



AHCA USE ONLY:

File #: _____
 Application #: _____
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Health Care Licensing Application

Adult Family Care Home

The Agency for Health Care Administration (AHCA) has implemented the **ONLINE LICENSING SYSTEM**, which allows the electronic submission of renewal and change during licensure period applications and fees, along with the ability to upload supporting documentation. To submit online please go to: <https://ahca.myflorida.com/health-care-policy-and-oversight/online-licensure-information/online-licensing-system>

Applications must be received **at least 60 days prior** to the expiration of the current license. If the renewal application is received by the Agency less than 60 days prior to the expiration date, it is subject to a late fee as set forth in statute. The application will be withdrawn from review if all the required documents and fees are not included with your application or received within 21 days of an omission notice. **Applications will not be considered for review until payment has been received.** **Renewal and Change During Licensure Period applications: Supporting documentation, responses to omissions and payments may be submitted using the online licensing system even if the application was originally mailed to the Agency.** Please fill in all blanks or mark N/A if not applicable.

Under the authority of Chapters 408 Part II and 429, Part II, Florida Statutes (F.S.) and Chapter 59A-37, Florida Administrative Code (F.A.C.), an application is hereby made to operate an adult family care home as indicated below:

1. Provider / Licensee Information

Note: Pursuant to section 429.67(2) F.S., any person who intends to be an Adult Family Care Home provider must live within the Adult Family Care Home that is to be licensed. Does the applicant live in the Adult Family Care Home to be licensed? YES
 NO If **NO**, you are **not eligible** to be licensed as an Adult Family Care Home.

A. PROVIDER INFORMATION – Please complete the following for the Adult Family Care Home name and location. Provider name, address and telephone number will be listed on <https://quality.healthfinder.fl.gov/index.html>

License Number (if applicable)	National Provider Identifier (NPI) (if applicable)	Medicare Number (CMS CCN)	Florida Medicaid Number
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Name of Applicant/Licensee _____

Street Address _____

City	County	State	Zip
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Telephone Number	Fax Number
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Provider Website _____ **Note:** By providing your e-mail address, you agree to accept e-mail correspondence from the Agency.

Mailing Address or Same as above _____

City	County	State	Zip
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Telephone Number	E-mail Address
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B. PROPERTY OWNER INFORMATION – Complete the following for the owner of the property if different from the licensee.

Does an individual or entity other than the licensee own the property where the principal office is located?

If NO, skip to **Section 1.C. – Contact Person**

If YES, please provide the following information:

Full Name of Property Owner		
<input type="checkbox"/> Owned	<input type="checkbox"/> Leased	Telephone Number
Primary Address		Effective Date

C. CONTACT PERSON – Please complete the following for the contact person for this application.

Contact Person for this application	Contact Telephone Number
Contact e-mail address or <input type="checkbox"/> Do not have e-mail	Note: By providing your e-mail address, you agree to accept e-mail correspondence from the Agency.

D. LICENSEE INFORMATION – Please complete the following for the entity seeking to operate the adult family care home.

Licensee Name		Federal Employer Identification Number (EIN) if applicable	
Mailing Address or <input type="checkbox"/> Same as above			
City		State	Zip
Telephone Number	Fax Number	E-mail Address	
Description of Licensee (check one):			
<input type="checkbox"/> For Profit <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Other			

2. Application Type and Fees

Indicate the type of application with an "X." **Applications will not be processed if not all applicable fees are included. Pursuant to section 408.805(4), F.S., fees are nonrefundable.** Renewal and Change of Address applications must be received 60 days prior to the expiration of the license or the proposed effective date of the change to avoid a late fine. If the renewal application is received by the Agency less than 60 days prior to the expiration date, it is subject to a late fee as set forth in statute. The applicant will receive notice of the amount of the late fee as part of the application process or by separate notice.

TYPE OF APPLICATION:

- Initial Licensure
 Renewal Licensure
 Change during licensure period (check all that apply):

Proposed Effective Date: _____

Fee Required

- Provider Name
 Provider Address

Proposed Effective Date: _____

No Fee Required

- Personnel Change

Beds/Capacity:

- Increase Decrease

ACTION	FEE	TOTAL FEES
License Fee (Initial or Renewal):	\$226.34	\$
Change During Licensure Period	\$25.00	\$
TOTAL FEES INCLUDED WITH APPLICATION		\$
Please make check or money order payable to the Agency for Health Care Administration (AHCA)		

3. Personnel

A. Administration – Provide the requested information for the individual(s) who perform each of the following required roles.

