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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 a home health agency as indicated below.

Pursuant to section 408.806 (1)(a) and (b), Florida Statutes, an application for licensure must include: the name, address and Social Security number of the applicant, administrator or similarly titled person who is responsible for the day to day operation of the provider, financial officer or similarly titled person who is responsible for the financial operation of the licensee or provider and each controlling interest, if the applicant or controlling interest is an individual; and the name, address, and federal employer identification number (EIN) of the applicant and each controlling interest, if the applicant or controlling interest is not an individual. Disclosure of Social Security number(s) is mandatory. The Agency for Health Care Administration shall use such information for purposes of securing the proper identification of persons listed on this application for licensure.

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/Facility Information

License # ______ National Provider Identifier ______ ☐ None ☐ Pending

Medicaid # ______ ☐ None ☐ Pending Medicare # (CMS CCN) ______ ☐ None ☐ Pending

Name of Home Health Agency (If operated under a fictitious name, enter as it appears in Florida Division of Corporations.)

Provider/Facility Location Address

Edit Address

Provider Location Address

Telephone ______ Ext ______ Fax # (___)___-____ ☐ None

Email Address ______ ☐ 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

Telephone (___) ___-____ Ext ______

Email Address ______ ☐ None

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Provider/Facility Information

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

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Licensee Information

Description of licensee (select only one option below)

◯ For Profit ◯ Not for Profit ◯ Public

Ownership Types

Entity Licensee Details

Licensee Name (may be same as provider name)

Federal Employer Identification # (EIN)

Mailing Address

Edit Address

Address

Telephone (___) ___-____

Ext

Fax # (___) ___-____

☐ None

Email Address

☐ None

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Controlling Interests of Licensee

Do any individuals or entities possess 5% or greater ownership interest in the licensee?

◯ Yes ◯ No

Provide the information for each individual or entity with 5% or greater ownership interest in the licensee .

To **add** a controlling interest -
Utilizing the pick list below, either choose an individual/entity that is already associated with this application or select 'New Controlling Interest - Individual' or 'New Controlling Interest - Entity' .

To **edit** an existing controlling interest -
Select "Edit/View"and edit as needed.

To **remove** an existing controlling interest -
Select "Remove" and enter the date the controlling interest's relationship with the licensee ended.

			Full Name of Individual/Entity	Type	Tax ID	Begin Date	End Date	Title	%
Remove	Edit/View			SSN					
Remove	Edit/View			SSN					

Total **100.00**

Removed: (-) Added: (+)

If the percentage of ownership interest indicated above does not equal 100%, please explain why in the space below:

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Management Company Information

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

○ Yes ○ No

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Management Company Controlling Interest

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

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Personnel

Personnel

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

- Administrator
- Alternate Administrator
- Alternate Director of Nursing (if applicable)
- Director of Nursing (if applicable)
- Financial Officer
- Registered Nurse (if applicable)

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

To **edit** an existing individual -
Select "Edit/View"and edit as needed.

To **remove** an existing individual -
Select "Remove" and enter the date the individual's relationship with the licensee ended.

		Full Name of Individual	Type	Tax ID	Roles	Begin Date	End Date
Remove	Edit/View		SSN		Director of Nursing		
Remove	Edit/View				Alternate Director of Nursing		
Remove	Edit/View		SSN		Administrator		
					Financial Officer		
Remove	Edit/View				Alternate Administrator		

Removed: (-) Added: (+)

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Required Disclosure

Convictions

Pursuant to subsection 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 subsection 408.809, Florida Statutes?

(These offenses are listed on the Attestation of Compliance with Background Screening Requirements, AHCA Form #3100-0008)

○ Yes ○ No

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Required Disclosure

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/entity listed in the Controlling Interests or Management Company Controlling Interests sections of this application been excluded, suspended, terminated or involuntarily withdrawn from participation in Medicare or Medicaid in any state?

○ Yes ○ No

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Required Disclosure

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:

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, 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.

○ 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

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Required Disclosure

Nonimmigrant Aliens

If the applicant or any controlling interests are nonimmigrant aliens according to 8 U.S.C. ss1101, 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 in the Supporting Documents section of this application.

