Provider:
Home Health Agency

Provider Type:
Home Health Agency

File#:
License #:
Expires:

Application:
Type: Initial Licensure
Status: Unopened
Application Received Date:

= Entered
= Entry Required

- Provider/Facility Information
  - Details
  - Contact Person
- Licensee Information
- Controlling Interests
- Management Company Information
- Personnel
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Rule 59A-35.060, Florida Administrative Code

Provider/Facility Information

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.

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/Facility Information

License #

National Provider Identifier ☐ None ☐ Pending

Medicaid #

Medicare # (CMS CCN)

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

Home Health Agency

Provider/Facility Location Address

Edit Address

Provider Location Address

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

Telephone (___) ___-____

Ext

Email Address

☐ None

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Provider/Facility Information

Provider/Facility Contact Person for this Application

First Name | Middle Name | Last Name | Suffix

Telephone | Ext | Fax #

(___) ___-____ | | (___) ___-____

☐ None

Contact Email Address (By providing your email address, you agree to accept email correspondence from the Agency.)

☐ None

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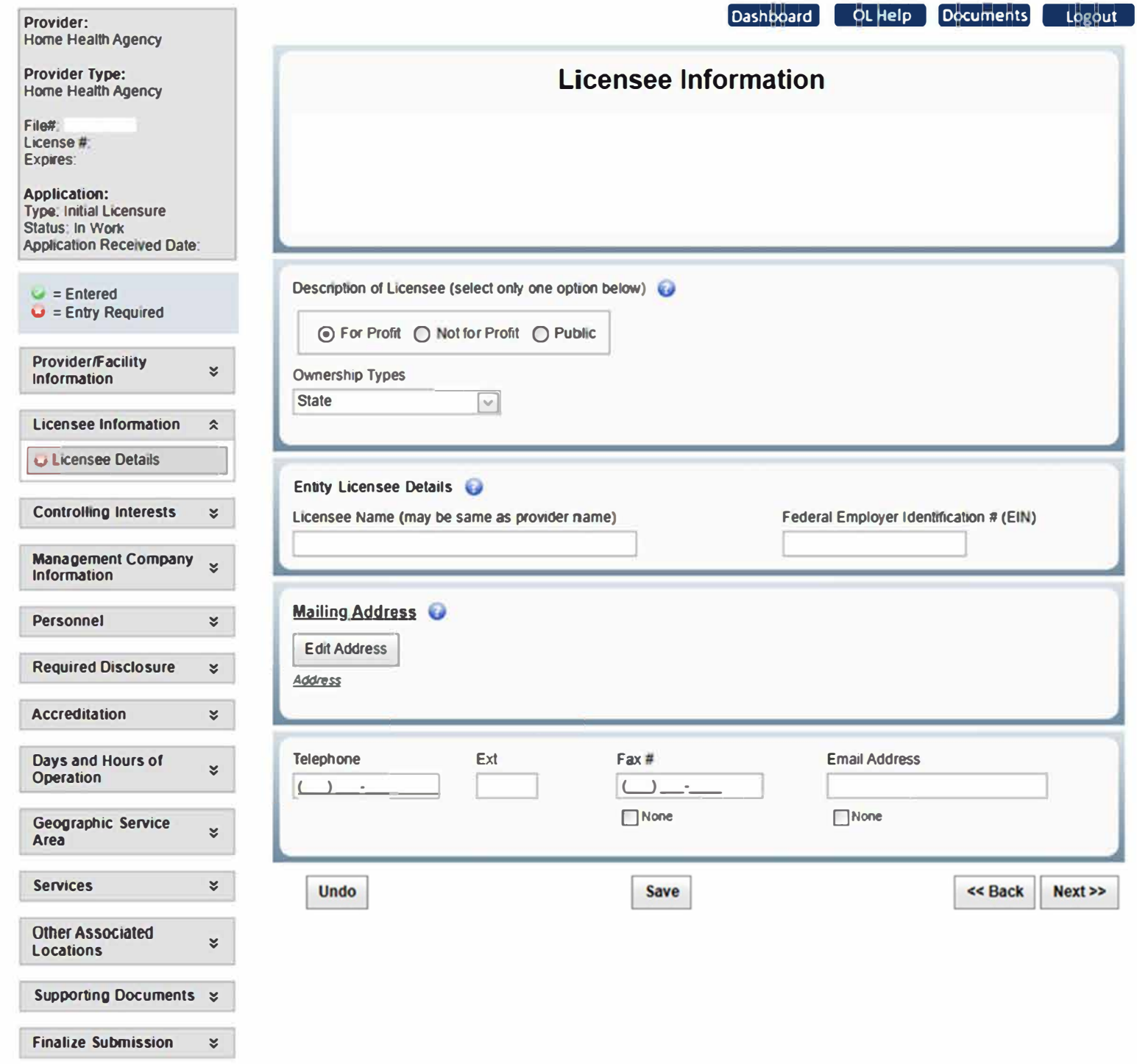

