RENIEW APPLICATION CHECKLIST

Health Care Licensing Application

Applicants **must** include the following attachments as stated in Chapters 408, Part II, and 400, Part III Florida Statues (F.S.), and Chapters 59A-35 and 59A- 8, Florida Administrative Code (F.A.C.). Applications must be received **at least 60 days prior to** the expiration of the current license or effective date of a change of ownership to avoid a late fine. ***The application will be withdrawn from review if all the required documents and fees are not included with this application or received within 21 days of receipt of an omission notice.***

All forms listed below may be obtained from the website: http://ahca.myflorida.com/Publications/Forms/HQA.shtml. Send completed applications to: Agency for Health Care Administration, Home Care Unit, 2727 Mahan Drive, Mail Stop 34, Tallahassee, FL 32308.

A. Initial, Renewal and Change of Ownership Applications must include:

NOTE TO ALL APPLICANTS: The Agency will verify that all applicants, licensees and controlling interests subject to Chapters 607, 608 or 617, Florida Statutes related to Business Organizations have complied with applicable Department of State registration and filing requirements. The principal and mailing addresses submitted with any application must be the same as the addresses that appear as registered with the Department of State, Division of Corporations.

1. Provider / Licensee Information

A. Provider Information – please complete the following for the home health agency name and location. *Provider name, address and telephone number will be listed on http://www.floridahealthfinder.gov/*

License # (for renewal & change of ownership applications)	**National Provider Identifier** (NPI) (if applicable)	**Medicare #** (CMS CCN)	**Medicaid #**

Name of Home Health Agency (if operated under a fictitious name, list that here)

Street Address

City	County	State	Zip

Telephone Number	Fax Number	E-mail Address	Provider Website

Mailing Address or ☐ Same as above (All mail will be sent to this location)

City	State	Zip

Contact Person for this application	Contact Telephone Number

Contact e-mail address or ☐ Do not have e-mail	***NOTE:*** By providing your e-mail address you agree to accept e-mail correspondence from the Agency

A. Individual and/or Entity Ownership of Licensee

FULL NAME of INDIVIDUAL or ENTITY	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER	EIN (No SSNs)	% OWNERSHIP INTEREST

B. *Board Members and Officers of Licensee*

TITLE	FULL NAME	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER	% OWNERSHIP INTEREST
Director/CEO				
President				
Vice President				
Secretary				
Treasurer				
Other:				

6. Provider Fines and Financial Information

Pursuant to subsection 408.831(1)(a), Florida Statutes, the Agency may take action against the applicant, licensee, or a licensee which shares a common controlling interest with the applicant if they have failed to pay all outstanding fines, liens, or overpayments assessed by final order of the agency or final order of the Centers for Medicare and Medicaid Services (CMS), not subject to further appeal, unless a repayment plan is approved by the agency.

Are there any incidences of outstanding fines, liens or overpayments as described above? YES ☐ NO ☐

If yes, please complete the following for each incidence (attach additional sheets if necessary):

Amount: $ _____ assessed by: ☐ Agency for Health Care Administration ☐ CMS

Date of related inspection, application or overpayment period if applicable: _____

Due date of payment: _____

Is there an appeal pending from a Final Order? YES ☐ NO ☐

Please attach a copy of the approved repayment plan if applicable.

7. Federal Certification

Does the provider participate in or intend to participate in the:

Medicaid program? YES ☐ NO ☐

Medicare program? YES ☐ NO ☐

8. Other Provider Relations

Does the licensee, owner or other controlling interest own or serve as a director or officer for any other licensed health care provider in Florida?

YES ☐ **NO** ☐

If yes, provide the following information; attach additional sheets, if necessary:

PROVIDER NAME	PROVIDER TYPE	LICENSE NUMBER	CITY	EIN (No SSNs)

9. Personnel

A. Please list the following. **Enclose a resume and copy of professional license(s) if applicable for positions marked with *.**

ADMINISTRATION

Administrator*	Full Name	Home Address	Telephone Number

Per subsection 400.476(1), Florida Statues, the administrator can only work for home health agencies that share identical controlling interests. *(Refer to subsection 408.803(7), Florida Statutes regarding controlling interests).*

Required Experience:

☐ Physician License #: _____

☐ Registered Nurse License #: _____

☐ One year of supervisory or administrative experience in home health care or in a facility licensed under chapter 395 (hospital), chapter 400, Part II (nursing home), or under chapter 429, Part I (assisted living facility).

☐ Full time or ☐ Part time

Alternate Administrator*	Full Name	Home Address	Telephone Number

Per subsection 400.476(1), Florida Statues, the alternate administrator can only work for home health agencies that share identical controlling interests. *(Refer to subsection 408.803(7), Florida Statutes regarding controlling interests).*

Required Experience:

☐ Physician License #: _____

☐ Registered Nurse License #: _____

☐ One year of supervisory or administrative experience in home health care or in a facility licensed under chapter 395 (hospital), chapter 400, Part II (nursing home), or under chapter 429, Part I (assisted living facility).

