

Provider/Facility Information

Under the authority of Chapters [408, Part II](#) and [400, Part II](#), Florida Statutes (F.S.), and Chapters [59A-35](#) and [59A-4](#), Florida Administrative Code (F.A.C.), an application is hereby made to operate a nursing home as indicated below.

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, administrator or similarly titled person who is responsible for the day to day operation of the provider, financial officer or similarly titled person who is responsible for the financial operation of the licensee or provider 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 (AHCA) shall use such information for purposes of securing the proper identification of persons listed on this application for licensure.

Review the information below and make any necessary edits. The Provider/Facility name, address, and telephone number will be listed on Florida Health Finder (<http://www.floridahealthfinder.gov>).

- *Provider NPI cannot be blank. Please enter number or check None or Pending checkbox below the field.*
- *Phone number is incomplete.*
- *Provider Fax # cannot be blank. Please check None checkbox below the field.*
- *Provider Email cannot be blank. Please enter an email or check None checkbox below the field.*
- *Provider Website information cannot be blank. Please enter a website or check None checkbox below the field.*
- *Provider Mailing Email cannot be blank. Please check None checkbox below the field.*

Provider/Facility Information

License #

National Provider Identifier

☐ None

☐ Pending

Medicaid #

Medicare # (CMS CCN)

Name of Nursing Home (If operated under a fictitious name, enter as it is filed with the Florida Division of Corporations.)

Provider/Facility Location Address

Provider Location Address

2819 W Bay Dr
BELLEAIR BLUFFS, FL 33770
US - United States
County - PINELLAS

Telephone

Ext

Fax #

☐ None

Email Address *Note: By providing your email address, you agree to accept email correspondence from the Agency.*

☐ None

Provider/Facility Website

☐ None

Provider/Facility Mailing Address (All mail will be sent to this address.)

☒ Check if same as Provider/Facility Location Address

Edit Address

Address

2819 W Bay Dr
BELLEAIR BLUFFS, FL 33770
US - United States
County - PINELLAS

Telephone

Ext

Email Address

☐ None

Undo

Save

Next >>

Licensee Information

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

- *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 one option below) ?

☒ For Profit ☐ Not for Profit ☐ Public

Ownership Types

Limited Liability Company ▼

Entity Licensee Details ?

Licensee Name (may be same as provider name)

TEST NURSING HOME

Federal Employer Identification # (EIN)

35-3535353

Mailing Address ?

Edit Address

Address

2727 MAHAN DR
TALLAHASSEE, FL 32308-5407
County - LEON
US - United States

Telephone

(850) 412-4291

Ext

Fax #

() -

☒ None

Email Address

☒ None

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Personnel

Personnel

Note: The administrator, financial officer, and medical director 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 must be screened, visit the [Background Screening](#) site.

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

- Administrator
- Financial Officer
- Medical Director

To **add** an individual -

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

To **edit** an existing individual -

Select "Edit/View" and edit as needed.

To **remove** an existing individual -

Select "Remove" and enter the date the individual's relationship with the licensee ended.

		Full Name of Individual	Type	Tax ID	Roles	Effective Date	End Date
Remove	Edit/View	KARL SWEDBERG	SSN	123-45-6789	☐ Administrator	04/25/2022	
					☐ Financial Officer	04/25/2022	
					☐ Medical Director	04/25/2022	

Removed: (-) Added: (+)

Required Disclosure

- *Either Yes or No must be selected for Financial/Ownership Actions*

Financial/Ownership Actions

Have any health care or resident entities in which the applicant, controlling interest, management company or administrator of the facility had financial or ownership in the past five years that meets the disclosure requirements as described in subsection [400.111](#), F.S?

☒ Yes ☐ No

Select an individual/entity from this list

No Individual/Entity exist!

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Full Name

TEST SUBJECT 1

Type Tax ID

SSN XXX-XX-8648

Type of Action*Action Date**Entity Name**EIN*[Edit Address](#)Mailing Address*Reason for above action:**List other adverse action by a regulatory agency:**Date of other adverse action by a regulatory agency:**If no longer have financial/ownership interest in the entity, indicate last date of interest:*

OK

Cancel

Required Disclosure

- *Either Yes or No must be selected for Civil Verdict.*

Civil Verdict

Pursuant to [400.071\(1\)\(e\)](#), F.S., has any civil verdict or judgment involving the applicant been rendered within the 10 years preceding the application, relating to medical negligence, violation of residents' rights, or wrongful death.

☒ Yes ☐ No

If yes, please provide to the Agency copies of any new verdict or judgment involving the applicant, relating to such matters, within 30 days after filing with the clerk of the court.

