AHCA USE ONLY:
File #:
Application #:
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Application for Certificate of Exemption from Licensure as a Home Health Agency

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 to avoid a late fee. If the renewal application is received by the Agency less than 60 days prior to the expiration date, it is subject to a late fee as set forth in statute. The applicant will receive notice of the amount of the late fee as part of the application process or by separate notice. The application will be withdrawn from review if all the required documents and fees are not included with your application or received within 21 days of an omission notice. 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-8, Florida Administrative Code (F.A.C.), an application is hereby made to operate an exempted provider as indicated below:

1. Provider / Licensee Information

A. Provider Information – please complete the following for the exempted home health agency name and location. Provider name, address and telephone number will be listed on https://quality.healthfinder.fl.gov/index.html

Exemption # (if applicable)	National Provider Identifier (NPI) (if applicable)	Medicare # (CMS CCN) (if applicable)	Florida Medicaid # (if applicable)
Name of Home Health Agency (if operated under a fictitious name, enter as it appears in Florida Division of Corporations)			
Street Address			
City	County	State	Zip
Telephone Number	Fax Number		
Provider Website	**Note**: By providing your e-mail address, you agree to accept e-mail correspondence from the Agency.		
Mailing Address or ☐ 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 Fax Number
Contact e-mail address or ☐ Do not have e-mail	**Note**: By providing your e-mail address, you agree to accept e-mail correspondence from the Agency regarding this application.	

C. Owner Information – complete the following for the individual or entity seeking an exemption from home health agency licensure.			
Owner Name (This is the legal name of the owner)		Federal Employer Identification Number (EIN)	
Mailing Address or ☐ Same as above			
City		State	Zip
Telephone Number	Fax Number	E-mail Address	

Description of Owner (check one):

For Profit	Not for Profit	Public
☐ Corporation	☐ Corporation	☐ State
☐ Limited Liability Company	☐ Religious Affiliation	☐ City/County
☐ Partnership	☐ Other	☐ Hospital District
☐ Individual		
☐ Sole Proprietor		
☐ Other		

2. Application Type and Fees

Indicate the type of application with an "X." **Applications will not be processed if all applicable fees are not included. All fees are nonrefundable.** Renewal applications must be received 60 days prior to the expiration of the certificate or the proposed effective date of the change.

☐ Initial Exemption **Proposed Effective Date**: _____

Was this entity previously licensed or exempt from licensure as a Home Health Agency in Florida? YES ☐ NO ☐

If YES, provide the name of the agency (if different), the EIN # and the date the prior license or exemption expired or closed:

NAME:	EIN #	Date Expired/Closed:

☐ Renewal Exemption **Proposed Effective Date**: _____

☐ Change During Exemption Period: (check all that apply) **Proposed Effective Date**: _____

- ☐ Name change of the facility
- ☐ Address change of the facility
- ☐ Service(s) change

ACTION	FEE	TOTAL FEES
Exemption Fee (Initial and Renewal):	$100.00	$
Change During Exemption Period	$25.00	$
TOTAL FEES INCLUDED WITH APPLICATION		**$**
Please make check or money order payable to the Agency for Health Care Administration (AHCA).		

3. Qualification for Exemption from Home Health Agency Licensure

Select the exemption type that the individual, entity or organization qualifies for. Complete only **one** section. **NOTE:** Documentation, as specified in Section 5, is required and must be submitted with the application. Lack of documentation will deem your application incomplete.

A. ☐ A home health agency operated by the Federal Government.

☐ License or Registration Number, if applicable**:** _____

B. ☐ Home health services provided by a state agency, either directly ☐ or through a contractor ☐ with:

☐ The Department of Elderly Affairs

☐ The Department of Health, a community health center, or a rural health network that furnishes home visits for the purpose of providing environmental assessments, case management, health education, personal care services, family planning, or follow-up treatment, or for the purpose of monitoring and tracking disease

☐ Services provided to persons with developmental disabilities, as defined in section 393.063, F.S.

☐ Companion and sitter organizations that were registered under section 400.509(1), F.S. on January 1, 1999, and were authorized to provide personal services under a developmental services provider certificate on January 1, 1999, may continue to provide such services to past, present, and future clients of the organization who need such services, notwithstanding the provisions of this act

☐ The Department of Children and Families

C. ☐ A health care professional, whether or not incorporated, who is licensed under chapter 457; chapter 458; chapter 459; part I of chapter 464; chapter 467; part I, part III, part V, or part X of chapter 468; chapter 480; chapter 486; chapter 490; or chapter 491; and who is acting alone within the scope of his or her professional license to provide care to patients in their homes.

