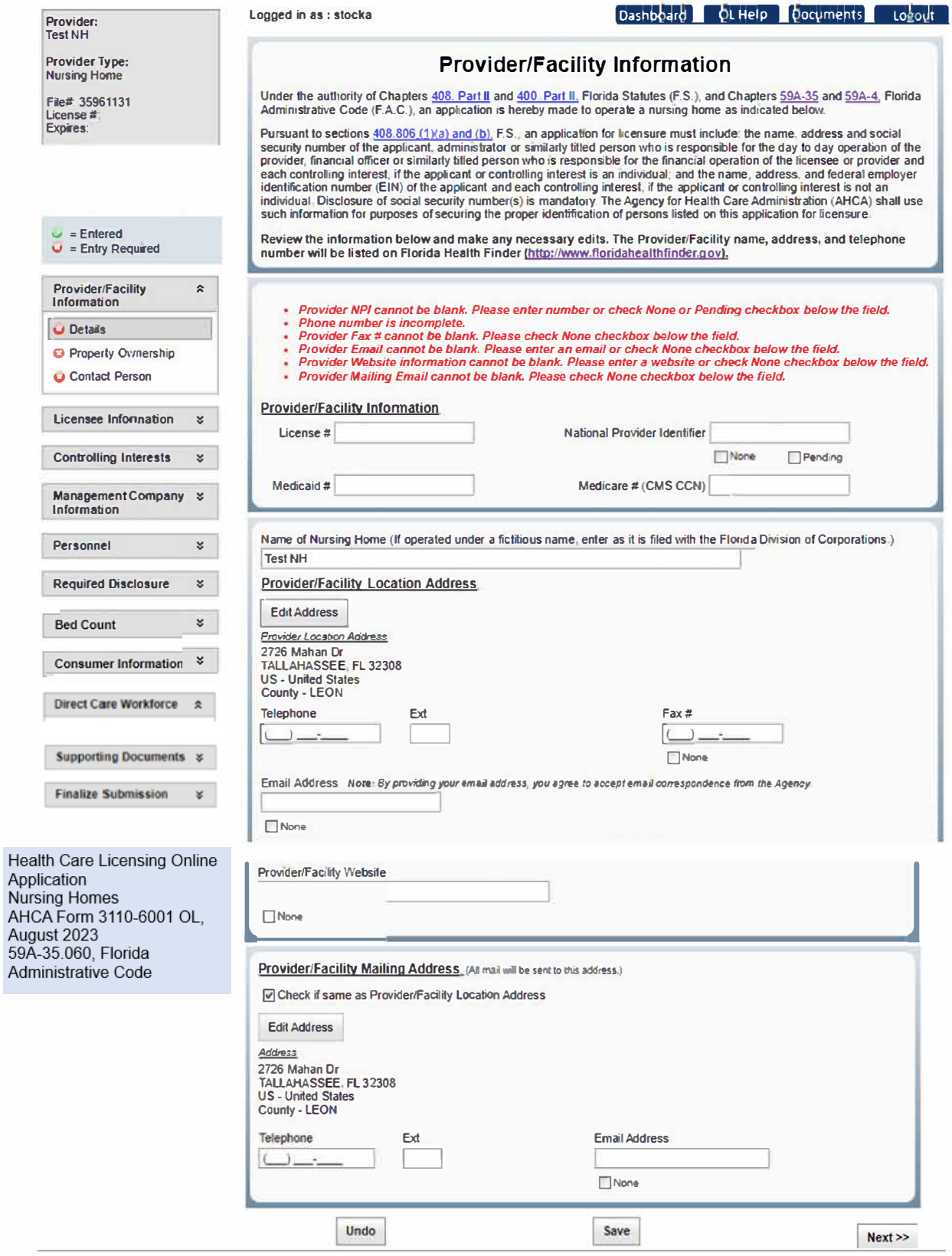

Health Care Licensing Online Application
Nursing Homes
AHCA Form 3110-6001 OL, August 2023
59A-35.060, Florida Administrative Code

Property Ownership

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

- *Select a property ownership type.*

Does the licensee own or lease this facility? If leased, provide the name of the property owner by following the instructions below.