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Bed Count

- *Licensed Beds*
 - *A response to the following is required – Community Beds*
 - *A response to the following is required – Sheltered Beds*
- *Certified Beds*
 - *A response to the following is required – Total Medicare only Beds*
 - *A response to the following is required – Total Medicaid only Beds*
 - *A response to the following is required – Total Duly Certified (Medicare and Medicaid)*
 - *A response to the following is required – Total Private Pay*
- *Room Type*
 - *A response to the following is required – Private Rooms*
 - *A response to the following is required – 2-Bed Rooms*
 - *A response to the following is required – 3-Bed Rooms*
 - *A response to the following is required – 4-Bed Rooms*
 - *A response to the following is required – Other Beds*
- *Bed Types*
 - *A response to the following is required – Assisted Living Facility Beds*
 - *A response to the following is required – Extended Congregation Care Beds*
 - *A response to the following is required – Inactive Beds*
 - *A response to the following is required – Hospice Beds*
 - *A response to the following is required – Pediatric Beds*
- *Questions*
 - *Answer regarding offering continuing care agreements is required*
 - *Answer regarding operating a geriatric outpatient clinic is required*
 - *Answer regarding providing respite care services is required*
 - *Answer regarding providing adult day care services is required*
 - *Answer regarding participating in alternate bed placement is required*
 - *Answer regarding utilizing licensed nurses to perform both licensed and certified nursing assistant duties is required*

Bed Count

The total number of licensed beds is used to calculate the total bed fee.

The renewal rate is \$112.50 per bed. Exception: any facility with sheltered beds pays \$100.50 per bed for all beds.

Licensed Beds

Community Beds

Sheltered Beds

Total Licensed Beds

Certified Beds

Total Medicare only Beds

Total Medicaid only Beds

Total Dually Certified (Medicare and Medicaid)

Total Private Pay

Total

Room-Type # Beds

Private Rooms x 1 =

2-Bed Rooms x 2 =

3-Bed Rooms x 3 =

4-Bed Rooms x 4 =

Other Rooms Bed Total =

Total

The total number of room-type beds must match the total number of licensed beds.

Bed Types

Nursing Home Beds used as ALF Beds pursuant to section [400.0712\(2\)](#), F.S.

Extended Congregate Care Beds

Inactive Beds

Hospice Beds

Pediatric Beds

Do you offer continuing care agreements as defined in Chapter [651](#), F.S.?

☐ YES

☐ NO

If yes, please provide effective date:

☐ NEVER, OR

If no, please provide end date:

☐ NOT SINCE
1/1/2011

Do you operate a geriatric outpatient clinic as defined in section [59A-4.150](#), F.A.C.?

☐ YES

☐ NO

If yes, please provide effective date:

☐ NEVER, OR

If no, please provide end date:

☐ NOT SINCE
1/1/2011

Do you provide respite care services as defined in section [400.172](#), F.S.?

☐ YES

☐ NO

☐ NEVER, OR
NOT SINCE
1/1/2011

If yes, please provide effective date:

If no, please provide end date:

Do you provide adult day care services as defined in section [429.901\(1\)](#), F.S.?

☐ YES

☐ NO

☐ NEVER, OR
NOT SINCE
1/1/2011

If yes, please provide effective date:

If no, please provide end date:

Do you plan to participate in alternate bed placement pursuant to section [400.23\(2\)\(a\)](#), F.S.?

☐ YES

☐ NO

☐ NEVER, OR
NOT SINCE
1/1/2011

If yes, please provide effective date:

If no, please provide end date:

Do you plan to utilize licensed nurses to perform both licensed nurse and certified nursing assistant duties during the same shift as defined in section [400.23\(3\)\(a\)4](#), F.S.?

☐ YES

☐ NO

☐ NEVER, OR
NOT SINCE
1/1/2011

If yes, please provide effective date:

If no, please provide end date:

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Consumer Information

The following information is provided for consumers through the [Florida Health Finder](#) website and the [Florida Nursing Home Guide](#).

Review the information below and make any necessary edits.

Daily Rate and Occupancy

Provide daily rate (\$) of semi-private room for skilled nursing care for a private pay new resident.

\$

Most recent available occupancy level: (Total # of beds that are occupied)

Payment Forms Accepted

- | | | |
|-----------------------------------|--|---|
| ☐ CHAMPUS | ☐ Insurance and/or HMO | ☐ Medicaid |
| ☐ Medicare | ☐ Veterans Administration | ☐ Workers Compensation |

Facility's Religious Affiliation (if any)

- | | | | |
|---|--|-----------------------------------|---------------------------------------|
| ☐ Adventist | ☐ Baptist | ☐ Buddhist | ☐ Catholic |
| ☐ Christian (non-denominational) | ☐ Christian Science | ☐ Hindu | ☐ Jewish |
| ☐ Lutheran | ☐ Methodist | ☐ Muslim | ☐ Presbyterian |
| ☐ Other | | | |

Languages Spoken by Administrator and Staff

- | | | | | |
|--|----------------------------------|-------------------------------------|-------------------------------------|----------------------------------|
| ☐ Arabic | ☐ Chinese | ☐ Creole | ☐ English | ☐ Farsi |
| ☐ Filipino | ☐ French | ☐ German | ☐ Hebrew | ☐ Hindi |
| ☐ Italian | ☐ Korean | ☐ Polish | ☐ Portuguese | ☐ Russian |
| ☐ Sign Language | ☐ Spanish | ☐ Vietnamese | | |
| ☐ Other | | | | |

Special Services - A checked box indicates that the services are provided at this facility and staff meet the necessary requirements ?

