Provider: Helping Hands Home Healt	th	Logged in as :	Dashboard	OL Help	Documents	L <b>t</b> g
Provider Type:		Provider/F	acility Informat	tion		
Home Health Agency File#: 19969172 License #:		Under the authority of Chapters 408, Part II and 400, Florida Administrative Code (F.A.C.), an application is	Part III, Florida Statutes (F.S	), and Chapte	rs <u>59A-35</u> and <u>59A-</u> ency as indicated b	8, elow.
Expires:		Pursuant to sections 408 806 (1)(a) and (b), FS, an a security number of the applicant, administrator or sim the provider, financial officer or similarly titled person provider and each controlling interest, if the applicant federal employer identification number (EIN) of the apinterest is not an individual. Disclosure of social secur	ilarly titled person who is res who is responsible for the fin or controlling interest is an in oplicant and each controlling ity number(s) is mandatory.	ponsible for the ancial operation dividual; and the interest, if the The Agency for	e day to day operation of the licensee or the name, address, applicant or controll Health Care	on of and ing
<ul><li> = Entered</li><li> = Entry Required</li></ul>		Administration (AHCA) shall use such information for application for licensure.  Review the information below and make any nece number will be listed on Florida Health Finder (htt	ssary edits. The Provider/F	acility name,		
Provider/Facility Information	*	6				_
<b>O</b> Details		Provider NPI cannot be blank. Please enter	number or check None or	Pending chec	kbox below the fie	ld.
Contact Person		Phone number is incomplete. Provider Fax # cannot be blank. Please che Provider Website information cannot be bla field.			e checkbox below	the
Licensee Information	*	Provider/Facility Information				
Controlling Interests	*	License #	National Provider Identifi	er		
Management Company Information	*	Medicaid#	Medicare # (CMS CCI	None	Pending	
Personnel	*	Medicald #	Wedicare # (CMS CCI	N)		
Required Disclosure	*	Name of Home Health Agency (If operated under a fic Corporations.)	ctitious name, enter as it is fil	ed with the Flo	rida Division of	
Accreditation	*	Helping Hands Home Health				
Days and Hours of Operation	*	Provider/Facility Location Address  Edit Address				
Geographic Service Area	*	Provider Location Address 2727 MAHAN DR TALLAHASSEE, FL 32308				
Services	*	US - United States County - LEON				
Other Associated Locations	*	Telephone Ext	Fax#	ne		
Direct Care Workforce	*	Email Address Note: By providing your email address, yo	u agree to accept email correspo	ondence from the	Agency.	
Supporting Documents	*	None				
Finalize Submission	¥	Provider/Facility Website				
		None				
alth Care Licensing Dication	Online					-
me Health Agency CA Form 3110-1011	10L,	Provider/Facility Mailing Address_(All mail will be  Check if same as Provider/Facility Location Addr				
/ 2024 e 59A-35.060, F.A.0	C.	Edit Address				
		Address 2/2/ VIAHAN UR TALLAHASSEE, FL 32308 US - United States County - LEON				
		Telephone Ext	Email Address H4@gmail.com	n		
			Ncne			

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# Provider/Facility Information

	Contact Person fo	or this Application		
irst Name		Middle Name	Last Name	Suffic
elephone	Ext	Fax#		
		None		
ontact Email Addre	ess (By providing you		ept email correspondence from t	he Agency.)

### **Licensee Information**

- · Organization information is incomplete

- Phone number is incomplete
  Licensee Email cannot be blank. Please enter an email or check None checkbox below the field.
  If Licensee does not have Fax number then please select the None check box below the field.
  Licensee mailing address line 1 must not be blank. Licensee mailing address city must not be blank. Licensee mailing address zip must not be blank.

Description of Licensee (select only on  For Profit Not for Profit  Ownership Types  Limited Liability Company			
Entity Licensee Details (2) Licensee Name (may be same as provi	ider name)	Federal Employer Identificatio	n # (EIN)
Mailing Address  Edit Address  Address			
Telephone	Fax # ()	Email Address	
Undo	Save	<	< Back Next >>

### **Controlling Interests of Licensee**

· Select either Yes or No option.

