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

Health Care Licensing Application
Home Health Agencies

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: https://ahca.myflorida.com/health-care-policy-and-oversight/online-licensure-information/online-licensing-system

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 *The application will be withdrawn from review if all the required documents and fees are not included with your application or received within 21 days of an omission notice.* **Applications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 Period 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.** Please fill in all blanks or mark N/A if not applicable

Under the authority of Chapters 408, Part II and 400, Part III, Florida Statutes (F.S.), and Chapters 59A-35 and 59A-8, Florida Administrative Code (F.A.C.), an application is hereby made to operate a home health agency as indicated below:

1. Provider / Licensee Information

A. PROVIDER INFORMATION – Please complete the following for the home health agency name and location. Provider name, address and telephone number will be listed on https://quality.healthfinder.fl.gov/index.html			
License # (if applicable)	National Provider Identifier (NPI) (if applicable)	Florida Medicaid # (if applicable)	
Name of Home Health Agency (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		
Email address	**Note**: By providing your e-mail address, you agree to accept e-mail correspondence from the Agency.		
Provider Website			
Mailing Address or ☐ Same as above			
City	County	State	Zip
Telephone Number	E-mail Address		

B. CONTACT PERSON - Please complete the following for the 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.

C. **LICENSEE INFORMATION –** Please complete the following for the entity seeking to operate the Home Health Agency.		
Licensee Name (This is the owner of the Home Health Agency)		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		

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 **Proposed Effective Date**: _____

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 date the prior license expired or closed:

NAME:	EIN #	Date Expired/Closed:

☐ Renewal Licensure

☐ Renewal of Excellence in Home Health Award*

**Requires submission of the Excellence in Home Health Award Application, AHCA Form 3110-9002, January 2023*

☐ Change of Ownership **Proposed Effective Date**: _____

☐ Licensee sale or transfer of ownership to a different individual/entity

☐ Transfer or assignment of 51% or more ownership, shares, membership, or controlling interest of the licensee

☐ Addition of Skilled Care Services (for currently licensed, non-skilled providers) **Proposed Effective Date**: _____

☐ Change During Licensure Period (check all that apply): **Proposed Effective Date**: _____

Fee Required

☐ Provider or Licensee Name Change

☐ Provider Address

☐ Main Office

☐ Satellite office ☐ Add ☐ Delete

☐ Drop-off site ☐ Add ☐ Delete

☐ Services/Qualifications:

☐ Services ☐ Add ☐ Delete

☐ Counties ☐ Add ☐ Delete

No Fee Required

☐ Personnel

☐ Management Company

☐ Hours of Operation

☐ Accreditation

☐ Mailing Address Only

☐ Transfer or assignment of less than 51% ownership, shares, membership, or controlling interest of the licensee

ACTION	FEE	TOTAL FEES
License Fee (Initial, Renewal, Change of Ownership, and Addition of Skilled Care Services): ☐ License Fee Exemption (State, County or Municipal Government pursuant to 400.471(5), F.S.) = $ 0.00	$1,705.00	$
Biennial Assessment (Initial, Renewal Addition of Skilled Services and Change of Ownership):	$300.00	$
Change During Licensure Period	$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 sections 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-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.

Note: For each controlling interest an AHCA screening through the Care Provider Background Screening 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 Background Screening (myflorida.com).

INSTRUCTIONS: Attach additional application pages if needed.
For new individual – complete all fields except the End Date.
For existing individuals – complete all fields except the Effective and End Date.
To remove an individual – complete all fields including the End Date.

A. Individual and/or Entity Ownership of Licensee as listed in Section 1C 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. **Note**: A written explanation will be required if the percentage of ownership interest indicated below does not equal 100%.

If any controlling interest qualifies as a nonimmigrant alien according to 8 U.S.C. §1101 the Nonimmigrant Alien box must be selected next to their name.

