State of Florida

PROVIDER APPLICANT REFERENCE FORM

The applicant below has applied to become a Medicaid Waiver Provider. Your cooperation in completing this reference will greatly assist the Agency for Persons with Disabilities (APD) in determining if the applicant meets the minimum qualifications to become a Waiver Provider.

- Please type or print legibly.
- Applicants must have references from **two (2) supervisors or co-workers** who are familiar with their work in a Developmental Disability setting.
- **APPLICANT** – Complete Part I, provide this form to your references with a return self-addressed envelope. Provide the completed form from your reference with your application materials.
- **REFERENCE** – Complete Part II and return this form to the applicant in the envelope provided to you.

PART I – APPLICANT

Name:

PART II - REFERENCE

REFERENCE NAME:

ADDRESS: _____
STREET CITY STATE ZIP

PHONE:

OTHER CONTACT INFORMATION:

RELATIONSHIP TO APPLICANT: ☐ SUPERVISOR ☐ CO-WORKER

DATES OF RELATIONSHIP: FROM: _____ TO: _____
MM/DD/YY

PROFESSIONAL POSITION WHEN WORKING WITH APPLICANT:

Title:

Agency/Institution:

Address:

RECOMMENDATION:

I ☐ Recommend ☐ Do Not Recommend the Applicant for Enrollment

ADDITIONAL COMMENTS:

[Please write any comments that would assist the APD Enrollment Liaison in making a decision on this Applicant for enrollment.]

Reference Signature	Date