SPECIALIZED THERAPEUTIC FOSTER CARE
PROVIDER AGENCY SELF-CERTIFICATION

This is to certify that:

Agency Name: _____

Address: _____

_____

Phone Number: (__)_____ Agency Medicaid No.: _____ (if enrolled)

meets the criteria for certification as a provider of specialized therapeutic foster care as outlined in the Florida Medicaid Specialized Therapeutic Services Coverage and Limitations Handbook.

_____ _____
Provider Agency Representative Date

Submit this form with your Florida Medicaid Provider Enrollment Application to the address listed below.

Florida Medicaid Provider Enrollment
P.O. Box 7070
Tallahassee, Florida 32314-7070

AHCA Form 5000-3513, Revised March 2014 (incorporated by reference in Rule 59G-4.295, F.A.C.)