FULL NAME of INDIVIDUAL or ENTITY	PRIMARY ADDRESS	TELEPHONE NUMBER	EIN (No SSN)	% OWNERSHIP	EFFECTIVE DATE	END DATE	NON-IMMIGRANT ALIEN
							☐
							☐
							☐
							☐

B. Board Members and Officers of Licensee as listed in Section 1C above – Provide the information for each individual 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					

4. Management Company

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

If ☐ NO, **skip to Section 6 – Personnel**.

If ☐ YES, provide the following information:

Name of Management Company		EIN (No SSN)	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	

5. Management Company Controlling Interests

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.

Note: For each controlling interest an AHCA screening through the Care Provider Background Screening 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 Background Screening (myflorida.com).

INSTRUCTIONS: Attach additional application pages if needed.

For new individual – complete all fields except the End Date.

For existing individuals – complete all fields except the Effective and End Date.

To remove an individual – complete all fields including the End Date.

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. **Note:** A written explanation will be required if the percentage of ownership interest indicated below does not equal 100%.

If any controlling interest qualifies as a nonimmigrant alien according to 8 U.S.C. §1101 the Nonimmigrant Alien box must be selected next to their name.

FULL NAME of INDIVIDUAL or ENTITY	PRIMARY ADDRESS	TELEPHONE NUMBER	EIN (No SSN)	% OWNERSHIP	EFFECTIVE DATE	END DATE	NON-IMMIGRANT ALIEN
							☐
							☐
							☐
							☐

B. Board Members and Officers of Management Company: Provide the information for each individual 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					

6. Personnel

Please provide the information below for the individual(s) who perform the following roles: administrator, alternate administrator, financial officer, and director of nursing, alternate director of nursing or registered nurse.

Note: For the administrator, alternate administrator, financial officer, and director of nursing, alternate director of nursing or registered nurse whose responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas, whether employed or contracted, an Agency Screening through the Care Provider Background Screening 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 Background Screening (myflorida.com).

INSTRUCTIONS: Attach additional application pages if needed.
For new individual – complete all fields except the End Date.
For existing individuals – complete all fields except the Effective and End Date.
To remove an individual – complete all fields including the End Date.

A. Administrator and Alternate Administrator – Pursuant to section 400.476(1), F.S., the administrator can only work for home health agencies that share identical controlling interests. An administrator cannot serve as the director of nursing if there are more than 10 full time equivalent staff including contracted personnel working in the home health agency.

INFORMATION	ADMINISTRATOR	ALTERNATE ADMINISTRATOR
Full Name		
Effective Date		
End Date		
Telephone Number		
Email Address		
Personal/Primary Address		
Qualification(s)	☐ Physician, FL DOH License #: _____ ☐ Physician Assistant, FL DOH License #: _____ ☐ Registered Nurse, FL DOH License #: _____ ☐ 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 #: _____ ☐ Physician Assistant, FL DOH License #: _____ ☐ Registered Nurse, FL DOH License #: _____ ☐ 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).
Work Status	☐ Full time Employee or ☐ Part time Employee	☐ Full time Employee or ☐ Part time Employee

B. Director of Nursing and Alternate Director of Nursing – Pursuant to section 400.476(2), F.S., the Director of Nursing can only work for home health agencies that share identical controlling interests.

INFORMATION	DIRECTOR OF NURSING	ALTERNATE DIRECTOR OF NURSING
Full Name		
Effective Date		
End Date		
Telephone Number		
Email Address		
Personal/Primary Address		
Required Experience	☐ One year of supervisory experience as an RN FL DOH License #: _____	☐ One year of supervisory experience as an RN FL DOH License #: _____
Work Status	☐ Full time Employee or ☐ Part time Employee	☐ Full time Employee or ☐ Part time Employee
Position Responsibilities	Will the Director of Nursing be expected to, or whose responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas? ☐ Yes ☐ No	Will the Alternate Director of Nursing be expected to, or whose responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas? ☐ Yes ☐ No

C. Registered Nurse – An RN is required for home health agencies providing only non-skilled services to perform supervisory visits to the patient's home in accordance with the patient's direction, approval, and agreement to pay the charge for the visits and to provide supervision and oversight of home health aides and certified nursing assistants as stated in section 400.487(3), F.S. and section 59A-8.0095(5), F.A.C.

