Regional iBudget Provider Enrollment Application – Non-WSC

1. Applicant Information	
Business Name:	
Owner Contact Name:	SunBiz Registered DBA *(if applicable)*:
Tax ID: ☐ FEIN: -OR- ☐ SSN:	Business/Office Phone Number:
Email:	Cell Phone Number:
Mailing Address:	
Physical Business Address (cannot be a PO Box):	

2. Geographical Provision
Please indicate the APD designated Region(s) you intend to serve: ☐ Northwest ☐ Northeast ☐ Central ☐ Suncoast ☐ Southeast ☐ Southern
Do you wish to serve all counties in the selected Region(s)? ☐ Yes ☐ No
If no, please list the counties you do not wish to serve within the selected Region(s): Click or tap here to enter text.

3. Provider Designation	
☐ Solo Provider *(Applicant alone will be providing services)*	☐ Agency Provider *(Two or more W-2 employees to provide services)*

4. *Services*

Personal Supports	**Residential Services**	**Therapeutic Supports and Wellness**
☐ Personal Supports	☐ Residential Habilitation – Standard	☐ Behavior Analysis Services ☐ Level 1 ☐ Level 2 ☐ Level 3
☐ Respite (Under 21)	☐ Residential Habilitation Live-In **For 1-3 person Foster Homes*	☐ Behavior Assistant Services
Life Skills Development	☐ Residential Habilitation Behavior Focus	☐ Dietician Services
☐ Life Skills Development I (Companion)	☐ Residential Habilitation Intensive Behavior	☐ Private Duty Nursing ☐ RN ☐ LPN
☐ Life Skills Development II (Supported Employment)	☐ Special Medical Home Care	☐ Residential Nursing ☐ RN ☐ LPN
☐ Life Skills Development III (Adult Day Training)	☐ Supported Living Coaching	☐ Skilled Nursing ☐ RN ☐ LPN
☐ Life Skills Development IV (Prevocational)	**Supplies and Equipment**	☐ Specialized Mental Health Counseling
Dental Services	☐ Consumable Medical Supplies	☐ Occupational Therapy
☐ Adult Dental Services	☐ Durable Medical Equipment and Supplies	☐ Physical Therapy
Transportation	☐ Environmental Accessibility Adaptations ☐ Assessment ☐ Adaptation	☐ Respiratory Therapy
☐ Transportation ☐ Mile ☐ Trip ☐ Month	☐ Personal Emergency Response Systems	☐ Speech Therapy
		☐ Skilled Respite

5. Prior Disciplinary Actions and Terminations

Have you ever experienced any disciplinary action by any state agency (to include any Medicaid or Waiver program)?
☐ No ☐ Yes If yes, provide details below and provide a copy of the disciplinary action.

APD Regions/	**Dates**	**Type of Disciplinary Action**	**Dates**

Other Programs		*(Fines, Administrative Complaints, Etc.)*	

Reason for Each Disciplinary Action:

Have you ever been terminated by any state agency (to include any Medicaid or 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 Each Termination:

6. Owner Education Information

List educational experience below and the date completed. Any documentation of education obtained from another country must be professionally verified through a credentialing service.

Degree Obtained	School/College/University	Date Completed

7. Required Documents *(Outlined in iBudget Handbook)*

☐ Copy of Identification Card ☐ Copy of SSN card ☐ Copy of IRS SS-4 or W-9 ☐ Proof of minimum qualifications for services requested☐ 2 Written Employer References	☐ Provider Policies and Procedures Attestation Letter ☐ Florida Business registration and Articles of incorporation (if applicable) ☐ Proof of My Florida Marketplace Vendor Registration (if applicable) ☐ Copy of any License(s) and/or Certificate(s) (if applicable)	☐ Background Screenings – Level II ☐ Background Screenings – Local Law ☐ Signed Attestation of Good Moral Character

8. Additional Documents Required at the Initiation of the Medicaid Waiver Services Agreement

- Proof of active and appropriate Florida Medicaid Number
- Documentation of Successful completion pre-service training, if applicable
- Copy of Declaration Pages of General or Professional Liability Business Insurance
    - APD must be listed as the certificate holder on the declaration page Initial:_____

By signing this application, I attest that the information contained in this application is complete and accurate.

Applicant Name *(please print)*:	Applicant Signature:	Date:
Click or tap here to enter text.	Click or tap here to enter text.	

Exhibit A – Provider Applicant Experience

Applicant Name:

*Describe your **related** work experience in detail, beginning with your **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. **Attach this sheet and any additional sheets to your application when complete.***

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

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

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Job Title:	**Hours/week:**	**Supervisor's Name:**		
Duties and Responsibilities:				
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Job Title:	**Hours/week:**	**Supervisor's Name:**		
Duties and Responsibilities:				
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Job Title:	**Hours/week:**	**Supervisor's Name:**		
Duties and Responsibilities:				
Reason for leaving:				