WAIVER ENROLLMENT FORM

BUSINESS INFORMATION

Company Name: _____ DBA (if applicable): _____

Address: _____ City/State/Zip: _____

Federal Tax ID: _____ Group NPI: _____

Phone: _____ Fax: _____

Email: _____ Hours of Operation: _____

DISCLOSURE OF OWNERSHIP INFORMATION

Owner #1: _____ Date of Birth (MM/DD/YYYY): _____

Home Address: _____ City/State/Zip: _____

Personal Phone: _____ Email: _____

% of Company Ownership: _____ DOH License Number (if applicable): _____

Degree Obtained: ☐ High School, or equivalent ☐ College/University ☐ Graduate School

Name of School: _____ Graduation Date: _____

Owner #2 (if applicable): _____ Date of Birth (MM/DD/YYYY): _____

Home Address: _____ City/State/Zip: _____

Personal Phone: _____ Email: _____

% of Company Ownership: _____ DOH License Number (if applicable): _____

Degree Obtained: ☐ High School, or equivalent ☐ College/University ☐ Graduate School

1840 W 49TH ST STE 723, HIALEAH, FL 33012
TOLL-FREE PH: (888) 483-8044 | LOCAL PH: (786) 203-9259
PROVIDERSERVICES@HELPINGHANDSTC.COM

Name of School: _____ Graduation Date: _____

WAIVER PROGRAM INFORMATION

Service Region(s): ☐ Southern ☐ Northwest ☐ Suncoast ☐ Northeast ☐ Central ☒ Southeast

Requested Services: ☐ Personal Support/Respite ☐ Behavior Analysis ☐ Behavior Assistant ☐ Speech Therapy ☐ Occupational Therapy ☐ Physical Therapy ☐ Respiratory Therapy ☐ Specialized Mental Health Counseling ☐ Private Duty Nursing (☐ RN / ☐ LPN) ☐ Skilled Nursing (☐ RN/ ☐ LPN) ☐ Skilled Respite ☐ Life Skills Development (Companion) ☐ Other: _____ ☐ Other: _____ ☐ Other: _____

Population Served: ☐ Pediatric ☐ Adult ☐ Both

Required Documents Checklist

- ✓ Resume for Owner(s), Direct Care Employee #, and Direct Care Employee #2
- ✓ Two (2) Provider Reference Forms for Each Employee (Please See Attachment)
- ✓ Proof of Education for Employee #1 and Employee #2
- ✓ Copy of Professional DOH License or Board Certification, if applicable
- ✓ Copy of Local Police Check, if recent, for Owner(s), Employee #1, and Employee #2
- ✓ Copy of Identification for Owner(s), Employee #1, and Employee #2
- ✓ Copy of Social Security Card for Owner(s), Employee #1, and Employee #2

Communication Preference

Please indicate how you would like documents that require direct care staff signatures to be handled. If you would like those documents to be sent directly to the applicable direct care staff member(s), please provide the appropriate email address(es) below. If you prefer all such documents, first be sent to the owner or authorized representative for coordination, please indicate that below.

Please select one:
☐ Send documents requiring direct care staff signatures directly to the applicable staff member(s) at the email address(es) provided below
☐ Send all documents requiring direct care staff signatures to the owner/authorized representative first for coordination

Owner/Authorized Representative Email: _____

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Direct Care Staff Name(s) and Email Address(es), if applicable:

Employee #1: _____

Employee #2: _____

Acknowledgment: The undersigned understands that certain documents may require signatures from specific individuals based on licensure, role, or enrollment requirements, and agrees to provide accurate contact information to support timely processing.

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