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

Health Care Licensing Application
Home Medical Equipment Provider

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 The application will be withdrawn from review if all the required documents and fees are not included with your application or received within 21 days of an omission notice.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 License 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 VII, Florida Statutes (F.S.), and Chapters 59A-35 and 59A-25, Florida Administrative Code (F.A.C.), an application is hereby made to operate a home medical equipment provider as indicated below:

1. Provider / Licensee Information

A. **PROVIDER INFORMATION** –Please complete the following for the home medical equipment provider 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 Home Medical Equipment Provider (if operated under a fictitious name, enter as it appears in 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 Home Medical Equipment Provider.			
Licensee Name (This is the legal name of the operating entity of the home medical equipment provider 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 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 a Home Medical Equipment Provider in Florida? YES ☐ NO ☐

If YES, please provide the provider name (if different), EIN # and the date the prior license expired or 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	☐ Hours of Operations
☐ Geographic Service Areas	☐ Management Company
	☐ Central Service, Distribution Centers or Warehouse Address(es)
	☐ Transfer or assignment of less than 51% ownership, shares, membership, or controlling interest of the licensee

Services/Qualifications:

☐ Change in Equipment and/or Services

B. LICENSURE FEES

ACTION	FEE	TOTAL FEES
Licensure Fee (Initial, Renewal and Change of Ownership): ☐ License Fee Exemption (State, County or Municipal Government pursuant to 400.931(5), F.S.) = $ 0.00	$304.50	$
Inspection (required unless provider is exempt – refer to Application Checklist)	$400.00	$
Change During Licensure 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 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: Pursuant to section 408.809, F.S., any controlling interest are required to have an Agency screening through the Care Provider Background Screening Clearinghouse. If background screening has been 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., the Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008 may be submitted in lieu of Agency screening. 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. To **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%.

If any controlling interest qualifes as a nonimmigrant alien according to 8 U.S.C. §1101 the Nonimmigrant Alien box must be selected next to their name.

FULL NAME of INDIVIDUAL or ENTITY	PRIMARY ADDRESS	TELEPHONE NUMBER	EIN (No SSN)	% OWNERSHIP	EFFECTIVE DATE	END DATE	NON-IMMIGRANT ALIEN
							☐
							☐
							☐
							☐

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					

4. Management Company

Does a company other than the licensee manage the licensed 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 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: 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.

If any controlling interest qualifes as a nonimmigrant alien according to 8 U.S.C. §1101 the Nonimmigrant Alien box must be selected next to their name.

FULL NAME of INDIVIDUAL or ENTITY	PRIMARY ADDRESS	TELEPHONE NUMBER	EIN (No SSN)	% OWNERSHIP	EFFECTIVE DATE	END DATE	NON-IMMIGRANT ALIEN
							☐
							☐

							☐
							☐

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 general manager/ 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).

Special Note: Rule 59A-25.004(1)(a), F.A.C., requires the general manager have "a minimum of 2 years' experience in business management or a college degree in business or a health care related field can substitute for the required experience year for year."

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	GENERAL MANAGER	FINANCIAL OFFICER / PERSON RESPONSIBLE FOR FINANCIAL OPERATIONS
Full Name		
Effective Date		
End Date		
Telephone Number		
Email Address		
Personal/Primary Address		

A. 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. Out of State Providers Only (without a physical location in Florida)

Provide the following information for any employees located in Florida (attach additional sheets if necessary):

FULL NAME	JOB TITLE	TELEPHONE #	ASSIGNED FLORIDA COUNTIES

8. Required Disclosures

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 and explanation of any convictions

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 ☐

D. If the applicant or any controlling interests are nonimmigrant aliens according to 8 U.S.C. §1101, then a surety bond of at least $500,000 payable to the Agency for Health Care Administration that guarantees the home medical equipment provider will act in full conformity with all legal requirements for operation pursuant to section 408.8065(2), F.S..

Are there any nonimmigrant aliens listed as a licensee or controlling interest in this application? YES ☐ NO ☐

If YES, enclose a copy of the surety bond with this application.

E. Pursuant to section 400.932(3), F.S., has the applicant previously:

Been found by any professional licensing, certifying or standards board or agency to have violated the standards or conditions relating to licensure or certification or the quality of services provided? YES ☐ NO ☐

Been or is currently excluded, suspended, terminated, or involuntarily withdrawn from participation in any governmental or private health care or health insurance program in any state? YES ☐ NO ☐

If YES, enclose the following information:

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

☐ A description/explanation of any violations found and the name of the professional board/agency and/or of the exclusion, suspension, termination or involuntary withdrawal and the name of the health care/insurance program

9. 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.

