AHCA USE ONLY:

File #: _____
Application #: _____
Check #: _____
Check Amt: _____

HEALTH CARE LICENSING APPLICATION
ASSISTED LIVING FACILITIES

The Agency for Health Care Administration (AHCA) has implemented the **ONLINE LICENSING SYSTEM, which** allows the electronic submission of renewal and change during licensure period applications and fees, along with the ability to upload supporting documentation. To submit online please go to https://ahca.myflorida.com/health-care-policy-and-oversight/online-licensure-information/online-licensing-system

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 fee. If the renewal application is received by the Agency less than 60 days prior to the expiration date, it is subject to a late fee as set forth in statute. The application will be withdrawn from review if all the required documents and fees are not included with your application or received within 21 days of an omission notice. **Applications will not be considered for review until payment has been received. Renewal and Change During Licensure Period applications: Supporting documentation, responses to omissions and payments may be submitted using the online system even if the application was originally mailed to the Agency.** Please fill in all blanks or mark N/A if not applicable.

Under the authority of Chapters 408 Part II, and 429, Part I, Florida Statutes (F.S.), and Chapters 59A-35, 59A-36, Florida Administrative Code (F.A.C.), an application is hereby made to operate an assisted living facility as indicated below:

1. Provider / Licensee Information

A. PROVIDER INFORMATION – Please complete the following for the assisted living facility name and location. Provider name, address and telephone number will be listed on https://quality.healthfinder.fl.gov/index.html

License Number (if applicable)	National Provider Identifier (NPI) (if applicable)	Medicare Number (CMS CCN)	Florida Medicaid Number

Name of Assisted Living Facility (if operated under a fictitious name, enter as it is filed with the Florida Division of Corporations)

Street Address

City	County	State	Zip

Telephone Number	Fax Number

E-mail Address	**Note**: By providing your e-mail address you agree to accept e-mail correspondence from the Agency

Provider Website

Mailing Address or ☐ Same as above

City	County	State	Zip

Telephone Number	E-mail Address

B. PROPERTY OWNER INFORMATION – Complete the following for the owner of the property if different from the licensee.

Does an individual or entity other than the licensee own the property where the principal office is located?

If ☐ NO, skip to **Section 1.C. – Contact Person**

If ☐ YES, please provide the following information:

Full Name of Property Owner

☐ Owned ☐ Leased	Telephone Number
Primary Address	Effective Date

C. **CONTACT PERSON -** Please complete the following for the contact person for this application.	
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.

D. **LICENSEE INFORMATION –** Please complete the following for the entity seeking to operate the assisted living facility.		
Licensee Name (this is the owner of the assisted living facility)		Federal Employer Identification Number (EIN)
Mailing Address or ☐ Same as above		
City	State	Zip
Telephone Number	Fax Number	Email Address

Description of Licensee (check one):

For Profit	Not for Profit	Public
☐ Corporation	☐ Corporation	☐ State
☐ Limited Liability Company	☐ Religious Affiliation	☐ City/County
☐ Partnership	☐ Other	☐ Hospital District
☐ Individual		
☐ Sole Proprietor		
☐ Other		

2. Application Type, Number of Beds and Fees

Indicate the type of application with an "X." **Applications will not be processed if all applicable fees are not included. Pursuant to section 408.805(4), F.S., fees are nonrefundable.** Renewal and Change of Ownership applications must be received 60 days prior to the expiration of the license or the proposed effective date of the change to avoid a late fine. If the renewal application is received by the Agency less than 60 days prior to the expiration date, it is subject to a late fee as set forth in statute. The applicant will receive notice of the amount of the late fee as part of the application process or by separate notice.

