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

Health Care Licensing Application
Hospice

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 applicant will receive notice of the amount of the late fee as part of the application process or by separate notice. The application will be withdrawn from review if all the required documents and fees are not included with your application or received within 21 days of an omission notice. **Applications will not be considered for review until payment has been received. Renewal and Change During 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 400, Part IV, Florida Statutes (F.S.), and Chapters 59A-35 and 59A-38, Florida Administrative Code (F.A.C.), an application is hereby made to operate a hospice as indicated below:

1. Provider/Licensee Information

A. PROVIDER INFORMATION – Please complete the following for the hospice 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 Hospice (if operated under a fictitious name, enter as filed with the Florida Division of Corporations)		
Street Address		

City	County	State	Zip

Telephone Number	Fax Number

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

Provider Website

Mailing Address or ☐ Same as above

City	County	State	Zip

Telephone Number	E-mail Address

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

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

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

If ☐ YES, please provide the following information:

Full Name of Property Owner		
☐ Owned	☐ Leased	Telephone Number

Primary Address	Effective Date

C. CONTACT PERSON - Please complete the following for the contact person for this application.	
Contact Person for this application	Contact Telephone Number
Contact e-mail address or ☐ Do not have e-mail	**Note**: By providing your e-mail address you agree to accept e-mail correspondence from the Agency.

D. LICENSEE INFORMATION – Please complete the following for the entity seeking to operate the hospice.			
Licensee Name (This is the legal name of the operating entity of the hospice 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 hospice in Florida? YES ☐ NO ☐

If yes, please provide the name of the hospice (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 During Licensure Period (check all that apply): **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

Fee Required

- ☐ Provider Name
- ☐ Provider Address
- ☐ Hospice Address
  - ☐ Satellite Location ☐ Add ☐ Remove
  - ☐ Freestanding Inpatient Facilities ☐ Add ☐ Remove
  - ☐ Residential Units ☐ Add ☐ Remove

Services/Qualifications:

- ☐ Geographic Service Area ☐ Add ☐ Delete

Beds/Capacity: ☐ Increase ☐ Decrease ☐ Conversion

No Fee Required

- ☐ Personnel
- ☐ Management Company
- ☐ Management Company Controlling Interest

Services/Qualifications:

- ☐ Services ☐ Add ☐ Delete

☐ Transfer or assignment of less than 51% ownership, shares, membership, or controlling interest of the licensee

☐ Governing Body

B. LICENSURE FEES

ACTION	FEE	TOTAL FEES
Licensure Fee (Initial, Renewal and Change of Ownership)	$1,218.00	$
Biennial Health Care Assessment Fee	$300.00	$
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: For each controlling interest an AHCA screening through the Care Provider Background Screening Clearinghouse is needed or the Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008 if background screening was conducted by the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S. To verify who is to be screened, visit Background Screening (myflorida.com)

INSTRUCTIONS: Attach additional application pages if needed.
For new individual – complete all fields except the End Date.
For existing individuals – complete all fields except the Effective and End Date.
To remove an individual – complete all fields including the End Date.

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

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

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

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

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

5. Management Company Controlling Interest

DEFINITION:

Controlling interests, as defined in section 408.803(7), F.S., are the applicant or licensee; a person or entity that serves as an officer of, is on the board of directors of, or has a 5% or greater ownership interest in the applicant or licensee; or a person or entity that serves as an officer of, is on the board of directors of, or has a 5% or greater ownership interest in the management company or other entity, related or unrelated, with which the applicant or licensee contracts to manage the provider. The term does not include a voluntary board member.

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

INSTRUCTIONS: Attach additional application pages if needed.
For new individual – complete all fields except the End Date.
For existing individuals – complete all fields except the Effective and End Date.
To remove an individual – complete all fields including the End Date.

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

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

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

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

6. Personnel

A. Please provide information for the individual(s) who perform the following roles: Administrator, Financial Officer, Medical Director and Nursing Supervisor.

