# Health Care Licensing Application
# NURSE REGISTRY

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

***APPLICANTS CAN NOW RENEW LICENSES ONLINE***

The Agency for Health Care Administration (AHCA) has implemented an **ONLINE LICENSING SYSTEM**, which allows for electronic submission of renewal applications 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 *The application will be withdrawn from review if all the required documents and fees are not included with your application or received within 21 days of an omission notice.* **Applications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-18, Florida Administrative Code (F.A.C.), an application is hereby made to operate a nurse registry as indicated below:

## 1. Provider / Licensee Information

***A. Provider Information – please complete the following for the nurse registry 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) | |
| Name of Nurse Registry (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 address) | | | |
| 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 – please complete the following for the entity seeking to operate the nurse registry.***

| | | | |
|---|---|---|---|
| **Licensee Name** *(name of corporation, LLC, etc.-may be the same as provider above)* | | **Federal Employer Identification Number (EIN)** | |
| Mailing Address or ☐ Same as above | | | |
| 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 | ☐ Special Tax 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: _____
- ☐ 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): | $2,000.00 | $ |
| 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), Florida Statutes, 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 SSNs) | 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.

| 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 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 |
|---|---|---|---|---|---|
| **Director/CEO** | | | | | |
| **President** | | | | | |
| **Vice President** | | | | | |
| **Secretary** | | | | | |
| **Treasurer** | | | | | |
| **Other** | | | | | |

## 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 #: ____<br>☐ Registered Nurse FL DOH License #: ____<br>☐ 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 #: ____<br>☐ Registered Nurse FL DOH License #: ____<br>☐ 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 |

| Information | Registered Nurse | 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<br>☐ Contract | ☐ Full time Employee or ☐ Part time Employee<br>☐ 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 Affidavit 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 ☐

## 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. Health care personnel provided by the nurse registry (check all that apply):

- ☐ Certified Nursing Assistants
- ☐ Licensed Practical Nurses
- ☐ Homemakers
- ☐ Registered Nurses
- ☐ Companions
- ☐ Home Health Aides

B. Types of facilities/clients served (check all that apply):

- ☐ Assisted Living Facility
- ☐ Hospice
- ☐ Nursing Home
- ☐ Private Residence / Home
- ☐ Adult Day Care
- ☐ Hospital
- ☐ Home Health Agency
- ☐ Other (please explain): _____

## 9. Geographic Service Area

For initial applications list all counties where this registry expects to provide services. For all other applications, list only those counties that this registry plans to add (A) or delete (D) from the existing license.

☐ No change (for renewals only)

**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.

## 10. Other Associated Locations

A *satellite office* is a secondary office in the same geographic service area as the nurse registry operational site, operating under the auspices of the nurse registry's license. Refer to section 59A-18.004, F.A.C., for requirements.

**Will this nurse registry operate a satellite office?** ☐ YES ☐ NO
If yes, list address(es) of satellite offices below:

| **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.

## 11. Days and Hours of Operation

List the nurse registry's operating hours. Section 59A-18.004(9)(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.

| **Nurse Registry – Operational Site** | | |
|---|---|---|
| **Day of the Week** | **Opening Time** | **Closing Time** |
| ☐ Monday | | |
| ☐ Tuesday | | |
| ☐ Wednesday | | |
| ☐ Thursday | | |
| ☐ Friday | | |
| ☐ Saturday | | |
| ☐ Sunday | | |

**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. 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-18, 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 Financial Ability to Operate, AHCA Form 3100-0009 | 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 |
| 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 |

## 13. 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
272MAHAN 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.