Provider:
Helping Hands Home Health

Provider Type:
Home Health Agency

File#: 19969172
License #:
Expires:

= Entered
= Entry Required

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

Health Care Licensing Online Application
Home Health Agency
AHCA Form 3110-1011 OL, August 2023
59A-35.060, Florida Administrative Code

Logged in as :

Dashboard | OL Help | Documents | Logout

Provider/Facility Information

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

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

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

- *Provider NPI cannot be blank. Please enter number or check None or Pending checkbox below the field.*
- *Phone number is incomplete.*
- *Provider Fax # cannot be blank. Please check None checkbox below the field.*
- *Provider Website information cannot be blank. Please enter a website or check None checkbox below the field.*

Provider/Facility Information

License #

National Provider Identifier ☐ None ☐ Pending

Medicaid #

Medicare # (CMS CCN)

Name of Home Health Agency (If operated under a fictitious name, enter as it is filed with the Florida Division of Corporations.)

Helping Hands Home Health

Provider/Facility Location Address

Edit Address

Provider Location Address
2727 MAHAN DR
TALLAHASSEE, FL 32308
US - United States
County - LEON

Telephone (___) ___-____ Ext Fax # (___) ___-____ ☐ None

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

H4@gmail.com ☐ None

Provider/Facility Website

☐ None

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

☑ Check if same as Provider/Facility Location Address

Edit Address

Address
2727 MAHAN DR
TALLAHASSEE, FL 32308
US - United States
County - LEON

Telephone (___) ___-____ Ext Email Address H4@gmail.com ☐ None

Undo | Save | Next >>

Provider/Facility Information

- *Contact first name must not be blank.*
- *Contact last name must not be blank.*
- *Phone number is incomplete.*
- *If there is no Fax # please check the None check box below it.*
- *If there is no Email address please check the None check box below it.*

Provider/Facility Contact Person for this Application

First Name | Middle Name | Last Name | Suffix

Telephone (___) ___-____ | Ext | Fax # (___) ___-____

☐ None

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

☐ None

Undo | Save | << Back | Next >>

Licensee Information

- *Organization information is incomplete*
- *Phone number is incomplete.*
- *Licensee Email cannot be blank. Please enter an email or check None checkbox below the field.*
- *If Licensee does not have Fax number then please select the None check box below the field.*
- *Licensee mailing address line 1 must not be blank. Licensee mailing address city must not be blank. Licensee mailing address zip must not be blank.*

Description of Licensee (select only one option below)

(•) For Profit ( ) Not for Profit ( ) Public

Ownership Types

Limited Liability Company

Entity Licensee Details

Licensee Name (may be same as provider name)

Federal Employer Identification # (EIN)

Mailing Address

Edit Address

Address

Telephone (___) ___-____

Ext

Fax # (___) ___-____

[ ] None

Email Address

[ ] None

Undo | Save | << Back | Next >>

Controlling Interests of Licensee

- *Select either Yes or No option.*

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.

Pursuant to section 400.991(4), F.S., an "applicant" for licensure as a health care clinic includes any individual owning or controlling indirectly, 5 percent or more of an interest in the clinic. These individuals are required to have an Agency screening through the Care Provider Background Screening Clearinghouse. Provide the information for each individual with 5% or greater indirect ownership in the clinic and attach an organizational chart showing each individual's relationship to the licensee. (Include EINs and percentage ownership for each listed entity.)

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

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

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

◯ Yes ◯ No

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Management Company Information

- *Select either Yes or No option.*

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

◯ Yes ◯ No

Undo | Save | << Back | Next >>

Management Company Controlling Interest

- *There is no Management Company associated with this application. Therefore, you are unable to add Management Company Controlling Interests. Select "Next" to proceed.*

Undo | Save | << Back | Next >>

Personnel

- *One Administrator should be entered for this application.*
- *One Alternate Administrator should be entered for this application.*
- *One Financial Officer should be entered for this application.*

Personnel

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

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

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

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

No Individuals exist!

Undo | Save | << Back | Next >>

Personnel

Safety Liaison

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

Safety Liaison

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

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

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

No Individuals exist!

Undo | Save | << Back | Next >>

Required Disclosure

- *Either Yes or No must be selected.*

Convictions

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

Has the applicant or any individual listed in the Controlling Interests or Management Company Controlling Interests sections of this application been convicted of any level 2 offense pursuant to section 408.809, F.S.?