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

INSTRUCTIONS: Attach additional application pages if needed.
For new individual – complete all fields except the End Date.
For existing individuals – complete all fields except the Effective and End Date.
To remove an individual – complete all fields including the End Date.

INFORMATION	ADMINISTRATOR (person responsible for day-to-day operation)	FINANCIAL OFFICER (person responsible for financial operation)
Full Name		
Effective Date		
End Date		
Telephone Number		
Email Address		
Personal/Primary Address		
FL Professional License # if any		

B. Medical Staff – Provide the requested information for the individual who performs the following required roles:

INFORMATION	MEDICAL DIRECTOR* (responsible for directing patient care & treatment)	NURSING SUPERVISOR** (responsible for coordinating patient plan of care)
Full Name		
Effective Date		
End Date		
Telephone Number		
Email Address		
Personal/Primary Address		
FL Professional License # if any		

*If the medical director has changed since the last application was submitted, please enclose verification that this physician has admission privileges at one or more hospitals commonly serving patients in the hospice's service area pursuant section 59A-38.008(2) F.A.C.

**Section 59A-38.009(2), F.A.C., requires the hospice employ a supervising registered nurse with supervisory or hospice experience that has completed a hospice training program sponsored by the employing hospice.

7. Required Disclosure

The following disclosures are required:

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

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

If YES, provide the following information:

☐ The full legal name of the individual and the position held

☐ An explanation of any convictions of offenses

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

Has the applicant or any individual/entity listed in Sections 3 and 4 of this application been excluded, suspended, terminated or involuntarily withdrawn from participation in Medicare or Medicaid in any state? YES ☐ NO ☐

If YES, enclose the following information:

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

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

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

Convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, Chapter 817, Chapter 893, 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396, Medicaid fraud, Medicare fraud, or insurance fraud, within the previous 15 years prior to the date of this application? YES ☐ NO ☐

Terminated for cause from the Medicare program or a state Medicaid program? YES ☐ NO ☐

If YES, has applicant been in good standing with the Medicare program or a state Medicaid program for the most recent five (5) years and the termination occurred at least twenty (20) years before the date of the application. YES ☐ NO ☐

8. Provider Fines and Financial Information

Pursuant to section 408.831(1)(a), F.S., the Agency may take action against the applicant, licensee, or a licensee which shares a common controlling interest with the applicant if they have failed to pay all outstanding fines, liens, or overpayments assessed by final order of the agency or final order of the Centers for Medicare and Medicaid Services (CMS), not subject to further appeal, unless a repayment plan is approved by the agency.

Are there any incidences of outstanding fines, liens or overpayments as described above? YES ☐ NO ☐

If YES, please complete the following for each incidence (attach additional sheets if necessary):

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

Please attach a copy of the approved

9. Accreditation with Deemed Status

Has this hospice received accreditation with deemed status through an accrediting organization approved by the Centers for Medicare & Medicaid Services (CMS)? ☐ YES ☐ NO

If YES, indicate the accrediting organization below, provide the requested information and attach documentation declaring current deemed status along with a copy of the survey report:

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				

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.

10. Geographic Service Area

For Initial applications check all counties where this registry expects to provide services. For all other applications, check only those counties that this registry plans to add or delete from the existing license. **Note**: A Certificate of Need should be submitted to verify approval of expansion into requested areas.

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

11. Satellite Offices

Section 59A-38.001(14), F.A.C. defines a satellite office as "an office or other physical location serving as a contact point for patients, which is remote from the provider's principal office, but is not separately licensed, and shares administration with the principal office."