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

◯ Yes ◯ No

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Days and Hours of Operation

List the regular 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 7:00 AM and 6:00 PM, excluding legal and religious holidays.

Note - Site inspections by Agency surveyors will occur during the business hours submitted. Failure to be open during the listed hours may result in a fine or the denial of an application.

☑ Indicate if the agency will have a 24-hour on-call system (required for all agencies offering skilled services).

Day	OpeningTime	Closing Time
MONDAY		
TUESDAY		
WEDNESDAY		
THURSDAY		
FRIDAY		
SATURDAY		
SUNDAY		

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Accreditation

If this home health agency is currently accredited or accredited with deemed status through one of the accrediting organizations recognized by the Agency for Health Care Administration, make the appropriate selection, and provide the requested information.

Otherwise, select the option below.

☐ Not accredited and/or not applicable (licensed prior to July 1, 2008; see 400.471(2)(h), F.S., for specifics)

☐ Non-skilled exempt from accreditation requirement per 400.471(2)(h), F.S., effective July 1,2014

Note – If accredited, you will be required to include documentation from the accrediting organization in the Supporting Documents section of this application. Documentation must include:

1. *Name of accrediting organization*
2. *Accrediting type and status*
3. *Beginning and expiration dates of accreditation*
4. *Beginning and expiration dates of deemed status (if applicable)*
5. *Accrediting organization's report of findings (inspection report)*
6. *Provider's response to the accrediting organization's report of findings (if a plan of correction was required)*
7. *Accrediting organization's final determination (such as an acceptance of the plan of correction)*

Accrediting Organization	Accrediting Org ID	Accreditation Begin Date	Accreditation Expiration Date	Survey Date	Deemed Status
☐ Joint Commission (JC)					
☐ Community Health Accreditation Program (CHAP)					
☐ Accreditation Commission for Health Care (ACHC)					

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Geographic Service Area

Indicate each county this business location will serve by selecting the appropriate checkboxes below. For your reference, a list of counties by geographical service areas is provided at the bottom of the page.

Note - This license covers only one office location. Each additional office must be separately licensed.

Counties Served

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

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

1. Please provide the following information on Service Personnel.

Note - "Direct employees" are those for whom the agency pays withholding taxes. State rules require that a licensed-only agency provide at least one of the services listed below by direct employees. If providing nursing services, some of the service must be provided by a direct employee as required in state law, section 400.487(5), F.S. Federal regulations require that Medicare and Medicaid agencies provide one of the skilled services (*) below totally by direct employees. (Medicaid does not include Medical Social Services as a home health agency service).

SERVICES	# DIRECT EMPLOYEES	#CONTRACTED EMPLOYEES
☐ 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		

2. 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.

3. Does your home health agency provide skilled services to children under the age of 21? ◯ Yes ◯ No

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Other Associated Locations

If the licensee of this application operates under any other location associated with this license, select "Add Location" below. Otherwise, select "Next" to proceed

Satellite Office

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) and (8), F.A.C., for requirements

Drop-Off Site

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 is allowed. Refer to section 59A-8.003(9), F.A.C., for requirements.

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

○ Yes ○ No

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Supporting Documents

Applicants **MUST** include the following attachments as stated in Chapters 408 Part II and 400 Part III, Florida Statutes (F.S.) and Chapter 59A-35 and 59A-8, Florida Administrative Code (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 Malpractice Insurance Coverage

Carrier

Policy #

Effective Date | Expiry Date

Policy Amount | Occurrence Policy Amount

☑ 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 | Occurrence Policy Amount

☑ 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...

Evidence of a Surety 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.

Browse...

Accreditation Documents

☐ 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...

Attestation of Compliance with Background Screening 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.

Browse...

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.

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 >>

Provider:

Provider Type:
Home Health Agency

File#:
License #:
Expires:

Application:
Type: Renewal Licensure
Status:
Date Received:

= Entered
= Entry Required

- Provider/Facility Information
- Licensee Information
- Controlling Interests
- Management Company Information
- Personnel
- Required Disclosure
- Accreditation
- Days and Hours of Operation
- Geographic Service Area
- Services
- Other Associated Locations
- Supporting Documents
- Finalize Submission
  - Finalize Application

Logged in as :

Dashboard OL Help Documents Logout

Finalize Application

Any areas marked in red are incomplete and must be completed before the application can be submitted. To submit the application, select the appropriate subsection below, or from the Applications Components list to the left, and provide the missing information.

