LICENSE DATA SHEET: www.pnsystem.com

REQUIRED: 305.818.5940

The biennial licensure fee (**$1,705.00 per license**)

Proof of current insurance coverage in an amount of not less than $250,000 per claim

Proof of Level 2 screening within the previous 5 years for the Administrator and/or Chief Financial Officer

INITIAL Applications:

Evidence that the applicant has sufficient funds to operate the facility such as bank statements, net worth statements or financial reports. Please complete and submit the Proof of Financial Ability to Operate, AHCA Form 3100-0009
Business Plan
Proof of Organization: Certificate of Status; Articles of Incorporation
A report or letter from the local government zoning office
Signed and notarized Distance Attestation form
Copy of a lease, sublease or rental agreement, or deed
Proof of federal employer identification number from the Internal Revenue Service

A. Provider Information – please complete the following for the home health agency name and location.

License # (for renewal & change of ownership applications**)** ______________________________

National Provider Identifier (NPI) (if applicable) ______________________________

Medicare # (CMS CCN) ______________________________

Medicaid # ______________________________

Name of Home Health Agency ______________________________

Street Address ______________________________

City ____________ County ____________ State ______ Zip ____________

Telephone Number ____________ Fax Number ____________

E-mail Address ______________________________

Provider Website ______________________________

Federal Employer Identification Number (EIN) ______________________________

Ownership Names: ____________ SS # : ____________ % ownership:

____________ SS # : ____________ % ownership:

____________ SS # : ____________ % ownership:

Administrator: ____________ License: ____________ SS #:

Home Address: ____________ Date Last Criminal Background

Alt. Administrator: ____________ License: ____________

Home Address: ______________________________

DON: ____________ License: ____________

Home Address: ______________________________

Alt. DON: ____________ License: ____________

Home Address: ______________________________

CFO: ____________ License: ____________ SS #:

Home Address: ____________ Date Last Criminal Background:

Your Agency Provide service to minor of 21 years old: Yes No

Other Providers Relations ?

PERSONNEL # DIRECT	EMPLOYEES	# CONTRACTED	EMPLOYEES IF SUB-CONTRACT FROM ANOTHER AGENCY, WRITE AGENCY NAME
Nursing*	___________	_____________	____
PT*	___________	_____________	____
ST*	___________	_____________	____
OT*	___________	_____________	____
RT	___________	_____________	____
IV Therapy	___________	_____________	____
HHA*	___________	_____________	____
Homemaker/Companion	___________	_____________	____
Nutritional Guidance	___________	_____________	____
Medical Equipment	___________	_____________	____
MSW*	___________	_____________	____
Other	___________	_____________	____

Provide the number of patients admitted by your Home Health Agency's most recent fiscal year, last calendar year or most recent 12 month period: _________________

Hours Operations: __________________ to __________________

Accreditation with: ______________________________________ Expired on: __________________________