Provider:

Provider Type:
Home Health Agency

File#:
License #:
Expires:

Application:
Type:
Status:
Application Received Date:

= Entered
= Entry Required

- Provider/Facility Information
  - Details
  - Contact Person
- Licensee Information
- Controlling Interests
- Management Company Information
- Personnel
- Required Disclosure
- Accreditation
- Days and Hours of Operation
- Geographic Service Area
- Services
- Other Associated Locations
- Supporting Documents
- Finalize Submission

Health Care Licensing Online Application
Home Health Agency
AHCA Form 3110-1011 OL, April 2019
59A-8.003, Florida Administrative Code

Provider/Facility Information

Under the authority of Chapters 408, Part II and 400, Part III, Florida Statutes (F.S.), and Chapters 59A-35 and 59A-8, Florida Administrative Code (F.A.C.), an application is hereby made to operate a home health agency as indicated below.

Pursuant to section 408.806 (1)(a) and (b), F.S., an application for licensure must include: the name, address and social security number of the applicant, administrator or similarly titled person who is responsible for the day to day operation of the provider, financial officer or similarly titled person who is responsible for the financial operation of the licensee or provider and each controlling interest, if the applicant or controlling interest is an individual; and the name, address, and federal employer identification number (EIN) of the applicant and each controlling interest, if the applicant or controlling interest is not an individual. Disclosure of social security number(s) is mandatory. The Agency for Health Care Administration (AHCA) shall use such information for purposes of securing the proper identification of persons listed on this application for licensure.

Review the information below and make any necessary edits. The Provider/Facility name, address, and telephone number will be listed on Florida Health Finder (http://www.floridahealthfinder.gov).

Provider/Facility Information

License # ________ National Provider Identifier ________

☐ None ☐ Pending

Medicaid # ________ Medicare # (CMS CCN) ________

Name of Home Health Agency (If operated under a fictitious name, enter as it appears in Florida Division of Corporations.)

____

Provider/Facility Location Address

Edit Address

Provider Location Address

Telephone ________ Ext ____ Fax # ________

☐ None

Email Address *Note: By providing your email address, you agree to accept email correspondence from the Agency.*

____

☐ None

Provider/Facility Website

____

☐ None

Provider/Facility Mailing Address (All mail will be sent to this address.)

☐ Check if same as Provider/Facility Location Address

Edit Address

Address

Telephone ________ Ext ____ Email Address ________

☐ None

Undo Save Next >>

Provider:

Provider Type:
Home Health Agency

File#:
License #:
Expires:

Application:
Type:
Status:
Application Received Date:

= Entered
= Entry Required

Provider/Facility Information
Details
Contact Person

Licensee Information
Controlling Interests
Management Company Information
Personnel
Required Disclosure
Accreditation
Days and Hours of Operation
Geographic Service Area
Services
Other Associated Locations
Supporting Documents
Finalize Submission

Provider/Facility Information

Provider/Facility Contact Person for this Application

First Name | Middle Name | Last Name | Suffix

Telephone | Ext | Fax #

☐ None

Contact Email Address (By providing your email address, you agree to accept email correspondence from the Agency.)

☐ None

Undo | Save | << Back | Next >>

Provider:

Provider Type:
Home Health Agency

File#: :
License #:
Expires: '

Application:
Type:
Status:
Application Received Date:

= Entered
= Entry Required

- Provider/Facility Information
- Licensee Information
  - Licensee Details
- Controlling Interests
- Management Company Information
- Personnel
- Required Disclosure
- Accreditation
- Days and Hours of Operation
- Geographic Service Area
- Services
- Other Associated Locations
- Supporting Documents
- Finalize Submission

Licensee Information

Description of licensee (select only one option below)

○ For Profit ○ Not for Profit ○ Public

Ownership Types

Entity Licensee Details

Licensee Name (may be same as provider name)

Federal Employer Identification # (EIN)

Mailing Address

Edit Address

Address

Telephone

Ext

Fax #

☐ None

Email Address

☐ None

Undo

Save

<< Back

Next >>

Health Care Licensing Online Application
Home Health Agency
AHCA Form 3110-1011 OL, April 2019
59A-8.003, Florida Administrative Code

