Provider:

Provider Type:
Nurse Registry

File#:
License #:
Expires:

Application:
Type: Renewal Licensure
Status:
Date Received:

= Entered
= Entry Required

Provider/Facility Information
- Details
- Contact Person

Licensee Information

Controlling Interests

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Logged in as :

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-18, Florida Administrative Code (F.A.C.), an application is hereby made to operate a nurse registry center.

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.

Provider/Facility Information

License #

National Provider Identifier

☐ None ☐ Pending

Name of Nurse Registry (If operated under a fictious 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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= Entered
= Entry Required

Logged in as :

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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Logged in as :

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Licensee Information

Please complete the following for the individual or entity seeking to operate the home health agency.

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 # | Email Address

None | 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** an 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					

Total

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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AGENCY FOR HEALTH CARE ADMINISTRATION

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Logged in as :

Management Company Information

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

○ Yes ○ No

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Management Company Information

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Logged in as :

Management Company Controlling Interest

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Logged in as :

Personnel

Personnel

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

- Administrator
- Alternate Administrator
- Financial Officer
- Registered Nurse

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		Administrator		
Remove Edit/View		SSN		Alternate Administrator Financial Officer		
Remove Edit/View		SSN		Registered Nurse		

Removed: (-) Added: (+)

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Required Disclosure

Convictions

Pursuant to subsection 408.809(1)(d), 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(1)(d), Florida Statutes?

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

○ Yes ○ No

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Logged in as :

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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Days and Hours of Operation

List the regular operating hours.

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.

Day	OpeningTime	Closing Time
MONDAY		
TUESDAY		
WEDNESDAY		
THURSDAY		
FRIDAY		
SATURDAY		
SUNDAY		

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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 - Counties must be within a single AHCA area (see below).

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
Area 11: Miami-Dade, Monroe

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Services

A. Health Care Personnel Provided by the Nurse Registry

Identify the health care personnel provided by the nurse registry (check all that apply).

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

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Services

B. Types of Providers Served

Identify the types of facilities/clients served by the nurse registry (check all that apply).

- [ ] Adult Day Care
- [ ] Assisted Living Facility
- [ ] Home Health Agency
- [ ] Hospice
- [ ] Hospital
- [ ] Nursing Home
- [ ] Private Home/Residence
- [ ] Other

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Other Associated Locations

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

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...

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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
7. Days and Hours of Operation
   a. Days and Hours of Operation
8. Geographic Service Area
   a. Geographic Service Area
9. Services
   a. Health Care Personnel
   b. Types of Providers Served
10. Other Associated Locations
    a. Satellite Offices
11. Supporting Documents
    a. Supporting Documents

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

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Payment Summary

You must provide payment before your application can be accepted by the Agency. Review the information below, and select one of the payment methods at the bottom of the page.

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

** Amounts shown may not reflect recent payments.*

Note - You may submit your application without paying all outstanding amounts, but you will not receive your license until they are settled. If you choose not to pay a particular amount at this time, uncheck the box to the left of the amount.

Biennial Licensure Fee and Other Amounts Due Upon Submission of Application

- The biennial licensure fee is $2,000
- Other amounts due (fines, assessment, fees, etc.) will be detailed in the 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 Statutes (F.S.).

(4) Pursuant to section 408.809 and 435.05, Florida Statutes (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.

Signature of Licensee or Authorized Representative | Title | Date

☐ I agree

Pay Online | Pay By Mail

Note - Your application will not be considered received until payment has been received. Selecting the "Pay by Mail" option will delay the Agency's receipt of your application, resulting in the assessment of late fees if payment is not received by the due date.

*****Please Note: Following your selection of payment method, you will not be able to make changes or additional payments until AHCA licensure staff have completed their review.*****

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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***

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.

AGENCY FOR HEALTH CARE ADMINISTRATION

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:	Click on the image to see Credit Card Security Value locations.
*Expiration Date:	01 / 2015
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

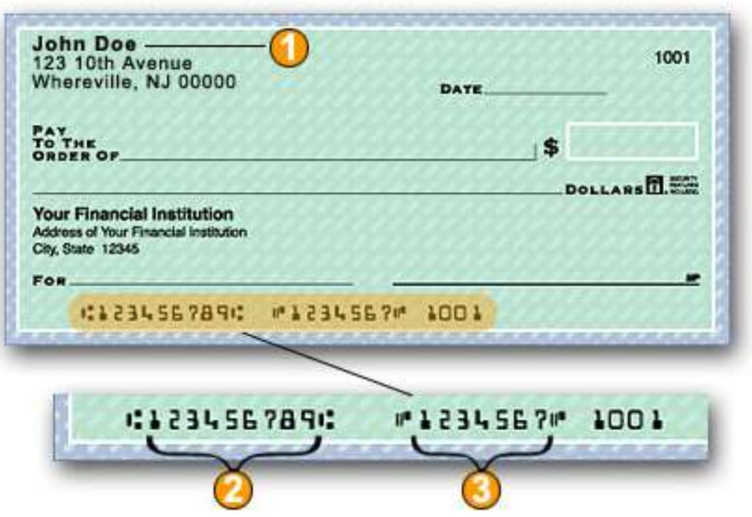
AGENCY FOR HEALTH CARE ADMINISTRATION

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.

Logged in as :

Dashboard | OL Help | Documents | Logout

Provider:

Provider Type:
Nurse Registry

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
- Days and Hours of Operation
- Geographic Service Area
- Services
- Other Associated Locations
- Supporting Documents
- Finalize Submission

Health Care Licensing Online Application
Nurse Registry
AHCA Form 3110-7004 OL, March 2016
59A-35.060, Florida Administrative Code

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 09/25/2013 in

View Statement

Provider:

Provider Type:
Nurse Registry

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
- Days and Hours of Operation
- Geographic Service Area
- Services
- Other Associated Locations
- Supporting Documents
- Finalize Submission

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
Your application will not be considered received until all

For Agency Use Only

View Statement

Health Care Licensing Online Application
Nurse Registry
AHCA Form 3110-7004 OL, March 2016
59A-35.060, Florida Administrative Code