**Provider Expansion Request Form**

|  |
| --- |
| 1. **Current Provider Designation**
 |
| [ ]  SOLO Provider: *Provider alone delivers service(s)* | [ ]  AGENCY Provider:*Agency has a minimum of two W-2 employees that are delivering service(s)* | [ ]  QUALIFIED ORGANIZATION: *Has a minimum of four treating Waiver Support Coordinators* |
| 1. **Current Provider Information**
 |
| Business Name:       | DBA *(if applicable):*   |
| [ ]  FEIN:       **or** [ ]  SSN:       | Medicaid Provider ID:       |
| Contact Name:       | Email address:       |
| Mailing Address:       |
| Physical Address:       |
| Phone Number:       | Cell Phone Number:       |
| Region Currently Approved to Provide Services:[ ]  Northwest [ ]  Northeast [ ]  Central [ ]  Suncoast [ ]  Southeast [ ]  Southern |
| 1. **New Provider Information *(if requesting expansion into Agency)***
 |
| Business Name:       | DBA *(if applicable):*  |
| [ ]  FEIN:       **or** [ ]  SSN:       | Medicaid Provider ID:       |
| Contact Name:       | Email address:       |
| Mailing Address:       |
| Physical Address:       |
| Phone Number:       | Cell Phone Number:       |
| 1. **Requested Action *(check all that apply)***
 |
| [ ] Region-to-Region Expansion: Expanding all currently enrolled services into another Region. *Complete Section A.1 and select all current services requesting to provide in Section A.2.*  |
| [ ]  Solo-to-Agency Expansion: Current Solo Provider expanding into an Agency as defined in the iBudget Handbook. *Complete Section B.* |
| [ ]  Service Expansion: Request to provide different and/or additional services than what you are currently providing. *Complete out Section A.2. and Section B.*  |
| 1. **Required Documents**
 |
| [ ]  Current Medicaid Waiver Services Agreement (MWSA)[ ]  Current Provider Service Listing Letter from Home Region and each currently expanded Region, if any[ ]  Copy of Declaration Page from current professional/general liability insurance; APD must be listed as the certificate holder on the Declaration page[ ]  Most recent Quality Improvement Organization (QIO) review with a score of 85% or above with no alerts[ ]  Proof of employee qualifications as outlined in the iBudget Handbook *(only for Solo-to-Agency Expansions)*[ ]  A letter signed by the provider or agency owner attesting to the existence of policies and procedures as required in the iBudget Handbook |

|  |
| --- |
| **SECTION A*****REGION-TO-REGION & SERVICE EXPANSION ONLY*** |
| 1. **Region-to-Region** *(Check all Regions you intend to serve)*
 |
| [ ]  Northeast[ ]  Suncoast | [ ]  Northwest[ ]  Southeast | [ ]  Central[ ]  Southern |
| 1. **Service Expansion** *(Check all new service(s) you are requesting to expand, then complete Section B)*
 |
| **Support Coordination** | **Residential Services** | **Therapeutic Supports and Wellness** |
| [ ]  CDC Consultant (Limited, Full, Enhanced)  | [ ]  Residential Habilitation – Standard | [ ]  Behavior Analysis Services  [ ]  Level 1 [ ]  Level 2 [ ]  Level 3 |
| **Personal Supports** | [ ]  Residential Habilitation Live-In \*For 1-3 Person Foster Homes | [ ]  Behavior Assistant Services |
| [ ]  Personal Supports | [ ]  Residential Habilitation Behavior Focus | [ ]  Dietician Services |
| [ ]  Respite (Under 21) | [ ]  Residential Habilitation Intensive Behavior | [ ]  Occupational Therapy |
| **Life Skills Development** | [ ]  Special Medical Home Care | [ ]  Physical Therapy |
| [ ]  Life Skills Development I (Companion) | [ ]  Supported Living Coaching | [ ]  Private Duty Nursing [ ]  RN [ ]  LPN |
| [ ]  Life Skills Development II (Supported Employment) | **Supplies and Equipment** | [ ]  Residential Nursing [ ]  RN [ ]  LPN |
| [ ]  Life Skills Development III (Adult Day Training) [ ]  Facility Based [ ]  Off Site | [ ]  Consumable Medical Supplies | [ ]  Skilled Nursing [ ]  RN [ ]  LPN |
| **Dental Services** | [ ]  Durable Medical Equipment and Supplies | [ ]  Respiratory Therapy |
| [ ]  Adult Dental Services | [ ]  Environmental Accessibility Adaptations[ ]  Assessment [ ]  Adaptation | [ ]  Specialized Mental Health Counseling |
| **Transportation** | [ ]  Personal Emergency Response Systems | [ ]  Skilled Respite |
| [ ]  Transportation [ ]  Mile [ ]  Trip [ ]  Month |  | [ ]  Speech Therapy |

|  |
| --- |
| **SECTION B*****ALL EXPANSIONS*****Instructions:** For providers expanding services **AND/OR** providers expanding to Agency status full out the following:  |
| 1. **Education information**
 |
| List educational experience below and the date completed. Waiver Support Coordinators are required to submit official sealed college transcripts. Any documentation of education obtained from another country must be professionally verified through a credentialing service. |
| **Degree Obtained** | **School/College/University** | **Date Completed** |
|       |       |       |
|       |       |       |
| 1. **Licenses or Certificates**
 |
| List other licenses and certificates that make the applicant qualified to perform each iBudget Florida service checked in Section A, #3 of this application.  |
| **License or Certificate(s)** | **Number** | **Effective Date** | **Expiration Date** | **State Licensing Agency** |
|       |       |       |       |       |
|       |       |       |       |       |
| 1. **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 services, dates (range), and APD Area where provided.  |
| **Services** | **Dates (Range)** | **Region** |
|  |  |  |

|  |
| --- |
| **By signing this application, I attest that the information contained in this application is complete and accurate.**  |
| Applicant Name *(please print)*:Click or tap here to enter text. | Applicant Signature:Click or tap here to enter text. | Date:      |