Provider:

Provider Type:
Home Health Agency

File#:
License #:
Expires:

Application:
Type:
Status:
Application Received Date:

= Entered
= Entry Required

- Provider/Facility Information
- Licensee Information
- Controlling Interests
  - Controlling Interests
- Management Company Information
- Personnel
- Required Disclosure
- Accreditation
- Days and Hours of Operation
- Geographic Service Area
- Services
- Other Associated Locations
- Supporting Documents
- Finalize Submission

Controlling Interests of Licensee

Controlling Interests, as defined in Section 408.803(7), F.S., are the applicant or licensee; a person or entity that serves as an officer of, is on the board of directors of, or has a 5% or greater ownership interest in the applicant or licensee; or a person or entity that serves as an officer of, is on the board of directors of, or has a 5% or greater ownership interest in the management company or other entity, related or unrelated, with which the applicant or licensee contracts to manage the provider. The term does not include a voluntary board member.

Note: For each controlling interest, an AHCA Screening through the Care Provider Background Screening Clearinghouse is needed, or the Attestation of Compliance with the Background Screening Requirements, AHCA Form 3100-0008 if background screening was conducted by the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S. To verify who must be screened, visit the Background Screening site.

Do any individuals or entities possess 5% or greater ownership interest in the licensee, or, function as a board member or officer?

○ Yes ○ No

To add a controlling interest -
Utilizing the picklist below, either choose an individual/entity that is already associated with this application or select 'New Controlling Interest - Individual' or 'New Controlling Interest - Entity'

To edit an existing controlling interest -
Select "Edit/View" and edit as needed.

To remove an existing controlling interest -
Select "Remove" and enter the date the controlling interest's relationship with the licensee ended.

			Full Name of Individual/Entity	Type	Tax ID	Effective Date	End Date	%
Remove	Edit/View			SSN				

Total 100.00

Removed: (-) Added: (+)

If the percentage of ownership interest indicated above does not equal 100%, please explain why in the space below:

Undo Save << Back Next >>

Add Individual

Individual Ownership of Licensee

Edit Individual

Board Member/Officer ☐

% Ownership Interest

Owner/Board Member

Effective Date

End Date

Personal Mailing Address

Edit Address

Mailing Address

Telephone # (___)___-____

Ext

Email Address

☐ None

Done Cancel

Provider:

Provider Type:
Home Health Agency

File#:
License #:
Expires:

Application:
Type:
Status:
Application Received Date.

= Entered
= Entry Required

- Provider/Facility Information
- Licensee Information
- Controlling Interests
- Management Company Information
  - Management Company Information
  - Management Company Controlling Interest
- Personnel
- Required Disclosure
- Accreditation
- Days and Hours of Operation
- Geographic Service Area
- Services
- Other Associated Locations
- Supporting Documents
- Finalize Submission

Management Company Information

Does a company other than the licensee manage the licensed provider?

○ Yes ○ No

Undo Save << Back Next >>

Add Management Company

Add Management Company

Name of Management Company

Federal Employer Identification # (EIN)

Effective Date

End Date

Location Address

Edit Address

Location Address

Telephone #

(__)__-____

Ext

Fax

(__)__-____

☐ None

Email Address

☐ None

Mailing Address

☐ Check if same as Management Company Location Address

Edit Address

Mailing Address

Contact Person

Edit Individual

Contact Person:

Telephone #

(__)__-____

Ext

Email Address

☐ None

Done Cancel

Provider:

Provider Type:
Home Health Agency

File#: :
License #:
Expires:

Application:
Type.
Status:
Application Received Date:

= Entered
= Entry Required

Provider/Facility Information
Licensee Information
Controlling Interests
Management Company Information
Management Company Information
Management Company Controlling Interest
Personnel
Required Disclosure
Accreditation
Days and Hours of Operation
Geographic Service Area
Services
Other Associated Locations
Supporting Documents
Finalize Submission

Management Company Controlling Interest

Controlling interests, as defined in Section 408.803(7), F.S., are the applicant or licensee; a person or entity that serves as an officer of, is on the board of directors of, or has a 5% or greater ownership interest in the applicant or licensee; or a person or entity that serves as an officer of, is on the board of directors of, or has a 5% or greater ownership interest in the management company or other entity, related or unrelated, with which the applicant or licensee contracts to manage the provider. The term does not include a voluntary board member.

