**Agency for Persons with Disabilities**

**Waiver Support Coordination Provider Enrollment Application**

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| **1. Provider Information** | | | | | | | | | |
| Business Name: | | | | DBA (if applicable): | | | | | |
| Contact Name, *if different than above*: | | | | | | | | | |
| Mailing Address, *or PO Box:* | | | | | | | | | |
| Physical Business Address, *if different than above*: | | | | | | | | | |
| Telephone No.: | | | | Cell Phone No.: | | | | | |
| Tax ID:  FEIN:       -OR-  SSN:  **Attachments:** *Attach a copy of a W9 or SSN card* | | | | Email Address: | | | | | |
| **2. Geographical Provision:** | | | | | | | | | |
| Please list the **counties** you intend to serve: | | | | | | | | | |
| **3. Provider Designation:** | | | | | | | | | |
| **SOLO Provider**  (WSC alone will be  providing services) | | **TREATING Provider**  (WSC working under  a WSC Agency) | | | | **GROUP Provider**  (Agency that has at least two  WSCs to perform services) | | | |
| **4. Education Information** | | | | | | | | | |
| List educational experience below and the date completed. Please submit a copy of your high school or college diploma. Waiver Support Coordinators are required to submit official sealed college transcripts. Any education obtained in another country must be translated. | | | | | | | | | |
| **Degree Obtained** | | **School/College/University** | | | | | | **Date Completed** | |
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| **5. WSC Pre-Service Training** | | | | | | | | | |
| **Attachments:** *The WSC Pre-Service training is required to be completed as a condition of eligibility to provide this service. Please attach a copy of your pre-service training certificate to this application.* | | | | | | | | | |
| **6. Resume** | | | | | | | | | |
| **Attachments:** *You must attach a resume or Exhibit A “Provider Experience”*. ***If you attach a resume, please include the following: your previous employer addresses, phone numbers, names of your supervisors, dates in which you were employed, average hours worked per week and reason for leaving.*** *All gaps in employment must be explained.* | | | | | | | | | |
| **7. 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 service, dates (range), and APD region where provided. | | | | | | | | | |
| **Service** | | | | | **Dates (Range)** | | | | **Regions** |
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| **8. Prior Termination** | | | | | | | | | |
| Have you ever been terminated from any other APD region **or** terminated from Medicaid or another Medicaid 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 Termination:** | | | | | | | | | |
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| **9. Administrative Policies, Procedures and Practices** | | | | | | | | | |
| Attach a copy of your administrative policies, procedures and practices per the Core Assurances, Section 3.0 of the DD Handbook (pp. A-11, 12). Please reference the Handbook for further detail.  **Attachment(s)** | | | | | | | | | |
| Applicant Signature: | | | | | | | Date: | | |
| APD Staff Signature: | | | | | | | Date Stamp: | | |
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