A. TYPE OF APPLICATION

☐ Initial Licensure **Proposed Effective Date**: _____

Was this entity previously licensed as an Assisted Living Facility? YES ☐ NO ☐

If YES, please provide the name of the facility (if different), the EIN # and the date the prior license expired/closed:

NAME:	EIN #	Date Expired/Closed:

☐ Renewal Licensure

☐ Change of Ownership **Proposed Effective Date**: _____

- ☐ Licensee sale or transfer of ownership to a different individual/entity
- ☐ Transfer or assignment of 51% or more ownership, shares, membership, or controlling interest of the licensee

☐ Change during licensure period - select all that apply: **Proposed Effective Date**: _____

Fee Required	No Fee Required
☐ Provider Name	☐ Personnel
☐ Provider Address	☐ Management Company
☐ Bed Capacity:	☐ Management Company Controlling Interest
☐ Increase ☐ Decrease	☐ Property Owner
Services/Qualifications:	☐ Transfer or assignment of less than 51% ownership, shares, membership, or controlling interest of the licensee
☐ Add Specialty License ☐ Remove Specialty License	

B. TYPE OF LICENSE: Select all that apply.

Required - ☐ Standard

Pursuant to section 429.07(3), F.S., Initial applicants may apply for LMH, LNS or ECC license.

Optional Specialty Licenses:

☐ Limited Nursing Services (LNS) ☐ Limited Mental Health (LMH)

Note: Pursuant section 429.07, F.S., in order for extended congregate care services to be provided, the agency must first determine that all requirements established in law and rule are met and must specifically designate, on the facility's license, that such services may be provided and whether the designation applies to all or part of the facility. If the assisted living facility has been licensed for less than two years, the initial ECC license will be issued as a Provisional License and may not exceed six months. The licensee shall notify the Agency, in writing, when it has admitted at least one ECC resident, after which an unannounced inspection shall be made to determine compliance with the requirements an ECC license. A licensee with a Provisional ECC License that demonstrates compliance with all requirements of an ECC license during the inspection shall be issued an ECC license.

☐ Extended Congregate Care (ECC)

If applying for an ECC license, provide the following information:

TOTAL BEDS	BUILDING	WING	FLOOR	ROOMS

If applying for a LNS or ECC license, has the facility maintained a standard license and has not been sanctioned for the past two calendar years?

☐ YES

☐ NO (STOP – You are not eligible; please skip to section C)

If applying for a LMH license, does the facility currently hold a Standard license and have no uncorrected deficiencies?

☐ YES

☐ NO (STOP – You are not eligible; please skip to section C)

C. NUMBER OF BEDS

Please enter the number of beds: *(currently licensed beds or proposed beds for initial applicants)*:

If this is a renewal application, did you admit a private pay resident into a designated OSS Bed?

☐ YES ☐ NO

If YES, please remit the fee for the OSS beds used for private pay residents ($64.96 x # of beds converted =$_____)

Note: To request an increase/decrease in the number of beds please see section 2E. Do not include the increase/decrease number of beds in this count.

OSS Beds: ___ + Private Pay Beds: ___ = Total Beds ***(OSS and Private Pay Beds):*** _____

Beds designated for recipients of optional state supplementation payments provided for in section 409.212, F.S. are exempt from the per bed fee.

D. LICENSURE FEES

Note: If this application is ***only*** to increase or decrease the number of licensed beds (not for initial, renewal or change of ownership) please skip to section E.

ACTION	FEE	TOTAL FEES
License Fee **Standard ALF** (Initial, Renewal and Change of Ownership):☐ License Fee Exemption (County or Municipal Government pursuant to section 429.07(5), F.S.) = $ 0.00	$64.96 per private pay bed x _____ number of beds + **$387.73** *(not to exceed $14,253.64)*	$
Specialty License - Extended Congregate Care (ECC)	$10.15 per bed x _____ total capacity + $546.07	$
Specialty License - Limited Nursing Service (LNS)	$10.15 per bed x _____ total capacity + $322.77	$
Specialty License - Limited Mental Health (LMH)	NO EXTRA FEE	$0.00
Biennial Assessment Fee – Not to exceed $300	$2.00 per bed x _____ # of beds	$
TOTAL FOR SECTION D - FEES TO BE INCLUDED WITH APPLICATION		**$**

E. INCREASE/DECREASE IN BED CAPACITY BETWEEN LICENSE RENEWAL PERIOD – If requesting an increase or decrease in the current number of licensed beds (not for an initial, renewal or change of ownership) please complete this section.

