



Health Care Licensing Application Nurse Registry

AHCA USE ONLY:

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

The Agency for Health Care Administration (AHCA) has implemented the **ONLINE LICENSING SYSTEM**, which allows the electronic submission of renewal and change during licensure period applications and fees, along with the ability to upload supporting documentation. To submit online please go to: <https://ahca.myflorida.com/health-care-policy-and-oversight/online-licensure-information/online-licensing-system>

Applications must be received **at least 60 days prior to** the expiration of the current license or effective date of a change of ownership to avoid a late fee. If the renewal application is received by the Agency less than 60 days prior to the expiration date, it is subject to a late fee as set forth in statute. The application will be withdrawn from review if all the required documents and fees are not included with the application or received within 21 days of an omission notice.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 III, Florida Statutes (F.S.), and Chapters 59A-35 and 59A-18, Florida Administrative Code (F.A.C.), an application is hereby made to operate a nurse registry as indicated below:

1. Provider / Licensee Information

A. PROVIDER INFORMATION – Please complete the following for the nurse registry 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) | | |
| Name of Nurse Registry (if operated under a fictitious name, enter as it is filed with the Florida Division of Corporation) | | | | |
| 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 <input type="checkbox"/> Same as above | | | | |
| City | | County | State | Zip |
| Telephone Number | | E-mail Address | | |

B. CONTACT PERSON - Please complete the following for the contact person for this application.

| | |
|-----------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| Contact Person for this application | Contact Telephone Number |
| Contact e-mail address or <input type="checkbox"/> Do not have e-mail | Note: By providing your e-mail address, you agree to accept e-mail correspondence from the Agency. |

| | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|-----|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|
| C. LICENSEE INFORMATION – Please complete the following for the entity seeking to operate the nurse registry. | | | | | | |
| Licensee Name (This is the owner of the nurse registry) | | Federal Employer Identification Number (EIN) | | | | |
| Mailing Address or <input type="checkbox"/> Same as above | | | | | | |
| City | | State | Zip | | | |
| Telephone Number | Fax Number | E-mail Address | | | | |
| Description of Licensee (check one): | | | | | | |
| <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> <u>For Profit</u> <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Partnership <input type="checkbox"/> Individual <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Other </td> <td style="width: 33%; vertical-align: top;"> <u>Not for Profit</u> <input type="checkbox"/> Corporation <input type="checkbox"/> Religious Affiliation <input type="checkbox"/> Other </td> <td style="width: 33%; vertical-align: top;"> <u>Public</u> <input type="checkbox"/> State <input type="checkbox"/> City/County <input type="checkbox"/> Hospital District </td> </tr> </table> | | | | <u>For Profit</u> <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Partnership <input type="checkbox"/> Individual <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Other | <u>Not for Profit</u> <input type="checkbox"/> Corporation <input type="checkbox"/> Religious Affiliation <input type="checkbox"/> Other | <u>Public</u> <input type="checkbox"/> State <input type="checkbox"/> City/County <input type="checkbox"/> Hospital District |
| <u>For Profit</u> <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Partnership <input type="checkbox"/> Individual <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Other | <u>Not for Profit</u> <input type="checkbox"/> Corporation <input type="checkbox"/> Religious Affiliation <input type="checkbox"/> Other | <u>Public</u> <input type="checkbox"/> State <input type="checkbox"/> City/County <input type="checkbox"/> Hospital District | | | | |

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.

