Health Care Licensing Application
HOME HEALTH AGENCIES

AHCA USE ONLY:
File #: _____
Application #: _____
Check #: _____
Check Amt: _____
Batch #: _____

APPLICANTS CAN NOW RENEW LICENSES ONLINE

The Agency for Health Care Administration (AHCA) has implemented the **ONLINE LICENSING SYSTEM** which allows the electronic submission of renewal applications and fees, along with the ability to upload supporting documentation.
To renew online please go to: http://ahca.myflorida.com/onlinelicensure

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 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 *The application will be withdrawn from review if all the required documents and fees are not included with your application or received within 21 days of an omission notice.* **Applications will not be considered for review until payment has been received. Renewal 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.**

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 a home health agency as indicated below:

1. Provider / Licensee Information

A. Provider Information – please complete the following for the home health agency name and location. *Provider name, address and telephone number will be listed on http://www.floridahealthfinder.gov/*

License # (for renewal & change of ownership applications)	**National Provider Identifier** (NPI) (if applicable)	**Medicare #** (CMS CCN)	**Florida Medicaid #**

Name of Home Health Agency (if operated under a fictitious name, list that here)

Street Address

City	County	State	Zip

Telephone Number	Fax Number	E-mail Address for Agency Contact	Provider Website

Mailing Address or ☐ Same as above (All mail will be sent to this location)

City	State	Zip

Contact Person for this application	Contact Telephone Number

Contact e-mail address	***NOTE:*** By providing your e-mail address you agree to accept e-mail correspondence from the Agency

B. Licensee Information – complete the following for the entity seeking to operate the home health agency.

Licensee Name *(name of corporation, LLC, etc.-may be the same as provider above)*	Federal Employer Identification Number (EIN)

Mailing Address

City	State	Zip

Telephone Number	Fax Number	E-mail Address

Description of Licensee (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 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

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

If yes, please provide the name of the agency (if different), the EIN # and the year the prior license expired or closed:

NAME:	EIN #	Year Expired/Closed:

☐ Renewal Licensure

☐ Change of Ownership Proposed Effective Date: _____

☐ Change during Licensure Period

- ☐ Name/address change of the facility* ***(circle one)*** Effective Date: _____
- ☐ Add/delete counties* ***(circle one)*** Effective Date: _____
- ☐ Add/delete satellite office* ***(circle one)*** Effective Date: _____
- ☐ Add/delete drop-off site ***(circle one - no fee required)*** Effective Date: _____
- ☐ Stock transfer less than 51% ***(no fee required)*** Effective Date: _____
- ☐ Personnel Change ***(no fee required)*** Effective Date: _____

Action	Fee	TOTAL FEES
License Fee (Initial, Renewal and Change of Ownership): ☐ License Fee Exemption (State, County or Municipal Government pursuant to 400.471(5), F.S.) = $ 0.00	$1,705.00	$
Biennial Assessment (Renewal application only)	$300.00	$
Change During Licensure Period (* *new license will be issued*) or Replacement License	$ 25.00	$
Total Fees Included With Application:		**$**

Please make check or money order payable to the Agency for Health Care Administration (AHCA)
NOTE: Starter checks and temporary checks are not accepted.

3. Controlling Interests of Licensee

AUTHORITY:
Pursuant to Section 408.806(1)(a) and (b), F.S., an application for licensure must include: the name, address and Social Security Number 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 subsection 408.803(7), Florida Statutes, 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-percent 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-percent 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.

A. Individual and/or Entity Ownership of Licensee (as listed in section 1B 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. *Note: This excludes Not-for-Profit and Publicly-held licensees.*

FULL NAME of INDIVIDUAL or ENTITY	PERSONAL/PRIMARY ADDRESS	TELEPHONE NUMBER	EIN (No SSNs)	% OWNERSHIP	BEGIN DATE	END DATE

B. Board Members and Officers of Licensee (as listed in section 1B above) – Provide the information for each individual or entity (corporation, partnership, association) 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	BEGIN DATE	END DATE
Director/CEO					
President					
Vice President					
Secretary					
Treasurer					
Other					

4. Management Company Controlling Interests

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

If ☐ NO, skip to section 5 – *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 ☐Same as above			
City		State	Zip
Contact Person	Contact E-mail	Contact Telephone Number	

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.