◯ Yes ◯ No

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Required Disclosure

- *Either Yes or No must be selected.*

Exclusions

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

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

◯ Yes ◯ No

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Required Disclosure

- *All questions related to Felonies/Terminations must be answered.*

Felonies/ Terminations

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

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

◯ Yes ◯ No

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

◯ Yes ◯ No

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

◯ Yes ◯ No

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Required Disclosure

- *Either Yes or No must be selected.*

Nonimmigrant Aliens

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 health agency provider will act in full conformity with all legal requirements for operation pursuant to section 408.8065(2), F.S. Include the surety bond in the Supporting Documents section of this application.

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

◯ Yes ◯ No

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Accreditation

- *Either select an Accreditation Pending, an Accrediting Organization or check the No longer accredited and/or deemed check box.*

If you were licensed after July 1, 2008 and provide skilled care, you must be accredited by one of the accrediting organizations listed below. Please check the appropriate accrediting organization in the table below and provide the additional accreditation information.

☐ Accreditation Pending – Application for accreditation has been submitted to one of the accrediting organizations listed below. A screen print receipt from the accrediting organization web site or letter of receipt of application from accrediting organization will be required on the Supporting Document section.

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

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

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

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

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

☐ No longer accredited and/or deemed

○ Not applicable/licensed prior to July 1, 2008

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

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Days and Hours of Operation

- *An agency must be open for 8 consecutive hours per day, Monday through Friday between the hours of 7:00 AM and 6:00 PM. Please make corrections below*
- *Enter opening and closing times.*

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

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

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

Day	Opening Time	Closing Time	By Appointment
MONDAY			
TUESDAY			
WEDNESDAY			
THURSDAY			
FRIDAY			
SATURDAY			☐
SUNDAY			☐

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Geographic Service Area

- *At least one county must be selected*

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

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

Counties Served

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

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

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Services

- *At least one Services/Employees combination must be selected.*
- *Select an option Yes or No in Question# 2*
- *Select an option Yes or No in Question# 3*
- *Select an option Yes or No in Question# 4*

1. Please provide the following information on Service Personnel.

Note - Home health agencies must provide at least one of the services listed below, in part, by direct employees.

If providing nursing services, some of the services must be provided by a direct employee as required in section 400.487(5), F.S. Pursuant to section 400.462(9), F.S., a direct employee means an employee for whom one of the following entities pays withholding taxes: a home health agency, a management company that has a contract to manage the home health agency on a day-to-day basis; or an employee leasing company that has a contract with the home health agency to handle the payroll and payroll taxes for the home health agency.

Medicare and Medicaid certified agencies must also provide one of the qualifying services (* below) totally by direct employees. Medicaid does not include Medical Social Services as a home health agency service.

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

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

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

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

4. Does your agency provide or plan to provide staffing services to a health care facility, school, or other business entity by licensed health care personnel, certified nursing assistants and home health aides who are employed by, or work under the auspices of, the home health agency pursuant to section 400.462(29), F.S.? ◯ Yes ◯ No

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Other Associated Locations

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

Satellite Office

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

Drop-Off Site

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

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

◯ Yes ◯ No

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Direct Care Workforce

- *Survey Start Date cannot be empty*
- *Survey End Date cannot be empty*
- *Please select atleast one worker category.*

This survey asks for information about direct care workers employed by your business over the previous 12 months. In accordance with section 408.822(4) F.S., renewal applicants must complete this survey to submit with their renewal application before a license may be issued.

Pursuant to section 408.822(1) a "direct care worker" means a certified nursing assistant, a home health aide, a personal care assistant, a companion services or homemaker services provider, a paid feeding assistant trained under s. 400.141(1)(v), or another individual who provides personal care as defined in s. 400.462 to individuals who are elderly, developmentally disabled, or chronically ill.

Survey

Specify the start and end dates of the 12 month period for which this survey was completed:

Start Date: End Date:

Worker Categories

Select all categories of workers that apply to your business. Create new categories as needed (up to 5).

Check all that apply:

- [ ] None Available
- [ ] Registered Nurse
- [ ] Licensed Practical Nurse
- [ ] Certified Nursing Assistant
- [ ] Home Health Aide
- [ ] Paid Feeding Assistant trained under s. 400.141, F.S.
- [ ] Personal Care Assistant
- [ ] Homemaker/Companion Service Provider

Add Worker Category

Undo Save << Back Next >>

Direct Care Workforce

There are missing and/or invalid entries. Please correct them.

