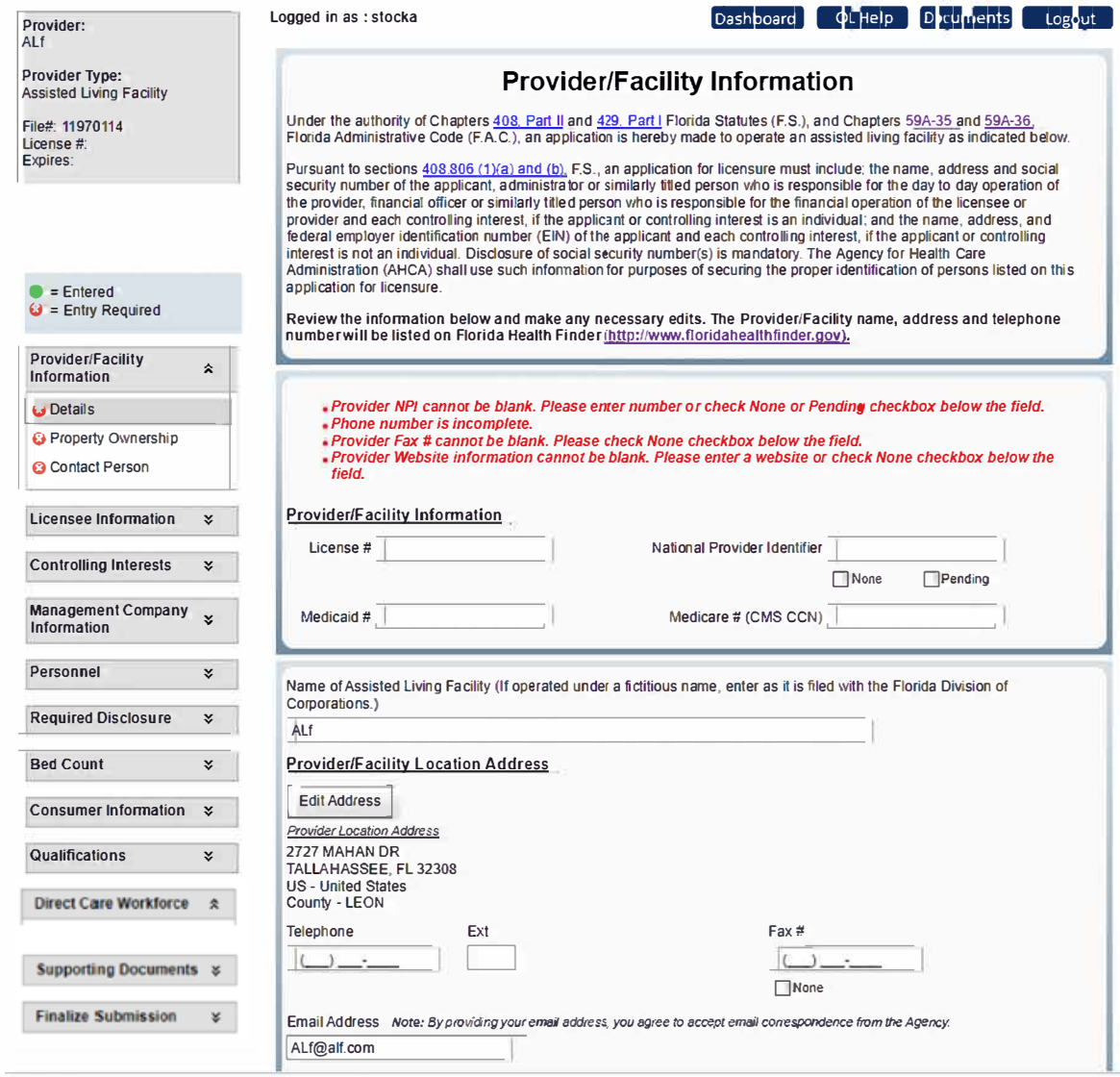
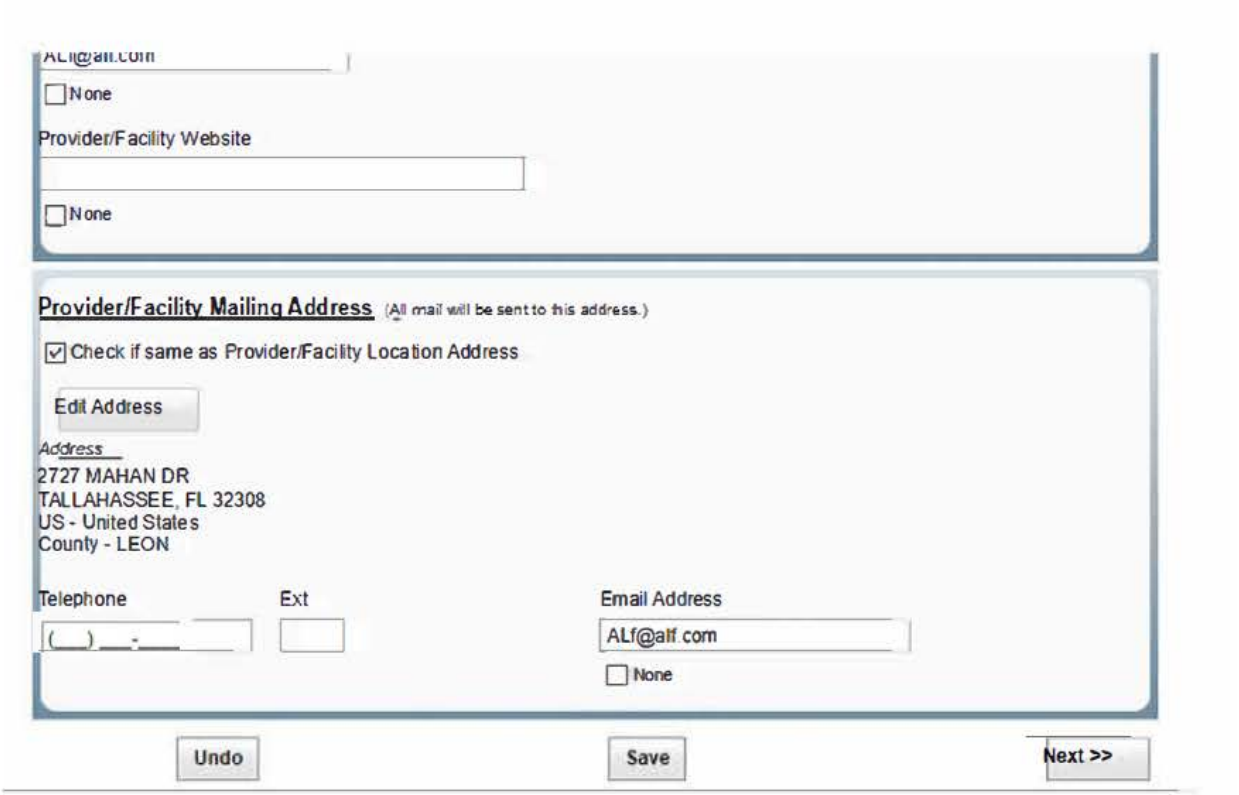