- ◯ Own
- ◯ Lease

Undo | Save | << Back | Next >>

Provider/Facility Information

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

Provider/Facility Contact Person for this Application

First Name | Middle Name | Last Name | Suffix

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

☐ None

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

☐ None

Undo | Save | << Back | Next >>

Licensee Information

- *Ownership Type is not selected.*
- *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.*
- *Select description of Licensee. (Profit, Non Profit or Public)*

Description of Licensee (select only one option below)

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

Ownership Types

Mailing Address

Edit Address

Address

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

Undo Save << Back Next >>

Controlling Interests of Licensee

- *Select either Yes or No option.*

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

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

Undo | Save | << Back | Next >>

Management Company Information

- *Select either Yes or No option.*

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

◯ Yes ◯ No

Undo | Save | << Back | Next >>

Management Company Controlling Interest

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

Undo | Save | << Back | Next >>

Personnel

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

Personnel

Note: The administrator and financial officer are required pursuant to section 408.809, F.S. to have an Agency screening through the Care Provider Background Screening Clearinghouse or submit the Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, if background screening was conducted by the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S. To verify who must be screened, visit the Background Screening site.

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

- Administrator
- Financial Officer

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

No Individuals exist!

Undo | Save | << Back | Next >>

Personnel

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 | Save | << Back | Next >>

Required Disclosure

- *Either Yes or No must be selected.*

Convictions

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

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

◯ Yes ◯ No

Undo | Save | << Back | Next >>

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

Undo | Save | << Back | Next >>

Required Disclosure

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

Felonies/ Terminations

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

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

◯ Yes ◯ No

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

◯ Yes ◯ No

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

◯ Yes ◯ No

Undo | Save | << Back | Next >>

Required Disclosure

- *Either Yes or No must be selected for Financial/Ownership Actions*

Financial/Ownership Actions

Have any health care or resident entities in which the applicant, controlling interest, management company or administrator of the facility had financial or ownership in the past five years that meets the disclosure requirements as described in subsection 400.111, F.S?

◯ Yes ◯ No

Undo | Save | << Back | Next >>

Required Disclosure

- *Either Yes or No must be selected for Civil Verdict.*

Civil Verdict

Pursuant to 400.071(1)(e), F.S., has any civil verdict or judgment involving the applicant been rendered within the 10 years preceding the application, relating to medical negligence, violation of residents' rights, or wrongful death.

◯ Yes ◯ No

If yes, please provide to the Agency copies of any new verdict or judgment involving the applicant, relating to such matters, within 30 days after filing with the clerk of the court.

Undo | Save | << Back | Next >>

Bed Count

- *Licensed Beds*
  - *A response to the following is required – Community Beds*
  - *A response to the following is required – Sheltered Beds*
- *Certified Beds*
  - *A response to the following is required – Total Medicare only Beds*
  - *A response to the following is required – Total Medicaid only Beds*
  - *A response to the following is required – Total Duly Certified (Medicare and Medicaid)*
  - *A response to the following is required – Total Private Pay*
- *Room Type*
  - *A response to the following is required – Private Rooms*
  - *A response to the following is required – 2-Bed Rooms*
  - *A response to the following is required – 3-Bed Rooms*
  - *A response to the following is required – 4-Bed Rooms*
  - *A response to the following is required – Other Beds*
- *Bed Types*
  - *A response to the following is required – Assisted Living Facility Beds*
  - *A response to the following is required – Extended Congregation Care Beds*
  - *A response to the following is required – Inactive Beds*
  - *A response to the following is required – Hospice Beds*
  - *A response to the following is required – Pediatric Beds*
- *Questions*
  - *Answer regarding offering continuing care agreements is required*
  - *Answer regarding operating a geriatric outpatient clinic is required*
  - *Answer regarding providing respite care services is required*
  - *Answer regarding providing adult day care services is required*
  - *Answer regarding participating in alternate bed placement is required*
  - *Answer regarding utilizing licensed nurses to perform both licensed and certified nursing assitant duties is required*

Bed Count

The total number of licensed beds is used to calculate the total bed fee.
The renewal rate is $112.50 per bed. Exception: any facility with sheltered beds pays $100.50 per bed for all beds.

