Agency for Persons with Disabilities
Provider Enrollment Application

1. 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:

2. Geographical Provision:

Providers: Please list the **regions** you intend to serve:	**Support Coordinators:** Please list the **counties** you intend to serve:

3. 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)	☐ **GROUP Provider** (WSC Agency that hired WSCs to perform services)

4. Provider Services:

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 - Behavior-Focus	☐	Dietician Services
☐	Personal Supports	☐	Residential Habilitation - Intensive Behavior	☐	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	☐	Personal Emergency Response Systems	☐	Specialized Mental Health Counseling
		Dental Services		☐	Speech Therapy
		☐	Adult Dental Services		

Reset Page 1

Applicant Background Information

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 region where provided.

Service	Dates (Range)	Regions

4. Prior Termination

Have you ever been terminated from any other APD region **or** terminated from Medicaid or another Medicaid waiver program?

☐ **NO** ☐ **YES** If YES, provide details below and provide a copy of the termination letter.

APD Regions/ Other Programs	Dates	Type of Termination *(Voluntary, Involuntary, Etc.)*	Dates

Reason for Termination:

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 **Residential Habilitation, Support Coordination, Supported Living Coaching,** or **Supported Employment**

☐ **Attachment(s)**

Reset Page 2

EXHIBIT A – PROVIDER EXPERIENCE

Describe your work experience in detail, beginning with your **current** or **most recent job**. Use a separate block to describe each position. Include military service (indicate rank) and job-related volunteer work, if applicable. Indicate number of employees supervised. Provide an explanation of any gaps in employment. If needed, attach additional sheets, using the same format as this sheet. **Resumes are acceptable for the description of duties and responsibilities only**. All other information in this section must be completed.

Name of Present or Last Employer:						
Address:				Phone number:		
Job Title:				Supervisor's Name:		
Months/Years of employment:	*From:*		*To:*		Hours Per Week:	
Your name, if different during employment:						
Duties and responsibilities:						
Reason(s) for leaving:						
Name of Employer:						
Address:				Phone number:		
Job Title:				Supervisor's Name:		
Months/Years of employment:	*From:*		*To:*		Hours Per Week:	
Your name, if different during employment:						
Duties and responsibilities:						
Reason(s) for leaving:						
Name of Employer:						
Address:				Phone number:		
Job Title:				Supervisor's Name:		
Months/Years of employment:	*From:*		*To:*		Hours Per Week:	
Your name, if different during employment:						
Duties and responsibilities:						
Reason(s) for leaving:						

Application Received by: _____	REGIONAL DATE STAMP ***STAMPED ONLY WHEN APPLICATION IS COMPLETE AND ACCURATE***

Reset Page 3 Reset All Pages Print