- *Survey End Date cannot be greater than the Survey Start Date*
- *Survey Start Date must be at least one year before today's Date*
- *Survey Start Date must be at least one year before Survey End Date*

This survey asks for information about direct care workers employed by your business over the previous 12 months. In accordance with section 408.822(4) F.S., renewal applicants must complete this survey to submit with their renewal application before a license may be issued.

Pursuant to section 408.822(1) a "direct care worker" means a certified nursing assistant, a home health aide, a personal care assistant, a companion services or homemaker services provider, a paid feeding assistant trained under s. 400.141(1)(v), or another individual who provides personal care as defined in s. 400.462 to individuals who are elderly, developmentally disabled, or chronically ill.

Survey

Specify the start and end dates of the 12 month period for which this survey was completed:

Start Date: 5/4/2023 End Date: 4/19/2023

Worker Categories

Select all categories of workers that apply to your business. Create new categories as needed (up to 5).

Check all that apply:

- [ ] None Available
- [x] Registered Nurse
- [ ] Licensed Practical Nurse
- [x] Certified Nursing Assistant
- [ ] Home Health Aide
- [x] Paid Feeding Assistant trained under s. 400.141, F.S.
- [ ] Personal Care Assistant
- [ ] Homemaker/Companion Service Provider
- [x] Other B
- [x] Other A

Add Worker Category

Direct Care Workforce

Changes have been saved.

This survey asks for information about direct care workers employed by your business over the previous 12 months. In accordance with section 408.822(4) F.S., renewal applicants must complete this survey to submit with their renewal application before a license may be issued.

Pursuant to section 408.822(1) a "direct care worker" means a certified nursing assistant, a home health aide, a personal care assistant, a companion services or homemaker services provider, a paid feeding assistant trained under s. 400.141(1)(v), or another individual who provides personal care as defined in s. 400.462 to individuals who are elderly, developmentally disabled, or chronically ill.

Survey

Specify the start and end dates of the 12 month period for which this survey was completed:

Start Date: 4/18/2022 End Date: 4/19/2023

Worker Categories

Select all categories of workers that apply to your business. Create new categories as needed (up to 5).

Check all that apply:

- [ ] None Available
- [x] Registered Nurse
- [ ] Licensed Practical Nurse
- [x] Certified Nursing Assistant
- [ ] Home Health Aide
- [x] Paid Feeding Assistant trained under s. 400.141, F.S.
- [ ] Personal Care Assistant
- [ ] Homemaker/Companion Service Provider
- [x] Other B
- [x] Other A

Add Worker Category

Direct Care Workforce

Changes have been saved.

Turnover and Vacancy

Provide information for each category of direct care worker from the previous 12 months to the time this survey form is being completed.

Note: Sections to be completed: 1.) Turnover and Vacancy, 2.) Factors Contributing to Leaving Employment, 3.) Benefits Costs, and 4.) Additional Training. Turnover Rate and Vacancy Rate are calculated based on the values provided.

Worker Categories	For each category, what is the total number of staff employed by your facility at the beginning of the 12 month period?	For each category, how many staff have left employment with the facility since the beginning of the 12 month period until now?	What is your total number of available positions for each category (both filled and vacant)?	Currently, what is your total number of vacancies for each category?	For each category, what is your total number of new hires since the beginning of the 12 month period until now?	For each category (if applicable), what is your total patient volume (hours) since the beginning of the 12 month period until now?	How many direct employee vacancies are filled by contracted workers?	Turnover Rate	Vacancy Rate
Registered Nurse	47	9	40	6	13	55	9	0.10	0.15
Certified Nursing Assistant	65	12	50	5	12	34	8	0.10	0.10
Paid Feeding Assistant trained under s. 400.141, F.S.	18	4	20	2	3	21	5	0.22	0.10
Other B	7	0	10	3	3	19	4	0.00	0.30
Other A	10	1	10	0	1	11	2	0.10	0.00

Direct Care Workforce

Factors Contributing to Leaving Employment

Out of the staff that left employment with your business (as indicated previously), please indicate how many employees left for each reason listed below over the previous 12 month period. If the reason is not known, indicate the number in the 'Not Known' column. If the reason does not apply to the worker category, indicate a '0' (zero) in the field.

Changes have been saved.