TITLE	FULL NAME	PERSONAL/PRIMARY ADDRESS	TELEPHONE NUMBER	BEGIN DATE	END DATE
Director/CEO					
President					
Vice President					
Secretary					
Treasurer					
Other					

B. Board Members and Officers of Management Company: Provide the information for each individual or entity (corporation, partnership, association) 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	BEGIN DATE	END DATE

5. Personnel

Information	Administrator/Managing Employee	Alternate Administrator
Full Name		
Date of Birth		
Telephone Number		
Email Address		
Personal/Primary Address		
Required Experience	☐ Physician FL DOH License #: _____ ☐ Registered Nurse FL DOH License #: _____ ☐ One year of supervisory or administrative experience in home health care or in a facility licensed under chapter 395 (hospital), chapter 400, Part II (nursing home), or under chapter 429, Part I (assisted living facility).	☐ Physician FL DOH License #: _____ ☐ Registered Nurse FL DOH License #: _____ ☐ One year of supervisory or administrative experience in home health care or in a facility licensed under chapter 395 (hospital), chapter 400, Part II (nursing home), or under chapter 429, Part I (assisted living facility).
Employment Status	☐ Full time Employee or ☐ Part time Employee	☐ Full time Employee or ☐ Part time Employee

Per subsection 400.476(1), Florida Statues, the administrator can only work for home health agencies that share identical controlling interests. *(Refer to subsection 408.803(7), Florida Statutes regarding controlling interests).* ***Administrator cannot serve as the Director of Nursing if there are 10 full time equivalent staff including contracted personnel working in the home health agency.***

Information	Director of Nursing (required if providing skilled services)	Alternate Director of Nursing
Full Name		
Date of Birth		
Telephone Number		
Email Address		
Personal/Primary Address		
Required Experience	☐ One year of supervisory experience as a Registered Nurse FL DOH License #: _____	☐ One year of supervisory experience as a Registered Nurse FL DOH License #: _____
Employment Status	☐ Full time Employee or ☐ Part time Employee	☐ Full time Employee or ☐ Part time Employee

Information	Registered Nurse (non-skilled service agencies that are not Medicare or Medicaid certified)	Chief Financial Officer / Person responsible for financial operations
Full Name		
Date of Birth		
Telephone Number		
Email Address		
Personal/Primary Address		
Required Experience	☐ Registered Nurse FL DOH License #: _____	
Employment Status	☐ Full time Employee or ☐ Part time Employee ☐ Contract	☐ Full time Employee or ☐ Part time Employee ☐ Contract

6. Required Disclosure

The following disclosures are required:

A. Pursuant to subsection 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, 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 subsection 408.809(1)(d), Florida Statutes? (These offenses are listed on the Attestation of Compliance with Background Screening Requirements, AHCA Form #3100-0008.) YES ☐ NO ☐

If yes, enclose the following information:

☐ The full legal name of the individual and the position held

☐ A description/explanation of the conviction(s) - If the individual has received an exemption from disqualification for the offense, include a copy

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 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 (and the position held) or the entity

☐ A description/explanation of the exclusion, suspension, termination or involuntary withdrawal.

C. Pursuant to section 408.815(4), F.S., has the applicant, 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

YES ☐ NO ☐ 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.
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 ☐

D. Nonimmigrant Aliens – If the applicant or any controlling interests are nonimmigrant aliens according to 8 U.S.C. §1101, then a surety bond of at least $500,000 must be filed, payable to AHCA that guarantees the home health agency will act in full conformity with all legal requirements for operation (408.8065(2), F.S.). Include the surety bond with the application.

Are there any nonimmigrant aliens listed as a licensee or controlling interest in this application?

☐ YES (enclose evidence of a surety bond with this application) ☐ NO

7. 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
	☐				☐	☐
	☐				☐	☐
	☐				☐	☐

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

8. Services

A. **RENEWAL APPLICATIONS ONLY:** Pursuant to section 400.471.(2)(c), F.S., provide the number of patients admitted by your Home Health Agency's most recent fiscal year, last calendar year or most recent 12 month period: _____.

