

Qualified Organization Application

This application **must** be completed by the prospective owner or the designated representative of a partnership, association, or corporation. A letter of designation should accompany the application if the applicant is not a member of the partnership, association, or corporation. Please see the Agency's support coordination webpage for instructions on completing this application.

1. Qualified Organization Information							
Qualified Organization Name	2:						
Owner Contact Name:				SunBiz Registered DBA (if applicable):			
Tax ID: 🗌 FEIN:	-OR-	SSN:		Business/Office Phone Number:			
Email:				Cell Phone Number:			
Qualified Organization Mailin	Qualified Organization Mailing Address:						
Physical Business Address (cannot be a PO Box):							
Please designate if Owner will also be a Support Coordinator. 🗌 Yes 📄 No							
2. Geographical Provision							
	heast 🗍 🤇	Central	Suncoast	Southeast Southern			
Does the Qualified Organizat							
If no, please list the counties	the Qualified	l Organizatio	on does <u>not</u> wish	to serve within the selected Region(s):			
3. Associated Support Coor	dinators (Qua	alified Organ	izations must ha	ve a minimum of four (4) associated support coordinators)			
 3. Associated Support Coordinators (Qualified Organizations must have a minimum of four (4) associated support coordinators) Please list <u>all</u> associated Support Coordinators, and if applicable, their associated Medicaid ID Number(s). Also, attach the Support Coordinator application for each new Support Coordinator applicant or current Medicaid Waiver Service Agreement for each existing Support Coordinator. 4. Services Provided Please indicate which services the Qualified Organization intends to provide: 							
Consultation under CDC+ 5. Prior Revocation(s), Suspension(s), and/or Termination(s) for any Director, Supervisor, Owner, Operator, or Manager							
Has any director, supervisor, owner, operator, or manager who will directly oversee the operations in Florida of this Qualified Organization had a license, certificate, Medicaid Number, or contract revoked, suspended, or terminated by any governmental authority (to include but not limited to any Medicaid or Waiver program), personally or as the director, supervisor, owner, operator, or manager of a business entity?							
Name of Department or		Date(s) of		olinary Action(s) (Revocation, Suspension, or Termination,			
Agency	Action(s)	Action	inc	luding whether it was voluntary or involuntary)			



6. Education Information fo	or Oualified	Organization	Leadership (D	efined in Rule 65G-14.002. F	.A.C.)	
List educational experien						ervisors, owners
operators, and managers			•	-		
as a Support Coordinator		•	• •			
of education obtained fro	-	-	-	_		
Name and Title		egree Obtai		School/College/Uni		Date Completed
			licu		versity	Bute completeu
7. Required Documents of t	he Qualified	Organizatio	n and its Owne	ership (Outlined in Rule 65G-	14.002, F.A.C.	and iBudget
Handbook)						
Copy of Identification Ca	rd			g Program		nd Screenings –
Copy of IRS SS-4 or W-9				nd Procedures	Level II	
Code of Ethics				Educational Qualifications (Official Backgroun Sealed Transcript) Local Law		
Disciplinary Process Table of Organization				/ritten Professional		or Exhibit A –
Support Coordinator app	lication(s) fo	or each new		References		
Support Coordinator				usiness Registration and	Owner Exper	testation of Good
Copy of Medicaid Waiver	^r Services Ag	reement	Articles of Inc	-	Moral Charac	
for existing Support Coordin	-			Ay Florida Marketplace		
Agencies			Vendor Regis	tration (if applicable)		
8. Additional Documents Required at the Initiation of the Medicaid Waiver Services Agreement						
Proof of active and appro	•					
Copy of Declaration Pages of General or Professional Liability Business Insurance						
APD must be listed as the certificate holder on the declaration page Initial:						
9. Additional Documents Required at or after Initiation of the Medicaid Waiver Services Agreement						
Certificate of completion of the competency-based assessment for Level 1 Training (Online Pre-Service) in accordance with						
the timeframes delineated in Chapter 65G-10, F.A.C. Certificate of completion of the competency-based assessment for Level 2 Training (Regional Pre-Service), if applicable, in						
accordance with the timeframes delineated in Chapter 65G-10, F.A.C.						
By signing this application, I attest that the information contained in this application is complete and accurate.						
Applicant Name (<i>please print</i>):	icat that the l		licant Signature:		Date:	
presse printy.		, , , , ,				



Exhibit A – Owner Experience

Owner Name:

Describe the owner's <u>related</u> work experience in detail, beginning with the owner's current or most recent job. Use a separate block to describe each position. Indicate number of employees supervised. Include all current and past services provided to individuals with intellectual and developmental disabilities, including type of service, dates, and APD region. If needed, attach additional sheets, using the same format as this sheet. A resume may be provided in lieu of the employment information below if resume contains all information elements requested.

Attach this sheet and any additional sheets to the Qualified Organization Application when complete.

Name of Employer:				
Address:	Phone Number:			
Job Title:	Supervisor's Name:			
Months/Years of Employment:	From: To: Hours per week:			
Duties and Responsibilities:				
Reason for leaving:				

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Job Title:	Supervisor's Name:		
Months/Years of Employment:	From:	To:	Hours per week:
Duties and Responsibilities:			
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Reason for leaving:			

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