Health Care Licensing Online Application
Assisted Living Facilities
AHCA Form 3110-1008OL, August 2023
59A-35.060, Florida Administrative Code


ALf@alf.com
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
2727 MAHAN DR
TALLAHASSEE, FL 32308
US - United States
County - LEON
Telephone
Ext
Email Address
ALf@alf.com
None
Undo
Save
Next >>

Property Ownership

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

- *Select a property ownership type.*

Does the licensee own or lease this facility? If leased, provide the name of the property owner by following the instructions below.

- ◯ Own
- ◯ Lease

Undo | Save | << Back | Next >>

Provider/Facility Information

- *Contact first name must not be blank.*
- *Contact last name must not be blank.*
- *Phone number is incomplete.*
- *If there is no Fax # please check the None check box below it.*
- *If there is no Email address please check the None check box below it.*

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

Undo | Save | << Back | Next >>

Licensee Information

- *Individual 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 one option below)

(•) For Profit ( ) Not for Profit ( ) Public

Ownership Types

Individual

Individual Licensee Details

Licensee Name

First Name | Middle Name | Last Name | Suffix

Tax ID | Type

Mailing Address

Edit Address

Address

Telephone | Ext | Fax # | Email Address

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

[ ] None | [ ] None

Undo | Save | << Back | Next >>

Controlling Interests of Licensee

- *You have selected 'Individual' as the licensee's ownership type. Therefore, you are unable to add Controlling Interests. Select 'Next' to proceed.*

Undo | Save | << Back | Next >>

Management Company Information

- *You have selected 'Individual' as the licensee's ownership type. Therefore, you are unable to add a Management Company. Select 'Next' to proceed.*

Undo | Save | << Back | Next >>

Management Company Controlling Interest

- *There is no Management Company associated with this application. Therefore, you are unable to add Management Company Controlling Interests. Select "Next" to proceed.*

Undo | Save | << Back | Next >>

Personnel

- *One Administrator / Managing Employee should be entered for this application.*
- *One Financial Officer should be entered for this application.*

Personnel

Note: The administrator and financial officer 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 / Managing Employee
- Financial Officer

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!

Undo | Save | << Back | Next >>

Personnel

B. 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!

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.?

◯ Yes ◯ No

Undo | Save | << Back | Next >>

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) 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

Undo | Save | << Back | Next >>

Required Disclosure

- *All questions related to Felonies/Terminations must be answered.*

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

Undo | Save | << Back | Next >>

Required Disclosure

- *Either Yes or No must be selected.*

Health and Residential Care

In the past 5 years, has the applicant or any controlling interest owned any entity that provided 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

Undo | Save | << Back | Next >>

Required Disclosure

- *Either Yes or No must be selected for all questions.*

Miscellaneous

Provide the following information for the requested positions:

1. Does the owner, administrator, or any facility representative serve as 'representative payee' or as power of attorney for any Assisted Living Facility residents?