Total number of currently licensed beds: _____ ☐ Increase: # of beds _____ ☐ Decrease: # of beds _____

TYPE OF BEDS	# INCREASED	# DECREASED	FEE	TOTAL FEES
Private Pay Beds			$64.96 per private pay bed x _____ number of new beds	$
OSS Beds			No bed fee required for increase of beds.	$0.00
LNS Beds			$10.15 per bed x _____ number of beds	$
LMH Beds			No bed fee required for increase of beds.	$0.00
ECC Beds			$10.15 per bed x _____ number of beds	$
			Change During Licensure Period	$25.00
TOTAL FOR SECTION E - FEES TO BE INCLUDED WITH APPLICATION				**$**

F. ADD A SPECIALTY BETWEEN LICENSE RENEWAL PERIOD OR CHANGE THAT REQUIRES A NEW OR REPLACEMENT LICENSE – If the facility currently holds a Standard License; complete this section to add a LNS or ECC specialty license between biennial license renewal periods:

ACTION	FEE	TOTAL FEES
Specialty License - Extended Congregate Care (ECC)	$10.15 per bed x _____ total capacity +$546.07 = *(fee is prorated at $22.75 per month x the # of months until the license expires + $10.15 per bed)*	$
Specialty License - Limited Nursing Service (LNS)	$10.15 per bed x _____ total capacity + $322.77 *(fee is prorated at 13.44 per month x the # of months until the license expires + $10.15 per bed)*	$
Specialty License – Limited Mental Health (LMH)	No bed fee required for increase of beds	$ 0.00
Change During Licensure Period	$25.00	$ 25.00
TOTAL FOR SECTION F - FEES TO BE INCLUDED WITH APPLICATION		$
Please make check or money order payable to the Agency for Health Care Administration (AHCA)		

3. Controlling Interests of Licensee

AUTHORITY:

Pursuant to sections 408.806(1)(a) and (b), F.S., an application for licensure must include: the name, address and social security number of the applicant 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 shall use such information for purposes of securing the proper identification of persons listed on this application for licensure. However, in an effort to protect all personal information, **do not include social security numbers on this form. All social security numbers must be entered on the Health Care Licensing Application Addendum, AHCA Form 3110-1024.**

DEFINITIONS:

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-percent 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-percent 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 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 is to be screened, visit Background Screening (myflorida.com).

INSTRUCTIONS:

For new individual – complete all fields except the End Date.
For existing individuals – complete all fields except the Effective and End Date.
To remove an individual – complete all fields including the End Date.

A. Individual and/or Entity Ownership of Licensee as listed in Section 1D above – Provide the information for each individual or entity (corporation, partnership, association) with 5% or greater ownership interest in the licensee. Attach additional sheets if necessary. This excludes Not-for-Profit and publicly held licensees. **Note**: A written explanation will be required if the percentage of ownership interest indicated below does not equal 100%.

FULL NAME of INDIVIDUAL or ENTITY	PERSONAL/PRIMARY ADDRESS	TELEPHONE NUMBER	EIN (No SSN)	% OWNERSHIP	EFFECTIVE DATE	END DATE

B. Board Members and Officers of Licensee as listed in section 1D above – Provide the information for each individual that serves as an officer or is on the board of directors. Do not include voluntary board members.

TITLE	FULL NAME	PERSONAL/PRIMARY ADDRESS	TELEPHONE NUMBER	EFFECTIVE DATE	END DATE
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					

4. Management Company

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

If ☐ NO, **skip to Section 6 – Personnel**.

If ☐ YES, please provide the following information:

Name of Management Company	EIN (No SSNs)	Telephone Number / Fax	
Street Address	Email Address		
City	County	State	Zip
Mailing Address or ☐Same as above			
City		State	Zip
Contact Person	Contact Email	Contact Telephone Number	

5. Management Company Controlling Interests

DEFINITION:

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 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 is to be screened, visit Background Screening (myflorida.com).

INSTRUCTIONS:

For new individual – complete all fields except the End Date.
For existing individuals – complete all fields except the Effective and End Date.
To remove an individual – complete all fields including the End Date.

A. Individual and/or Entity Ownership of Management Company: Provide the information for each individual or entity (corporation, partnership, association) with 5% or greater ownership interest in the management company. Attach additional sheets if necessary.