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Controlling Interests of Licensee

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?

◯ Yes ◯ No

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Management Company Information

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

○ Yes ○ No

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Management Company Controlling Interest

- *As previously indicated, there is no Management Company for this provider. No Management Company Controlling Interests are required.* ***Select "Next" to proceed to the next section.***

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  - Safety Liaison
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Personnel

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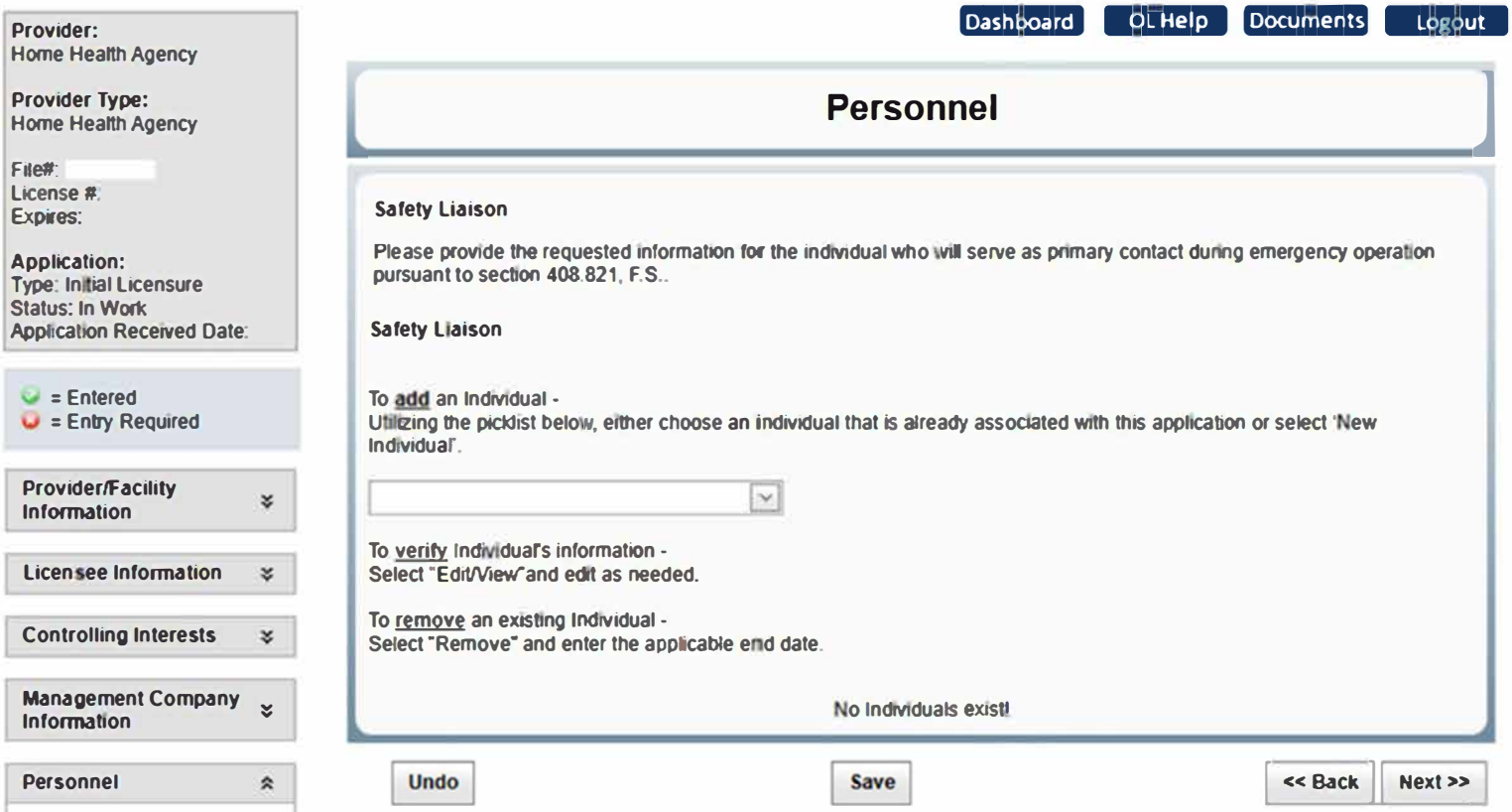
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Safety Liaison
Please provide the requested information for the individual who will serve as primary contact during emergency operation pursuant to section 408.821, F.S..
Safety Liaison
To add an individual -
Utilizing the picklist below, either choose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