Worker Categories	Increased Pay	Different Working Hours/ Working Conditions	Retirement	Termination	Other	Not Known
Registered Nurse	9	5	13	1	2	0
Certified Nursing Assistant	7	2	0	4	1	3
Paid Feeding Assistant trained under s. 400.141, F.S.	1	0	0	0	0	0
Other B	2	3	8	0	1	0
Other A	0	10	0	2	5	5

Direct Care Workforce

- *All cost of employment benefits are required for each worker category.*

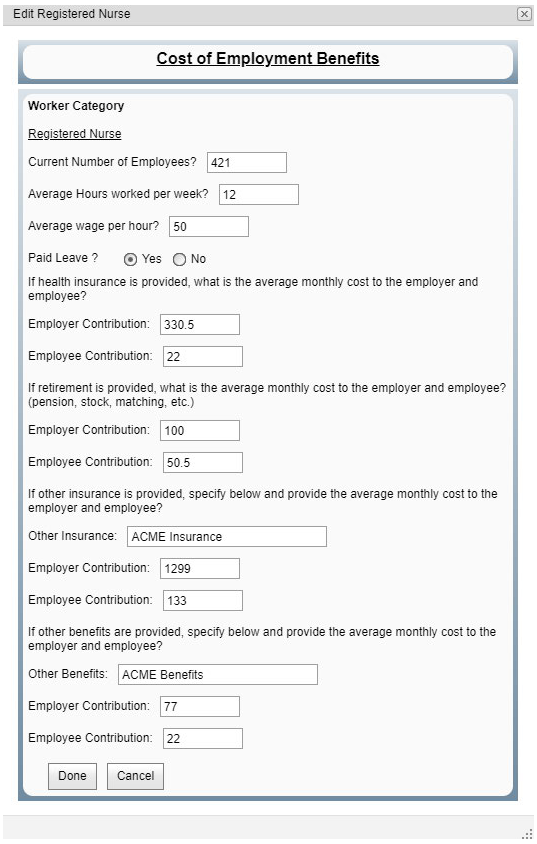
Cost of Employment Benefits

This section asks for information on the cost of benefits for direct care workers currently employed at your facility.

Respond to the questions below and indicate which benefits are provided for each category of worker along with the average monthly cost of those benefits to your business and your employees.

To add or edit information for each worker category select "Edit/View."

	Worker Category	Current Number of Employees
Edit/View	Registered Nurse	
Edit/View	Certified Nursing Assistant	
Edit/View	Paid Feeding Assistant trained under s. 400.141, F.S.	
Edit/View	Other B	
Edit/View	Other A	


Edit Registered Nurse
Cost of Employment Benefits
Worker Category
Registered Nurse
Current Number of Employees? 421
Average Hours worked per week? 12
Average wage per hour? 50
Paid Leave ? Yes No
If health insurance is provided, what is the average monthly cost to the employer and employee?
Employer Contribution: 330.5
Employee Contribution: 22
If retirement is provided, what is the average monthly cost to the employer and employee? (pension, stock, matching, etc.)
Employer Contribution: 100
Employee Contribution: 50.5
If other insurance is provided, specify below and provide the average monthly cost to the employer and employee?
Other Insurance: ACME Insurance
Employer Contribution: 1299
Employee Contribution: 133
If other benefits are provided, specify below and provide the average monthly cost to the employer and employee?
Other Benefits: ACME Benefits
Employer Contribution: 77
Employee Contribution: 22
Done
Cancel

Direct Care Workforce

Changes have been saved.

Cost of Employment Benefits

This section asks for information on the cost of benefits for direct care workers currently employed at your facility.

Respond to the questions below and indicate which benefits are provided for each category of worker along with the average monthly cost of those benefits to your business and your employees.

To add or edit information for each worker category select "Edit/View."

	Worker Category	Current Number of Employees
Edit/View	Registered Nurse	421
Edit/View	Certified Nursing Assistant	72
Edit/View	Paid Feeding Assistant trained under s. 400.141, F.S.	14
Edit/View	Other B	5
Edit/View	Other A	11

Direct Care Workforce

Additional Training

This section asks for information about additional training available for direct care workers employed by your business. "Additional training" is training offered in addition to training required by applicable statutes and rules. Do not include mandatory training required by statute or rule in this section.

If additional training is not available, please answer "NO" below to complete this section. If training is available, please answer "YES" below and indicate which trainings are available.

Is additional training available for direct care workers employed by your business?

- ○ Yes
- ◉ No

Direct Care Workforce

Additional Training

This section asks for information about additional training available for direct care workers employed by your business. "Additional training" is training offered in addition to training required by applicable statutes and rules. Do not include mandatory training required by statute or rule in this section.

If additional training is not available, please answer "NO" below to complete this section. If training is available, please answer "YES" below and indicate which trainings are available.

