agency for persons with disabilities
State of Florida

APD Provider Enrollment
Initial Intent Notification

This form is for APD Provider enrollment applicants who do **not** currently have an "APD General" line item eligibility determination in the AHCA ***Care Provider Background Screening Clearinghouse***. This needs to be done in order for the applicant to gain the correct access in the Clearinghouse; **prior** to going to a Live scan Vendor. Please email this form to your specific Regional email address (see your Regional APDCARES webpage for details). Between 5-10 business days after emailing this form, applicant may then register in the Clearinghouse portal. If you will be operating a company with employees, register as the company name. If you are a solo provider, register yourself. **You will search for yourself by the name you registered, so please remember how you registered.**

Please provide the following information:

Today's Date: _____

(If applicable) Company Name: _____

Last Name: **(If a solo provider, your name. If you have a company, the owner/operator):**

_____

First Name: **(If a solo provider, your name. If you have a company, the owner/operator):**

_____

County: _____

E-mail _____

Phone: _____

Mailing Address Line 1: _____

Mailing Address Line 2: _____

City: _____

State: _____

Zip: _____