O Yes O No

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.

Pursuant to section 400.991(4), F.S., an "applicant" for licensure as a health care clinic includes any individual owning or controlling indirectly, 5 percent or more of an interest in the clinic. These individuals are required to have an Agency screening through the Care Provider Background Screening Clearinghouse. Provide the information for each individual with 5% or greater indirect ownership in the clinic and attach an organizational chart showing each individual's relationship to the licensee. (Include EINs and percentage ownership for each listed entity.)

Note: For each controlling interest, an AHCA screening through the Care Provider Background Screening Clearinghouse is needed, or the Attestation of Compliance with the 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 must be screened, visit the Background Screening site.

Note: 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.

Do any individuals or entities possess 5% or greater ownership interest in the licensee, or, function as a board member, manager or officer?

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	Management Company Informa	ation
	nanagement Company micros	
Select either Yes or	No option.	
es a company other than	the licensee manage the licensed/registered provider?	
Yes No		
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mounts	C C Ct III	
	agement Company Controlling	g interest
Mana		
Man		
There is no Manager	ment Company associated with this application. Ther any Controlling Interests. Select "Next" to proceed.	- and the second second
There is no Manager	ment Company associated with this application. Ther	- 1200 (100 and 100 an
There is no Manage	ment Company associated with this application. Ther	- 1200 (100 and 100 an

### Personnel

- · One Administrator should be entered for this application.
- One Alternate Administrator should be entered for this application.
- · One Financial Officer should be entered for this application.

#### Personnel

Note: For the administrator, alternate administrator, financial officer, 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 must be screened, visit the Background Screening site.

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

- Administrator
- Alternate Administrator
- · Alternate Director of Nursing (if applicable)
- . Director of Nursing (if applicable)
- Financial Officer
- · Registered Nurse (if applicable)

To add an individual -

Utilizing the picklist below, either choose an individual that is already associated with this application or select 'New Individual'.



No Individuals exist!

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Personnel
Safety Liaison
Please provide the requested information for the individual who will serve as primary contact during emergency operation pursuant to section 408.821, F.S
Safety Liaison
To <u>add</u> an Individual - Utilizing the picklist below, either choose an individual that is already associated with this application or select 'New Individual'.
V
To <u>verify</u> Individual's information - Select "Edit/View"and edit as needed.
To <u>remove</u> an existing Individual - Select "Remove" and enter the applicable end date.
No Individuals exist!
Undo Save << Back Next >>

## **Required Disclosure**

· Either Yes or No must be selected.

### Convictions

Pursuant to section 408.809, 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 section 408.809, F.S.?



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# **Required Disclosure** · Either Yes or No must be selected. **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) Has the applicant or any individual 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? O Yes O No << Back

### **Required Disclosure**

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· All questions related to Felonies/Terminations must be answered.

### Felonies/ Terminations

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Purguant 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:
1. 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 5 years and the termination occured at least 20 years before the date of the application?
Yes No

Save

## **Required Disclosure**

· Either Yes or No must be selected.

### **Nonimmigrant Aliens**

O Yes O No

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 payable to the Agency for Health Care Administration that guarantees the home health agency provider will act in full conformity with all legal requirements for operation pursuant to section 408.8065(2), F.S. Include the surety bond in the Supporting Documents section of this application.

Are there any nonimmigrant aliens listed as a licensee or controlling interest in this application?

4	<u> </u>	
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## Accreditation

