

Provider:
AngelCare Services

Provider Type:
Nurse Registry

File#: 42984382
License #:
Expires:

Logged in as : kelli.fillyaw

[Dashboard](#) [OL Help](#) [Documents](#) [Logout](#)

Provider/Facility Information

Under the authority of Chapters [408 Part II](#) and [400 Part II](#), 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 center.

Pursuant to sections [408806 \(1\)\(a\) 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.

= Entered
 = Entry Required

Provider/Facility Information

Details

Contact Person

Licensee Information

Controlling Interests

Management Company Information

Personnel

Required Disclosure

Days and Hours of Operation

Geographic Service Area

Services

Other Associated Locations

Supporting Documents

Finalize Submission

- 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

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

Provider/Facility Location 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.*

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

Address

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

Telephone Ext Email Address

None

Health Care Licensing Online
Application
Nurse Registry
AHCA Form 3110-7004 OL,
August 2023
59A-35.060, Florida
Administrative Code

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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Telephone	Ext	Fax #	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
		<input type="checkbox"/> None	
Contact Email Address (By providing your email address, you agree to accept email correspondence from the Agency.)			
<input type="text"/>			
<input type="checkbox"/> None			

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Licensee Information

Please complete the following for the individual or entity seeking to operate the home health agency.

- *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

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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.

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.

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

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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.*

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Personnel

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

Personnel

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 the [Background Screening](#) site.

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

- Administrator
- Alternate Administrator
- Financial Officer
- Registered Nurse

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!

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Personnel

B. 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

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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 occurred at least 20 years before the date of the application?

Yes No

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Days and Hours of Operation

- *Either select the Opening and Closing time or select the By Appointment option*

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.

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.

<u>Day</u>	<u>Opening Time</u>	<u>Closing Time</u>	<u>By Appointment</u>
MONDAY	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
TUESDAY	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
WEDNESDAY	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
THURSDAY	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
FRIDAY	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
SATURDAY	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
SUNDAY	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

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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 - Counties must be within a single AHCA area (see below).

Counties Served

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

- *Add at least one service.*

A. Health Care Personnel Provided by the Nurse Registry

Identify the health care personnel provided by the nurse registry (check all that apply).

- Certified Nursing Assistants
- Companions
- Home Health Aides
- Homemakers
- Licensed Practical Nurses
- Registered Nurses

Undo

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Services

- *Applicant must make at least one selection.*

B. Types of Providers Served

Identify the types of facilities/clients served by the nurse registry (check all that apply).

- Adult Day Care
- Assisted Living Facility
- Home Health Agency
- Hospice
- Hospital
- Nursing Home
- Private Home/Residence
- Other

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Other Associated Locations

- *Select either Yes or No option.*

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

Note: For each satellite office, Evidence of Right to Occupy and Evidence of Appropriate Zoning will be required in the Supporting Document section.

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

Yes No

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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.

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 Financial Ability to Operate**
 - Upload document is required/check the document mailed checkbox.
- **Documentation from the appropriate local government office showing that the applicant has met local zoning requirements**
 - Upload document is required/check the document mailed checkbox.

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.

Documentation from the appropriate local government office showing that the applicant has met local zoning requirements

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.

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.

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.

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.

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](#)
- ❑ 7. Days and Hours of Operation
 - a. [Days and Hours of Operation](#)
- ❑ 8. Geographic Service Area
 - a. [Geographic Service Area](#)
- ❑ 9. Services
 - a. [Health Care Personnel](#)
 - b. [Types of Providers Served](#)
- ❑ 10. Other Associated Locations
 - a. [Satellite Offices](#)
- ❑ 11. 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 \$2,000
- 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.