

**Application Checklist**

#### Homemaker and Companion Services

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>

**All forms listed below may be obtained from the website:** http://ahca.myflorida.com/HQALicensureForms

**Send completed applications to: Agency for Health Care Administration, Long Term Care Services Unit, 2727 Mahan Drive, Mail Stop 34, Tallahassee, FL 32308.**

**Application types and definitions:**

**Initial** – application for an initial license/registration/certification

**Renewal** – biennial renewal of existing license/registration/certification

**Change of Ownership (CHOW)** – licensee sells/transfers ownership to a different individual/entity or change of 51% or more of the ownership (controlling interest of licensee)

**Change During Licensure Period (C)** – request to amend /change provider information

**Fee Required:**

* Name Change
* Address Change
* Geographic Service Areas
* Replacement License

**No Fee Required:**

* Stock Transfer of less than 51%
* Management Company Change
* Personnel Change

Hours of Operation

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**Provider Information- (Application Types: All)**

* Fictitious name (if applicable), street address, mailing address, telephone number, fax number, email address, website

address, and if applicable, Medicare provider number, Medicaid provider number and National Provider Identifier (NPI)

**Licensee (Owner) Information (Application Types: All)**

* Organization type, complete legal name, mailing address, EIN/SSN, email address, telephone number, and fax number. Legal name and address submitted with application must be the same that is registered with Department of State, Division of Corporations

**Contact Person** **(Application Types: All)**

* Name, email address, and telephone number

**Licensee Controlling Interests, Board Members, and Officers** **(Application Types: All)**

* Name, EIN/SSN, mailing address, telephone number, % ownership interest, effective and end dates for each controlling interest, board member and officer

**Management Company, (if applicable)** **(Application Types: All)**

* Name, EIN, street address, mailing address, telephone number, fax number; email address, and contact person’s name, email address, and phone number

**Management Company Controlling Interests, Board Members, and Officer (Application Types: All)**

* Name, EIN/SSN, mailing address, telephone number, % ownership interest, effective and end dates for each controlling interest, board member and officer

**Personnel (Application Types: All)**

* Administrator: Name, SSN, date of birth, personal/primary address, email address, telephone number, effective and end dates of employment
* Financial Officer: Name, SSN, date of birth, personal/primary address, email address, telephone number, effective and end dates of employment

**Disclosures (Application Types: All)**

* Legal information (if any) for licensee, licensee controlling interests, management company, and management company controlling interests related to any convictions of criminal offenses and any exclusions, suspensions or terminations from the Medicare or Medicaid programs or CLIA, if applicable

**Provider Fines and Financial Information (Application Types: All)**

* Assessing entities, related case numbers, dates of assessment, final orders, next payment due dates of any monies owed to the Agency (AHCA)

**Hours of Operations (Application Types: All)**

* Regular operating days and hours

**Geographic Service Area (Application Types: I, R, CHOW, and C, if applicable)**

* Florida counties served

**Request to Change the Name or Address of Provider**

* Sections 1A, 2 and 11 of the Health Care Licensing Application, AHCA Form 3110-1003

**Request to Change Administrator or Financial Officer**

* Sections 1A, 2, 5 and 11 of the Health Care Licensing Application, AHCA Form 3110-1003
* Section 1A of the Health Care Licensing Application Addendum, AHCA, Form 3110-1024
* No fee required

**Request to Change Geographic Service Areas**

* Sections 1A, 2, 8, and 11 of the Health Care Licensing Application, AHCA Form 3110-1003

**Supporting Documents (Application Types: All, unless otherwise specified)**

* Health Care Licensing Application Addendum, AHCA Form 3110-1024 - (Application Types: I, R, CHOW)
* Documentation of change of ownership transaction stating effective date and executed by all parties - (Application Types: CHOW, C)
* Required disclosures related to actions taken by Medicare, Medicaid or CLIA, if applicable - (Application Types: All, if documentation is required due to responses provided in application)
* Approved repayment plan (if applicable re: Medicaid/Medicare)

**Biennial Licensure Fee and Other Amounts (Due Upon Submission of Application)**

* The biennial licensure fee is $50.75. Check or money order payable to the Agency for Health Care Administration (AHCA)
* The amended license certificate fee is $25.00
* Other amounts due (fines, assessment, fees, etc.) will be detailed in the application

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| ***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.
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