☐ Initial Licensure

Proposed Effective Date: _____

Was this entity previously licensed as a nurse registry in Florida? YES ☐ NO ☐

If yes, please provide the name of the nurse registry (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: _____

☐ Licensee sale or transfer of ownership to a different individual/entity

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

☐ Change during licensure period (check all that apply):

Proposed Effective Date: _____

Fee Required

No Fee Required

☐ Provider Name

☐ Personnel

Provider Addresses:

☐ Hours of Operations

☐ Nurse Registry Address

☐ Management Company

☐ Satellite Location ☐ Add ☐ Remove

☐ Management Company Controlling Interest

Services/Qualifications:

Services/Qualifications:

☐ Geographic Service Area ☐ Add ☐ Delete

☐ Services ☐ Add ☐ Delete

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

| ACTION | FEE | TOTAL FEES |
|-----------------------------------------------------------------------------------------------------|------------|------------|
| License Fee (Initial, Renewal and Change of Ownership): | \$2,000.00 | \$ |
| Change During Licensure Period | \$25.00 | \$ |
| Other: _____ | | \$ |
| 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 (SSN) 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 \(myflorida.com\)](https://myflorida.com/background-screening)

INSTRUCTIONS:

For new individual – complete all fields except the End Date.

For existing individuals – complete all fields except the Effective and End Date.

To remove an individual – complete all fields including the End Date.

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

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

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

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

4. Management Company

Does a company other than the licensee manage the 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 <input type="checkbox"/> 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 \(myflorida.com\)](https://myflorida.com/background-screening)

INSTRUCTIONS:

For new individual – complete all fields except the End Date.

For existing individuals – complete all fields except the Effective and End Date.

To remove an individual – complete all fields including the End Date.

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

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

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

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

| | | | | | |
|-------------------------|--|--|--|--|--|
| Board Member/Officer | | | | | |
|-------------------------|--|--|--|--|--|

6. Personnel

A. Please provide information for the individual(s) who perform the following roles. Administrator, Alternate Administrator, Registered Nurse, Financial Officer and Safety Officer.

Note: For the administrator, alternate administrator, registered nurse 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 \(myflorida.com\)](https://myflorida.com)

INSTRUCTIONS:

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 | ALTERNATE ADMINISTRATOR |
|---------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Full Name | | |
| Effective Date | | |
| End Date | | |
| Telephone Number | | |
| Email Address | | |
| Personal Address | | |
| Florida Dept of Health License Number | | |
| Experience | Does the Alternate Administrator have training and at least one year of supervisory or administrative experience in the health care field? <input type="checkbox"/> Yes <input type="checkbox"/> No | Does the Alternate Administrator have training and at least one year of supervisory or administrative experience in the health care field? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Work Status | <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time | <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time |

B. Registered Nurse:

| INFORMATION | REGISTERED NURSE |
|---------------------------------------|---------------------------------------------------------------------------------------------------------|
| Full Name | |
| Effective Date | |
| End Date | |
| Telephone Number | |
| Email Address | |
| Personal Address | |
| Florida Dept of Health License Number | |
| Work Status | <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Contract |

C. Safety Liaison and Financial Officer: Provide the requested information for the individual who will serve as primary contact during emergency operations pursuant to section 408.821, F.S. and the financial officer.

| INFORMATION | FINANCIAL OFFICER / PERSON RESPONSIBLE FOR FINANCIAL OPERATIONS | SAFETY LIAISON |
|--------------------------|-----------------------------------------------------------------|----------------|
| Full Name | | |
| Effective Date | | |
| End Date | | |
| Personal/Primary Address | | |

| | | |
|------------------|--|--|
| Telephone Number | | |
| Email 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/entity and the position held
☐ A description/explanation of the convictions

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

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

If YES, enclose the following information:

- ☐ The full legal name of the individual/entity and the position held
☐ 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 |
| | <input type="checkbox"/> | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| | <input type="checkbox"/> | | | | <input type="checkbox"/> | <input type="checkbox"/> |
| | <input type="checkbox"/> | | | | <input type="checkbox"/> | <input type="checkbox"/> |

Please attach a copy of the approved repayment plan if applicable.