1. Provider/Facility Information
   a. Details
   b. Contact Person

2. Licensee Information
   a. Licensee Details

3. Controlling Interests
   a. Controlling Interests

4. Management Company Information
   a. Management Company Information
   b. Management Company Controlling Interest

5. Personnel
   a. Administration

6. Required Disclosure
   a. Convictions
   b. Exclusions
   c. Felonies/Terminations
   d. Nonimmigrant Aliens

7. Accreditation
   a. Accreditation

8. Days and Hours of Operation
   a. Days and Hours of Operation

9. Geographic Service Area
   a. Geographic Service Area

10. Services
   a. Services

11. Other Associated Locations
   a. Other Associated Locations

12. Supporting Documents
   a. Supporting Documents

Select the Document Mailer link below, print the mailer, and include it with the documents you mail.

Document Mailer

Item	Document
1	Proof of Malpractice Insurance Coverage
2	Proof of General Liability Insurance Coverage

After completing all sections of your application, click the button below to submit your uploaded documents to the Agency and make payment (if necessary).

Submit Application

Health Care Licensing Online Application
Home Health Agency
AHCA Form 3110-1011 OL, March 2016
59A-35.060, Florida Administrative Code

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AGENCY FOR HEALTH CARE ADMINISTRATION

Provider:

Provider Type:
Home Health Agency

File#:
License #:
Expires:

Application:
Type: Renewal Licensure
Status:
Date Received:

= Entered
= Entry Required

Provider/Facility Information
Details
Contact Person
Licensee Information
Controlling Interests
Management Company Information
Personnel
Required Disclosure
Accreditation
Days and Hours of Operation
Geographic Service Area
Services
Other Associated Locations
Supporting Documents
Finalize Submission

Logged in as :

Dashboard OL Help Documents Logout

Payment Summary

You have submitted your application and there are no outstanding licensure related fees or fines (subject to review by Agency staff). An email confirmation will be sent to the email address for your Online user account with instructions on viewing your application. Please allow 24 hours after submission to view your application.

I , under penalty of perjury, attest as follows:

(1) Pursuant to section 837.06, Florida Statutes (F.S.), 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 Statues (F.S.), 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 Statues (F.S.), the applicant is in compliance with the provisions of section 408.806 and Chapter 435, Florida Statues (F.S.).

(4) Pursuant to section 408.809 and 435.05, Florida Statues (F.S.), 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 (F.S.), 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 (F.S.), 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 (F.S.), 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.

SHARON WOODBERY		5/11/2016
Signature of Licensee or Authorized Representative	Title	Date

☐ I agree

REMINDER

You have indicated that you will be mailing documents to the Agency.

☐ I agree

Download and print your document mailer if you have not yet done so.

Document Mailer

Select the Submit button below to finish the application process.

****Please Note: After selecting the Submit button, you will not be able to make changes or make payments, if applicable, until AHCA licensure staff have completed their review.****

Submit

Health Care Licensing Online Application
Home Health Agency
AHCA Form 3110-1011 OL, March 2016
59A-35.060, Florida Administrative Code

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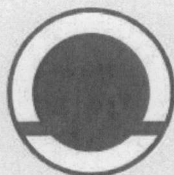

AGENCY FOR HEALTH CARE ADMINISTRATION

HOME | ABOUT US | MEDICAID | LICENSURE & REGULATION | FIND A FACILITY | REPORT FRAUD

Provider:

Provider Type:
Home Health Agency

File#:
License #:
Expires:

Application:
Type: Renewal Licensure
Status:
Date Received:

= Entered
= Entry Required

Provider/Facility Information
- Details
- Contact Person

Licensee Information

Controlling Interests

Management Company Information

Personnel

Required Disclosure

Accreditation

Days and Hours of Operation

Geographic Service Area

Services

Other Associated Locations

Supporting Documents

Finalize Submission

Health Care Licensing Online Application
Home Health Agency
AHCA Form 3110-1011 OL, March 2016
59A-35.060, Florida Administrative Code