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.?

○ Yes ○ No

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Required Disclosure

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) programs.

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?

○ Yes ○ No

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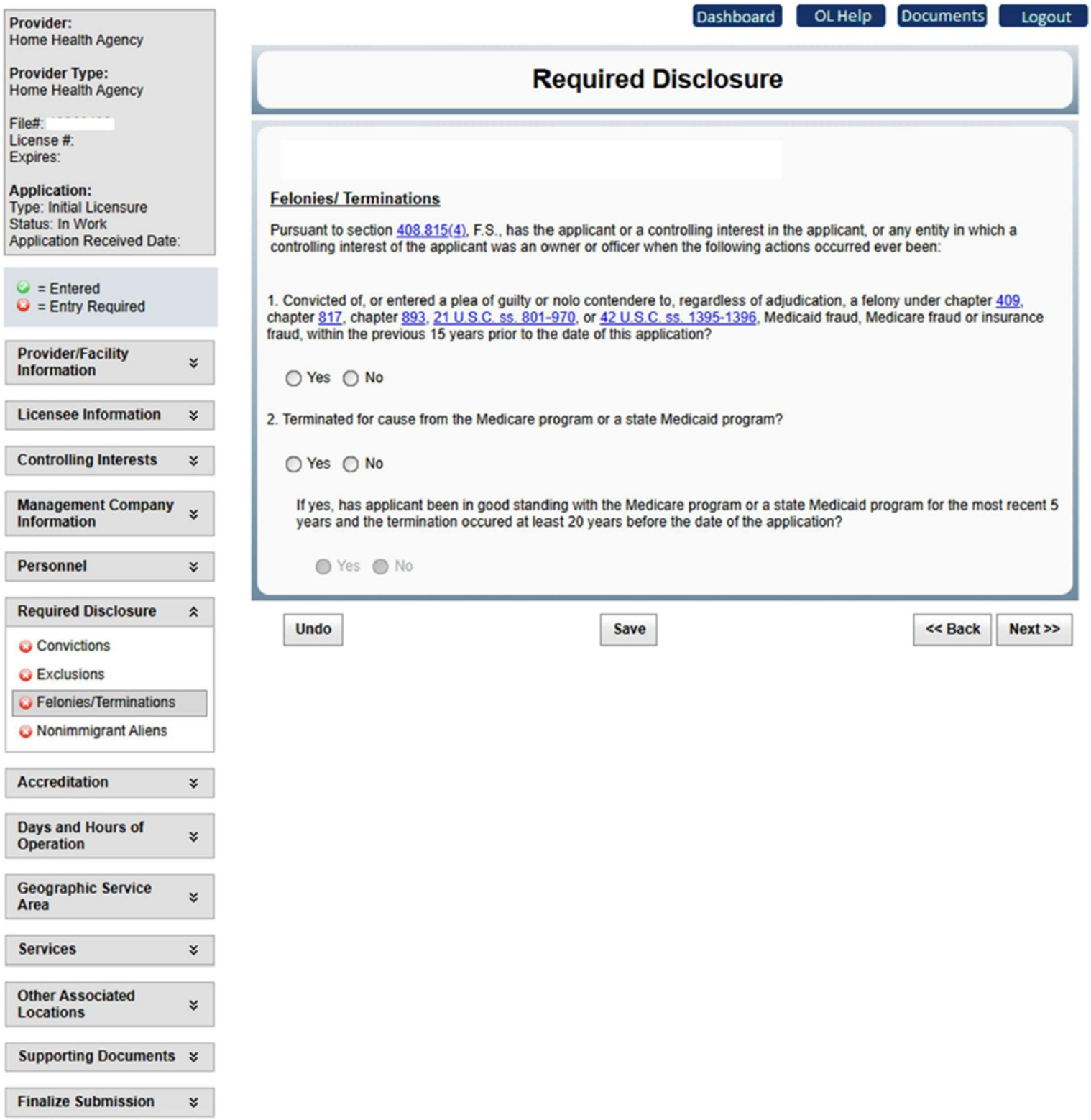
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Required Disclosure
Felonies/ Terminations
Pursuant to section 408.815(4), F.S., has the applicant or a controlling interest in the applicant, or any entity in which a controlling interest of the applicant was an owner or officer when the following actions occurred ever been:
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
2. 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
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Required Disclosure