Licensed Beds	#
Community Beds	
Sheltered Beds	
Total Licenced Beds	0

Certified Beds	#
Total Medicare only Beds	
Total Medicaid only Beds	
Total Dually Certified (Medicare and Medicaid)	
Total Private Pay	
Total	0

Room-Type	#		**Beds**
Private Rooms		x 1 =	0
2-Bed Rooms		x 2 =	0
3-Bed Rooms		x 3 =	0
4-Bed Rooms		x 4 =	0
Other Rooms Bed Total		=	
Total			0

The total number of room-type beds must match the total number of licensed beds.

Bed Types	#
Nursing Home Beds used as ALF Beds pursuant to section 400.0712(2),F.S.	
Extended Congregate Care Beds	
Inactive Beds	
Hospice Beds	

Pediatric Beds

Do you offer continuing care agreements as defined in Chapter 651, F.S.?

- ○ YES
- ○ NO — If yes, please provide effective date:
- ○ NEVER, OR NOT SINCE 1/1/2011 — If no, please provide end date:

Do you operate a geriatric outpatient clinic as defined in section 59A-4.150, F.A.C.?

- ○ YES
- ○ NO — If yes, please provide effective date:
- ○ NEVER, OR NOT SINCE 1/1/2011 — If no, please provide end date:

Do you provide respite care services as defined in section 400.172, F.S.?

- ○ YES
- ○ NO — If yes, please provide effective date:
- ○ NEVER, OR NOT SINCE 1/1/2011 — If no, please provide end date:

Do you provide adult day care services as defined in section 429.901(1), F.S.?

- ○ YES
- ○ NO — If yes, please provide effective date:
- ○ NEVER, OR NOT SINCE 1/1/2011 — If no, please provide end date:

Do you plan to participate in alternate bed placement pursuant to section 400.23(2)(a), F.S.?

- ○ YES
- ○ NO — If yes, please provide effective date:
- ○ NEVER, OR NOT SINCE 1/1/2011 — If no, please provide end date:

Do you plan to utilize licensed nurses to perform both licensed nurse and certified nursing assistant duties during the same shift as defined in section 400.23(3)(a)4, F.S.?

- ○ YES
- ○ NO — If yes, please provide effective date:
- ○ NEVER, OR NOT SINCE 1/1/2011 — If no, please provide end date:

Undo | Save | << Back | Next >>

Consumer Information

The following information is provided for consumers through the Florida Health Finder website and the Florida Nursing Home Guide.

Review the information below and make any necessary edits.

Daily Rate and Occupancy

Provide daily rate ($) of semi-private room for skilled nursing care for a private pay new resident.

$ [ ]

Most recent available occupancy level: [ ] (Total # of beds that are occupied)

Payment Forms Accepted

- [ ] CHAMPUS
- [ ] Insurance and/or HMO
- [ ] Medicaid
- [ ] Medicare
- [ ] Veterans Administration
- [ ] Workers Compensation

Facility's Religious Affiliation (if any)

- [ ] Adventist
- [ ] Baptist
- [ ] Buddhist
- [ ] Catholic
- [ ] Christian (non-denominational)
- [ ] Christian Science
- [ ] Hindu
- [ ] Jewish
- [ ] Lutheran
- [ ] Methodist
- [ ] Muslim
- [ ] Presbyterian
- [ ] Other