Does the hospice operate any satellite offices? YES ☐ NO ☐ If YES, provide the requested information for each below:

STREET ADDRESS	CITY	ZIP	PHONE #	DATE	
				OPENED	CLOSED

12. Freestanding Inpatient Facilities

Does the hospice operate any freestanding inpatient facilities? YES ☐ NO ☐
If YES, provide the requested information for each below (Do not list contracted hospital, Skilled Nursing Facility, Nursing Facility or Intermediate Care Facility beds.):

STREET ADDRESS	CITY	ZIP	PHONE #	# BEDS	DATE	
					OPENED	CLOSED

13. Residential Units

Does the hospice operate any residential units? YES ☐ NO ☐
If YES, provide the requested information for each below:

STREET ADDRESS	CITY	ZIP	PHONE #	# BEDS	DATE	
					OPENED	CLOSED

14. Governing Body

Section 400.610(1), F.S., states, “A hospice shall have a clearly defined organized governing body, consisting of a minimum of seven persons who are representative of the general population of the community served. The governing body shall have autonomous authority and responsibility for the operation of the hospice and shall meet at least quarterly.” Section 59A-38.004(1)(a), F.A.C. further requires, “Members must reside or work in the hospice’s service area as defined in paragraph 59C-1.0355(2)(k), F.A.C.”

Please provide the following information for each member of the hospice’s governing body. Attach additional sheets if necessary. If a listed individual is a paid employee, the individual’s social security number must be included on the Health Care Licensing Application Addendum, AHCA Form 3110-1024.

FULL NAME	FULL PERSONAL/BUSINESS ADDRESS	COUNTY	PHONE NUMBER

15. Services

Indicate the number of employees under each of the listed services, which are required to be **directly** provided by the hospice [Section 59A-38.001(6), F.A.C. recognizes employment on either a salary or volunteer basis.]:

REQUIRED DIRECT SERVICE	NUMBER OF EMPLOYEES
Nursing	
Medical Social Work	
Dietary Counseling	Provided by ☐ licensed nutritionist/dietitian/nutrition counselors, registered dietitians and/or ☐ nurses
Pastoral or Counseling	
Bereavement Counseling	
Volunteer Coordination	

16. Supporting Documents

Applicants **must** include the following attachments as stated in Chapters 408, Part II and 400, Part IV, F.S. and Chapters 59A-35 and 59A-38, F.A.C. **Note: Required documents listed below are dependent on the type of application being submitted. (Initial, Renewal, Change of Ownership, Change During Licensure Period)**

Documents to be Provided:	Required for:
Accreditation report, if applicable	Initial, Renewal and Change of Ownership applications types, if hospice is accredited with deemed status
Proof of Financial Ability to Operate, AHCA Form 3100-0009	Initial and Change of Ownership application types
Property Occupancy documentation, examples: facility ownership/lease documentation (if applicable) for principal office and each satellite office, inpatient facility and residential unit	Initial, Change of Ownership involving change of licensee and change of address application types
Documentation from local government proving compliance with local zoning requirements	Initial, Change of Ownership and change of address – principal office only; addition & renovation of inpatient facility application types
Plan for delivery of services per section 400.606(1), F.S.	Initial and Change of Ownership application types
Visitation Policy and Procedure	Initial, Renewal, and Change of Ownership application types
Documentation of change of ownership transaction stating effective date and executed by all parties	Change of Ownership application and any change of controlling interest affecting % ownership of licensee application types
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
Medical director's proof of hospital admitting privileges per 59A-38.008(1), F.A.C. (if not previously reported)	Any application type, if medical director has changed
Health Care Licensing Application Addendum, AHCA Form 3110-1024	Initial, Renewal and Change of Ownership 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

17. Attestation

I, _____, attest as follows:

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

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

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

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

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

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

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

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

Signature of Licensee or Authorized Representative	Title	Date

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

RETURN THIS COMPLETED FORM WITH FEES TO:

AGENCY FOR HEALTH CARE ADMINISTRATION
LONG TERM CARE SERVICES UNIT
2727 MAHAN DR., MS 33
TALLAHASSEE FL 32308-5407

Questions? Visit the Agency's website : https://ahca.myflorida.com/ or contact the Long Term Care Services Unit at (850) 412-4303 or Email: LTCStaff@ahca.myflorida.com

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

- Place checks or money orders on top of the application
- Include license number, AHCA file 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
- ***Do not bind any*** documents submitted to the Agency