Note: For each controlling interest, an AHCA Screening through the Care Provider Background Screening Clearinghouse is needed, or the Attestation of Compliance with the Background Screening Requirements, AHCA Form 3100-0008 if background screening was conducted by the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S. To verify who must be screened, visit the Background Screening site.

To add a controlling interest -
Utilizing the picklist below, either choose an Individual/entity that is already associated with this application or select 'New Controlling Interest - Individual' or 'New Controlling Interest - Entity'.

To edit an existing controlling interest -
Select "Edit/View" and edit as needed.

To remove an existing controlling interest -
Select "Remove" and enter the date the controlling interest's relationship with the licensee ended.

			Full Name of Individual/Entity	Type	Tax ID	Effective Date	End Date	%
Remove	Edit/View			SSN				

Total 0.00

Removed: (-) Added. (+)

If the percentage of ownership interest indicated above does not equal 100%, please explain why in the space below:

Undo Save << Back Next >>

Health Care Licensing Online Application
Home Health Agency
AHCA Form 3110-1011 OL, April 2019
59A-8.003, Florida Administrative Code

Add Individual

Individual Ownership of Management Company

Edit Individual

Board Member/Officer

% Ownership Interest

Owner/Board Member

Effective Date | *End Date*

Personal Mailing Address

Edit Address

Mailing Address

Telephone # (__)___-____ | *Ext*

Email Address

☐ None

Done | Cancel

Provider:

Provider Type:
Home Health Agency

File#:
License #:
Expires:

Application:
Type:
Status:
Application Received Date:

= Entered
= Entry Required

Provider/Facility Information
Licensee Information
Controlling Interests
Management Company Information
Personnel
Administration
Safety Liaison
Required Disclosure
Accreditation
Days and Hours of Operation
Geographic Service Area
Services
Other Associated Locations
Supporting Documents
Finalize Submission

Personnel

Personnel

Note: For the administrator, alternate administrator, financial officer, director of nursing, alternate director of nursing or registered nurse whose responsibilities may require him or her to provide personal care or services directly to clients or have access to client funds, personal property, or living areas, whether employed or contracted, an Agency Screening through the Care Provider Background Screening Clearinghouse is needed or the Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, if background screening was conducted by the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S.. To verify who must be screened, visit the Background Screening site.

Provide the information for the individual(s) who perform the following roles:

- Administrator
- Alternate Administrator
- Alternate Director of Nursing (if applicable)
- Director of Nursing (if applicable)
- Financial Officer
- Registered Nurse (if applicable)

To add an individual -
Utilizing the picklist below, either choose an individual that is already associated with this application or select 'New Individual'.

To edit an existing individual -
Select "Edit/View" and edit as needed.

To remove an existing individual -
Select "Remove" and enter the date the individual's relationship with the licensee ended.

		Full Name of Individual	Type	Tax ID	Roles	Effective Date	End Date
Remove	Edit/View		SSN				

Removed: (-) Added: (+)

Undo Save << Back Next >>

Health Care Licensing Online Application
Home Health Agency
AHCA Form 3110-1011 OL, April 2019
59A-8.003, Florida Administrative Code

Administration

Administration

Edit Individual

Individual

* If this individual fills the role of Administrator or Financial Officer, you must provide their TaxID as stated in subsection 408.806(1)(a), F.S. Failing to do so will result in an omission.

Select the roles below that apply to the individual listed above.

Role	Effective Date	End Date	Experience
☐ Administrator			Experience
☐ Alternate Administrator			Experience
☐ Alternate Director of Nursing			Experience
☐ Director of Nursing			Experience
☐ Financial Officer			
☐ Registered Nurse			Experience

Edit Address

Address

Contacts

Telephone # (___)___-____ Ext

Email Address

☐ None

Done Cancel

Experience

Administrator
Pursuant to section 400.476(1), F.S., the administrator can only work for home health agencies that share identical controlling interest. An administrator cannot serve as the director of nursing if there are more than 10 full time equivalent staff including contracted personnel working in the home health agency.