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 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?

○ Yes ○ No

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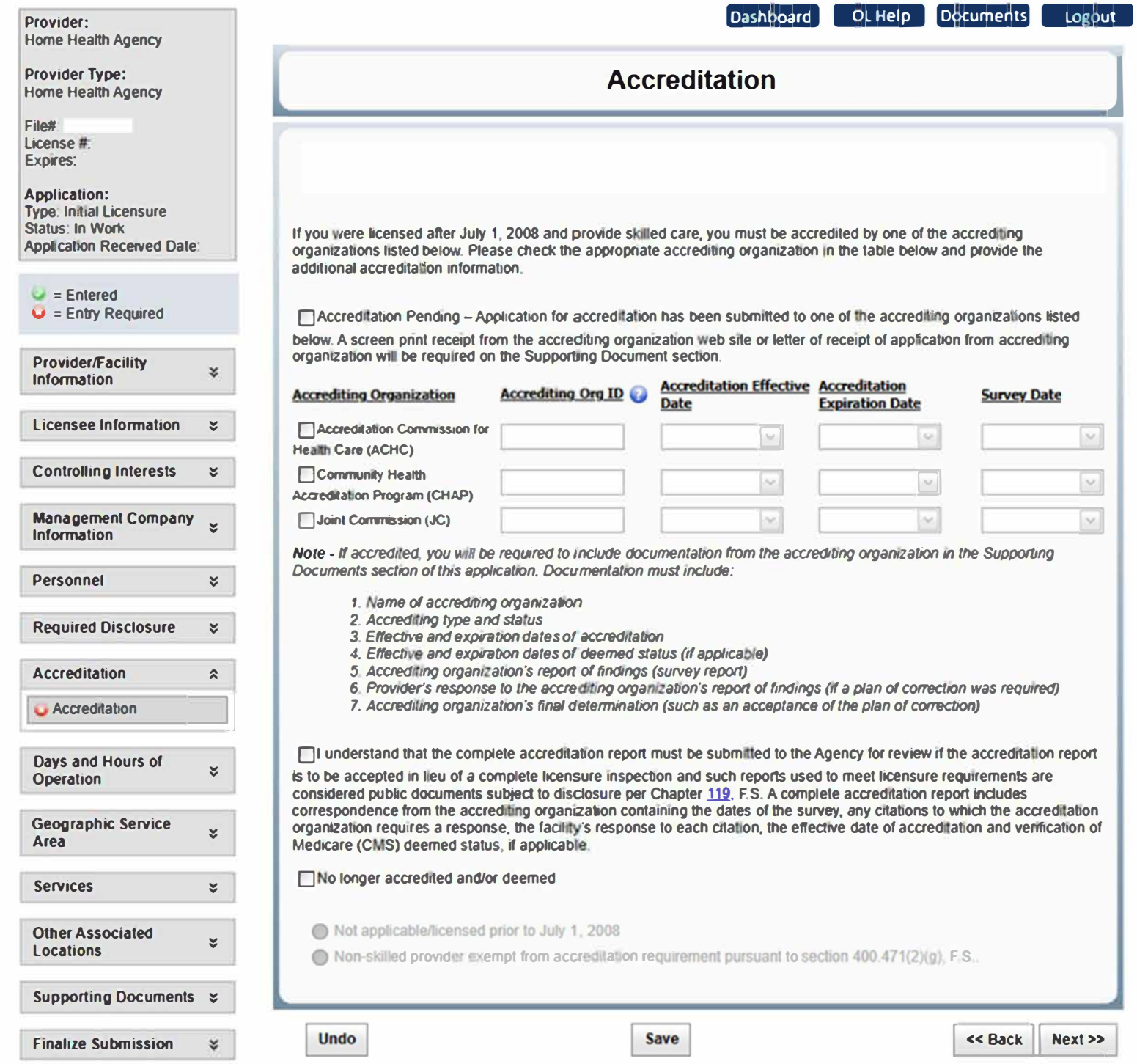
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Accreditation
If you were licensed after July 1, 2008 and provide skilled care, you must be accredited by one of the accrediting organizations listed below. Please check the appropriate accrediting organization in the table below and provide the additional accreditation information.
Accreditation Pending – Application for accreditation has been submitted to one of the accrediting organizations listed below. A screen print receipt from the accrediting organization web site or letter of receipt of application from accrediting organization will be required on the Supporting Document section.
Accrediting Organization
Accrediting Org ID
Accreditation Effective Date
Accreditation Expiration Date
Survey Date
Accreditation Commission for Health Care (ACHC)
Community Health Accreditation Program (CHAP)
Joint Commission (JC)
Note - If accredited, you will be required to include documentation from the accrediting organization in the Supporting Documents section of this application. Documentation must include:
1. Name of accrediting organization
2. Accrediting type and status
3. Effective and expiration dates of accreditation
4. Effective and expiration dates of deemed status (if applicable)
5. Accrediting organization's report of findings (survey report)
6. Provider's response to the accrediting organization's report of findings (if a plan of correction was required)
7. Accrediting organization's final determination (such as an acceptance of the plan of correction)
I understand that the complete accreditation report must be submitted to the Agency for review if the accreditation 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 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.
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.
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Days and Hours of Operation

