**Regional Waiver Support Coordinator Enrollment Application – WSC**

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| **1. Applicant Information** | | | | | | |
| Applicant Name: | | | | Applicant Tax ID:  FEIN:       -OR-  SSN: | | |
| Application Contact Phone Number: | | | | Applicant Contact Email: | | |
| Applicant Address: | | | | | | |
| Qualified Organization Name: | | | | Assigned Mentor *(if applicable)*: | | |
| **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 | | | | | | |
| 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)?  No  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)?  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: | | | | | | |
| **4. 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** | |
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| **5. Required Documents** *(Outlined in the iBudget Handbook)* | | | | | | |
| Copy of Identification card  Copy of Social Security card  Proof of minimum qualifications  Two Written Employer References  Exhibit A: Provider Applicant Experience | | | | Background Screenings – Level II  Background Screenings – Local Law  Signed Attestation of Good Moral Character | | |
| **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: | | | | | | |

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| **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: |
| Mentor Name*, if applicable* *(Please print)*: Click or tap here to enter text. | Mentor Signature:  Click or tap here to enter text. | Date: |
| Qualified Organization Contact Name *(please print)*: Click or tap here to enter text. | Qualified Organization Contact Signature:  Click or tap here to enter text. | 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.***

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

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| **Duties and Responsibilities:** | | | | | | |
| **Reason for leaving:** | | | | | | |

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| **Duties and Responsibilities:** | | | | | | |
| **Reason for leaving:** | | | | | | |
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| **Reason for leaving:** | | | | | | |

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| **Duties and Responsibilities:** | | | | | | |
| **Reason for leaving:** | | | | | | |