Qualification

- ○ Holding a professional healthcare license; or
- ○ Work Experience

Select the appropriate profession from the list, and provide the license number in the space provided.

Experience

Does the Administrator hold one year of supervisory 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)?

- ○ Yes
- ○ No

The Administrator's work status is:

- ○ Full Time
- ○ Part time

Done Cancel

Experience

Alternate Administrator
Pursuant to section 400.476(1), F.S., the alternate administrator can only work for home health agencies that share identical controlling interest. An administrator cannot serve as the director of nursing if there are more than 10 full time equivalent staff including contracted personnel working in the home health agency.

Qualification

- ○ Holding a professional healthcare license; or
- ○ Work Experience

Select the appropriate profession from the list, and provide the license number in the space provided.

Experience

Does the Alternate Administrator hold one year of supervisory 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)?

- ○ Yes
- ○ No

The Alternate Administrator's work status is:

- ○ Full Time
- ○ Part time

Done | Cancel

Experience

Director of Nursing

Pursuant to section 400.476(2), F.S., the Director Nursing can only work for home health agencies that share identical controlling interests.

Select the appropriate profession from the list, and provide the license number in the space provided.

One year of supervisory experience as a registered nurse

- ○ Yes
- ○ No

The Director of Nursing's work status is:

- ○ Full Time
- ○ Part time

Will the Director of Nursing be expected to, or whose responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas?

- ○ Yes
- ○ No

Done | Cancel

Experience

Alternate Director of Nursing
Pursuant to section 400.476(2), F.S., the Alternate Director Nursing can only work for home health agencies that share identical controlling interests.

Select the appropriate profession from the list, and provide the license number in the space provided.

One year of supervisory experience as a registered nurse

○ Yes
○ No

The Alternate Director of Nursing's work status is:

○ Full Time
○ Part time

Will the Alternate Director of Nursing be expected to, or whose responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas?

○ Yes
○ No

Done Cancel

Experience

Registered Nurse
An RN is required for home health agencies providing only non-skilled services to perform supervisory visits to the patient's home in accordance with the patient's directions, approval, and agreement to pay the charge for the visit and to provide supervision and oversight of home health aides and certified nursing assistants as stated in section 400.487(3), F.S., and section 59A-8.0095(5), F.A.C.

Select the appropriate profession from the list, and provide the license number in the space provided.

The Registered Nurse's work status is:

- ○ Full Time
- ○ Part time

Done Cancel

Experience

Financial Officer

Select the appropriate profession from the list, and provide the license number in the space provided.

The Financial Officer's work status is:

○ Full Time ○ Part time ○ Contract

Done Cancel

Provider:

Provider Type:
Home Health Agency

File#:
License #:
Expires:

Application:
Type:
Status:
Application Received Date:

= Entered
= Entry Required

Provider/Facility Information
Licensee Information
Controlling Interests
Management Company Information
Personnel
Administration
Safety Liaison
Required Disclosure
Accreditation
Days and Hours of Operation
Geographic Service Area
Services
Other Associated Locations
Supporting Documents
Finalize Submission

Personnel

Safety Liaison

Please provide the requested information for the individual who will serve as primary contact during emergency operation pursuant to section 408.821, F.S..

Safety Liaison

To add an individual -
Utilizing the picklist below, either choose an individual that is already associated with this application or select 'New Individual'.

To verify individual's information -
Select "Edit/View" and edit as needed.

To remove an existing individual -
Select "Remove" and enter the applicable end date.

	Full Name of Individual	Mailing Address	Effective Date	End Date
Remove Edit/View (+)				

Removed: (-) Added: (+)

Undo Save << Back Next >>

Safety Liaison

Safety Liaison

Edit Individual

Individual

Effective Date

End Date

Personal Mailing Address

Edit Address

Address

Contacts

Telephone # Ext

Email Address

☐ None

Done Cancel

Provider:

Provider Type:
Home Health Agency

File#:
License #:
Expires:

Application:
Type:
Status
Application Received Date:

= Entered
= Entry Required

- Provider/Facility Information
- Licensee Information
- Controlling Interests
- Management Company Information
- Personnel
- Required Disclosure
  - Convictions
  - Exclusions
  - Felonies/Terminations
  - Nonimmigrant Aliens
- Accreditation
- Days and Hours of Operation
- Geographic Service Area
- Services
- Other Associated Locations
- Supporting Documents
- Finalize Submission

Required Disclosure

Convictions

Pursuant to section 408.809, F.S., the applicant shall submit to the agency a description and explanation of any convictions or offenses prohibited by sections 435.04 and 408.809(4), F.S.. for each controlling interest.