Either select an Accred deemed check box.	ditation Pending, an Ac	crediting Organization	or check the No long	ger accredited and/or
If you were licensed after July organizations listed below. Plea additional accreditation information	ase check the appropriate			
Accreditation Pending – Ap	nlication for accreditation	has been submitted to r	one of the accrediting	organizations listed
below. A screen print receipt fro organization will be required on	om the accrediting organi	zation web site or letter o		
Accrediting Organization	Accrediting Org ID	Accreditation Effective Date	Accreditation Expiration Date	<u>Survey Date</u>
Accreditation Commission for				
Health Care (ACHC)				
Community Health		V	V	
Accreditation Program (CHAP)				
Joint Commission (JC)		~	~	~
Effective and expira     Accrediting organize     Provider's response	tion dates of accreditatio tion dates of deemed sta ation's report of findings a to the accrediting organ	atus (if applicable)		
I understand that the complist to be accepted in lieu of a co- considered public documents s correspondence from the accre- organization requires a responsible Medicare (CMS) deemed status	mplete licensure inspect ubject to disclosure per ( diting organization conta se, the facility's response	ion and such reports use Chapter <u>119,</u> F.S. A comp iining the dates of the su	d to meet licensure re plete accreditation reprivey, any citations to v	equirements are ort includes which the accreditation
Note: If accredited, provide a caccrediting organization.	opy of the full accreditati	on survey, award letter a	nd any follow up letter	rs to or from the
☐ No longer accredited and/o	r deemed			
Not applicable/licensed p	prior to July 1, 2008			
Non-skilled provider exer	mpt from accreditation re	equirement pursuant to se	ection 400.471(2)(g), F	F.S.,
	100			
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## **Days and Hours of Operation**

 An agency must be open for 8 consecutive hours per day, Monday through Friday between the hours of 7:00 AM and 6:00 PM. Please make corrections below · Enter opening and closing times. List the regular 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 7:00 AM and 6:00 PM, excluding legal and religious holidays. 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. Indicate if the agency will have a 24-hour on-call system (required for all agencies offering skilled services). **Opening Time Closing Time By Appointment** <u>Day</u> MONDAY V TUESDAY WEDNESDAY V THURSDAY ~ FRIDAY V SATURDAY SUNDAY V

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## Geographic Service Area

Indicate each county th		serve by selecting the appro provided at the bottom of th		olow. For your reference, a
Note - This license cov	ers only one office location	on. Each additional office m	ust be separately licer	nsed.
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	SANTAROSA
☐ SARASOTA	SEMINOLE	ST. JOHNS	ST. LUCIE	SUMTER
SUWANNEE	☐ TAYLOR	UNION	─ VOLUSIA	WAKULLA
WALTON     ■ WALTON	■ WASHINGTON			
Area 1: Escambia, Okaloosa, Santa Rosa, Walton  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

1. 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  $\underline{400.487(5)}$ , F.S. Pursuant to section  $\underline{400.462(9)}$ , 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		
Nursing *				
Physical Therapy *				
Speech Therapy *				
Occupational Therapy *				
Respiratory Therapy				
□ IV therapy				
Nutritional Guidance				
Medical Supplies				
Medical Social Services *				
OTHER SERVICE PERSONNEL	# DIRECT EMPLOYEES	#CONTRACTED EMPLOYEES		
Home Health Aide *				
Certified Nursing Assistant *				
Homemaker / Companion				
2. Does your home health agen	cy provide skilled	services to children under the age of 21?	⊃ No	
Does your agency participate children program?	or plan to particip	pate in the home health aide for medically fragile	Yes	) No
Does your agency provide on nursing assistant, homemaker, a		vices which include home health aide, certified ervices?	○ Yes     •	) No
other business entity by license	d health care pers	taffing services to a health care facility, school, or sonnel, certified nursing assistants and home health uspices of, the home health agency pursuant to	⊚ Yes ○	) No

### Services

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 Nursing \* Physical Therapy \* Speech Therapy \* Occupational Therapy \* Respiratory Therapy Nutritional Guidance Medical Supplies Medical Social Services \* #CONTRACTED # DIRECT OTHER SERVICE PERSONNEL **EMPLOYEES EMPLOYEES** Home Health Aide \* Certified Nursing Assistant \* Homemaker / Companion 2. Does your home health agency provide skilled services to children under the age of 21? 

(C) Yes (E) No 3. Does your agency participate or plan to participate in the home health aide for medically fragile O Yes O No children program? 4. Does your agency provide only non-skilled services which include home health aide, certified Yes No nursing assistant, homemaker, and companion services? 5. 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 Yes No aides who are employed by, or work under the auspices of, the home health agency pursuant to section 400.462(29), F.S.? 6. Pursuant to 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.