Logged in as :

Dashboard | OL Help | Documents | Logout

Pay Online

Item	Description	Type	Total Amount	Current Due	Payment	Due Date
1	Application Fee					
		Total:				

** Amounts shown may not reflect recent payments.*

Division

Transaction Amount ***Service Charge*** ***Total Amount***
$2,005.00

Select Payment Method
○ Credit Card ○ Checking

Pay Total Amount

Terms, Conditons & Fees for Payments:
A non-refundable convenience fee of 2.5% will be added to all credit card payments and $0.18 on all e-check (checking) payments. Please allow 2 to 5 business days for the payments to be settled and posted.

Refund Policy
The refund processing of your payment will begin upon receipt of the Application for Refund form. Applications for refund are processed in accordance with Florida Administrative Code 12-26.002 and Florida Administrative Code 69I-44.020. We will notify you if, for any reason, we are not able to process the refund. Section 215.26, Florida Statutes, requires all requests for refunds be submitted within 3 years of the initial payment to the State of Florida. Depending upon the users's method of payment, refunds may be issued using the original method of payment.

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AGENCY FOR HEALTH CARE ADMINISTRATION

HOME | ABOUT US | MEDICAID | LICENSURE & REGULATION | FIND A FACILITY | REPORT FRAUD

Provider:

Provider Type:
Home Health Agency

File#:
License #:
Expires:

Application:
Type: Renewal Licensure
Status:
Date Received:

= Entered
= Entry Required

- **Provider/Facility Information**
  - Details
  - Contact Person
- **Licensee Information**
- **Controlling Interests**
- **Management Company Information**
- **Personnel**
- **Required Disclosure**
- **Accreditation**
- **Days and Hours of Operation**
- **Geographic Service Area**
- **Services**
- **Other Associated Locations**
- **Supporting Documents**
- **Finalize Submission**

Logged in as :

Dashboard | OL Help | Documents | Logout

Status

Application Submitted

Your application has been submitted to the Agency and is now under review. You will be contacted by the Agency should there be any questions or further information needed regarding your application.

Also, if you indicated that you will be mailing documents to the Agency, do so as soon as possible as a delay could impact the issuance of a license.

Division ***Account Number***

Transaction Amount ***Service Charge*** ***Total Amount***

Payment Method ***Payment Status*** ***Approval Code***

Print This Page

PLEASE KEEP THIS FOR YOUR RECORDS

Current Date :
File # :
License # :
Application # :
Provider Type :
Licensure Unit :

Paid to:

Agency for Health Care Administration
2727 Mahan Drive; (MS #34)
Tallahassee, FL 32308

Online Licensing (Renewal Licensure) Payment

Item	Description	Type	Total Amount	Current Due	Payment	Due Date
1	Application Fee					
		Total:				

** Amounts shown may not reflect recent payments.*

NOTE
Your application will not be considered received until all monies owed have been received. Please remember that you will be assessed a late fee if your application and application fees are not received by 02/28/2014 in

View Statement

Health Care Licensing Online Application
Home Health Agency
AHCA Form 3110-1011 OL, March 2016
59A-35.060, Florida Administrative Code

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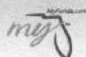


To schedule your one-time payment enter your credit card and payment information below.

Remit Information	
* Transaction Amount:	
* Service Fee:	
* Division Name:	
* Account Number:	
* eMail Address:	
* indicates a required field	

Payment Information for Transaction ID: 3392	
*Payment Account Type:	MasterCard
*Name on Credit Card:	(The name must appear as it does on the credit card account.)
*Address Line 1:	
Address Line 2:	
*City, State, Zip:	
*Credit Card Account Number:	
*Credit Card Security Value:	MasterCard AMERICAN EXPRESS DISCOVER NOVUS Click on the image to see Credit Card Security Value locations.
*Expiration Date:	/
Please enter payment amount. For on-time posting of the payment to your account, please allow 3 business days prior to the due date for processing.	
*Payment Date:	
*Payment Amount:	
* indicates a required field	

