

**HOME HEALTH AGENCY** Laboratory (CLIA) Application  
**APPLICATION FOR INITIAL LICENSURE (NECESSARY DATA)**



(1) HOME HEALTH AGENCY'S INFORMATION			
Name of Agency		Telephone Number	
Street Address		Fax	
City	County	State	Zip Code
E-mail Address			
Mailing Address (if different from above) Same			
City		State	Zip Code

(2) AGENCY OFFICE COMPLIANCE WITH LOCAL ZONING AND DISTANCE FROM OTHER HOME HEALTH AGENCIES OWNED BY THE SAME OWNERS
<p><b>Enclose the following document:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <b>A report or letter from the local government zoning office</b> that the office location is zoned appropriately for use as a home health agency and evidence of legal right to occupy the office such as a lease, deed, rental agreement or contract. Refer to s.408.810 (6), F.S.</li> </ul>

Employer Identification #
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(c) Check and enclose copies of all that are appropriate to the ownership:
<ul style="list-style-type: none"> <li><input type="checkbox"/> Articles of Incorporation. (corporations) <span style="float: right;">COPY OF LEASE      BANK STATEMENT</span></li> <li><input type="checkbox"/> Current Bylaws. (corporations) <span style="float: right;">Letter</span></li> <li><input type="checkbox"/> Partnership Agreement. (partnerships and limited partnerships)</li> <li><input type="checkbox"/> Company organizational papers. (limited liability companies, other)</li> <li><input type="checkbox"/> Certificate of Status or Authorization as filed with the Florida Department of State, Division of Corporations.</li> <li><input type="checkbox"/> Certificate of Foreign Incorporation as filed with the Florida Department of State, Division of Corporations, if applicable. (corporations established in another state)</li> <li><input type="checkbox"/> Affidavit of Fictitious Name as filed with Division of Corporations, if home health agency will operate under a name other than the name of the partnership or corporation.</li> <li><input type="checkbox"/> Proof of federal employer identification number from the Internal Revenue Service (<b>required</b>).</li> </ul>

(8) HOURS OF OPERATION
<p><b>Indicate the regular business hours of this agency by listing the time the agency office will open for business and the time it will close</b> [59A-8.003(10)(a), F.A.C., requires that an agency be open for 8 consecutive hours per day, Monday through Friday between the hours of 7 a.m. and 6 p.m., excluding legal and religious holidays]:</p> <p>Time will open <u>  9:00  </u> a.m.      Time will close <u>  5:00  </u> p.m.      Days of the Week <u>  Monday-Friday  </u></p>

<ul style="list-style-type: none"> <li><input type="checkbox"/> <b>Enclose <i>Financial Schedules 1 through 7</i>, compiled and signed by a certified public accountant, and proof of assets</b> as required by s. 400.471(2) (d) through (f), F.S., and 59A-8.004(5), F.A.C. <b>A business plan is also required</b> as stated in the instructions with the financial schedules. See AHCA Form 3110-1013 July 08, Home Health Agency Financial Schedules and instructions. <b>ACCOUNTANT</b></li> </ul>
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