☐ Full time or ☐ Part time

Director of Nursing*	Full Name	Home Address	License Number

Per subsection 400.476(2), F.S., the DON can only work for home health agencies that share identical controlling interests. (*Refer to subsection 408.803(7), Florida Statutes regarding controlling interests.)*

Required Experience:

☐ One year of supervisory experience as a registered nurse.

☐ Full time or ☐ Part time

RN Delegate*	Full Name	Home Address	License Number

Required Experience:

☐ One year of supervisory experience as a registered nurse.

☐ Full time or ☐ Part time

RN* (non-skilled service agencies who are not Medicare or Medicaid certified)	Full Name	Home Address	License Number

☐ Full time ☐ Part time or ☐ Contract

Chief Financial Officer	Full Name	Home Address	Telephone Number

☐ Full time ☐ Part time or ☐ Contract

B. Please provide the following information on Service Personnel.

NOTE: "Direct employees" are those for whom the agency pays withholding taxes. State rules require that a licensed-only agency provide at least one of the services listed below by direct employees. If providing nursing services, some of the service must be provided by a direct employee as required in state law, section 400.487(5), F.S. Federal regulations require that Medicare and Medicaid agencies provide one of the skilled services (*) below totally by direct employees. (Medicaid does not include Medical Social Services as a home health agency service).

PERSONNEL	# DIRECT EMPLOYEES	# CONTRACTED EMPLOYEES	IF SUB-CONTRACT FROM ANOTHER AGENCY, WRITE AGENCY NAME BELOW
Nursing*			
Physical Therapy*			
Speech Therapy*			
Occupational Therapy*			
Respiratory Therapy			
IV Therapy			
Home Health Aide*			
Homemaker / Companion			
Nutritional Guidance			
Medical Equipment & Supplies			
Medical Social Services*			
Other:			

C. **RENEWAL APPLICATIONS ONLY:** Pursuant to section 400.471.(2)(c), F.S., 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: _____.

10. Geographic Service Area

For initial applications list all counties where this agency expects to provide services. For all other applications, list only those counties that this agency plans to add (A) or delete (D) counties from the existing license.

NOTE: Counties must be within a single AHCA area (see below)

COUNTY	(A)dd / (D)elete	COUNTY	(A)dd / (D)elete
1.		9.	
2.		10.	
3.		11.	
4.		12.	
5.		13.	
6.		14.	
7.		15.	
8.		16.	

AHCA Area 1: Escambia, Okaloosa, Santa Rosa, Walton; **AHCA Area 2:** Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, Washington; **AHCA Area 3:** Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, Union. **AHCA Area 4:** Duval, Baker, Clay, Flagler, Nassau, St. Johns, Volusia; **AHCA Area 5:** Pasco, Pinellas; **AHCA Area 6:** Hardee, Highlands, Hillsborough, Manatee, Polk; **AHCA Area 7:** Brevard, Orange, Osceola, Seminole; **AHCA Area 8:** Charlotte, Collier, DeSoto, Glades, Hendry, Lee, Sarasota; **AHCA Area 9:** Indian River, Martin, Okeechobee, Palm Beach, St. Lucie; **AHCA Area 10:** Broward; **AHCA Area 11:** Dade, Monroe.

11. Days and Hours of Operation

Day of the Week	Opening Time	Closing Time
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

☐ Indicate if the agency will have a 24-hour on-call system (required for agencies offering skilled services).

12. Accreditation / Deemed Status

Renewal Applicants: If you applied and were licensed after July 1, 2008, you must be accredited with one of the accrediting organizations listed below. Please check the appropriate accrediting organization and include a current copy of your accreditation report with this application.

Renewal Applications with prior accreditation and/or deemed status: If your agency is still accredited or accredited and deemed, please check the appropriate accrediting organization box below and include a current copy of your accreditation and/or deemed status report.

Accrediting Organization

☐ Joint Commission (JC) ☐ Community Health Accreditation Program (CHAP) ☐ Accreditation Commission for Health Care (ACHC)

☐ ***Expiration date of accreditation:*** _____

☐ Proof of accreditation enclosed

☐ Proof of application for accreditation – a screen print receipt from accrediting organization web site or letter of receipt of application from accrediting organization.

☐ No longer accredited and/or deemed

RETURN THIS COMPLETED FORM WITH FEES TO:

AGENCY FOR HEALTH CARE ADMINISTRATION
HOME CARE UNIT
2727 MAHAN DR., MS 34
TALLAHASSEE FL 32308-5407

Questions? Visit the Agency's website : http://ahca.myflorida.com: or contact the Home Care Unit at (850) 414-6010