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).

Day	Opening Time	Closing Time	By Appointment
MONDAY			
TUESDAY			
WEDNESDAY			
THURSDAY			
FRIDAY			
SATURDAY			☐
SUNDAY			☐

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Geographic Service Area

Indicate each county this business location will serve by selecting the appropriate checkboxes below. For your reference, a list of counties by geographical service areas is provided at the bottom of the page.

Note - This license covers only one office location. Each additional office must be separately licensed.

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	☐ SAINT JOHNS
☐ SAINT LUCIE	☐ SANTA ROSA	☐ SARASOTA	☐ SEMINOLE	☐ SUMTER
☐ SUWANNEE	☐ TAYLOR	☐ UNION	☐ VOLUSIA	☐ WAKULLA
☐ WALTON	☐ WASHINGTON			

Area 1:	Escambia, Okaloosa, Santa Rosa, Walton
Area 2:	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, Manon, 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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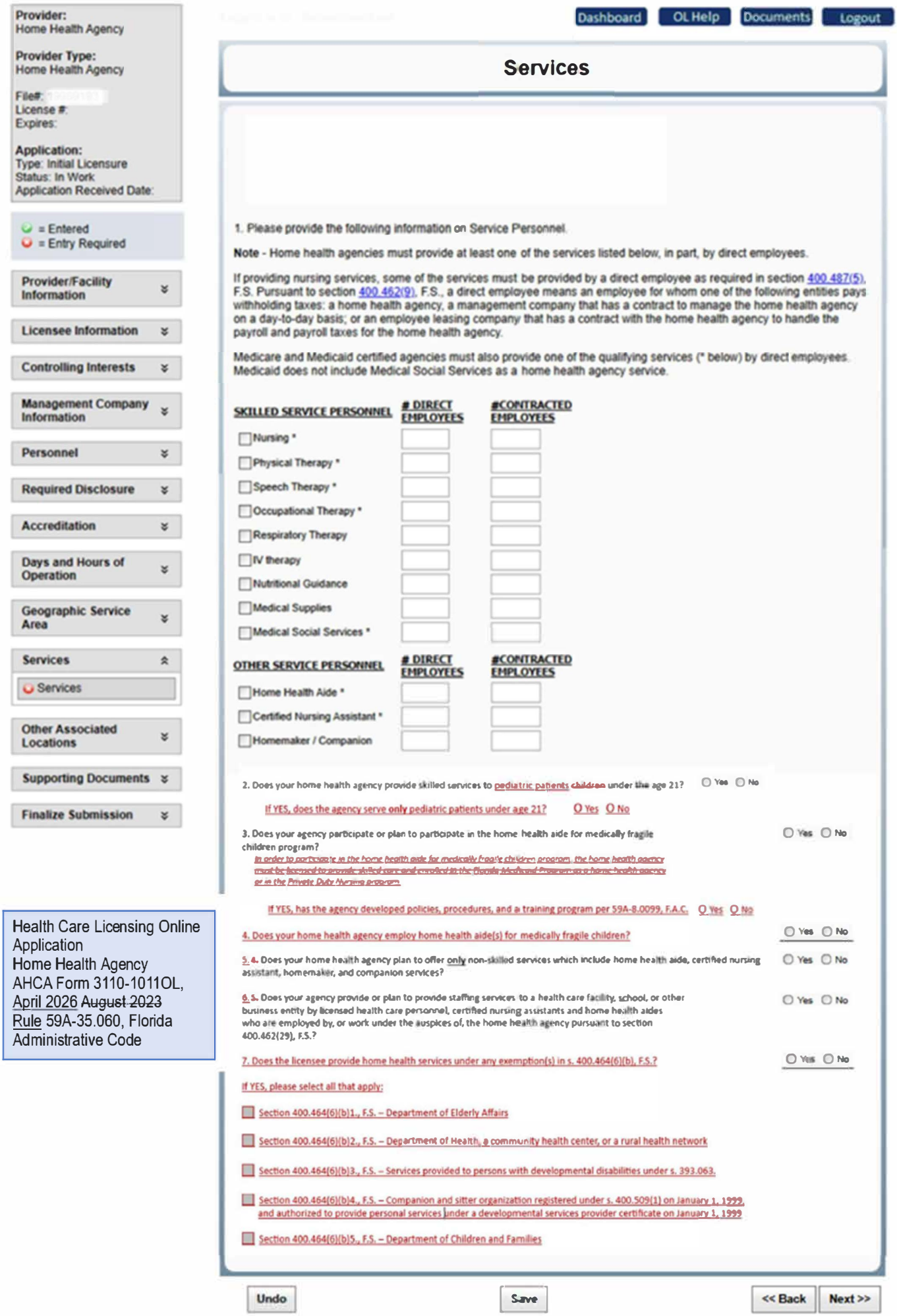
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1. Please provide the following information on Service Personnel.
Note - Home health agencies must provide at least one of the services listed below, in part, by direct employees.
If providing nursing services, some of the services must be provided by a direct employee as required in section 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
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 agency provide skilled services to pediatric patients children under the age 21? Yes No
If YES, does the agency serve only pediatric patients under age 21? Yes No
3. Does your agency participate or plan to participate in the home health aide for medically fragile children program? Yes No
In order to participate in the home health aide for medically fragile children program, the home health agency must be licensed to provide skilled nursing and enrolled in the Florida Medicaid Program as a home health agency or in the Private Duty Nursing program.