Has the applicant or any individual listed in the Controlling Interests or Management Company Controlling Interests sections of this application been convicted of any level 2 offense pursuant to subsection 408.809, Florida Statutes?

○ Yes ○ No

Undo Save << Back Next >>

Provider:

Provider Type:
Home Health Agency

File#.
License #
Expires:

Application:
Type:
Status.
Application Received Date:

= Entered
= Entry Required

Provider/Facility Information
Licensee Information
Controlling Interests
Management Company Information
Personnel
Required Disclosure
Convictions
Exclusions
Felonies/Terminations
Nonimmigrant Aliens
Accreditation
Days and Hours of Operation
Geographic Service Area
Services
Other Associated Locations
Supporting Documents
Finalize Submission

Required Disclosure

Exclusions

Pursuant to section 408.810(2), F.S., the applicant must provide a description and explanation of any exclusions, suspensions, or terminations from the Medicare, Medicaid, or federal Clinical Laboratory Improvement Amendment (CLIA) programs.

Has the applicant or any individual/entity listed in the Controlling Interests or Management Company Controlling Interests sections of this application been excluded, suspended, terminated or involuntarily withdrawn from participation in Medicare or Medicaid in any state?

○ Yes ○ No

Undo Save << Back Next >>

Health Care Licensing Online Application
Home Health Agency
AHCA Form 3110-1011 OL, April 2019
59A-8.003, Florida Administrative Code

Provider:

Provider Type:
Home Health Agency

File#:
License #:
Expires.

Application:
Type.
Status
Application Received Date:

= Entered
= Entry Required

Provider/Facility Information
Licensee Information
Controlling Interests
Management Company Information
Personnel
Required Disclosure
Convictions
Exclusions
Felonies/Terminations
Nonimmigrant Aliens
Accreditation
Days and Hours of Operation
Geographic Service Area
Services
Other Associated Locations
Supporting Documents
Finalize Submission

Required Disclosure

Felonies/ Terminations

Pursuant to section 408.815(4), F.S , has the applicant or a controlling interest in the applicant, or any entity in which a controlling interest of the applicant was an owner or officer when the following actions occurred ever been:

1. Convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409 , chapter 817, chapter 893, 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396, Medicaid fraud, Medicare fraud or insurance fraud, within the previous 15 years prior to the date of this application;

○ Yes ○ No

2. Terminated for cause from the Medicare program or a state Medicaid program.

○ Yes ○ No

If yes, has applicant been in good standing with the Medicare program or a state Medicaid program for the most recent 5 years and the termination occured at least 20 years before the date of the application.

Yes

Undo Save << Back Next >>

Provider:

Provider Type:
Home Health Agency

File#:
License #:
Expires:

Application:
Type:
Status:
Application Received Date:

= Entered
= Entry Required

- Provider/Facility Information
- Licensee Information
- Controlling Interests
- Management Company Information
- Personnel
- Required Disclosure
  - Convictions
  - Exclusions
  - Felonies/Terminations
  - Nonimmigrant Aliens
- Accreditation
- Days and Hours of Operation
- Geographic Service Area
- Services
- Other Associated Locations
- Supporting Documents
- Finalize Submission

Required Disclosure

Nonimmigrant Aliens

If the applicant or any controlling interests are nonimmigrant aliens according to 8 U.S.C. ss1101, then a surety bond of at least $500,000 must be filed, payable to AHCA, that guarantees the home health agency will act in full conformity with all legal requirements for operation pursuant to section 408.8065(2), F.S.. Include the surety bond in the Supporting Documents section of this application.

Are there any nonimmigrant aliens listed as a licensee or controlling interest in this application?