INFORMATION	REGISTERED NURSE
Full Name	
Effective Date	
End Date	
Telephone Number	
Email Address	
Personal/Primary Address	
Required Experience	☐ Registered Nurse, FL DOH License #: _____
Work Status	☐ Full time Employee or ☐ Part time Employee

D. Financial Officer and Safety Liaison – Provide the requested information for the financial officer and the individual who will serve as primary contact during emergency operations pursuant to section 408.821, F.S.

INFORMATION	FINANCIAL OFFICER / PERSON RESPONSIBLE FOR FINANCIAL OPERATIONS	SAFETY LIAISON
Full Name		
Effective Date		
End Date		
Telephone Number		
Email Address		
Personal Address		

7. 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(4), 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, F.S.? YES ☐ NO ☐

If YES, provide the following information:

☐ The full legal name of the individual and the position held

☐ A description and explanation of any convictions

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/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.

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. Nonimmigrant Aliens - If the applicant or any controlling interests are nonimmigrant aliens according to 8 U.S.C. §1101, then a surety bond of at least $500,000 must be filed, payable to AHCA that guarantees the home health agency will act in full conformity with all legal requirements for operation pursuant to section 408.8065(2), F.S...

Are there any nonimmigrant aliens listed as a licensee or controlling interest in this application? YES ☐ NO ☐

If YES, include documentation of the surety bond with this application.

8. 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.

9. Accreditation

INITIAL APPLICANTS:
An applicant that will provide skilled care must provide proof of accreditation that is not conditional or provisional within 120 days of the Agency's receipt of the licensure application pursuant to section 400.471(2)(g), F.S. Please check the appropriate accrediting organization in the table below and provide proof of accreditation or proof of application for accreditation with this application.

RENEWAL APPLICANTS:
If you were licensed after July 1, 2008, and provide skilled care, you must be accredited by one of the accrediting organizations listed below. Please check the appropriate accrediting organization in the table below and include a copy of the most recent accreditation award letter and accreditation survey report with this application.

Note: Effective July 1, 2014, a home health agency that does not provide skilled care is exempt from the accreditation requirement.

ACCREDITING ORGANIZATION		ACCREDITATION ID	EFFECTIVE DATE	EXPIRATION DATE	SURVEY END DATE
☐	The Joint Commission (JC)				
☐	Community Health Accreditation Partner (CHAP)				
☐	Accreditation Commission for Health Care (ACHC)				

☐ Proof of accreditation enclosed – a copy of the accreditation award letter and accreditation survey report.
☐ Proof of application for accreditation enclosed – a screen print receipt from accrediting organization web site or letter of receipt of application from accrediting organization.

☐ No longer accredited and/or deemed
- ☐ Not applicable/licensed prior to July 1, 2008
- ☐ Non-skilled provider exempt from accreditation requirement pursuant to section 400.471(2)(g), F.S.

NOTE: If accredited, provide a copy of the full accreditation survey, award letter and any follow up letters to or from the accrediting body. Please review section.119, F.S. for additional information.

☐ I understand that the complete accreditation survey report must be submitted to the Agency for review if the accreditation survey report is to be accepted in lieu of a complete licensure inspection and such reports used to meet licensure requirements are considered public documents subject to disclosure per chapter 119, F.S. A complete accreditation survey report includes correspondence from the accrediting organization containing the dates of the survey, any citations to which the accreditation organization requires a response, the facility's response to each citation, the effective date of accreditation and verification of Medicare (CMS) deemed status, if applicable.