10. Accreditation

The applicant participates in (select accrediting organization below or ☐ Not accredited):

ACCREDITING ORGANIZATION	ACCREDITATION ID	ACCREDITATION WITH DEEMED STATUS		SURVEY END DATE
		EFFECTIVE DATE	END DATE	
☐ Accreditation Commission for Health Care (ACHC)				
☐ Community Health Accreditation Program (CHAP)				
☐ The Joint Commission				
☐ Board of Certification/Accreditation (BOC)				
☐ The Compliance Team (TCT)				
☐ Healthcare Quality Association on Accreditation (HQAA)				

Special Note: An HME Provider physically located outside of Florida must submit documentation of accreditation in accordance with section 400.931(2), F.S.

Note: If accredited, provide a copy of the full accreditation survey, award letter and any follow up letters to or from the accrediting organization.

☐ 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.

11. Days and 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 or denial of application.

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

12. Geographic Service Area

For Initial applications check all counties where this agency expects to provide services. For all other applications, check only those counties that will be HME plans to add or delete from the existing license

☐ **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 ☐ St. 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 ☐ St. Lucie ☐ **AREA 10** ☐ Broward ☐ **AREA 11** ☐ Miami-Dade ☐ Monroe

13. Equipment and Services

A. Indicate all equipment to be provided directly and/or through contract.

Pursuant to section 400.934(2), F.S. and section 59A-25.005(1)(c) F.A.C., a home medical equipment provider **must provide at least one category of equipment directly from its own inventory** (not through another contracted provider). Categories are defined as mobility aids, ambulation aids, respiratory modalities, sickroom setup and disposables.

MOBILITY AIDS	Direct	Contract
Motorized Scooters	☐	☐
Wheelchairs	☐	☐
Passive Motion Devices	☐	☐
Electrostimulation Equipment	☐	☐
Other:	☐	☐

AMBULATION AIDS	Direct	Contract
Walkers	☐	☐
Walking Canes	☐	☐
Crutches	☐	☐
Other:	☐	☐
Other:	☐	☐

RESPIRATORY MODALITIES	Direct	Contract
Continuous Positive Airway Pressure Machines	☐	☐
Intermittent Positive Airway Pressure Machines	☐	☐
Apnea Monitors	☐	☐
Oxygen & Related Respiratory Equipment	☐	☐
Other:	☐	☐
Other:	☐	☐

DISPOSABLE SUPPLIES*	Direct	Contract
Diabetic	☐	☐
Ostomy	☐	☐
Urological	☐	☐
Wound Care	☐	☐
Other:	☐	☐

SICKROOM SETUP	Direct	Contract
Hospital Beds	☐	☐
Patient Lifts	☐	☐
Specialty Prescribed Cribs (child safety)	☐	☐
Suction Machines	☐	☐
Phototherapy Lights w/Photometer	☐	☐
Pressure Ulcer Care Equipment	☐	☐
Enteral Feeding Pumps	☐	☐
Infusion Pumps	☐	☐
Portable Home Dialysis Equipment	☐	☐
Trapeze equipment	☐	☐
Vacuum Constriction Device (ED Pump)	☐	☐
Other:	☐	☐

***Diabetic monitors and disposable supplies have been identified as equipment and supplies that do not require services. Locations that supply only these items are not required to obtain a home medical equipment provider license.**

B. Indicate services to be provided directly and/or via contract.

SERVICE CATEGORY	Direct	Contract		SERVICE CATEGORY	Direct	Contract
Intake*	☐	☐		Equipment Selection	☐	☐
Delivery	☐	☐		Setup and Installation	☐	☐
Patient Training	☐	☐		Ongoing Service and Maintenance	☐	☐
Retrieval	☐	☐		***A distribution center would not provide intake services directly or through contract. Refer to section 11 for information.***		

C. Does this provider possess an oxygen permit? ☐ Yes ☐ No

If YES, Oxygen Permit Number: Permit Effective Date: Permit Expiration Date:

14. Contracted Equipment/Services

Provide the name, license number (if applicable) and address of all companies with whom the provider contracts or plans to contract. List both those that the provider uses to provide equipment and/or services to its consumers and those for whom the applicant provides equipment and/or services. Attach an additional sheet if necessary.

