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:	
Owner Contact Name:	SunBiz Registered DBA *(if applicable)*:
Tax ID: ☐ FEIN: -OR- ☐ SSN:	Business/Office Phone Number:
Email:	Cell Phone Number:
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

Please indicate the APD designated Region(s) the Qualified Organization intends to serve:

☐ Northwest ☐ Northeast ☐ Central ☐ Suncoast ☐ Southeast ☐ Southern

Does the Qualified Organization wish to serve all counties in the selected Region(s)? ☐ Yes ☐ No

If no, please list the counties the Qualified Organization does **not** wish to serve within the selected Region(s):

3. Associated Support Coordinators *(Qualified Organizations must have a minimum of four (4) associated support coordinators)*

Please list **all** 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:

☐ Support coordination

☐ 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?

☐ No ☐ Yes If Yes, provide details below and provide a copy of the Revocation, Suspension, or Termination.

Name of Department or Agency	**State of Action(s)**	**Date(s) of Action**	**Type of Disciplinary Action(s)** *(Revocation, Suspension, or Termination, including whether it was voluntary or involuntary)*

6. Education Information for Qualified Organization Leadership *(Defined in Rule 65G-14.002, F.A.C.)*

List educational experience below and the date completed. Qualified Organization directors, supervisors, owners, operators, and managers who directly oversee Support Coordinators in the State of Florida and who are not enrolled as a Support Coordinator with the Agency are required to submit official sealed college transcripts. Any documentation of education obtained from another country must be professionally verified through a credentialing service.

Name and Title	Degree Obtained	School/College/University	Date Completed

7. Required Documents of the Qualified Organization and its Ownership *(Outlined in Rule 65G-14.002, F.A.C. and iBudget Handbook)*

☐ Copy of Identification Card	☐ Mentoring Program	☐ Background Screenings – Level II
☐ Copy of IRS SS-4 or W-9	☐ Policies and Procedures	☐ Background Screenings – Local Law
☐ Code of Ethics	☐ Educational Qualifications (Official Sealed Transcript)	☐ Resume or Exhibit A – Owner Experience
☐ Disciplinary Process	☐ Two (2) Written Professional References	☐ Signed Attestation of Good Moral Character
☐ Table of Organization	☐ Florida Business Registration and Articles of Incorporation	
☐ Support Coordinator application(s) for each new Support Coordinator	☐ Proof of My Florida Marketplace Vendor Registration (if applicable)	
☐ Copy of Medicaid Waiver Services Agreement for existing Support Coordinators and Provider Agencies		

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

☐ Proof of active and appropriate Florida Medicaid Number

☐ 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. 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:

Exhibit A – Owner Experience

Owner Name:

*Describe the owner's **related** 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:			

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:			