10. Days and Hours of Operation

List the home health agency's main office operating hours. Section 59A-8.003(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.

HOME HEALTH AGENCY – MAIN OFFICE			
DAY OF THE WEEK	**OPENING TIME**	**CLOSING TIME**	**BY APPOINTMENT**
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			☐
Sunday			☐
☐ Indicate if the agency will have a 24-hour on-call system (required for agencies offering skilled services).			
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 or denial of an application.			

11. Geographic Service Area

For Initial, Change of Ownership, and Addition of Skilled Care Services applications, check all counties where this agency expects to provide services. For all other applications, check only those counties that this agency plans to add or delete from the existing license.

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		

12. Services

A. **RENEWAL APPLICATIONS ONLY:** Pursuant to section 400.474(7), F.S. provide the number of patients who receive home health services by your home health agency on the day that the license renewal application is filed.

B. Does your home health agency provide skilled services to children under the age 21? Yes ☐ No ☐

C. Does your agency participate or plan to participate in the home health aide for medically fragile children program? Yes ☐ No ☐

D. Does your home health agency plan to offer **only** non-skilled services which include home health aide, certified nursing assistant, homemaker, and companion services? Yes ☐ No ☐

E. Does your agency provide or plan to provide staffing services to a health care facility, school, or other business entity by licensed health care personnel, certified nursing assistants and home health aides who are employed by, or work under the auspices of, the home health agency pursuant to section 400.462(29), F.S.? Yes ☐ No ☐

F. Please provide the following information on Service Personnel.

Note: Home health agencies must provide at least one of the services listed below, in part, by direct employees.

If providing nursing services, some of the services must be provided by a direct employee as required in section 400.487(5), F.S. Pursuant to section 400.462(9), F.S., a direct employee means an employee for whom one of the following entities pays withholding taxes: a home health agency, a management company that has a contract to manage the home health agency on a day-to-day basis; or an employee leasing company that has a contract with the home health agency to handle the payroll and payroll taxes for the home health agency.

Medicare and Medicaid certified agencies must also provide **one** of the qualifying services (* below) by direct employees. Medicaid does not include Medical Social Services as a home health agency service.

SKILLED SERVICE PERSONNEL	# DIRECT EMPLOYEES	# CONTRACTED EMPLOYEES	IF SUB-CONTRACT FROM ANOTHER AGENCY, WRITE AGENCY NAME BELOW
Nursing*			
Physical Therapy*			

Speech Therapy*			
Occupational Therapy*			
Respiratory Therapy			
IV Therapy			
Nutritional Guidance			
Medical Supplies (restricted to drugs and biologicals prescribed by a physician)			
Medical Social Services*			

OTHER SERVICE PERSONNEL	# DIRECT EMPLOYEES	# CONTRACTED EMPLOYEES	IF SUB-CONTRACT FROM ANOTHER AGENCY, WRITE AGENCY NAME BELOW
Home Health Aide*			
Certified Nursing Assistant			
Homemaker / Companion			

13. Associated Locations

A. Satellite Office: A satellite office is a related office in the same geographic service area as the main office, operating under the auspices of the main office's license. Refer to sections 59A-8.003(5) and 6), F.A.C., for requirements.

Will this agency operate a satellite office? ☐ YES ☐ NO If YES, list address(es) of satellite offices below.
Please attach additional sheets if necessary.

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.
- **Liability and Malpractice Insurance** – A current certificate of insurance for the requested location.

B. Drop-Off Site: A drop-off site may be located in any county within the licensed geographic service area. This is merely a workstation for direct care staff. Neither billing nor prospective patient contact is allowed. Refer to section 59A-8.003(7), F.A.C., for requirements.