B. Does your home health agency provide skilled services to children under the age 21? Yes ☐ No ☐

C. Does your agency plan to offer only non-skilled services which include home health aide, certified nursing assistant, homemaker, and companion services? Yes ☐ No ☐

D. Provide the following information on Service Personnel.

Note: *If providing nursing services, some of the services must be provided by a direct employee as required in Section 400.487(5), F.S. Per Section 400.462(9), F.S., a direct employee means an employee for whom one of the following entities pays withholding taxes: a home health agency, a management company that has a contract to manage the home health agency on a day-to-day basis; or an employee leasing company that has a contract with the home health agency to handle the payroll and payroll taxes for the home health agency.*

Medicare and Medicaid certified agencies must also provide ***one*** *of the qualifying services (* below) totally by direct employees (Medicaid does not include Medical Social Services as a home health agency service).*

Home health agencies that are not Medicare or Medicaid must also provide at least one of the services listed below, in part, by direct employees.

SERVICE PERSONNEL	# DIRECT EMPLOYEES	# CONTRACTED EMPLOYEES	IF SUB-CONTRACT FROM ANOTHER AGENCY, WRITE AGENCY NAME BELOW
Nursing*			
Physical Therapy*			
Speech Therapy*			
Occupational Therapy*			
Respiratory Therapy			
IV Therapy			
Home Health Aide*			
Homemaker / Companion			
Nutritional Guidance			
Medical Equipment & Supplies			
Medical Social Services*			
Certified Nursing Assistant			
Other:			

9. Geographic Services Area

For initial applications (including initials due to a change of ownership), list all counties where this agency expects to provide services. For all other applications, list only those counties that this agency plans to add (A) or delete (D) counties from the existing license.

NOTE: Counties must be within a single AHCA area (see below)

COUNTY	(A)dd / (D)elete	COUNTY	(A)dd / (D)elete
1.		9.	
2.		10.	
3.		11.	
4.		12.	
5.		13.	
6.		14.	
7.		15.	
8.		16.	

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

ADD COUNTY(IES): Include a written plan that describes professional staff coverage that takes into account projected number of patients and the supervision of the staff for the additional counties.

DELETE COUNTY(IES): Indicate which counties to be deleted from license.

10. Other Associated Locations

Satellite Offices

A *satellite office* is a related office in the same geographic service area as the main office, operating under the auspices of the main office's license. Refer to section 59A-8.003(7), F.A.C., for requirements.

Will this agency operation a satellite office? ☐ YES ☐ NO

If yes, list address(es) of satellite offices below. Please attach additional sheets if necessary.

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:

- **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.
- **Liability and Malpractice Insurance** – A current certificate of insurance for the requested location.
- **Evidence of Accreditation (accredited HHAs only)** – Acknowledgement from the accrediting organization that a satellite office will be added.
- **Evidence of Medicare Branch Approval (certified HHAs only)** – A copy of the tie-in notice from the Centers for Medicare and Medicaid Services approving the requested location as a branch office.

Drop-Off Sites

A *drop-off site* may be located in any county within the licensed geographic service area. This is merely a workstation for direct care staff. Neither billing nor prospective patient contact is allowed. Refer to section 59A-8.003(9), F.A.C., for requirements.

Will this agency operate a drop-off site? ☐ YES ☐ NO

If yes, list address(es) of Drop-Off Sites below. Attach additional sheets if necessary:

Drop Off-Site #1		
Street Address		
City	Zip	County
Drop-Off Site #2		
Street Address		
City	Zip	County
Drop-Off Site #3		
Street Address		
City	Zip	County

11. Days and Hours of Operation

List the home health agency's operating hours. Section 59A-8.003(11)(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.

Home Health Agency – Main Office		
Day of the Week	**Opening Time**	**Closing Time**
☐ Monday		
☐ Tuesday		
☐ Wednesday		
☐ Thursday		
☐ Friday		
☐ Saturday		
☐ Sunday		
☐ Indicate if the agency will have a 24-hour on-call system (required for agencies offering skilled services).		
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		

12. Accreditation / Deemed Status

Initial Applicants:

Effective July 1, 2008, new applicants for home health licensure that will be providing nursing or other skilled services must submit either: (select one)

☐ proof of accreditation or ☐ proof of application for accreditation from an accrediting organization listed below.

