AHCA USE ONLY:
File #: _____
Application #: _____
Check #: _____
Check Amt: _____
Batch #: _____

Health Care Licensing Application
Health Care Services Pool

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 registration 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 applicant will receive notice of the amount of the late fee as part of the application process or by separate notice. The application will be withdrawn from review if all the required documents and fees are not included with your application or received within 21 days of an omission notice.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 Registration 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 400, Part IX, Florida Statutes (F.S.), and Chapters 59A-35 and 59A-27, Florida Administrative Code (F.A.C.), an application is hereby made to operate a health care services pool as indicated below:

1. Provider / Licensee Information

A. PROVIDER INFORMATION – Please complete the following for the health care services pool 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)	Florida Medicaid Number (if applicable)

Name of Health Care Services Pool (if operated under a fictitious name, enter as it 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. 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.

C. **LICENSEE INFORMATION –** Please complete the following for the entity seeking to operate the health care services pools.			
Licensee Name (This is the legal name of the operating entity of the health care service pools as filed with the Florida Division of Corporation)			Federal Employer Identification Number (EIN)
Mailing Address or ☐ Same as above			
City		State	Zip
Telephone Number	Fax Number	E-mail 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 and Fees

Indicate the type of application with an "X." **Applications will not be processed if not all applicable fees are 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 registration 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 Registration **Proposed Effective Date**: _____

Was this entity previously registered as a Health Care Services Pool in Florida? YES ☐ NO ☐

If YES, please provide the name of the agency (if different), the EIN # and the date the prior registration expired or closed:

NAME:	EIN #	Date Expired/Closed:

☐ Renewal Registration

☐ 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 Registration Period – select all that apply **Proposed Effective Date**: _____

Fee Required
- ☐ Provider Name
- ☐ Provider Address

Services/Qualifications
- ☐ Services

No Fee Required
- ☐ Personnel
- ☐ Management Company
- ☐ Management Company Controlling Interest
- ☐ Hours of Operation
- ☐ Transfer or assignment of less than 51% ownership, shares, membership, or controlling interest of the licensee

B. LICENSURE FEES

ACTION	FEE	TOTAL FEES
Registration fee (Initial, Renewal and Change of Ownership):	$616.00	$
Change During Registration Period	$25.00	$
TOTAL FEES 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 registration 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% 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: Attach additional application pages if needed.
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 1C 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 1C 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					

4. Management Company

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

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

If ☐ YES, provide the following information:

Name of Management Company	EIN (No SSN)	Telephone Number / Fax

Street Address		E-mail Address	
City	County	State	Zip
Mailing Address or ☐ Same as above			
City		State	Zip
Contact Person	Contact E-mail	Contact Telephone Number	

5. Management Company Controlling Interest

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: Attach additional application pages if needed.
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	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

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: Attach additional application pages if needed.
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		

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 and the position held

☐ A description/explanation of any convictions of offenses

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/entity 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 ☐

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. Services

A. Identify the health care personnel provided by the health care service pool (check all that apply):

HEALTH CARE PERSONNEL PROVIDED BY THE HEALTH CARE SERVICES POOL			
☐	Audiologist	☐	Occupational Therapist
☐	Audiologist Aide	☐	Paramedic
☐	Certified Nursing Assistants	☐	Pharmacist
☐	Clinical Social Worker	☐	Pharmacy Technician
☐	Dental Hygienist	☐	Physical Therapist
☐	Emergency Medical Technician	☐	Radiology Technician
☐	Medical Doctor	☐	Respiratory Therapist
☐	Medical Technician	☐	Speech Therapist
☐	Nurses – LPN	☐	Other: _____
☐	Nurses – RN	☐	Other: _____
☐	Nurse Aide		

B. Identify the types of providers served by the health care service pool (check all that apply):

TYPES OF PROVIDERS SERVED			
☐	Assisted Living Facility	☐	Home Health Agency
☐	Ambulatory Surgical Center	☐	Hospice
☐	Clinic	☐	Hospital
☐	Correctional Facility	☐	Nursing Home
☐	Dialysis Center	☐	School
☐	Doctor's Office	☐	Other: _____
☐	Health Maintenance Organization		

10. Financial Responsibility

As required in section 400.980, F.S., and rule 59A-27.009, F.A.C, each Health Care Services Pool must demonstrate financial responsibility to pay claims and costs ancillary thereto, arising out of the rendering of services or failure to render services by the Pool or its employees.

Please check which of the following methods the Health Care Services Pool uses. Submit proof with this application. **Note:** The address on the insurance proof document must match the name in Section 1 of the application.

☐ Professional liability insurance coverage in an amount of not less than $1,000,000 per claim, with a minimum aggregate of not less than $3,000,000 from one of the following (submit proof of insurance):

- ☐ An authorized insurer as defined under section 624.09, F.S.;
- ☐ An eligible surplus lines as defined under subsection 626.918(2), F.S.;
- ☐ A risk retention group or purchasing group as defined under section 627.942, F.S
- ☐ A plan of self-insurance as provided in section 627.357, F.S.

☐ Escrow account consisting of cash or assets eligible for deposit in accordance with section 625.52, F.S. The cash or assets deposited shall be in an amount not less than $1,000,000 per claim, with a minimum aggregate deposit of not less than $3,000,000. (Provide statement from bank or savings association).

☐ Unexpired irrevocable letter of credit issued by any bank or savings association in this state in an amount not less than $1,000,000 per claim, with a minimum aggregate amount of credit not less than $3,000,000. (Provide statement from bank or financial institution).

11. Hours of Operation

List the regular operating hours. **Note:** Site inspections by surveyors will occur during the business hours submitted. Failure to be open during the listed hours may result in a fine.

DAY OF THE WEEK	OPENING TIME	CLOSING TIME	BY APPOINTMENT
☐ Monday			☐
☐ Tuesday			☐
☐ Wednesday			☐
☐ Thursday			☐
☐ Friday			☐
☐ Saturday			☐
☐ Sunday			☐

12. Supporting Documentation

Applicants must include the following attachments as stated in Chapters 408, Part II and 400, Part IX F.S. and Chapters 59A-35 and 59A-9, 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
Health Care Licensing Application Addendum, AHCA Form 3110-1024	Initial, Renewal, Change of Ownership, and Change of Personnel or Controlling Interest application types
Documentation of change of ownership transaction stating effective date and executed by all parties	Change of Ownership applications
A signed agreement to pay any outstanding payments owed to the Agency. The agreement must include who will pay and when payment will be made	Change of Ownership application
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

13. 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
LONG TERM CARE SERVICES UNIT
2727 MAHAN DR., MS 33
TALLAHASSEE FL 32308-5407

Questions? Visit the Agency's website : https://ahca.myflorida.com/ or contact the Long Term Care Services Unit at (850) 412-4303 or Email: LTCStaff@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
- No staples, paperclips, binder clips, folders, or notebooks
- Please ***do not bind any*** of the documents submitted to the Agency