AHCA USE ONLY:
File #:
Application #:
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HEALTH CARE LICENSING APPLICATION
TRANSITIONAL LIVING FACILITY

The Agency for Health Care Administration (AHCA) has implemented the **ONLINE LICENSING SYSTEM,** which allows the electronic submission of renewal and change during licensure period applications and fees, along with the ability to upload supporting documentation.

To submit 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 The application will be withdrawn from review if all the required documents and fees are not included with your application or received within 21 days of an omission notice.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 and Change During Licensure 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 provision of Chapters 400, Part XI, Florida Statutes, (F.S.) and Chapters 59A-35 and 59A-17, Florida Administrative Code, (F.A.C.), an application is hereby made to operate a Transitional Living Facility as indicated below:

1. Provider / Licensee Information

A. PROVIDER INFORMATION – Please complete the following for the transitional living facility 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)	Florida Medicaid # (if applicable)	
Name of Transitional Living Facility (if operated under a fictitious name, enter as it appears in Florida Division of Corporations)			
Street Address			
City	County	State	Zip
Telephone Number	Fax Number		
Mailing Address or ☐ Same as above			
City	County	State	Zip
Telephone Number	E-mail Address		
Provider Website	*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 transitional living facility.			
Licensee Name (This is the owner of the transitional living facility)		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	☐ Hospital District
☐ Individual		
☐ Sole Proprietor		
☐ Other		

C. **CONTACT PERSON** - For this application	
Contact Person for this application	Contact Telephone Number
Contact e-mail address or ☐ Do not have e-mail	NOTE: By providing your e-mail address you agree to accept e-mail correspondence from the Agency.

D. PROPERTY OWNER INFORMATION – Complete the following for the owner of the property if different from the licensee.

Does an individual or entity other than the licensee own the property where the principal office is located?

If ☐ NO, skip to section 2 – Application Type and Fees

If ☐ YES, please provide the following information:

FULL NAME OF PROPERTY OWNER	PERSONAL/PRIMARY ADDRESS	TELEPHONE NUMBER

2. Application Type, Number of Beds and Fees

Indicate the type of application with an "X." **Applications will not be processed if 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 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.

A. TYPE OF APPLICATION

☐ Initial Licensure

Was this entity previously licensed as a Transitional Living Facility 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

☐ Change during licensure period - select all that apply:

Fee Required

☐ Provider Name

☐ Provider Address

Proposed Effective Date: _____

Proposed Effective Date: _____

No Fee Required

☐ Personnel

☐ Management Company

Bed Capacity:
☐ Increase or ☐ Decrease
☐ Replacement License

☐ Property Owner

B. FEES

ACTION	FEE	TOTAL FEES
License Fee (Initial, Renewal and Change of Ownership):	$4,588.00 + 90.00 per bed x ____ # of beds	$
Increase in Bed Capacity between licensure period	$90.00 per bed x _____ number of new beds	$
Change During Licensure Period/Replacement License	$25.00	$
TOTAL FEES INCLUDED WITH APPLICATION		**$**
Please make check or money order payable to the Agency for Health Care Administration (AHCA)		

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 Section 408.803(7), F.S., 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% 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% 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	EFFECTIVE 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	EFFECTIVE DATE	END DATE
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					

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, please provide the following information:

Name of Management Company	EIN (No SSNs)	Telephone Number / Fax	
Street Address	Email Address		
City	County	State	Zip
Mailing Address or ☐Same as above			
City		State	Zip
Contact Person	Contact Email	Contact Telephone Number	

DEFINITION:

Controlling interests, as defined in Section 408.803(7), F.S., 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% 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% 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 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	EFFECTIVE 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	EFFECTIVE DATE	END DATE
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					

5. Personnel

A. **Please provide information for the individual(s) who perform the following roles. NOTE:** For the administrator, and financial officer an AHCA Screening through the Care Provider Background Screening Clearinghouse (Clearinghouse) is needed or the Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008 if background screening was conducted by the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S. To verify who is to be screened, visit ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/Rqrd_Screening.shtml.