○ Yes ○ No

Undo Save << Back Next >>

Provider:

Provider Type:
Home Health Agency

File#:
License #:
Expires:

Application:
Type
Status:
Application Received Date:

= Entered
= Entry Required

Provider/Facility Information
Licensee Information
Controlling Interests
Management Company Information
Personnel
Required Disclosure
Accreditation
Accreditation
Days and Hours of Operation
Geographic Service Area
Services
Other Associated Locations
Supporting Documents
Finalize Submission

Accreditation

If you were licensed after July 1, 2008 and provide skilled care, you must be accredited by one of the accrediting organizations listed below. Please check the appropriate accrediting organization in the table below and include a copy of the most recent accreditation award letter and accreditation survey report with this application.

Accrediting Organization	Accrediting Org ID	Accreditation Effective Date	Accreditation Expiration Date	Survey Date
☐ Accreditation Commission for Health Care (ACHC)				
☐ Community Health Accreditation Partner (CHAP)				
☐ Joint Commission (JC)				

Note – If accredited, you will be required to include documentation from the accrediting organization in the Supporting Documents section of this application. Documentation must include:

1. *Name of accrediting organization*
2. *Accrediting type and status*
3. *Effective and expiration dates of accreditation*
4. *Effective and expiration dates of deemed status (if applicable)*
5. *Accrediting organization's report of findings (survey report)*
6. *Provider's response to the accrediting organization's report of findings (if a plan of correction was required)*
7. *Accrediting organization's final determination (such as an acceptance of the plan of correction)*

☐ I understand that the complete accreditation report must be submitted to the Agency for review if the accreditation report is to be accepted in lieu of a complete licensure inspection and such reports used to meet licensure requirements are considered public documents subject to disclosure per chapter 119, F.S A complete accreditation report includes correspondence from the accrediting organization containing the dates of the survey, any citations to which the accreditation organization requires a response, the facility's response to each citation, the effective date of accreditation and verification of Medicare (CMS) deemed status, if applicable.

Note: Effective July 1, 2014, a home health agency that does not provide skilled care is exempt from the accreditation requirement.

☐ No longer accredited and/or deemed

○ Not applicable/licensed prior to July 1, 2008

○ Non-skilled provider exempt from accreditation requirement pursuant to section 400.471(2)(g), F.S..

Undo Save << Back Next >>

Provider:

Provider Type:
Home Health Agency

File#.
License #:
Expires:

Application:
Type:
Status:
Application Received Date:

= Entered
= Entry Required

Provider/Facility Information
Licensee Information
Controlling Interests
Management Company Information
Personnel
Required Disclosure
Accreditation
Days and Hours of Operation
Days and Hours of Operation
Geographic Service Area
Services
Other Associated Locations
Supporting Documents
Finalize Submission

Days and Hours of Operation

List the regular operating hours. Section 59A-8.003(9)(a).F.A.C., requires that an agency be open for 8 consecutive hours per day, Monday through Friday between the hours of 7:00 AM and 6:00 PM, excluding legal and religious holidays.

Note - Site inspections by Agency surveyors will occur during the business hours submitted. Failure to be open during the listed hours may result in a fine or the denial of an application.

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

Day	Opening Time	Closing Time
MONDAY		
TUESDAY		
WEDNESDAY		
THURSDAY		
FRIDAY		
SATURDAY		
SUNDAY		

Undo Save << Back Next >>

Provider:

Provider Type:
Home Health Agency

File#:
License #:
Expires:

Application:
Type:
Status:
Application Received Date:

= Entered
= Entry Required

Provider/Facility Information
Licensee Information
Controlling Interests
Management Company Information
Personnel
Required Disclosure
Accreditation
Days and Hours of Operation
Geographic Service Area
Geographic Service Area
Services
Other Associated Locations
Supporting Documents
Finalize Submission

Geographic Service Area

Indicate each county this business location will serve by selecting the appropriate checkboxes below. For your reference, a list of counties by geographical service areas is provided at the bottom of the page.

Note - This license covers only one office location. Each additional office must be separately licensed.