Will this agency operate a drop-off site? ☐ YES ☐ NO

If YES, list address(es) of drop-off Sites below. Attach additional sheets, if necessary:

Drop-Off Site #1		
Street Address		
City	Zip	County

Drop-Off Site #2		
Street Address		
City	Zip	County
Drop-Off Site #3		
Street Address		
City	Zip	County

14. Supporting Documents

Applicants **must** include the following attachments as stated in Chapters 408, Part II and 400, Part III, F.S. and Chapters 59A-35 and 59A-8, 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 and Addition of Skilled Care Services)**

DOCUMENTS TO BE PROVIDED:	REQUIRED FOR:
Proof of Liability and Malpractice Insurance Coverage	Initial, Renewal, Change of Ownership and Address Change application types (excluding change of geographic service area)
Evidence of a Surety Bond, if required pursuant to section 408.8065, F.S.	Initial, Renewal, Change of Ownership, and Addition of Skilled Care Services application types
Proof of Accreditation documentation and survey report	Initial, Renewal, Change of Ownership, and Addition of Skilled Care Services application types, if home health agency is required to be accredited
Proof of Financial Ability to Operate, AHCA Form 3100-0009	Initial, Change of Ownership, and Addition of Skilled Care Services application types
Business Plan signed by applicant, detailing the home health agency's methods to obtain patients and its plan to recruit and maintain staff	Initial, Change of Ownership and Addition of Skilled Care Services application types
Proof of legal right to occupy property may include but not limited to, copies of warranty deeds, lease or rental agreements, contracts for deeds, quitclaim deeds, or other such documentation for principal office and each satellite office	Initial, Change of Ownership involving change of licensee and Change of address application types
Documentation from the appropriate local government official, which states that the applicant has met zoning requirement	Initial, Change of Ownership and Change of address application types
Plan for delivery of services	Application for addition of counties within geographic service area only
Copy of Comprehensive Emergency Management Plan (CEMP) Approval Letter or Documentation of the CEMP submission for review within the last 365 days	Renewal application type
Documentation of change of ownership transaction stating effective date and executed by all parties	Change of Ownership and any change of controlling interest affecting % ownership of licensee application types
A signed agreement to pay any outstanding payments owed to the Agency. The agreement must include who will pay and when payment will be made	Change of Ownership application type
Health Care Licensing Application Addendum, AHCA Form 3110-1024	Initial, Renewal, Change of Ownership, Addition of Skilled Care Services and Change of Personnel or Controlling Interest application types
Required disclosures related to actions taken by Medicare, Medicaid or CLIA, if applicable	Any application types, if required for applicant, licensee, or any controlling interest due to responses provided in application
Approved repayment plan, if applicable	Any application types, if required for applicant, licensee, or any controlling interest due to responses provided in application

15. 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.

(6) Pursuant to section 408.810(12), Florida Statutes, the licensee ensures that no person holds any ownership interests, either directly or indirectly, regardless of ownership structure; who has a disqualifying offense pursuant to section 408.809, Florida Statutes or in a provider that had a license revoked or application denied pursuant to section 408.815, Florida Statutes.

(7) Pursuant to sections 408.810(14) and 408.051(3), FS, the licensee ensures that all patient information stored in an offsite physical or virtual environment, including through a third-party or subcontracted computing facility or an entity providing cloud computing services, is physically maintained in the continental United States or its territories or Canada.

(8) Pursuant to section 408.810(15), FS, the licensee ensures that controlling interests of the licensee do not hold, either directly or indirectly, regardless of ownership structure, an interest in an entity that has a business relationship with a foreign country of concern or that is subject to section 287.135, FS.

_____	_____	_____
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 TO:

AGENCY FOR HEALTH CARE ADMINISTRATION
LABORATORY AND IN-HOME SERVICES UNIT
2727 MAHAN DR., MS 32
TALLAHASSEE FL 32308-5407

Questions? Visit the Agency's website : https://ahca.myflorida.com/ or contact the Laboratory and In-Home Services Unit at (850) 412-4500 or 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.