INFORMATION	ADMINISTRATOR/MANAGING EMPLOYEE	FINANCIAL OFFICER / PERSON RESPONSIBLE FOR FINANCIAL OPERATIONS
Full Name		
Date of Birth		
Effective Date		
End Date		
Telephone Number		
Email Address		
Personal/Primary Address		

B. **Safety Liaison –** Provide the requested information for the individual who will serve as primary contact during emergency operations pursuant to 408.821, Florida Statutes.

INFORMATION	SAFETY LIAISON
Full Legal Name	
Date of Birth	
Effective Date	
End Date	
Personal/Primary Address	
Telephone Number	
Email Address	

6. Required Disclosure

The following disclosures are required:

A. Pursuant to section 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 section 408.809, Florida Statutes? YES ☐ NO ☐
If YES, provide the following information the full legal name of the individual and the position held

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 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, 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? YES ☐ NO ☐

If YES, has applicant been in good standing with the Medicare program or a state Medicaid program for the most recent five (5) years and the termination occurred at least twenty (20) years before the date of the application. YES ☐ NO☐

D. Pursuant to 400.9981 (3)(b) & (c), F.S., does the licensee or administrator or an employee, or representative act as:

YES ☐ NO ☐ A competent client's payee for social security, veteran's, or railroad benefits?

YES ☐ NO ☐ The attorney in fact for a client?

If YES, please provide a copy of the surety bond if applicable.

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. General Information

A. Beds:

Please enter the number of beds requested for this application: Total number of beds: _____

B. Accreditation:

ACCREDITING ORGANIZATION	ACCREDITING ORG ID	EFFECTIVE DATE	EXPIRATION DATE	SURVEY END DATE
☐ Commission on Accreditation of Rehabilitation Facilities (CARF)				
☐ The Joint Commission (JC)				
☐ Other: Please specify:				

9. Supporting Documents

Applicants must include the following attachments as stated in Chapter 408, Part II and Chapter 400, Part XI, F.S. and Chapters 59A-35 and 58A-17, F.A.C. **Note: Required documents listed below are dependent on the type of application submitted. (Initial, Renewal, Change of Ownership, Change during licensure period)**

DOCUMENTS TO BE PROVIDED:	REQUIRED FOR:
General Liability and Professional Insurance	All applications types
Fire Safety Inspection Report	Initial, Renewal, Change of Ownership, Request to Change Address and Capacity Increase application types
Department of Health Food Permit	Initial, Renewal, Change of Ownership and Capacity Increase application types
Documentation of continual accreditation by an accrediting organization that specializes in evaluating rehabilitation facilities.	Renewal, Change of Ownership and Capacity increase application types
Documentation from the appropriate local government office showing that the applicant has met local zoning requirements	Initials, Change of Ownership and Capacity increase application types
Documentation proving compliance with the Community Residential Homes site selection requirements specified pursuant to Chapter 419, Florida Statutes	Initial, CHOW, and Change During Licensure application types
Proof of Property Occupancy, Examples: Lease, Mortgage, and Transfer Agreement.	Initial, Renewal, Change of Ownership, Request to Change Name or Address of Provider application types
A signed agreement to correct all outstanding licensure deficiencies incurred by the previous owner	Change of Ownership
Closing documents signed and dated by all parties	Change of Ownership
Surety Bond	All application types – See section 6E
Health Care Licensing Application Addendum, AHCA Form 3110-1024	Initial, Renewal, Change of Administrator or Financial Officer and Change of Ownership 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

10. Attestation

I, _____, 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, under penalty of perjury, 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.

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.

RETURN THIS COMPLETED FORM WITH FEES AND ALL REQUIRED DOCUMENTS TO:

AGENCY FOR HEALTH CARE ADMINISTRATION
LONG TERM CARE UNIT
2727 MAHAN DR., MS 33
TALLAHASSEE FL 32308-5407

Questions?
Review the information available at http://ahca.myflorida.com or contact the Assisted Living Unit at (850) 412-4303.
Email: LTCStaff@ahca.myflorida.com