**AHCA USE ONLY:**

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

# Health Care Licensing Application

## Adult Day Care Center

The Agency for Health Care Administration (AHCA) has implemented the **ONLINE LICENSING SYSTEM** which allows the electronic submission of renewal and change during licensure 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 *The application will be withdrawn from review if all the required documents and fees are not included with your application or received within 21 days of an omission notice.* **Applications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 III, Florida Statutes (F.S.), and Chapters 59A-35 and 59A-16, Florida Administrative Code (F.A.C.), an application is hereby made to operate an adult day care center as indicated below:

## 1. Provider / Licensee Information

**A. PROVIDER INFORMATION –** Please complete the following for the adult day care center name and location. Provider name, address and telephone number will be listed on https://quality.healthfinder.fl.gov/index.html

| License # (if applicable) | National Provider Identifier (NPI) (if applicable) | Medicare # (CMS CCN) | Florida Medicaid # |
|---|---|---|---|
| | | | |

Name of Adult Day Care Center (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

**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 adult day care center. | | | |
|---|---|---|---|
| Licensee Name (This is the owner of the adult day care center) | | | Federal Employer Identification Number (EIN) |
| Mailing Address | | | |
| 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 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 an adult day care center? YES ☐ NO ☐

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

| NAME: | EIN # | Date Expired/Closed: |
|---|---|---|
| | | |

☐ Renewal Licensure

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

- ☐ Change of licensee, as listed in Section 1D above (owner)
- ☐ Transfer or assignment of 51% or more ownership, shares, membership, or controlling interest of the licensee

☐ Change During Licensure Period (check all that apply): **Proposed Effective Date**: _____

Fee Required

- ☐ Provider Name
- ☐ Provider Address

Participant Capacity:

- ☐ Increase ☐ Decrease

No Fee Required

- ☐ Personnel

Services/Qualifications:

- ☐ Specialized Alzheimer's Services (SAS)
- ☐ 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 |
|---|---|---|
| License Fee (Initial, Renewal and Change of Ownership): | $172.55 | $ |

| | | |
|---|---|---|
| ☐ License Fee Exemption (County or Municipal Government pursuant to 429.907(4), F.S.) = $ 0.00 | | |
| 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% 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).

**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. Note: This excludes Not-for-Profit and Publicly held licensees.

**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

| 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** | | | | | |

## 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).

**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.

**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.

| 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 center operator 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 | CENTER OPERATOR/MANAGING EMPLOYEE | FINANCIAL OFFICER / PERSON RESPONSIBLE FOR FINANCIAL OPERATIONS |
|---|---|---|
| **Full Name** | | |
| **Effective Date** | | |
| **End Date** | | |
| **Telephone Number** | | |
| **Email Address** | | |
| **Personal/Primary Address** | | |

**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 ☐

## 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. Facility and Service Provisions

Information below should reflect facility description and services ***currently provided*** at this center. All information listed below is subject to verification. **Note:** Pursuant to section 59A-16.106, F.A.C., the facility must make services available for a minimum of five hours per day five days a week, excluding legal holidays posted by the facility.

**A.** Maximum participant capacity: _____

**B.** Total square footage available for participants (in feet): _____

**C**. Identify below all the optional services provided by the facility. Please indicate the frequency with which the **optional** services are provided (i.e., daily, weekly, and not provided). **Note:** These basic services are required: providing a protective setting that is as noninstiutional as possible; therapeutic programs of social and health actitvities and services, leisure actitvities, self-care training, rest, nutritional services and respite care.

| OPTIONAL SERVICES | FREQUENCY |
|---|---|
| Social Activities | |
| Speech Therapy | |
| Physical Therapy | |
| Occupational Therapy | |
| Modified Diet | |
| Adult Day Health Care | |

## 10. Specialized Alzheimer's Services

Please mark only **one** box below.

☐ The center does not provide Specialized Alzheimer's Services.

☐ The authorized representative identified in section 18 of this application attests the center meets the following criteria:

a. The operator or operator designee has a bachelor's degree in health care services, social services, or a related field, 1 year of staff supervisory experience in social services or health care services setting, and a minimum of 1 year of experience in providing services to persons who have dementia.

b. The operator or operator designee is a registered or practical nurse licensed in this state, have 1 year of staff supervisory experience in a social services or health care services setting, and have a minimum of 1 year of experience in providing services to persons who have dementia.

c. The operator or operator designee has 5 years of staff supervisory experience in social services or health care services setting and a minimum of 3 years of experience in providing services to persons who have dementia.

## 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 |
|---|---|---|
| ☐ Monday | | |
| ☐ Tuesday | | |
| ☐ Wednesday | | |
| ☐ Thursday | | |
| ☐ Friday | | |
| ☐ Saturday | | |
| ☐ Sunday | | |

## 12. Supporting Documents

Applicants must include the following attachments as stated in Chapters 408, Part II and 429, Part III F.S. and Chapters 59A-35 and 59A-16, 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 |
| 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 Change of Ownership application types |
| Department of Health Food Inspection Report | All applications types |
| Proof of Financial Ability to Operate (AHCA Form 3100-0009) | Initials and Change of Ownership application types |
| Proof of Property Occupancy, Examples: Lease, Mortgage, or Transfer Agreement | Initial, Renewal, Change of Ownership, Request to Change Name application types |
| Documentation from the appropriate local government office showing that the applicant has met local zoning requirements | Initials, Change of Ownership and Capacity Increase application types |
| Health Care Licensing Application Addendum, AHCA Form 3110-1024 | All applications types |
| Proof of legal right to occupy property may include but not limited to, copies of warranty deeds, lease or rental agreements, contracts for deeds, quitclaim deeds, or other such documentation | Initails and Change of Ownership applications 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 |
| Required disclosures related to actions taken by Medicare, Medicaid or CLIA, if applicable | All applications, if documentation is required due to responses provided in application types |

| | |
|---|---|
| Approved repayment plans, if applicable | All applications 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
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