Continue Cancel

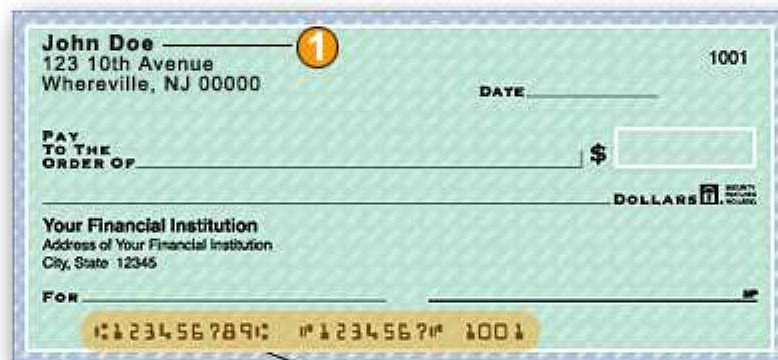
AGENCY FOR
HEALTH CARE
ADMINISTRATION

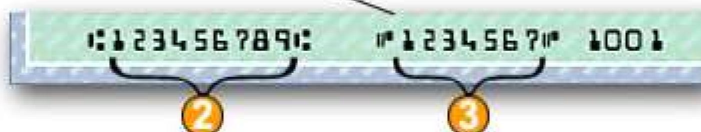
To schedule your one-time payment enter your banking and payment information below.

Remit Information	
* Transaction Amount:	
* Service Fee:	
* Division Name:	
* Account Number:	
* eMail Address:	
* indicates a required field	

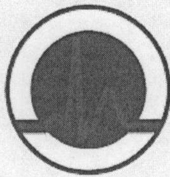
Payment Information for Transaction ID #: 3390	
*Payment Account Type:	○ Personal Checking ○ Personal Savings ○ Business Checking ○ Business Savings
*Name on Bank Account:	
*Bank Routing Number (ABA):	
*Banking Account Number (DDA):	
Please enter payment amount. For on-time posting of the payment to your account, please allow 3 business days prior to the due date for processing.	
*Payment Date:	
*Payment Amount:	
* indicates a required field	

Continue Cancel





(1) The name on the account is found at the top of your check.
(2) The Bank Routing Number is found on the bottom of your check between the two colons.
(3) The Bank Account Number is found on the bottom of your check after the nine-digit bank routing number.



AGENCY FOR HEALTH CARE ADMINISTRATION

HOME | ABOUT US | MEDICAID | LICENSURE & REGULATION | FIND A FACILITY | REPORT FRAUD

Application is Read Only
Provider:

Provider Type:
Home Health Agency

File#:
License #:
Expires:

Application:
Type: Renewal Licensure
Status:
Date Received:

= Entered
= Entry Required

- Provider/Facility Information
  - Details
  - Contact Person
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- Supporting Documents
- Finalize Submission

Health Care Licensing Online Application
Home Health Agency
AHCA Form 3110-1011 OL, March 2016
59A-35.060, Florida Administrative Code

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Status

Application Submitted - Awaiting Payment

Your application has been submitted to the Agency. As a reminder, your application is not considered received until the appropriate payment has been received by the Agency. Be sure to include the statement with your mailed payment.

Also, if you indicated that you will be mailing documents to the Agency, do so as soon as possible as a delay could impact the issuance of a license.

Once your payment and any additional documents have been received, you will be contacted by the Agency should there be any questions or further information regarding your application.

IN ORDER TO ENSURE THAT YOUR FUNDS ARE PROPERLY APPLIED, YOU MUST INCLUDE THIS STATEMENT WITH YOUR SUBMISSION TO THE AGENCY

Current Date
File #
License #
Application #
Provider Type
Licensure Unit

Mail to:

Agency for Health Care Administration
2727 Mahan Drive; (MS #34)
Tallahassee, FL 32308

Online Licensing (Renewal Licensure) Statement

Item	Description	Type	Total Amount	Current Due	Payment	Due Date
1	Application Fee					
		Total:				

** Amounts shown may not reflect recent payments.*

NOTE

View Statement

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