Counties Served

☐ ALACHUA	☐ BAKER	☐ BAY	☐ BRADFORD	☐ BREVARD
☐ BROWARD	☐ CALHOUN	☐ CHARLOTTE	☐ CITRUS	☐ CLAY
☐ COLLIER	☐ COLUMBIA	☐ DESOTO	☐ DIXIE	☐ DUVAL
☐ ESCAMBIA	☐ FLAGLER	☐ FRANKLIN	☐ GADSDEN	☐ GILCHRIST
☐ GLADES	☐ GULF	☐ HAMILTON	☐ HARDEE	☐ HENDRY
☐ HERNANDO	☐ HIGHLANDS	☐ HILLSBOROUGH	☐ HOLMES	☐ INDIAN RIVER
☐ JACKSON	☐ JEFFERSON	☐ LAFAYETTE	☐ LAKE	☐ LEE
☐ LEON	☐ LEVY	☐ LIBERTY	☐ MADISON	☐ MANATEE
☐ MARION	☐ MARTIN	☐ MIAMI-DADE	☐ MONROE	☐ NASSAU
☐ OKALOOSA	☐ OKEECHOBEE	☐ ORANGE	☐ OSCEOLA	☐ PALM BEACH
☐ PASCO	☐ PINELLAS	☐ POLK	☐ PUTNAM	☐ SANTA ROSA
☐ SARASOTA	☐ SEMINOLE	☐ ST. JOHNS	☐ ST. LUCIE	☐ SUMTER
☐ SUWANNEE	☐ TAYLOR	☐ UNION	☐ VOLUSIA	☐ WAKULLA
☐ WALTON	☐ WASHINGTON			

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

Undo | Save | << Back | Next >>

Provider:

Provider Type:
Home Health Agency

File#:
License #:
Expires:

Application:
Type
Status:
Application Received Date:

= Entered
= Entry Required

- Provider/Facility Information
- Licensee Information
- Controlling Interests
- Management Company Information
- Personnel
- Required Disclosure
- Accreditation
- Days and Hours of Operation
- Geographic Service Area
- Services
  - Services
- Other Associated Locations
- Supporting Documents
- Finalize Submission

Services

1. 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).

SKILLED SERVICE PERSONNEL	# DIRECT EMPLOYEES	#CONTRACTED EMPLOYEES
☐ Nursing *		
☐ Physical Therapy *		
☐ Speech Therapy *		
☐ Occupational Therapy *		
☐ Respiratory Therapy		
☐ IV therapy		
☐ Nutritional Guidance		
☐ Medical Supplies		
☐ Medical Social Services *		

OTHER SERVICE PERSONNEL	# DIRECT EMPLOYEES	#CONTRACTED EMPLOYEES
☐ Home Health Aide *		
☐ Certified Nursing Assistant *		
☐ Homemaker / Companion		

2. Does your home health agency provide skilled services to children under the age of 21? ○ Yes ○ No

3. Does your agency provide only non-skilled services which include home health aide, certified nursing assistant, homemaker, and companion services? ○ Yes ○ No

4. Does your agency provide or plan to provide staffing services to a health care facility, school, or other business entity by licensed health care personnel, certified nursing assistants and home health aids who are employed by, or work under the auspices of, the home health agency pursuant to s. 400.462(30), F.S.? ○ Yes ○ No

5. Pursuant to s. 400.474(7), F.S., provide the number of patients who receive home health services by your home health agency on the day that the license renewal application is filed. [ ]

Undo | Save | << Back | Next >>

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Controlling Interests

Management Company Information

Personnel

Required Disclosure

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Geographic Service Area

Services

Other Associated Locations

Other Associated Locations

Supporting Documents

Finalize Submission

Other Associated Locations

If the licensee of this application operates under any other location associated with this license, select "Add Location" below. Otherwise, select "Next" to proceed

Satellite Office

A Satellite Office is a related office in the same geographic service area as the main office, operating under the auspices of the main office's license. Refer to sections 59A-8.003(5) and (6), F.A.C., for requirements.

Drop-Off Site

A Drop-off site may be located in any county within the licensed geographic service area. This is merely a workstation for direct care staff. Neither billing nor prospective patient is allowed. Refer to section 59A-8.003(7), F.A.C., for requirements.

Does the licensee of this application operate under any other location as described above?

