Provider:
B and B Home Health

Provider Type:
HHA - Exemptions

File#: 6895006824
License #:
Expires:

Logged in as : kelli.fillyaw

Dashboard | OL Help | Documents | Logout

= Entered
= Entry Required

- Provider/Facility Information
  - Details
  - Contact Person
- Ownership Information
- Exemption Qualification
- Provider Types and Services
- Supporting Documents
- Finalize Submission

Online Application for Certificate of Exemption from Licensure as a Home Health Agency, AHCA Form 3110-1009OL, August 2023 59A-35.060, Florida Administrative Code

Provider/Facility Information

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:

Review the information below and make any necessary edits. The Provider/Facility name, address, and telephone number will be listed on Florida Health Finder (http://www.floridahealthfinder.gov).

- *Provider NPI cannot be blank. Please enter number or check None or Pending checkbox below the field.*
- *Phone number is incomplete.*
- *Provider Website information cannot be blank. Please enter a website or check None checkbox below the field.*

Provider/Facility Information

Exemption #

National Provider Identifier ☐ None ☐ Pending

Medicaid #

Medicare # (CMS CCN)

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

B and B Home Health

Provider/Facility Location Address

Edit Address

Provider Location Address

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

Telephone (___) ___-____ Ext

Email Address *Note: By providing your email address, you agree to accept email correspondence from the Agency.*

bandbhh@gmail.com

☐ 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

Edit Address

Address

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

Telephone (___) ___-____ Ext

Email Address bandbhh@gmail.com

☐ None

Undo | Save | 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 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

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

☐ None

Undo | Save | << Back | Next >>

Owner Information

- *Organization information is incomplete*
- *Phone number is incomplete.*
- *Licensee Email cannot be blank. Please enter an email or check None checkbox 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 owner (select only one option below)

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

Ownership Types

Limited Liability Company

Entity Owner Details

Owner Name (may be same as provider name)

Federal Employer Identification # (EIN)

Mailing Address

Edit Address

Address

Telephone

(___) ___-____

Ext

Email Address

[ ] None

Undo | Save | << Back | Next >>

Qualifications 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 the Supporting Documents section of this application, is required and must be submitted with the application. Lack of documentation will deem your application incomplete.

- *An Exemption Qualification must be selected.*

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

License or Registration #

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

◯ 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.

License or Registration #

◯ 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 #

◯ 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 # (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 #

◯ 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 #

◯ 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 #

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

License #

◯ 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 #

◯ 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 # (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 #

◯ 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. This exemption does not entitle a person to perform home health services without the required professional license.

License or Registration #

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

Undo | Save | << Back | Next >>

Types and Services

- *At least one service provider must be selected*

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

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

- [ ] Other

Undo | Save | << Back | Next >>

Supporting Documents

Applicants **MUST** include the following attachments as stated in Chapter 400, Part III, F.S. and Chapters 59A-35 and 59A-8, 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.

- ***Please select an 'Exemption Type' to see which Supporting Documents are required for your application submission.***

Required for Exemption A : Letter on official letterhead and signed by an authorized representative of the federal government confirming the operation of the home health agency

☐ 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...

Required for Exemption B : 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

☐ 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...

Required for Exemption D : Copy of the certified nursing assistant license, registration, or certification or home health aide training 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.

Browse...

Required for Exemption E : Letter from the individual stating the services that will be provided and required training documentation, if applicable

☐ 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...

Required for Exemption F : 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

☐ 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...

Required for Exemption K : Copy of the Community Residential Home license under Chapter 419, F.S.

☐ 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...

Required for Exemption L : 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

☐ 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...

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.

Browse...

Undo | Save | << Back | Next >>

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. Ownership Information
   a. *Owner Information*

3. Exemption Qualification
   a. *Exemption Qualification*

4. Provider Types and Services
   a. *Types and Services*

5. 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.

KELLI FILLYAW	GOC III	09/22/2023
Signature of Licensee or Authorized Representative	Title	Date

☐ I agree

Amounts Due Upon Submission of Application

Selecting the 'Submit Application' you will no longer be able to make changes to your application.

Submit Application