(s): _____

5. If applicant is an agency or 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).

6. Complete if applicant is an agency or group provider; or a solo provider wishing to provide one or more of the following iBudget Florida service(s): Life Skills Development III, Residential Habilitation, Support Coordination, Life Skills Development II, Supported Living Coaching:

- A description in detail of how **each service** being applied for will be implemented. Include in the description how iBudget Florida services being provided will meet the needs and/or support the individual (person-centered). (How will consumer needs be assessed and training or iBudget Florida services be implemented? How will success or needed change be determined for the training and/or service)

7. Applicants of Support Coordination (excluding limited Support Coordination), Residential Habilitation and Supported Living Coaching iBudget Florida services applicants only:

- Attach a detailed description of your plan for 24-hour/7 days a week service and appropriate qualified back-up.

I certify that all licenses, insurances, certificates, etc. are current and any changes will be transmitted to the area office of the application origination.

_____ _____

Signature Date