Name of Contracted Company	License # (If Applicable)	Address	Equipment	Service
			Yes ☐ No ☐	Yes ☐ No ☐
			Yes ☐ No ☐	Yes ☐ No ☐
			Yes ☐ No ☐	Yes ☐ No ☐
			Yes ☐ No ☐	Yes ☐ No ☐
			Yes ☐ No ☐	Yes ☐ No ☐
			Yes ☐ No ☐	Yes ☐ No ☐

15. Warehouse Information

Will this provider maintain a warehouse location away from the licensed address? YES ☐ NO ☐

If YES, list address (es) below (attach additional sheets if necessary). Do not list locations that are already listed in sections 1 or 11:

STREET ADDRESS	CITY	STATE	ZIP

Note: Only inventory may be physically located in a warehouse. If this location provides selection, delivery, set up, consumer instruction or maintenance of equipment, it must be separately licensed.

16. Location of Required Items

Check the personnel and items below that are located at the address being licensed:

- ☐ General Manager
- ☐ Delivery personnel
- ☐ Intake personnel
- ☐ Maintenance/Repair personnel
- ☐ Other: _ _____
- ☐ Consumer records
- ☐ Personnel records
- ☐ Consumer complaint records
- ☐ Inventory
- ☐ Contracts as listed in Section 13
- ☐ Insurance policies; state & local government permits

FOR PERSONNEL AND ITEMS NOT CHECKED ABOVE, LIST THE ADDRESS (ES) WHERE EACH IS LOCATED OR MARK N/A AND EXPLAIN.
_____;
_____;
_____;
_____

17. Licensed Central Service/Distribution Centers Only

Does the licensee as listed in section 1B of this application operate more than one licensed home medical equipment provider location?

If ☐ NO, **skip to Section 18**

If ☐ YES, the following information may apply

CENTRAL SERVICE CENTER:
A central service center (as defined in 59A-25.001, F.A.C.) is the licensed premises that are in charge of taking consumer orders, dispatching the orders to licensed distribution centers owned and operated by the same licensee that provide home medical equipment services, and maintaining consumer and personnel records. The central service center is responsible for the operation of its designated distribution centers. **A business is not considered a central service center unless it has at least one other separately licensed location owned and operated by the same licensee that serves as a distribution center.**

The licensing fee and survey fees are required for a central service center. If the central service center has a current medical oxygen retail establishment permit issued by the Department of Business & Professional Regulation or is accredited by an organization recognized by the Agency, then the survey fee would not be required (refer to the checklist and section 2 of this application).

Is this application for a central service center as defined above? YES ☐ NO ☐
If yes, provide the information for its licensed distribution center(s) below:

NAME	LICENSE #	ADDRESS

DISTRIBUTION CENTER:

A distribution center (as defined in section 59A-25.001, F.A.C.) is those licensed premises that are not located at the address of the central service center but are owned and operated by the same licensee, receive orders from the central service center and are utilized to provide home medical equipment services. **A business is not considered a distribution center unless it operates under a separately licensed central service center owned by the same licensee.** A licensure fee is required; a survey fee may not be.

Is this application for a distribution center as defined above? YES ☐ NO ☐

If YES, provide the information for its licensed central service center below:

NAME	LICENSE #	ADDRESS

18. Supporting Documentation

Applicants must include the following attachments as stated in Chapters 408, Part II and 400, Part VII and Chapters 59A-35 and 59A-25, 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:
Current medical oxygen retail establishment permit issued by the Florida Department of Business & Professional Regulation in the provider's/licensee's name at the provider's street address, if applicable.	Initial, Renewal, and Change of Ownership application types
Accreditation and survey report, and plan of correction (if applicable).	Initial, Renewal, and Change of Ownership application types
Certificate of commercial and professional liability insurance coverage	Initial, Renewal, and Change of Ownership application types
Documentation from the appropriate local government office showing that the applicant has met local zoning requirements	Initial, and Change of Ownership application types
Surety or Continuation Bond, if required per section 408.8065, F.S.	Initial, Renewal, and Change of Ownership application types
Proof of Financial Ability to Operate (AHCA Form 3100-0009)	Initial and Change of Ownership application types
Documentation of change of ownership transaction stating effective date and executed by all parties	Change of Ownership application
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
Proof of Property Occupancy, Examples: Lease, Mortgage, and Transfer Agreement if applicable.	Initial, Renewal, Change of Ownership, Request to Change Name or Address of Provider 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
Health Care Licensing Application Addendum, AHCA Form 3110-1024	Initial, Renewal, Change of Ownership, and Change of Personnel and 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

19. 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 AND ALL REQUIRED DOCUMENTS 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
- 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.