- | | | | |
|---|---|--|--|
| ☐ 24-Hour Onsite RN Coverage | ☐ Adult Day Care | ☐ Alzheimer's | ☐ Dialysis |
| ☐ Eden Alternative | ☐ HIV Care | ☐ Hospice | ☐ Pediatric Care |
| ☐ Pet Therapy | ☐ Respite | ☐ Secured Unit | ☐ Therapeutic Spa |
| ☐ Tracheotomy | ☐ Ventilator Dependent | ☐ Water Therapy | ☐ Weight Training |
| ☐ Yoga | | | |
| ☐ Other | | | |

Accreditation - A checked box indicates that the facility and its staff is accredited or accredited with commendation by the Joint Commission on Accreditation of Healthcare Organization (JCAHO) for that health area.

- | | |
|--|--|
| ☐ JCAHO accredited Sub-Acute Program | ☐ JCAHO accredited Dementia Special Care Unit |
| ☐ JCAHO accredited Long Term Care Program | |

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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 [59A-4](#), 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 Compliance with Patient Trust Bond Requirements*
 - *Carrier is required*
 - *Policy number is required*
 - *Aggregate policy amount is required*
 - *Effective date is required*
 - *Expiry date 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 Professional 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.*
- *Copy of Visitation Policy and Procedure*
 - *Upload document is required/check the document mailed checkbox.*
- *Fire Safety Inspection Report*
 - *Upload document is required/check the document mailed checkbox.*
- *Financial Ability to Operate*
 - *Upload document is required/check the document mailed checkbox.*

Proof of Compliance with Patient Trust Bond Requirements

Carrier

Policy #

Effective Date

Expiry Date

Policy Amount

- ☐ An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Proof of General Liability Insurance Coverage

Carrier

Policy #

Effective Date

Expiry Date

Aggregate Policy Amount

Occurrence Policy Amount

- ☐ An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Proof of Professional Liability Insurance Coverage

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Copy of Visitation Policy and Procedure

- ☐ An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Fire Safety Inspection Report

☐ An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Financial Ability to Operate

☐ An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Plan for Quality Assurance and for Conducting Risk Management

☐ An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Documentation signed by the appropriate local government official, which states that the applicant has met zoning requirements

☐ An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Civil Verdict Documentation

☐ An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Surety of Continuation Bond

☐ An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Medicaid Lease Bond

- ☐ An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Browse...

Required Disclosures Related to Actions Taken by Medicare, Medicaid, or CLIA ?

- ☐ An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Browse...

Facility Ownership/Lease Documentation

- ☐ An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Browse...

Approved Repayment Plan

- ☐ An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Browse...

Additional Documentation

- ☐ An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Browse...

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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. Property Ownership
 - c. Contact Person
- ✔ 2. Licensee Information
 - a. Licensee Details
- ✔ 3. Controlling Interests
 - a. Controlling Interests
- ✔ 4. 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. Financial/Ownership Actions
 - e. Civil Verdict
- ✔ 7. Bed Count
 - a. Bed Count
- ✔ 8. Consumer Information
 - a. Consumer Information
- ✔ 9. Supporting Documents
 - a. Supporting Documents

Select the Document Mailer link below, print the mailer, and include it with the documents you mail.

[Document Mailer](#)

Item	Document
1	Proof of Compliance with Patient Trust Bond Requirements
2	Proof of General Liability Insurance Coverage
3	Proof of Professional Liability Insurance Coverage
4	Copy of Visitation Policy and Procedure
5	Fire Safety Inspection Report
6	Financial Ability to Operate
7	Plan for Quality Assurance and for Conducting Risk Management
8	Documentation signed by the appropriate local government official, which states that the applicant has met zoning requirements
9	Civil Verdict Documentation
10	Surety of Continuation Bond
11	Medicaid Lease Bond
12	Required Disclosures Related to Actions Taken by Medicare, Medicaid, or CLIA
13	Facility Ownership/Lease Documentation
14	Approved Repayment Plan
15	Additional Documentation

I **AMY WILLIAMS**, 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 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 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.

AMY WILLIAMS

RECORDS SPECIALIST

12/09/2022

Signature of Licensee or Authorized Representative

Title

Date

☒ I agree

REMINDER

You have indicated that you will be mailing documents to the Agency.

☒ I agree

Download and print your document mailer if you have not yet done so.

[Document Mailer](#)

Biennial Licensure Fee and Other Amounts Due Upon Submission of Application

- The biennial licensure fee is \$112.50 per bed
- The biennial licensure fee for sheltered bed is \$100.50 per bed
- The biennial assessment fee is \$4.00 per bed, not to exceed \$1,000
- Other amounts due (fines, assessment, fees, etc.) will be detailed in the application

Selecting the 'Submit Application' you will no longer be able to make changes to your application.

Submit Application