

**AHCA USE ONLY:**

File #:

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#### Health Care Licensing Application

#### Homemaker And Companion Services Provider

The Agency for Health Care Administration (AHCA) has implemented the **ONLINE LICENSING SYSTEM,** whichallows 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 *The application will be withdrawn from review if all the required documents and fees are not included with your application or received within 21 days of an omission notice.* **Applications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 authority of Chapters 408, Part II and 400, Part III, Florida Statutes (F.S.), and Chapters 59A-35 and 59A-8.025, Florida Administrative Code (F.A.C.), an application is hereby made to operate a homemaker and companion services provider as indicated below:

**1. Provider / Licensee Information**

|  |
| --- |
| A. **PROVIDER INFORMATION** – Please complete the following for the homemaker and companion services name and location. Provider name, address and telephone number will be listed on <http://www.floridahealthfinder.gov/> |
| License # (if applicable)       | National Provider Identifier (NPI) (if applicable)       | Florida Medicaid #(if applicable)       |
| Name of Homemaker and Companion Services (if operated under a fictitious name, enter as it appears in Florida Division of Corporations) |
| Street Address      |
| CityMiami  | County | State | Zip      |
| Telephone Number       | Fax Number       |
| Mailing Address or [ ]  Same as above       |
| City      | County      | State      | Zip      |
| Telephone Number       | E-mail Address for Agency Contact      |
| Provider Website      | NOTE: By providing your e-mail address, you agree to accept e-mail correspondence from the Agency. |

|  |
| --- |
| 1. **LICENSEE INFORMATION** – Please complete the following for the entity seeking to operate the homemaker & companion services provider
 |
| Licensee Name (This is the owner of the homemaker & companion services provider) | 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 |

**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.

[x]  Initial Registration Proposed Effective Date:

Was this entity previously registered as a Homemaker & Companion Services Provider in Florida? YES [ ]  NO [x]

If YES, please provide the provider name (if different), EIN # and the year the prior registration expired or closed:

|  |  |  |
| --- | --- | --- |
| NAME:  | EIN #:  | Year Expired/Closed:       |

[ ]  Renewal Registration

[ ]  Change of Ownership Proposed Effective Date:

[ ]  Change during Registration Period – select all that apply Proposed Effective Date:

Fee Required No Fee Required

[ ]  Provider Name [ ]  Personnel

[ ]  Provider Address [ ]  Management Company

[ ]  Geographic Service Areas (Counties)

[ ]  Duplicate License

|  |  |  |
| --- | --- | --- |
| **ACTION** | **FEE** | **TOTAL FEES** |
| Registration Fee (Initial, Renewal and Change of Ownership):[x]  Registration Fee Exemption (State, County or Municipal Agencies per 59A-8.025(4), F.A.C.) = $ 0.00 | $50.75 | $ 50.75 |
| Change During Registration Period/Replacement Registration  | $25.00 | $       |
| **TOTAL FEES INCLUDED WITH APPLICATION** | **$ 50.75** |
| **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.

**Special note:** Pursuant to section 408.809, F.S., any controlling interest are required to have an Agency screening through the Care Provider Background Screening Clearinghouse. If background screening has been 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., the Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008 may be submitted in lieu of Agency screening. To verify who is to be screened, visit [[http://ahca.myflorida.com/MCHQ/Central\_Services/Background\_Screening/.](http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/.%20)](http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/Rqrd_Screening.shtml.%20)

1. **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** |
|  |       |       |       |  |  |       |
|       |       |       |       |       |       |       |
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|       |       |       |       |       |       |       |

1. **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** |       |       |       |  |  |
| **Board Member/Officer** |       |       |       |  |  |

**4. Management Company Controlling Interests**

**Does a company other than the licensee manage the registered provider?**

If [x]  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 |

**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.

**Special note:** Pursuant to section 408.809, F.S., any controlling interest are required to have an Agency screening through the Care Provider Background Screening Clearinghouse. If background screening has been 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., the Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008 may be submitted in lieu of Agency screening. To verify who is to be screened, visit [[http://ahca.myflorida.com/MCHQ/Central\_Services/Background\_Screening/.](http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/.%20)](http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/Rqrd_Screening.shtml.%20)

1. **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** |
|       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |
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|       |       |       |       |       |       |       |

1. **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** |       |       |       |  |  |
| **Board Member/Officer** |       |       |       |  |  |

**5. Personnel**

**Please provide information for the individual(s) who perform the following roles.** Special note: the administrator and financial officer are required pursuant to section 408.809, F.S. to have an Agency screening through the Care Provider Background Screening Clearinghouse or submit 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 [[http://ahca.myflorida.com/MCHQ/Central\_Services/Background\_Screening/.](http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/.%20)](http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/Rqrd_Screening.shtml.%20)

|  |  |  |
| --- | --- | --- |
| **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** |  |  |

**6. Required Disclosure**

**The following disclosures are required:**

1. 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

[ ]  A description/explanation of any convictions of offenses

1. 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 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.