If YES, has the agency developed policies, procedures, and a training program per 59A-8.0099, F.A.C. Yes No
4. Does your home health agency employ home health aide(s) for medically fragile children? Yes No
5. 4. 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
6. 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 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
7. Does the licensee provide home health services under any exemption(s) in s. 400.464(6)(b), F.S.? Yes No
If YES, please select all that apply:
Section 400.464(6)(b)1., F.S. – Department of Elderly Affairs
Section 400.464(6)(b)2., F.S. – Department of Health, a community health center, or a rural health network
Section 400.464(6)(b)3., F.S. – Services provided to persons with developmental disabilities under s. 393.063.
Section 400.464(6)(b)4., F.S. – Companion and sitter organization registered under s. 400.509(1) on January 1, 1999, and authorized to provide personal services under a developmental services provider certificate on January 1, 1999
Section 400.464(6)(b)5., F.S. – Department of Children and Families
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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 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		
☐ 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 agency provide skilled services to pediatric patients children under the age 21? ○ Yes ○ No

If YES, does the agency serve only pediatric patients under age 21? ○ Yes ○ No

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

In order to participate in the home health aide for medically fragile children program, the home health agency must be licensed to provide skilled care and enrolled in the Florida Medicaid Program as a home health agency or in the Private Duty Nursing program.