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## **Other Associated Locations**

If the licensee of this application operates under any other location associated with this license, select "Add Location" below. Otherwise, select "Next" to proceed
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.
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 is allowed. Refer to section 59A-8.003(7), 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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· Survey Start Date cannot be empty · Survey End Date cannot be empty · Please select atleast one worker category. This survey asks for information about direct care workers employed by your business over the previous 12 months. In accordance with section 408.822(4) F.S., renewal applicants must complete this survey to submit with their renewal application before a license may be issued. Pursuant to section 408.822(1) a "direct care worker" means a certified nursing assistant, a home health aide, a personal care assistant, a companion services or homemaker services provider, a paid feeding assistant trained under s. 400.141(1) (v), or another individual who provides personal care as defined in s. 400.462 to individuals who are elderly, developmentally disabled, or chronically ill. Survey Specify the start and end dates of the 12 month period for which this survey was completed: Start Date: End Date: Worker Categories Select all categories of workers that apply to your business. Create new categories as needed (up to 5). Check all that apply: ☐ None Available Registered Nurse Licensed Practical Nurse Certified Nursing Assistant Home Health Aide Paid Feeding Assistant trained under s. 400.141, F.S. Personal Care Assistant Homemaker/Companion Service Provider Add Worker Category

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There are missing and/or invalid entries. Please correct them.

Survey End Date cannot be greater than the Survey Start Date
Survey Start Date must be at least one year before today's Date
Survey Start Date must be at least one year before Survey End Date

This survey asks for information about firect care workers employed by your business over the previous 12 months. In accordance with section 408.822(4) F.S., renewal application complete this survey to submit with their renewal application before a license may be issued.

Pursuant to section 408.822(1) a "direct care worker" means a certified nursing assistant, a home health aide, a personal care assistant, a companion services or homemaker services provider, a paid feeding assistant trained under s. 400.141(1) (v), or another individual who provides personal care as defined in s. 400.462 to individuals who are elderly, developmentally disabled, or chronically iii.

Survey

Specify the start and end dates of the 12 month period for which this survey was completed:

Start Date: 5/4/2023 End Date: 4/19/2023 Worker Categories

Select all categories of workers that apply to your business. Create new categories as needed (up to 5).

Check all that apply:

None Available

Registered Nurse

Licensed Practical Nurse

Certified Nursing Assistant

Home Health Aide

Add Worker Category

Other B
Other A

☐ Personal Care Assistant

Paid Feeding Assistant trained under s. 400.141, F.S.

☐ Homemaker/Companion Service Provider

### Changes have been saved. This survey asks for information about direct care workers employed by your business over the previous 12 months. In accordance with section 408.822(4) F.S., renewal applicants must complete this survey to submit with their renewal application before a license may be issued. Pursuant to section 408.822(1) a "direct care worker" means a certified nursing assistant, a home health aide, a personal care assistant, a companion services or homemaker services provider, a paid feeding assistant trained under s. 400.141(1) (v), or another individual who provides personal care as defined in s. 400.462 to individuals who are elderly, developmentally disabled, or chronically ill. Survey Specify the start and end dates of the 12 month period for which this survey was completed: Worker Categories Select all categories of workers that apply to your business. Create new categories as needed (up to 5). Check all that apply: ☐ None Available Registered Nurse ☐ Licensed Practical Nurse Certified Nursing Assistant ☐ Home Health Aide Paid Feeding Assistant trained under s. 400.141, F.S. Personal Care Assistant ☐ Homemaker/Companion Service Provider Other B Other A Add Worker Category

## Changes have been saved. Turnover and Vacancy

Provide Information for each category of direct care worker from the previous 12 months to the time this survey form is being completed.

Note: Sections to be completed: 1.) Turnover and Vacancy, 2.) Factors Contributing to Leaving Employment, 3.) Benefits Costs, and 4.) Additional Training. Turnover Rate and Vacancy Rate are calculated based on the values provided.