☐ Chapter 457 – Acupuncture

☐ Chapter 458 – Medical Practice

☐ Chapter 459 – Osteopathic Medicine

☐ Chapter 464, Part I – Nursing

☐ Chapter 467 – Midwifery

☐ Chapter 468, Part I – Speech-Language Pathology and Audiology

☐ Chapter 468, Part III – Occupational Therapy

☐ Chapter 468, Part V – Respiratory Therapy

☐ Chapter 468, Part X – Dietetics and Nutrition

☐ Chapter 480 – Massage Therapy

☐ Chapter 486 – Physical Therapy

☐ Chapter 490 – Psychological Services

☐ Chapter 491 – Clinical, Counseling, and Psychotherapy Services

☐ License or Registration Number, if applicable: _____

D. ☐ A home health aide or certified nursing assistant who is acting in his or her individual capacity, within the definitions and standards of his or her occupation, and who provides hands-on care to patients in their homes.

☐ License or Registration Number, if applicable: _____

E. ☐ An individual who acts alone, in his or her individual capacity, and who is not employed by, affiliated with a licensed home health agency, or registered with a licensed nurse registry. This exemption does not entitle an individual to perform home health services without the required professional license.

F. ☐ The delivery of instructional services in home dialysis and home dialysis supplies and equipment.

☐ Medicare Certification Number (CCN): _____

G. ☐ The delivery of nursing home services for which the nursing home is licensed under part II of Chapter 400, to serve its residents in its facility.

☐ License Number: _____

H. ☐ The delivery of assisted living facility services for which the assisted living facility is licensed under part I of Chapter 429, F.S., to serve its residents in its facility.

☐ License Number**:** _____

I. ☐ The delivery of hospice services for which the hospice is licensed under part IV of Chapter 400, to serve hospice patients admitted to its service.

☐ License Number**:** _____

J. ☐ A hospital that provides services for which it is licensed under Chapter 395, F.S.

☐ License Number: _____

K. ☐ The delivery of community residential services for which the community residential home is licensed under Chapter 419, F.S., to serve the residents in its facility.

☐ License Number: _____

L. ☐ A not-for-profit, community-based agency that provides early intervention services to infants and toddlers.

M. ☐ Certified rehabilitation agencies and comprehensive outpatient rehabilitation facilities that are certified under Title 18 of the Social Security Act.

☐ Medicare Certification Number (CCN): _____

N. ☐ The delivery of adult family-care home services for which the adult family-care home is licensed under part II of Chapter 429, F.S., to serve the residents in its facility.

☐ License Number: _____

O. ☐ A person *or entity* that provides skilled care by health care professionals licensed solely under part I of Chapter 464; part I, part III, or part V of Chapter 468; or Chapter 486, F.S. This exemption does not entitle a person to perform home health services without the required professional license.

☐ Chapter 464, Part I – Nursing

☐ Chapter 468, Part I – Speech-Language Pathology and Audiology

☐ Chapter 468, Part III – Occupational Therapy

☐ Chapter 468, Part V – Respiratory Therapy

☐ Chapter 486 – Physical Therapy

P. ☐ A person *or entity* that provides services using only volunteers or individuals related by blood or marriage to the patient or client.

4. Provider Type and Services

Services provided by the person, entity or organization (check all that apply):

☐	Nursing Service
☐	Physical Therapy
☐	Speech Therapy
☐	Occupational Therapy
☐	Respiratory Therapy
☐	Home Infusion (IV)
☐	Home Health Aide Services
☐	Certified Nursing Assistant Services
☐	Homemaker Services
☐	Companion/Sitter Services
☐	Nutritional Guidance Services
☐	Medical Equipment & Supplies
☐	Medical Social Services

☐	Other:
☐	
☐	
☐	
☐	
☐	

5. Supporting Documentation

Note: Required documents listed below are dependent upon the type of exemption you are seeking.

Documents to be Provided:	Qualification Type:
Letter on official letterhead and signed by an authorized representative of the federal government confirming the operation of the home health agency.	Section 400.464(6)(a), F.S.
Letter on official letterhead and signed by an authorized representative of the state agency confirming the direct provision of home health services or, if contracted with a state agency, a copy of the current contract with the state agency for the provision of home health services.	Section 400.464(6)(b), F.S.
Copy of the certified nursing assistant license, registration, or certification or home health aide training documentation.	Section 400.464(6)(d), F.S.
Letter from the individual stating the services that will be provided and required training documentation, if applicable.	Section 400.464(6)(e), F.S.
Letter on company letterhead and signed by an authorized representative of the entity or organization detailing the provision of instructional services in home dialysis and home dialysis supplies and equipment to be provided.	Section 400.464(6)(f), F.S.
Copy of the Community Residential Home license under Chapter 419, F.S..	Section 400.464(6)(k), F.S.
Letter on company letterhead and signed by an authorized representative of the not-for-profit, community-based agency confirming the provision of early intervention services to infants and toddlers and listing all governmental programs through which the agency is affiliated.	Section 400.464(6)(l), F.S.

6. 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.

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 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? Review the information available 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 that you please remember to:

- Please place checks or money orders on top of the application
- Include license 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
- Please ***do not bind any*** of the documents submitted to the Agency.