If YES, has the agency developed policies, procedures, and a training program per 59A-8.0099, F.A.C. ○ Yes ○ No

4. Does your home health agency employ home health aide(s) for medically fragile children? ○ Yes ○ No

5. ~~4.~~ 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

6. ~~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 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

7. Does the licensee provide home health services under any exemption(s) in s. 400.464(6)(b), F.S.? ○ Yes ○ No

If YES, please select all that apply:

☐ Section 400.464(6)(b)1., F.S. – Department of Elderly Affairs

☐ Section 400.464(6)(b)2., F.S. – Department of Health, a community health center, or a rural health network

☐ Section 400.464(6)(b)3., F.S. – Services provided to persons with developmental disabilities under s. 393.063

☐ Section 400.464(6)(b)4., F.S. – Companion and sitter organization registered under s. 400.509(1) on January 1, 1999, and authorized to provide personal services under a developmental services provider certificate on January 1, 1999

☐ Section 400.464(6)(b)5., F.S. – Department of Children and Families

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Health Care Licensing Online Application
Home Health Agency
AHCA Form 3110-1011OL, April 2026 ~~August 2023~~
Rule 59A-35.060, Florida Administrative Code

Provider:
Home Health Agency

Provider Type:
Home Health Agency

File#:
License #:
Expires:

Application:
Type: Initial Licensure
Status: In Work
Application Received Date:

= Entered
= Entry Required

- Provider/Facility Information
- Licensee Information
- Controlling Interests
- Management Company Information
- Personnel
- Required Disclosure
- Accreditation
- Days and Hours of Operation
- Geographic Service Area
- Services
- Other Associated Locations
  - Other Associated Locations
- Supporting Documents
- Finalize Submission

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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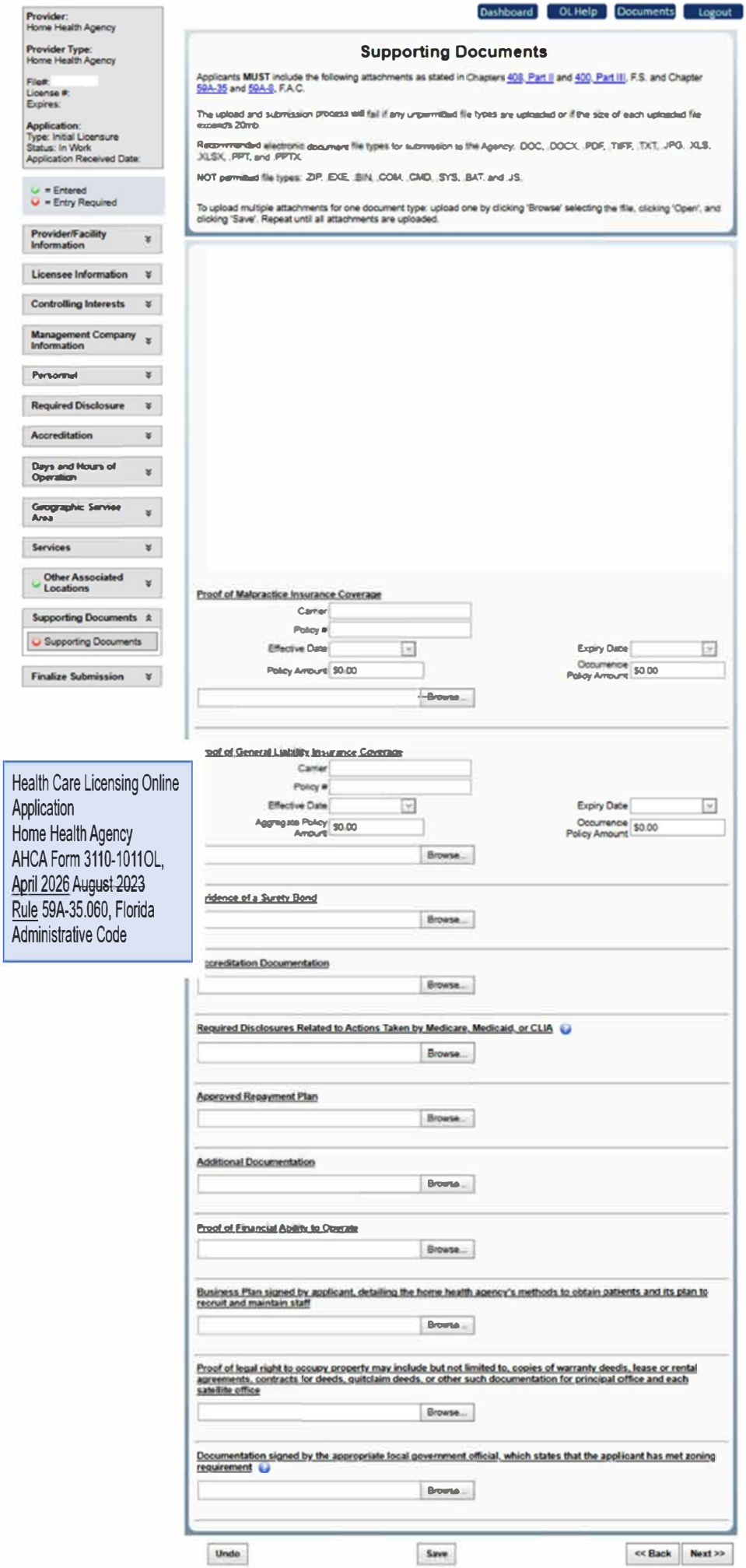