Languages Spoken by Administrator and Staff

- [ ] Arabic
- [ ] Chinese
- [ ] Creole
- [ ] English
- [ ] Farsi
- [ ] Filipino
- [ ] French
- [ ] German
- [ ] Hebrew
- [ ] Hindi
- [ ] Italian
- [ ] Korean
- [ ] Polish
- [ ] Portuguese
- [ ] Russian
- [ ] Sign Language
- [ ] Spanish
- [ ] Vietnamese
- [ ] Other

Special Services - A checked box indicates that the services are provided at this facility and staff meet the necessary requirements

- [ ] 24-Hour Onsite RN Coverage
- [ ] Adult Day Care
- [ ] Alzheimer's
- [ ] Dialysis
- [ ] Eden Alternative
- [ ] HIV Care
- [ ] Hospice
- [ ] Pediatric Care
- [ ] Pet Therapy
- [ ] Respite
- [ ] Secured Unit
- [ ] Therapeutic Spa
- [ ] Tracheotomy
- [ ] Ventilator Dependent
- [ ] Water Therapy
- [ ] Weight Training
- [ ] Yoga
- [ ] Other

Accreditation - A checked box indicates that the facility and its staff is accredited or accredited with commendation by the Joint Commission on Accreditation of Healthcare Organization (JCAHO) for that health area.

- [ ] JCAHO accredited Sub-Acute Program
- [ ] JCAHO accredited Dementia Special Care Unit
- [ ] JCAHO accredited Long Term Care Program

Undo | Save | << Back | Next >>

Direct Care Workforce

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

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

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

Survey

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

Start Date: End Date:

Worker Categories

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

Check all that apply:

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

Add Worker Category

Undo Save << Back Next >>

Direct Care Workforce

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

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

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

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

Survey

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

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

Worker Categories

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

Check all that apply:

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

Add Worker Category

Direct Care Workforce

Changes have been saved.

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

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

Survey

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

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

Worker Categories

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

Check all that apply:

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

Add Worker Category

Direct Care Workforce

Changes have been saved.

Turnover and Vacancy

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

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

Worker Categories	For each category, what is the total number of staff employed by your facility at the beginning of the 12 month period?	For each category, how many staff have left employment with the facility since the beginning of the 12 month period until now?	What is your total number of available positions for each category (both filled and vacant)?	Currently, what is your total number of vacancies for each category?	For each category, what is your total number of new hires since the beginning of the 12 month period until now?	For each category (if applicable), what is your total patient volume (hours) since the beginning of the 12 month period until now?	How many direct employee vacancies are filled by contracted workers?	Turnover Rate	Vacancy Rate
Registered Nurse	47	9	40	6	13	55	9	0.19	0.15
Certified Nursing Assistant	65	12	50	5	12	34	8	0.18	0.10
Paid Feeding Assistant trained under s. 400.141, F.S.	18	4	20	2	3	21	5	0.22	0.10
Other B	7	0	10	3	2	19	4	0.00	0.30
Other A	10	1	10	0	1	11	2	0.10	0.00

Direct Care Workforce

Factors Contributing to Leaving Employment

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

Changes have been saved.

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

Direct Care Workforce

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

Cost of Employment Benefits

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

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

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

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

Edit Registered Nurse

Cost of Employment Benefits

Worker Category

Registered Nurse

Current Number of Employees? 421

Average Hours worked per week? 12

Average wage per hour? 50

Paid Leave ? (•) Yes ( ) No

If health insurance is provided, what is the average monthly cost to the employer and employee?

Employer Contribution: 330.5

Employee Contribution: 22

If retirement is provided, what is the average monthly cost to the employer and employee? (pension, stock, matching, etc.)

Employer Contribution: 100

Employee Contribution: 50.5

If other insurance is provided, specify below and provide the average monthly cost to the employer and employee?

Other Insurance: ACME Insurance

Employer Contribution: 1299

Employee Contribution: 133

If other benefits are provided, specify below and provide the average monthly cost to the employer and employee?