Note: For the provider and financial officer an AHCA screening through the Care Provider Background Screening Clearinghouse is needed or the Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, if background screening was conducted by the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S. To verify who is to be screened, visit [Background Screening \(myflorida.com\)](https://myflorida.com).

INSTRUCTIONS: Attach additional application pages if needed.

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

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

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

INFORMATION	APPLICANT/PROVIDER (person responsible for day-to-day operation)	FINANCIAL OFFICER (person responsible for financial operation)
Full Name		
Effective Date		
End Date		
FL Professional License Nbr, if any		
Telephone Number		
Email Address		
Personal/Primary Address		

B. Other Personnel – Provide the requested information for the individual(s) who perform the following required roles:

INFORMATION	DESIGNATED RELIEF PERSON (Must have at least one)	DESIGNATED RELIEF PERSON
Full Legal Name		
Effective Date		
End Date		
FL Professional License Nbr , if any		
Telephone Number		
Email Address		
Personal/Primary Address		

INFORMATION	STAFF PERSON	STAFF PERSON
Full Legal Name		
Effective Date		
End Date		
FL Professional License Nbr , if any		
Telephone Number		
Email Address		
Personal/Primary Address		

INFORMATION	ADULT HOUSEHOLD MEMBER*	ADULT HOUSEHOLD MEMBER*
Full Legal Name		
Effective Date		
Telephone Number		
Email Address		
Personal/Primary Address		

*Note: Adult household member means the provider and any person, 18 years of age or older, who is permanently or regularly present in the home for more than a few hours at a time. A person shall be considered a household member even though the person has another residence if the person is in a position of familial authority or perceived familial authority.

4. Required Disclosure

The following disclosures are required:

- A. Pursuant to section 408.809, F.S., the applicant shall submit to the agency a description and explanation of any convictions of offenses prohibited by sections 435.04 and 408.809(4), F.S., for each controlling interest.

Has the applicant or any individual listed in Sections 3 and 4 of this application been convicted of any level 2 offense pursuant to section 408.809, F.S.? YES NO

If YES, provide the following information:

- The full legal name of the individual
 The position held

- B. Pursuant to section 408.810(2), F.S., the applicant must provide a description and explanation of any exclusions, suspensions, or terminations from the Medicare, Medicaid, or federal Clinical Laboratory Improvement Amendment (CLIA) programs.

Has the applicant or any individual listed in sections 3 and 4 of this application been excluded, suspended, terminated or involuntarily withdrawn from participation in Medicare or Medicaid in any state? YES NO

If YES, enclose the following information:

- The full legal name of the individual (and the position held) or the entity
 A description/explanation of the exclusion, suspension, termination or involuntary withdrawal.

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

Convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, Chapter 817, Chapter 893, 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396, Medicaid fraud, Medicare fraud, or insurance fraud, within the previous 15 years prior to the date of this application? YES NO

Terminated for cause from the Medicare program or a state Medicaid program? YES NO

If YES, has applicant been in good standing with the Medicare program or a state Medicaid program for the most recent five (5) years and the termination occurred at least twenty (20) years before the date of the application. YES NO

D. In the past five (5) years, has the applicant or any controlling interest owned any entity that provides health or residential care in Florida or any other state? YES NO

If YES: Has any entity the applicant or controlling interest owned been closed due to financial inability to operate; had a receiver appointed or a license denied, suspended, or revoked; was subject to a moratorium; or had an injunctive proceeding initiated against it: YES NO

5. Provider Fines and Financial Information

Pursuant to section 408.831(1)(a), F.S., the Agency may take action against the applicant, licensee, or a licensee which shares a common controlling interest with the applicant if they have failed to pay all outstanding fines, liens, or overpayments assessed by final order of the agency or final order of the Centers for Medicare and Medicaid Services (CMS), not subject to further appeal, unless a repayment plan is approved by the agency.

Are there any incidences of outstanding fines, liens or overpayments as described above? YES NO

If YES, please complete the following for each incidence (attach additional sheets if necessary):

AHCA CASE NUMBER	CMS	ASSESSED AMOUNT	DATE OF RELATED INSPECTION, APPLICATION, OR OVERPAYMENT	PAYMENT DUE DATE	PENDING APPEAL OF FINAL ORDER	
					YES	NO
	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>

Please attach a copy of the approved repayment plan if applicable.