FULL NAME of INDIVIDUAL or ENTITY	PERSONAL/PRIMARY ADDRESS	TELEPHONE NUMBER	EIN (No SSN)	% OWNERSHIP	EFFECTIVE DATE	END DATE

B. Board Members and Officers of Management Company: Provide the information for each individual that serves as an officer or is on the board of directors. Do not include voluntary board members.

TITLE	FULL NAME	PERSONAL/PRIMARY ADDRESS	TELEPHONE NUMBER	EFFECTIVE DATE	END DATE
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					

6. Personnel

A. Please provide information for the individual(s) who perform the following roles. Note: For the administrator and financial officer an AHCA 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 is to be screened, visit Background Screening (myflorida.com).

INSTRUCTIONS:
For new individual – complete all fields except the End Date.
For existing individuals – complete all fields except the Effective and End Date.
To remove an individual – complete all fields including the End Date.

INFORMATION	ADMINISTRATOR/MANAGING EMPLOYEE	FINANCIAL OFFICER / PERSON RESPONSIBLE FOR FINANCIAL OPERATIONS
Full Name		
Effective Date		
End Date		
Telephone Number		
Email Address		
Personal/Primary Address		
Training/Experience	**Core Training ID #** **Core Training Effective Date:** **High School Diploma ☐ GED ☐**	**N/A**
Licensed Nursing Home Administrator	**NO ☐** **YES ☐ If YES, provide license number**	**N/A**
Will the administrator be serving as administrator of more than this ALF? YES ☐ NO ☐ **Note: An administrator may manage a maximum of 3 ALFs.** **If YES, provide the name of the other facility or facilities.**		**N/A**
		N/A
Facility Name		**N/A**
License Number		**N/A**
		N/A
Facility Name		
License Number		**N/A**

B. Safety Liaison – Provide the requested information for the individual who will serve as primary contact during emergency operations pursuant to section 408.821, F.S.

INFORMATION	SAFETY LIAISON
Full Name	
Effective Date	
End Date	
Telephone Number	
Email Address	
Personal/Primary Address	

7. Required Disclosure

The following disclosures are required:

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

Has the applicant or any individual listed in Sections 3 and 4 of this application been convicted of any level 2 offense pursuant to section 408.809, F.S.? YES ☐ NO ☐

If YES, provide the following information:

☐ The full legal name of the individual

☐ The position held

B. 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 listed in Sections 3 and 4 of this application been excluded, suspended, terminated or involuntarily withdrawn from participation in Medicare or Medicaid in *any* state? YES ☐ NO ☐

If YES, enclose the following information:

☐ The full legal name of the individual (and the position held) or the entity

☐ A description/explanation of the exclusion, suspension, termination or involuntary withdrawal.

C. 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:

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 ☐

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 five (5) years and the termination occurred at least twenty (20) years before the date of the application. YES ☐ NO ☐

D. In the past five (5) years, has the applicant or any controlling interest owned any entity that provides health or residential care in Florida or any other state? YES ☐ NO ☐

If YES, has any entity the applicant or controlling interest owned been closed due to financial inability to operate; had a receiver appointed or a license denied, suspended, or revoked; was subject to a moratorium; or had an injunctive proceeding initiated against it: YES ☐ NO ☐

E. Please provide the following information for the requested positions:

Does the owner, administrator, or any facility representative serve as “representative payee” or as power of attorney for any ALF residents? ☐ YES ☐ NO

Representative Payee is an individual or entity who receives payments on behalf of a resident (i.e. social security benefits, supplemental social security or optional state supplementation). A resident must give consent for an owner, administrator or facility representative to act as their representative payee or power of attorney.

If YES, section 429.27(2), F.S., states that you must obtain a surety bond or continuum bond from a licensed surety company. Has a surety or continuum bond been obtained? ☐ YES ☐ NO If YES, please attach a copy.

Is the ALF a part of a continuing care retirement community (CCRC) pursuant to Chapter 651, F.S.? ☐ YES ☐ NO
If YES, attach a copy of your Certificate of Authority with the initial or change of ownership application.