Other Benefits: ACME Benefits

Employer Contribution: 77

Employee Contribution: 22

Done Cancel

Direct Care Workforce

Changes have been saved.

Cost of Employment Benefits

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

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

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

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

Direct Care Workforce

Additional Training

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

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

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

○ Yes ◉ No

Direct Care Workforce

Additional Training

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

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

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

- *At least one training must be selected.*

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

(•) Yes ( ) No

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

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

Supporting Documents

Applicants **MUST** include the following attachments as stated in Chapters 408,Part II and 400,Part II ,F.S. and Chapters 59A-35 and 59A-4, 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 Compliance with Patient Trust Bond Requirements*
  - *Carrier is required*
  - *Policy number is required*
  - *Aggregate policy amount is required*
  - *Effective date is required*
  - *Expiry date is required*
  - *Upload document is required/check the document mailed checkbox.*
- *Proof of General Liability Insurance Coverage*
  - *Carrier is required*
  - *Policy number is required*
  - *Aggregate policy amount is required*
  - *Effective date is required*
  - *Expiry date is required*
  - *Occurrence policy amount is required*
  - *Upload document is required/check the document mailed checkbox.*
- *Proof of Professional Liability Insurance Coverage*
  - *Carrier is required*
  - *Policy number is required*
  - *Aggregate policy amount is required*
  - *Effective date is required*
  - *Expiry date is required*
  - *Occurrence policy amount is required*
  - *Upload document is required/check the document mailed checkbox.*
- *Copy of Visitation Policy and Procedure*
  - *Upload document is required/check the document mailed checkbox.*
- *Fire Safety Inspection Report*
  - *Upload document is required/check the document mailed checkbox.*
- *Financial Ability to Operate*
  - *Upload document is required/check the document mailed checkbox.*
- *Documentation signed by the appropriate local government official, which states that the applicant has met zoning requirements*
  - *Upload document is required/check the document mailed checkbox.*

Proof of Compliance with Patient Trust Bond Requirements

Carrier
Policy #
Effective Date
Expiry Date
Policy Amount $0.00

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

Browse...

Proof of General Liability Insurance Coverage

Carrier
Policy #
Effective Date
Expiry Date
Aggregate Policy Amount $0.00
Occurrence Policy Amount $0.00

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

Browse...

Proof of Professional Liability Insurance Coverage

Carrier

Policy #

Effective Date

Expiry Date

Aggregate Policy Amount $0.00

Occurrence Policy Amount $0.00

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

Browse...

Copy of Visitation Policy and Procedure

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

Browse...

Fire Safety Inspection Report

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

Browse...

Financial Ability to Operate

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

Browse...

Plan for Quality Assurance and for Conducting Risk Management

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

Browse...

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

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Civil Verdict 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.

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Surety of Continuation Bond

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

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Medicaid Lease Bond

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

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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.

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Facility Ownership/Lease Documentation

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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.

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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.

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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. Property Ownership
  - c. Contact Person
- 2. Licensee Information
  - a. Licensee Details
- 3. Controlling Interests
  - a. Controlling Interests
- 4. Management Company Information
  - a. Management Company Information
  - b. Management Company Controlling Interest
- 5. Personnel
  - a. Administration
  - b. Safety Liaison
- 6. Required Disclosure
  - a. Convictions
  - b. Exclusions
  - c. Felonies/Terminations
  - d. Financial/Ownership Actions
  - e. Civil Verdict
- 7. Bed Count
  - a. Bed Count
- 8. Consumer Information
  - a. Consumer Information
- 9. Supporting Documents
  - a. Supporting Documents

I **ANGEL STOCK**, 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.

ANGEL STOCK	ANALYST	05/21/2023
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 $112.50 per bed
- The biennial licensure fee for sheltered bed is $100.50 per bed
- The biennial assessment fee is $4.00 per bed, not to exceed $1,000
- 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.

Submit Application