

Regional Waiver Support Coordinator Enrollment Application – WSC

1. Applicant Information			
Applicant Name:		Applicant Tax ID: <input type="checkbox"/> FEIN: -OR- <input type="checkbox"/> SSN:	
Applicant Contact Phone Number:		Applicant Contact Email:	
Applicant Address:			
Qualified Organization Name:		Assigned Mentor (<i>if applicable</i>):	
2. Geographical Provision			
Please indicate the APD designated Region(s) you intend to serve: <input type="checkbox"/> Northwest <input type="checkbox"/> Northeast <input type="checkbox"/> Central <input type="checkbox"/> Suncoast <input type="checkbox"/> Southeast <input type="checkbox"/> Southern			
Do you wish to serve all counties in the selected Region(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please list the counties you wish to serve within the selected Region(s): 			
3. Prior Disciplinary Actions and Terminations			
Have you ever experienced any disciplinary action by any state agency (to include any Medicaid or Waiver program)? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, provide details below and provide a copy of the disciplinary action.			
APD Regions/ Other Programs	Dates	Type of Disciplinary Action (Fines, Administrative Complaints, Etc.)	Dates
Reason for Each Disciplinary Action: 			
Have you ever been terminated by any state agency (to include any Medicaid or Waiver program)? <input type="checkbox"/> No <input type="checkbox"/> 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: 			
4. Education Information			
List educational experience below and the date completed. Waiver Support Coordinators are required to submit <u>official</u> 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	

5. Required Documents (Outlined in the iBudget Handbook)

- | | |
|---|---|
| <input type="checkbox"/> Copy of Identification card | <input type="checkbox"/> Background Screenings – Level II |
| <input type="checkbox"/> Copy of Social Security card | <input type="checkbox"/> Background Screenings – Local Law |
| <input type="checkbox"/> Proof of minimum qualifications | <input type="checkbox"/> Signed Attestation of Good Moral Character |
| <input type="checkbox"/> Two Written Employer References | |
| <input type="checkbox"/> Exhibit A: Provider Applicant Experience | |

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

- Proof of active and appropriate Florida Medicaid Number
- Successful completion of Mentoring Program (if applicable)
- Successful completion of Level 1 Training
- Successful completion of the competency-based assessment(s)

Initial: _____

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

Applicant Name <i>(Please print):</i>	Applicant Signature:	Date:
Mentor Name, <i>if applicable (Please print):</i>	Mentor Signature:	Date:
Qualified Organization Contact Name <i>(please print):</i>	Qualified Organization Contact Signature:	Date:

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. 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 your 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:							

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:							

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:

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:							

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:							

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:							