

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