Worker Categories	For each category, what is the total number of staff employed by your facility at the beginning of the 12 month period?	For each category, how many staff have left employment with the facility since the beginning of the 12 month period until now?	What is your total number of available positions for each category (both filled and vacant)?	Currently, what is your total number of vacancies for each category?	For each category, what is your total number of new hires since the beginning of the 12 month period until now?	For each category (if applicable), what is your total patient volume (hours) since the beginning of the 12 month period until now?	How many direct employee vacancies are filled by contracted workers?	Turnover Rate	Vacancy Rate
Registered Nurse	47	9	40	6	13	55	9	0.10	0.15
Certified Nursing Assistant	65	12	50	5	12	34	8	0.10	0.10
Paid Feeding Assistant trained under s 400.141. F.S	18	4	20	2	3	21	5	0.22	0.10
Other B	7	0	10	3	3	19	4	0.00	0.30
Other A	10	1	10	0	1	11	2	0.10	0.00

### Factors Contributing to Leaving Employment

Out of the staff that left employment with your business (as indicated previously), please indicate how many employees left for each reason listed below over the previous 12 month period. If the reason is not known, indicate the number in the 'Not Known' column. If the reason does not apply to the worker category, indicate a '0' (zero) in the field.

Changes have been saved.

Worker Categories	Increased Pay	Different Working Hours/ Working Conditions	Retirement	Termination	Other	Not Known
Registered Nurse	9	5	13	1	2	0
Certified Nursing Assistant	7	2	0	4	1	3
Paid Feeding Assistant trained under s. 400.141, F.S.	1	0	0	0	0	0
Other B	2	3	8	0	1	0
Other A	0	10	0	2	5	5

All cost of employment benefits are required for each worker category.

#### Cost of Employment Benefits

This section asks for information on the cost of benefits for direct care workers currently employed at your facility.

Respond to the questions below and indicate which benefits are provided for each category of worker along with the average monthly cost of those benefits to your business and your employees.

To add or edit information for each worker category select "Edit/View."

	Worker Category	Current Number of Employees
Edit/View	Registered Nurse	
Edit/View	Certified Nursing Assistant	
Edit/View	Paid Feeding Assistant trained under s. 400.141, F.S.	
Edit/View	Other B	
Edit/View	Other A	

	Cost of Employment Benefits	
Worker Category		
Registered Nurse		
Current Number of Emp	loyees? 421	
Average Hours worked (	per week? 12	
Average wage per hour?	? 50	
Paid Leave ?    Ye	s O No	
If health insurance is pro employee?	ovided, what is the average monthly cost to the employer and	
Employer Contribution:	330.5	
Employee Contribution:	22	
If retirement is provided, (pension, stock, matchin	, what is the average monthly cost to the employer and employee? ng, etc.)	
Employer Contribution:	100	
Employee Contribution:	50.5	
If other insurance is provemployer and employee	vided, specify below and provide the average monthly cost to the	
Other Insurance: ACM	1E Insurance	
Employer Contribution:	1299	
Employee Contribution:	133	
If other benefits are prov employer and employee	vided, specify below and provide the average monthly cost to the	
Other Benefits: ACME	Benefits	
Employer Contribution:	77	
Employee Contribution:	22	

#### Changes have been saved.

#### Cost of Employment Benefits

This section asks for information on the cost of benefits for direct care workers currently employed at your facility.

Respond to the questions below and indicate which benefits are provided for each category of worker along with the average monthly cost of those benefits to your business and your employees.

To add or edit information for each worker category select "Edit/View."

	Worker Category	Current Number of Employees
Edit/View	Registered Nurse	421
Edit/View	Certified Nursing Assistant	72
Edit/View	Paid Feeding Assistant trained under s. 400.141, F.S.	14
Edit/View	Other B	5
Edit/View	Other A	11

#### **Additional Training**

This section asks for information about additional training available for direct care workers employed by your business. "Additional training" is training offered in addition to training required by applicable statutes and rules. Do not include mandatory training required by statute or rule in this section.

If additional training is not available, please answer "NO" below to complete this section. If training is available, please answer "YES" below and indicate which trainings are available.