There are missing and/or invalid entries. Please correct them.

- *At least one training must be selected.*

Is additional training available for direct care workers employed by your business?

(•) Yes ( ) No

For each category of direct care worker, check the boxes to indicate which trainings are available at or provided by your business.

Worker Categories	Pediatric Care Training	Ventilator Training	Tracheostomy Training	Gastrostomy Tube Training	Wound Training	IV Training	Other training not required by applicable statute or rule
Registered Nurse	☐	☐	☐	☐	☐	☐	☐
Certified Nursing Assistant	☐	☐	☐	☐	☐	☐	☐
Paid Feeding Assistant trained under s. 400.141, F.S.	☐	☐	☐	☐	☐	☐	☐
Other B	☐	☐	☐	☐	☐	☐	☐
Other A	☐	☐	☐	☐	☐	☐	☐

Supporting Documents

Applicants **MUST** include the following attachments as stated in Chapters 408, Part II and 400, Part III, F.S. and Chapter 59A-35 and 59A-8, F.A.C.

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

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

- *Proof of Malpractice Insurance Coverage*
  - *Carrier is required*
  - *Policy number is required*
  - *Aggregate policy amount is required*
  - *Effective date is required*
  - *Expiry date is required*
  - *Occurrence policy amount is required*
  - *Upload document is required/check the document mailed checkbox.*
- *Proof of General Liability Insurance Coverage*
  - *Carrier is required*
  - *Policy number is required*
  - *Aggregate policy amount is required*
  - *Effective date is required*
  - *Expiry date is required*
  - *Occurrence policy amount is required*
  - *Upload document is required/check the document mailed checkbox.*
- *Proof of Financial Ability to Operate*
  - *Upload document is required/check the document mailed checkbox.*
- *Business Plan signed by applicant, detailing the home health agency's methods to obtain patients and its plan to recruit and maintain staff*
  - *Upload document is required/check the document mailed checkbox.*
- *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 for principal office and each satellite office*
  - *Upload document is required/check the document mailed checkbox.*
- *Documentation signed by the appropriate local government official, which states that the applicant has met zoning requirement*
  - *Upload document is required/check the document mailed checkbox.*

Proof of Malpractice Insurance Coverage

Carrier

Policy #

Effective Date

Expiry Date

Policy Amount $0.00

Occurrence Policy Amount $0.00

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

Browse...

Proof of General Liability Insurance Coverage

Carrier

Policy #

Effective Date

Expiry Date

Aggregate Policy Amount $0.00

Occurrence Policy Amount $0.00

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

Browse...

Evidence of a Surety Bond

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

Browse...

Accreditation Documentation

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

Browse...

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

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

Browse...

Approved Repayment Plan

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

Browse...

Additional Documentation

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

Browse...

Proof of Financial Ability to Operate

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

Browse...

Business Plan signed by applicant, detailing the home health agency's methods to obtain patients and its plan to recruit and maintain staff

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

Browse...

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 for principal office and each satellite office

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

Browse...

Documentation signed by the appropriate local government official, which states that the applicant has met zoning requirement

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

Browse...

Undo | Save | << Back | Next >>

Finalize Application

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

1. Provider/Facility Information
   a. *Details*
   b. *Contact Person*

2. Licensee Information
   a. *Licensee Details*

3. Controlling Interests
   a. *Controlling Interests*

4. Management Company Information
   a. *Management Company Information*
   b. Management Company Controlling Interest

5. Personnel
   a. *Administration*
   b. Safety Liaison

6. Required Disclosure
   a. *Convictions*
   b. *Exclusions*
   c. *Felonies/Terminations*
   d. *Nonimmigrant Aliens*

7. Accreditation
   a. *Accreditation*

8. Days and Hours of Operation
   a. *Days and Hours of Operation*

9. Geographic Service Area
   a. *Geographic Service Area*

10. Services
    a. *Services*

11. Other Associated Locations
    a. Other Associated Locations

12. Supporting Documents
    a. *Supporting Documents*

I **KELLI FILLYAW**, attest as follows:

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

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

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

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

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

(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), Florida Statutes, 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), Florida Statutes, 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, Florida Statutes.

KELLI FILLYAW	GOC III	09/25/2023
Signature of Licensee or Authorized Representative	Title	Date

☐ I agree

Biennial Licensure Fee and Other Amounts Due Upon Submission of Application

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

Selecting the 'Submit Application' you will no longer be able to make changes to your application.

Submit Application