***Note**: Within 120 days of the Agency's receipt of the licensure application, the applicant must obtain accreditation that is not conditional or provisional. The accreditation must be maintained at all times to keep licensure as a home health agency per subsection 400.471(2)(h), F.S. for skilled agencies. Effective July 1, 2014 new applicants that provide non-skilled services and do not plan to become Medicare or Medicaid certified are exempt from accreditation. Non-skilled services include home health aide, certified nursing assistant and homemaker/companion.*

Renewal Applicants:

If you applied and were licensed after July 1, 2008 and provide nursing or other skilled services ,you must be accredited with one of the accrediting organizations listed below. Please check the appropriate accrediting organization and include a current copy of your accreditation report with this application. Effective July 1, 2014, renewal applicants that provide non-skilled services and do not plan to be Medicare or Medicaid certified are exempt from accreditation. Non-skilled services include home health aide, certified nursing assistant and homemaker/companion. AHCA will conduct surveys for non-skilled agencies after 7/1/2014.

Renewal Applications with prior accreditation and/or deemed status

If your agency is still accredited or accredited and deemed, please check the appropriate accrediting organization box below and include a current copy of your accreditation and/or deemed status report.

Accrediting Organization

☐ Joint Commission (JC) ☐ Community Health Accreditation Program (CHAP) ☐ Accreditation Commission for Health Care (ACHC)

☐ ***Effective date of accreditation:*** _____

☐ ***Expiration date of accreditation:*** _____

☐ Proof of accreditation enclosed

☐ Proof of application for accreditation – a screen print receipt from accrediting organization web site or letter of receipt of application from accrediting organization.

Not Accredited

☐ Not accredited and/or not applicable/licensed prior to July 1, 2008

☐ Non-Skilled provider exempt from accreditation requirement per 400.471 (2) (h), F.S. effective 7/1/2014.

13. Supporting Documents

Applicants **must** include the following attachments as stated in Chapters 408, Part II and Chapter 400, Part III, F.S. and Chapters 59A-35 and 59A-8, 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 Liability and Malpractice Insurance Coverage	Initial, Renewal, Change of Ownership and Address Change application types (excluding change of geographic service area)
Evidence of a Surety Bond	Initial, Renewal and Change of Ownership application types
Proof of Accreditation – documentation and report	Initial, Renewal, Change of Ownership and Address Change application types (excluding change of geographic service area)
Proof of Financial Ability to Operate, AHCA Form 3100-0009	Initial and Change of Ownership application types
Business plan, signed by the applicant, detailing the home health agency's methods to obtain patients and its plan to recruit and maintain staff.	Initial and Change of Ownership application types
Proof of legal right to occupy the property for principal office and each satellite office, inpatient facility and residential unit	Initial, Change of Ownership involving change of licensee and change of address application types
Documentation signed by the appropriate local government official, which states that the applicant has met local zoning requirements.	Initial, Change of Ownership and change of address application types
Plan for delivery of services per Rule 59A-8.007(2), F.A.C.	Address Change application type, for addition of counties within geographic service area only
Proof of Medicare branch approval, if home health agency is certified	Address Change application type, for addition of satellite offices only
Documentation of change of ownership transaction stating effective date and executed by all parties	Change of Ownership application and any change of controlling interest affecting % ownership of licensee application types
Health Care Licensing Application Addendum, AHCA Form 3110-1024	Initial, Renewal and Change of Ownership application types
Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008 for administrator and financial officer	Initial, Renewal and Change of Ownership application types, if background screening was conducted by a state agency other than the Agency for Health Care Administration
Exemption from disqualification for documented offense, if applicable.	All application types
Required disclosures related to actions taken by Medicare, Medicaid or CLIA, if applicable	All application types, if documentation is required due to responses provided in application
Approved repayment plan, if applicable	All application types

14. Attestation

I, _____, under penalty of perjury, 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, 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.

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 AND ALL REQUIRED DOCUMENTS TO:

AGENCY FOR HEALTH CARE ADMINISTRATION
HOME CARE UNIT
2727 MAHAN DR., MS 34
TALLAHASSEE FL 32308-5407

Questions?
Review the information available at http://ahca.myflorida.com
or contact the Home Care Unit at (850) 412-4403. **Email**: **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.