Is additional training available for direct care workers employed by your business?

Yes No

#### **Additional Training**

This section asks for information about additional training available for direct care workers employed by your business. "Additional training" is training offered in addition to training required by applicable statutes and rules. Do not include mandatory training required by statute or rule in this section.

If additional training is not available, please answer "NO" below to complete this section. If training is available, please answer "YES" below and indicate which trainings are available.

#### There are missing and/or invalid entries. Please correct them.

At least one training must be selected.

Is additional training available for direct care workers employed by your business?

Yes N

For each category of direct care worker, check the boxes to indicate which trainings are available at or provided by your business.

Worker Categories	Pediatric Care Training	Ventilator Training	Tracheostomy Training	Gastrostomy Tube Training	Wound Training	IV Training	Other training not required by applicable statute or rule
Registered Nurse							
Certified Nursing Assistant							
Paid Feeding Assistant trained under s. 400.141, F.S.		0	0	0			
Other B							
Other A							

### **Supporting Documents**

Applicants MUST include the following attachments as stated in Chapters 408, Part III, and 400, Part III, F.S. and Chapter 59A-35 and 59A-8, 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.

- · Proof of Malpractice Insurance Coverage
  - Carrier is required
  - Policy number is required
  - Aggregate policy amount is required
  - Effective date is required
  - · Expiry date is required
  - Occurrence policy amount is required
  - Upload document is required/check the document mailed checkbox.
- · Proof of General Liability Insurance Coverage
  - Carrier is required
  - Policy number is required
  - Aggregate policy amount is required
  - Effective date is required
  - Expiry date is required
  - Occurrence policy amount is required
  - Upload document is required/check the document mailed checkbox.
- · Proof of Financial Ability to Operate
  - Upload document is required/check the document mailed checkbox.
- Business Plan signed by applicant, detailing the home health agency's methods to obtain patients and its
  plan to recruit and maintain staff
  - Upload document is required/check the document mailed checkbox.
- 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
  - Upload document is required/check the document mailed checkbox.
- Documentation signed by the appropriate local government official, which states that the applicant has met zoning requirement

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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
- Q4. Management Company Information
  - a. Management Company Information
  - b. Management Company Controlling Interest
- 5. Personnel
  - a. Administration
  - b. Safety Liaison
- 6. Required Disclosure
  - a. Convictions
  - b. Exclusions
  - c. Felonies/Terminations
  - d. Nonimmigrant Aliens

- 7. Accreditation
  - a. Accreditation
- ©8. Days and Hours of Operation
  - a. Days and Hours of Operation
- 9. Geographic Service Area
  - a. Geographic Service Area
- €10. Services
  - a. Services
- 11. Other Associated Locations
  - a. Other Associated Locations
- @12. Supporting Documents
  - a. Supporting Documents

#### I KELLI FILLYAW, attest as follows:

- (1) Pursuant to section <u>837.06</u>, 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 section 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 interests, either directly or indirectly, regardless of ownershi section 408.809, Florida Statutes or in a provider that had a section 408.815, Florida Statutes.	p structure, who has a	disqualifying offense pursuant to
(7) Pursuant to sections 408.810(14) and 408.051(3), Floinformation stored in an offsite physical or virtual environme computing facility or an entity providing cloud computing set States or its territories or Canada.	nt, including through a	third-party or subcontracted
(8) Pursuant to section 408.810(15), Florida Statutes, the licensee do not hold, either directly or indirectly, regardless business relationship with a foreign country of concern or the	of ownership structure,	an interest in an entity that has a
KELLI FILLYAW	GOC III	09/25/2023
Signature of Licensee or Authorized Representative	Title	Date
☐ I agree		
Biennial Licensure Fee and Other Amounts Due Upon Sub	mission of Applicatio	<u>n</u>
The biennial licensure fee is \$1,705 The biennial health care assessment fee is \$300 Other amounts due (fines, assessment, fees, etc.) will	be detailed in the appli	cation
Selecting the 'Submit Application' you will no longer be a	ble to make changes	to your application.

Submit Application