Does the Assisted Living facility participate in Long Term Care, Managed Care, or MMA (Managed Medical Assistance)?
☐ YES ☐ NO If YES, please provide your Medicaid number:

Pursuant to section 429.905(2), F.S., does the ALF plan to offer services during the day to adults who are not residents of the ALF? ☐ YES ☐ NO

8. Provider Fines and Financial Information

Pursuant to section 408.831(1)(a), F.S., 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):

AHCA CASE NUMBER	CMS	ASSESSED AMOUNT	DATE OF RELATED INSPECTION, APPLICATION, OR OVERPAYMENT	PAYMENT DUE DATE	PENDING APPEAL OF FINAL ORDER	
					YES	NO
	☐				☐	☐
	☐				☐	☐
	☐				☐	☐

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

9. Consumer Information

The following information will be made available to consumers through the Florida Health Finder website. You may access this information at https://quality.healthfinder.fl.gov/index.html. Only check boxes that **currently apply** to your facility.

Please note: All information listed below is subject to verification.

CAPACITY AND BED AVAILABILITY	
Total Licensed Capacity: _____ # of Private Rooms Offered: _____ # of Semi Private Rooms Offered: _____	Bed Hold Policy: (Will the facility reserve beds for residents during a temporary absence?) ☐ YES ☐ NO
Most Recent Available Occupancy Level: _____(Total # of beds that are occupied)	

RELIGIOUS AFFILIATIONS (if any) CHECK YOUR AFFILIATED RELIGION IF DESIRED:			
☐ Adventist ☐ Baptist ☐ Buddhist ☐ Catholic	☐ Christian Non-Denominational ☐ Christian Science ☐ Hindu ☐ Jewish	☐ Lutheran ☐ Methodist ☐ Muslim ☐ Presbyterian	☐ Other _____

LANGUAGES SPOKEN (by administrator and staff)				
☐ Arabic	☐ Farsi	☐ Hebrew	☐ Polish	☐ Spanish
☐ Chinese	☐ Filipino	☐ Hindi	☐ Portuguese	☐ Vietnamese
☐ Creole	☐ French	☐ Italian	☐ Russian	☐ Other _____
☐ English	☐ German	☐ Korean	☐ Sign Language	

AVAILABILITY OF NURSES

(Please only check boxes that currently apply to your facility)

Note: *As defined in rule 59A-36.002(39)* ***"Third Party"*** *means any individual or business entity providing services to residents who is not staff of the facility. As defined in rule 58A-5.0131(23)* ***"Nurse"*** *means a licensed practical nurse (LPN), registered nurse (RN), or advanced practice registered nurse (APRN) licensed under Chapter 464, F.S.*

☐ 24hr – Onsite Direct Employee	☐ 24hr – Onsite Third Party Staff	☐ None Available
☐ Part Time – Onsite Direct Employee	☐ Part Time – Onsite Third Party Staff	

PAYMENT FORMS ACCEPTED

☐ Insurance and/or HMO	☐ Medicaid	☐ Other _____
☐ CHAMPUS	☐ Veterans Administration	
☐ Medicare	☐ Workers Compensation	

RECREATIONAL PROGRAMS AND GROUP ACTIVITIES

☐ Arts and Crafts	☐ Exercise Class	☐ Music Programs	☐ Social Events
☐ Cooking	☐ Games/Cards	☐ Music Programs	☐ Theater and Movies
☐ Dancing	☐ Gardening	☐ Shopping	☐ Other _____

SPECIAL CARE UNITS AND PROGRAMS

☐ Audiology	☐ Occupational Therapy	☐ Speech Therapy
☐ Massage Therapy/Spa	☐ Pet Therapy	☐ Water Therapy
☐ Memory Care	☐ Physical Therapy	☐ Other _____

10. Supporting Documents

Applicants must include the following attachments as stated in Chapters 408, Part II and 419 and 429, F.S. and Chapters 59A-35 and 59A-36, F.A.C. **Note: Required documents listed below are dependent on the type of application submitted. (Initial, Renewal, Change of Ownership, Change During Licensure Period)**