1. 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 [ ]

**7. Provider Fines and Financial Information**

Pursuant to subsection 408.831(1)(a), Florida Statutes, 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 [x]

 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. Geographic Service Area**

Initial and change of ownership applicants may apply to serve clients in the counties of a single geographic service area, as defined in 408.032(5), F.S., in which the address of record is located any homemaker and companion services provider holding a current registration from the AHCA may continue to serve clients in the counties listed on its registration.

|  |
| --- |
| Please check a single service area below and then check the counties to be served within that area. Remember the street address of the provider as listed in section 1A of this application must be located in one of the counties served. |
| **[ ]  AREA 1** | **[ ]  AREA 2** | **[ ]  AREA 3** | **[ ]  AREA 4** | **[ ]  AREA 7** | **[ ]  AREA 9** |
| [ ]  Escambia | [ ]  Bay | [ ]  Alachua | [ ]  Baker | [ ]  Brevard | [ ]  Indian River |
| [ ]  Okaloosa | [ ]  Calhoun | [ ]  Bradford | [ ]  Clay | [ ]  Orange | [ ]  Martin |
| [ ]  Santa Rosa | [ ]  Franklin | [ ]  Citrus | [ ]  Duval | [ ]  Osceola | [ ]  Okeechobee |
| [ ]  Walton | [ ]  Gadsden | [ ]  Columbia | [ ]  Flagler | [ ]  Seminole | [ ]  Palm Beach |
|  | [ ]  Gulf | [ ]  Dixie | [ ]  Nassau |  | [ ]  St. Lucie |
|  | [ ]  Holmes | [ ]  Gilchrist | [ ]  St. Johns |  |  |
|  | [ ]  Jackson | [ ]  Hamilton | [ ]  Volusia |  |  |
|  | [ ]  Jefferson | [ ]  Hernando |  |  |  |
|  | [ ]  Leon | [ ]  Lafayette | **[ ]  AREA 5** | **[ ]  AREA 8** | **[ ]  AREA 10** |
|  | [ ]  Liberty | [ ]  Lake | [ ]  Pasco | [ ]  Charlotte | [ ]  Broward |
|  | [ ]  Madison | [ ]  Levy | [ ]  Pinellas | [ ]  Collier |  |
|  | [ ]  Taylor | [ ]  Marion |  | [ ]  DeSoto |  |
|  | [ ]  Wakulla | [ ]  Putnam | **[ ]  AREA 6** | [ ]  Glades | **[ ]  AREA 11** |
|  | [ ]  Washington | [ ]  Sumter | [ ]  Hardee | [ ]  Hendry | [ ]  Miami-Dade |
|  |  | [ ]  Suwannee | [ ]  Highlands | [ ]  Lee | [ ]  Monroe |
|  |  | [ ]  Union | [ ]  Hillsborough | [ ]  Sarasota |  |
|  |  |  | [ ]  Manatee |  |  |
|  |  |  | [ ]  Polk |  |  |

**10. Supporting Documents**

Applicants must include the following attachments as stated in Chapters 408, Part II and 400, Part II, F.S. and Chapters 59A-35 and 58A-8.025, 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** |
| Documentation of change of ownership transaction stating effective date and executed by all parties  | Change of Ownership applications. |
| Health Care Licensing Application Addendum, AHCA Form 3110-1024  | Initial, Renewal 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 |

**11. 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.

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

AGENCY FOR HEALTH CARE ADMINISTRATION

HOME CARE UNIT

2727 MAHAN DR., MS 33

TALLAHASSEE FL 32308-5407

**Questions?**

Review the information available at <http://ahca.myflorida.com> or contact the Home Care Unit at (850) 412-4303.

**Email**: LTCstaff@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.