

**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):**

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

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 **County: ­­­­­­­­­­­­­­**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **E-mail** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Phone: ­­­­­­­­**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Mailing Address Line 1:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Mailing Address Line 2:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **State:** \_\_\_\_\_\_\_\_\_\_\_

 **Zip:** \_\_\_\_\_\_\_\_\_\_\_\_\_