DOCUMENTS TO BE PROVIDED	REQUIRED FOR
Certificate of General Liability Insurance	Initial, Renewal, Change of Ownership and Capacity Increase application types
Surety or Continuum Bond	All application types that check YES on Section 6E
Emergency Environmental Control Plan Approval Letter and Consumer Friendly Summary	Initial and Change of Ownership application types
Fire Safety Inspection Report	Initial, Renewal, Change of Ownership and Capacity Increase application types
Department of Health septic system or water supply evaluation report (if facility is on a septic system)	Initial and Capacity Increases application types
Department of Health Food Hygiene Inspection	All application types, *for providers with 11 beds or more*
Department of Health Residential Group Care Inspection Report	Initial, Renewal, Change of Ownership and Capacity Increase application types
Documentation from the appropriate local government office showing that the applicant has met local zoning requirements.	Initial, Change of Ownership and Capacity Increase application types
Documentation proving compliance with the community residential homes site selection requirements specified pursuant to Chapter 419, F.S.	Initial, Change of Ownership and Capacity Increase application types, for providers that are community residential homes
Proof of Financial Ability to Operate (AHCA Form 3100-0009)	Initial and Change of Ownership application types
Copy of Administration's high school diploma or GED certificate	Initial, Change of Ownership or New Administrators application types
Proof of property occupancy, examples: lease, mortgage, and transfer agreement.	Initial, Renewal, Change of Ownership, Request to Change Name or Address of Provider application types
Certificate of Authority if part of a continuing care retirement community (CCRC)	Initial and Change of Ownership application types
Copy of Comprehensive Emergency Management Plan (CEMP) Approval Letter or Documentation of the CEMP submission for review within the last 365 days	Renewal application type
Visitation Policy and Procedure	Initial, Renewal, and Change of Ownership application types
Health Care Licensing Application Addendum, AHCA Form 3110-1024	Initial, Renewal, Change of Ownership, and Change of Personnel or Controlling Interest application types
Required disclosures related to actions taken by Medicare, Medicaid or CLIA, if applicable	All application types, if documentation is required due to responses provided in application
Approved repayment plan, if applicable	All application types

11. Attestation

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 sections 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.

(6) Pursuant to section 408.810(12), Florida Statutes, the licensee ensures that no person holds any ownership interests, either directly or indirectly, regardless of ownership structure; who has a disqualifying offense pursuant to section 408.809, Florida Statutes or in a provider that had a license revoked or application denied pursuant to section 408.815, Florida Statutes.

(7) Pursuant to sections 408.810(14) and 408.051(3), FS, the licensee ensures that all patient information stored in an offsite physical or virtual environment, including through a third-party or subcontracted computing facility or an entity providing cloud computing services, is physically maintained in the continental United States or its territories or Canada.

(8) Pursuant to section 408.810(15), FS, the licensee ensures that controlling interests of the licensee do not hold, either directly or indirectly, regardless of ownership structure, an interest in an entity that has a business relationship with a foreign country of concern or that is subject to section 287.135, FS.

Signature of Licensee or Authorized Representative	Title	Date

NOTICE: If you are a **Medicaid** provider, you may have a separate obligation to notify the Medicaid program of a name/address change, change of ownership or other change of information. Please refer to your Medicaid handbooks for additional information about Medicaid program policy regarding changes to provider enrollment information.

RETURN THIS COMPLETED FORM WITH FEES TO:

AGENCY FOR HEALTH CARE ADMINISTRATION
ASSISTED LIVING UNIT
2727 MAHAN DR., MS 30
TALLAHASSEE FL 32308-5407

Questions? Visit the Agency's website: https://ahca.myflorida.com/ or contact the Assisted Living Unit at (850) 412-4304 or Email: assistedliving@ahca.myflorida.com.

The Agency for Health Care Administration scans all documents for electronic storage. In an effort to facilitate this process, we ask that you please remember to:

- Please place checks or money orders on top of the application
- Include license number or case number on your check
- Do not submit carbon copies of documents
- Do not fold any of the documents being submitted
- No staples, paperclips, binder clips, folders, or notebooks
- Please ***do not bind any*** of the documents submitted to the Agency.