6. Number of Resident Beds

Total number of resident beds (1 to 5) for which you are applying? _____

OSS Beds + Private Beds = total Beds (Total number can not exceed 5)

Note: Each AFCH must have at least one licensed bed designated for an OSS (optional state supplementation) recipient. Pursuant to section 429.67(8), F.S., adult foster homes or assisted living facilities that are converting to an AFCH that were licensed prior to January 1, 1994 are exempt from this requirement.

7. Supporting Documents

Applicants must include the following attachments as stated in Chapters 408, Part II and 429, Part II, F.S. and Chapters 59A-35 and 59A-37, Florida Administrative Code (F.A.C.). **Note: Required documents listed below are dependent on the type of application submitted. (Initial, Renewal, Change During Licensure Period)**

Documents to be Provided:	Required For:
Fire safety inspection report	Initial, Renewal, Change of Address and Capacity Increase application types
Documentation proving compliance with the community residential homes site selection requirements specified pursuant to Chapter 419, F.S., if applicable	Initial, Change of Address and Capacity Increase application types
Department of Health residential group care inspection report	Initial, Renewal, Change of Address and Change during licensure period application types
Proof of property occupancy, examples: lease and/or mortgage	Initial and Renewal application types
Income and Expenses Report , AHCA Form 3180-1017	Initial application types
Documentation from the appropriate local government office showing that the applicant has met local zoning requirements	Initial, Change of Address and Capacity Change during Licensure period application types
Documentation of homestead exemption or, lease or rental agreement accompanied by a corresponding utility bill and telephone bill, or personal identification issued by a state or federal agency	Initial and Change of Address
Health Care Licensing Application Addendum, AHCA Form 3110-1024	Initial, Renewal and Change of Address application types
Required disclosures related to actions taken by Medicare, Medicaid or CLIA, if applicable	All application types , if documentation is required due to responses provided in application
Approved repayment plan, if applicable	All application types

8. Attestation

I, _____, attest as follows:

- (1) Pursuant to section 837.06, Florida Statutes, I have not knowingly made a false statement with the intent to mislead the Agency in the performance of its official duty.
- (2) Pursuant to section 408.815, Florida Statutes, I acknowledge that false representation of a material fact in the license application or omission of any material fact from the license application by a controlling interest may be used by the Agency for denying and revoking a license or change of ownership application.
- (3) Pursuant to section 408.806, Florida Statutes, under the penalty of perjury, the applicant is in compliance with the provisions of Section 408.806 and Chapter 435, Florida Statutes.
- (4) Pursuant to sections 408.809 and 435.05, Florida Statutes, every employee of the applicant required to be screened has attested, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to Chapter 408, Part II, and Chapter 435, Florida Statutes, and has agreed to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer.
- (5) Pursuant to section 435.05, Florida Statutes, the applicant has conducted a level 2 background screening through the Agency on every employee required to be screened under Chapter 408, Part II, or Chapter 435, Florida Statutes, as a condition of employment and continued employment and that every such employee has satisfied the level 2 background screening standards or obtained an exemption from disqualification from employment.
- (6) Pursuant to section 408.810(12), Florida Statutes, the licensee ensures that no person holds any ownership interests, either directly or indirectly, regardless of ownership structure; who has a disqualifying offense pursuant to section 408.809, Florida Statutes or in a provider that had a license revoked or application denied pursuant to section 408.815, Florida Statutes.

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

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

Signature of Licensee or Authorized Representative

Title

Date

NOTICE: If you are a **Medicaid** provider, you may have a separate obligation to notify the Medicaid program of a name/address change, change of ownership or other change of information. Please refer to your Medicaid handbooks for additional information about Medicaid program policy regarding changes to provider enrollment information.

The Agency for Health Care Administration scans all documents for electronic storage. In an effort to facilitate this process, we ask that you please remember to:

- Please place checks or money orders on top of the application
- Include license number or case number on your check
- Do not submit carbon copies of documents
- Do not fold any of the documents being submitted
- No staples, paperclips, binder clips, folders, or notebooks
- Please **do not bind any** of the documents submitted to the Agency.

RETURN THIS COMPLETED FORM WITH FEES TO:

AGENCY FOR HEALTH CARE ADMINISTRATION
ASSISTED LIVING UNIT
2727 MAHAN DR., MS 30
TALLAHASSEE FL 32308-5407

Questions? Visit the Agency's website: <https://ahca.myflorida.com/> or contact the Assisted Living Unit at (850) 412-4304 or Email: assistedliving@ahca.myflorida.com