○ Yes ○ No

Undo

Save

<< Back

Next >>

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- Controlling Interests
- Management Company Information
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- Accreditation
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- Services
- Other Associated Locations
- Supporting Documents
  - Supporting Documents
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Health Care Licensing Online Application
Home Health Agency
AHCA Form 3110-1011 OL, April 2019
59A-8.003, Florida Administrative Code

Supporting Documents

Applicants MUST include the following attachments as stated in Chapters 408 Part II and 400 Part III, Florida Statutes (F.S.) and Chapter 59A-35 and 59A-8, Florida Administrative Code (F.A.C)

The following file types are suggested for uploading and submitting electronic documents to the Agency: .DOC, .PDF, .TIFF, .TXT, .JPG, .XLS, and .PPT.

The following file types are NOT permitted for upload: .ZIP, .EXE, .BIN, .COM, .CMD, .SYS, .BAT, and .JS.
The upload and submission process will fail if any of these unpermitted file types are selected.

Proof of Malpractice Insurance Coverage

Carrier
Policy #
Effective Date
Expiry Date
Policy Amount
Occurrence Policy Amount

☐ An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Browse .

Uploaded Documents

View

Proof of General Liability Insurance Coverage

Carrier
Policy #
Effective Date
Expiry Date
Aggregate Policy Amount
Occurrence Policy Amount

☐ An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Browse

Uploaded Documents

View

Evidence of a Surety Bond

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Browse .

Accreditation Documentation

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Browse .

Required Disclosures Related to Actions Taken by Medicare, Medicaid, or CLIA

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Browse.

Approved Repayment Plan

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Browse .

Additional Documentation

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Browse

Undo | Save | << Back | Next >>

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Accreditation
Days and Hours of Operation
Geographic Service Area
Services
Other Associated Locations
Supporting Documents
Finalize Submission
Finalize Application

Finalize Application

Any areas marked in red are incomplete and must be completed before the application can be submitted. To submit the application, select the appropriate subsection below, or from the Applications Components list to the left, and provide the missing information.

1. Provider/Facility Information
   a. Details
   b. Contact Person
2. Licensee Information
   a. Licensee Details
3. Controlling Interests
   a. Controlling Interests
4. Management Company Information
   a. Management Company Information
   b. Management Company Controlling Interest
5. Personnel
   a. Administration
   b. Safety Liaison
6. Required Disclosure
   a. Convictions
   b. Exclusions
   c. Felonies/Terminations
   d. Nonimmigrant Aliens
7. Accreditation
   a. Accreditation
8. Days and Hours of Operation
   a. Days and Hours of Operation
9. Geographic Service Area
   a. Geographic Service Area
10. Services
    a. Services
11. Other Associated Locations
    a. Other Associated Locations
12. Supporting Documents
    a. Supporting Documents

I _, attest as follows:

(1) Pursuant to section 837.06, Florida Statutes, I have not knowingly made a false statement with the intent to mislead the Agency in the performance of its official duty.

(2) Pursuant to section 408.815, Florida Statutes, I acknowledge that false representation of a material fact in the license application or omission of any material fact from the license application by a controlling interest may be used by the Agency for denying and revoking a license or change of ownership application.

(3) Pursuant to section 408.806, Florida Statutes, under penalty of perjury, the applicant is in compliance with the provisions of section 408.806 and Chapter 435, Florida Statutes.

(4) Pursuant to section 408.809 and 435.05, Florida Statutes, every employee of the applicant required to be screened has attested, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to Chapter 408, Part II and Chapter 435, Florida Statutes, and has agreed to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer.

(5) Pursuant to section 435.05, Florida Statutes, the applicant has conducted a level 2 background screening through the Agency on every employee required to be screened under Chapter 408, Part II or Chapter 435, Florida Statutes, as a condition of employment and continued employment and that every such employee has satisfied the level 2 background screening standards or obtained an exemption from disqualification from employment.

Signature of Licensee or Authorized Representative ______ Title ______ Date ______

☐ I agree

Biennial Licensure Fee and Other Amounts Due Upon Submission of Application

- The biennial licensure fee is $1,705
- The biennial health care assessment fee is $300
- Other amounts due (fines, assessment, fees, etc) will be detailed in the application