9. Days and Hours of Operation

List the nurse registry's operating hours. Section 59A-18.004(0)(a), F.A.C., requires that an agency be open for 8 consecutive hours per day, Monday through Friday between the hours of 7 a.m. and 6 p.m., excluding legal and religious holidays.

| DAY OF THE WEEK | OPENING TIME | CLOSING TIME |
|-----------------|--------------|--------------|
| Sunday | | |
| Monday | | |
| Tuesday | | |
| Wednesday | | |
| Thursday | | |
| Friday | | |
| Saturday | | |

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.

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

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

11. Services

A. Health care personnel provided by the nurse registry (check all that apply):

| | | | |
|--------------------------|------------------------------|--------------------------|-------------------|
| <input type="checkbox"/> | Certified Nursing Assistants | <input type="checkbox"/> | Registered Nurses |
| <input type="checkbox"/> | Licensed Practical Nurses | <input type="checkbox"/> | Companions |
| <input type="checkbox"/> | Homemakers | <input type="checkbox"/> | Home Health Aides |

B. Types of facilities/clients served (check all that apply):

| | | | |
|--------------------------|--------------------------|--------------------------|-------------------------------|
| <input type="checkbox"/> | Assisted Living Facility | <input type="checkbox"/> | Adult Day Care |
| <input type="checkbox"/> | Hospice | <input type="checkbox"/> | Hospital |
| <input type="checkbox"/> | Nursing Home | <input type="checkbox"/> | Home Health Agency |
| <input type="checkbox"/> | Private Residence / Home | <input type="checkbox"/> | Other (please explain): _____ |

12. Satellite Office

A satellite office is a secondary office in the same health service planning district as the nurse registry operational site, operating under the auspices of the nurse registry's license. Refer to section 59A-18.004, F.A.C., for requirements.

Will this agency operate a satellite office? ☐ YES ☐ NO If YES, list address(es) of Satellite offices below:

| | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|--------|------------------|
| Satellite Office #1 | | | |
| Street Address | | | |
| City | Zip | County | Telephone Number |
| Satellite Office #2 | | | |
| Street Address | | | |
| City | Zip | County | Telephone Number |
| Satellite Office #3 | | | |
| Street Address | | | |
| City | Zip | County | Telephone Number |
| Note: For each satellite office, the following information must be submitted with the application: | | | |
| <ul style="list-style-type: none">○ Evidence of Right to Occupy – Proof may include copies of warranty deeds, lease or rental agreements, contracts for deeds etc.○ Evidence of Appropriate Zoning – A letter or report from the local government zoning office indicating that the office location is appropriately zoned for use as home health agency. An occupational license or business tax receipt does not meet the requirement for proof of zoning. | | | |

13. Supporting Documents

Applicants **must** include the following attachments as stated in Chapters 408, Part II and 400, Part III, F.S. and Chapters 59A-35 and 59A-18, 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: |
|----------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| Proof of Financial Ability to Operate, AHCA Form 3110-7004A | Initial and Change of Ownership application types |
| Documentation from the appropriate local government office showing that the applicant has met local zoning requirements | Initial, Change of Ownership and Change During License Period - Address Change application types |
| Copy of Comprehensive Emergency Management Plan (CEMP) Approval Letter or Documentation of the CEMP submission for review within the last 365 days | Renewal application type |
| Documentation of change of ownership transaction stating effective date and executed by all parties | Change of Ownership and Change During License Period application type |
| 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 type |
| Health Care Licensing Application Addendum, AHCA Form 3110-1024 | Initial, Renewal, Change of Ownership and Change of Personnel or Controlling application types |
| Required disclosures related to actions taken by Medicare, Medicaid or CLIA, if applicable | All application types |
| Approved repayment plan, if applicable | All application types |

14. 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
LABORATORY AND IN-HOME SERVICES UNIT
2727 MAHAN DR MS 32
TALLAHASSEE FL 32308-5407

Questions? Visit the Agency's website at <https://ahca.myflorida.com/> or contact the Laboratory and In-Home Services Unit at 850-412-4500 or E-mail: hqahomehealth@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