Agency for Persons with Disabilities
Provider Expansion Request Form
Please fill out this form in its entirety and submit it to your home office.

This request for a (check all that apply):			
☐ **Region-to-Region Expansion: Expanding all or fewer current services into another Region(s). To expand into another Region with more services, please check 'Service Expansion' also.** *Fill out Section A.1 and designate which of your current services will be expanded in Section A.2.*			
☐ **Solo-to-Agency Expansion: Hiring staff to carry out services.** *Fill out Section A.3*			
☐ **Service Expansion: Request to provide different services than what you are currently providing.** *Fill out Section A.2 and Section B.*			
Provider Information			
Business Name:		DBA (if applicable):	
Contact Name, *if different than above*:			
Mailing Address, *or PO Box:*			
Physical Business Address, *if different than above*:			
Telephone No.:		Cell Phone No.:	
Tax ID: ☐ FEIN: -OR- ☐ SSN:		Email Address:	
Current Provider Designation:			
☐ **SOLO Provider** (Applicant alone will be providing services)	☐ **AGENCY Provider** (Applicant hired others to perform services)	☐ **TREATING Provider** (WSC applicant working under a WSC Agency) Agency Provider ID: _____	☐ **GROUP Provider** (WSC Agency that hired WSCs to perform services)
Medicaid Provider ID: _____			

Required Attachments For All Expansion Types
Please check that you have attached the following to this request:

- ☐ Current Med-Waiver Services Agreement (MWSA)
- ☐ Current Provider Service Listing Letter from Home Region and each currently expanded Region, if any
- ☐ Declaration Page from current professional/general liability insurance
- ☐ Most recent Delmarva review that is 85% or above with no alerts and/or unresolved recoupments, if available

Reset Page 1

SECTION A

REGIONAL & SERVICE EXPANSION ONLY

1. Regional Expansion:

Into which Regions do you intend to expand services?

☐ Northeast Region ☐ Northwest Region ☐ Central Region
☐ Suncoast Region ☐ Southeast Region ☐ Southern Region

☐ If currently an agency provider, attach an updated Policy and Procedures and Table of Organization that of which include the planned staffing in the new Region(s).

2. Service Expansion:

Please check all the new service(s) of which you are requesting to expand, then fill out Section B.

Support Coordination		Residential Services		Therapeutic Supports and Wellness	
☐	Support Coordination (Limited, Full, Enhanced)	☐	Residential Habilitation Standard	☐	Behavior Analysis Services ☐ Level 1 ☐ Level 2 ☐ Level 3 ☐ All
☐	CDC Consultant (Limited, Full, Enhanced)	☐	Residential Habilitation Live-In **For 1-3 Person Foster Homes*	☐	Behavior Assistant Services
Personal Supports		☐	Residential Habilitation Intensive Behavior	☐	Dietician Services
☐	Personal Supports	☐	Residential Habilitation Behavior-Focused	☐	Occupational Therapy
☐	Respite (Under 21)	☐	Specialized Medical Home Care	☐	Physical Therapy
Life Skills Development		☐	Supported Living Coaching	☐	Private Duty Nursing ☐ RN ☐ LPN
☐	Life Skills Development I (Companion)	**Supplies and Equipment**		☐	Residential Nursing ☐ RN ☐ LPN
☐	Life Skills Development II (Supported Employment)	☐	Consumable Medical Supplies	☐	Respiratory Therapy
☐	Life Skills Development III (Adult Day Training) ☐ Facility-Based ☐ Off Site	☐	Durable Medical Equipment and Supplies	☐	Skilled Nursing ☐ RN ☐ LPN
Transportation		☐	Environmental Accessibility Adaptations	☐	Skilled Respite
☐	Transportation ☐ Mile ☐ Trip ☐ Month ☐ All	☐	Personal Emergency Response Systems	☐	Specialized Mental Health Counseling
		Dental Services		☐	Speech Therapy
		☐	Adult Dental Services		

Reset Page 2

3. Solo to Agency: New Agency Information (if different than Page 1)	
Business Name:	DBA (if applicable):
Mailing Address, *or PO Box:*	
Physical Business Address, *if different than above*:	
Telephone No.:	Cell Phone No.:
Tax ID: ☐ FEIN:	Email Address:

SECTION B

REGIONAL, SERVICE and/or SOLO-TO-AGENCY EXPANSION

Instructions: For providers expanding services **AND/OR** providers expanding to Agency status fill out the following:

1. Education Information

List educational experience below and the date completed. Please submit a copy of your high school or college diploma. Waiver Support Coordinators are required to submit official sealed college transcripts. Any education obtained in another country must be translated.

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.*

Qualification(s)	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)	Region

5. Administrative Policies, Procedures and Practices

Attach a copy of your administrative policies, procedures and practices per the Core Assurances, Section 3.0 of the DD Handbook (pp. A-11, 12). Please reference the Handbook for further detail.

Documentation Required By:

- **ALL** Agency/Group Providers
- Solo Providers of **Support Coordination, Residential Habilitation, Supported Living Coaching,** or **Supported Employment**

☐ **Attachment(s)**

Reset Page 3 Reset All