Provider:
Home Health Agency

Provider Type:
Home Health Agency

File#:
License #:
Expires:

Application:
Type: Initial Licensure
Status: In Work
Application Received Date:

= Entered
= Entry Required

Provider/Facility Information
Licensee Information
Controlling Interests
Management Company Information
Personnel
Required Disclosure
Accreditation
Days and Hours of Operation
Geographic Service Area
Services
Other Associated Locations
Supporting Documents
Supporting Documents
Finalize Submission

Dashboard | OL Help | Documents | Logout

Supporting Documents

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

The upload and submission process will fail if any unpermitted file types are uploaded or if the size of each uploaded file exceeds 20mb.

Recommended electronic document file types for submission to the Agency: .DOC, .DOCX, .PDF, .TIFF, .TXT, .JPG, .XLS, .XLSX, .PPT, and .PPTX.

NOT permitted file types: .ZIP, .EXE, .BIN, .COM, .CMD, .SYS, .BAT, and .JS.

To upload multiple attachments for one document type: upload one by clicking 'Browse' selecting the file, clicking 'Open', and clicking 'Save'. Repeat until all attachments are uploaded.

Proof of Malpractice Insurance Coverage

Carrier
Policy #
Effective Date
Expiry Date
Policy Amount $0.00
Occurrence Policy Amount $0.00
Browse...

oof of General Liability Insurance Coverage

Carrier
Policy #
Effective Date
Expiry Date
Aggregate Policy Amount $0.00
Occurrence Policy Amount $0.00
Browse...

idence of a Surety Bond

Browse...

creditation Documentation

Browse...

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

Browse...

Approved Repayment Plan

Browse...

Additional Documentation

Browse...

Proof of Financial Ability to Operate

Browse...

Business Plan signed by applicant, detailing the home health agency's methods to obtain patients and its plan to recruit and maintain staff

Browse...

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

Browse...

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

Browse...

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Health Care Licensing Online Application
Home Health Agency
AHCA Form 3110-1011OL, April 2026 ~~August 2023~~
Rule 59A-35.060, Florida Administrative Code

Provider:
Home Health Agency

Provider Type:
Home Health Agency

File#:
License #
Expires:

Application:
Type: Initial Licensure
Status: In Work
Application Received Date:

= Entered
= Entry Required

- Provider/Facility Information
- Licensee Information
- Controlling Interests
- Management Company Information
- Personnel
- Required Disclosure
- Accreditation
- Days and Hours of Operation
- Geographic Service Area
- Services
- Other Associated Locations
- Supporting Documents
- Finalize Submission
  - Finalize Application

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
4. Management Company Information
   a. Management Company Information
   b. Management Company Controlling Interest
5. Personnel
   a. Administrator
   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 _____, 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.

(7) Pursuant to sections 408.810(14) and 408.051(3), Florida Statutes, 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), Florida Statutes, 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, Florida Statutes.

Signature of Licensee or Authorized Representative | Title | Date

☐ I agree

Biennial Licensure Fee and Other Amounts Due Upon Submission of Application

- 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 application

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

Submit Application