Representative Payee is an individual or entity who receives payments on behalf of a resident (i.e., social security benefits, supplemental social security, or optional state supplementation). A resident must give consent for an owner, administrator, or facility representative to act as their representative payee or power of attorney.

If yes, provide a copy of the Surety Bond in the Supporting Documents section of this application.

◯ Yes ◯ No

2. Is the Assisted Living Facility a part of a continuing care retirement community (CCRC) pursuant to Chapter 651, F.S.?

If yes, attach a copy of your Certificate of Authority in the Supporting Documents section of this application.

◯ Yes ◯ No

3. Does the Assisted Living facility participate in Long Term Care, Managed Care, or MMA (Managed Medical Assistance).

If yes, provide your Medicaid number below.

◯ Yes ◯ No

Medicaid # _____

4. Do you offer or do you plan to offer adult day care services in your assisted living facility?

◯ Yes ◯ No

Undo | Save | << Back | Next >>

Bed Count

- *There must be at least one Private Pay or OSS bed.*

Enter/Verify the number of beds by bed type below.

# Private Pay Beds	
# OSS Beds	
TOTAL CAPACITY	0

Undo | Save | << Back | Next >>

Consumer Information

The following information is provided for consumers through the Florida Health Finder website.

Review the information below and make any necessary edits.

Room Type

Occupancy

Semi-Private Beds

Private Beds

Bed Hold? Yes No

Payment Forms Accepted

- Insurance/ HMO
- CHAMPUS
- Medicare
- Medicaid
- Veterans Administration
- Workers Comp
- Other

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

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

Special Programs - A checked box indicates that the programs are provided at this facility and staff meet the necessary requirements

- [ ] Arts and Crafts
- [ ] Cooking Classes
- [ ] Dancing
- [ ] Exercise Class
- [ ] Games/Cards
- [ ] Gardening
- [ ] Music Programs
- [ ] Shopping
- [ ] Social Events
- [ ] Theater & Movie
- [ ] Yoga
- [ ] Other

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

- [ ] Audiology
- [ ] Massage Therapy
- [ ] Memory Care
- [ ] Occupational Therapy
- [ ] Pet Therapy
- [ ] Physical Therapy
- [ ] Speech Therapy
- [ ] Water Therapy
- [ ] Other

Nurse Availability

- [ ] Direct 24hr
- [ ] Direct Part Time
- [ ] Third Party 24hr
- [ ] Third Party Part Time
- [ ] None

Undo | Save | << Back | Next >>

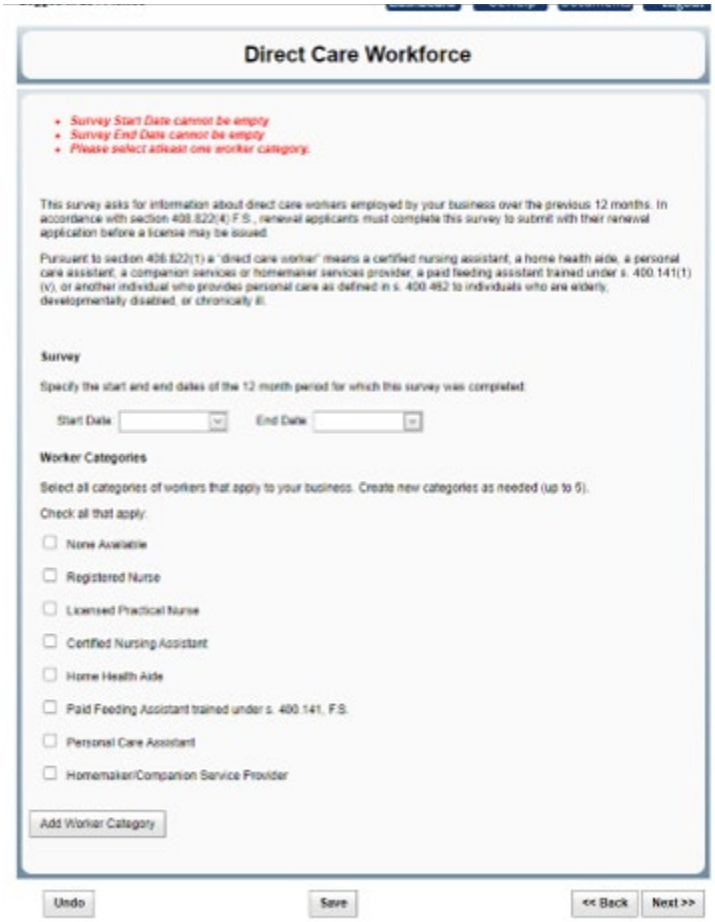
Qualifications

- *An answer to the question below is required.*

1. Identify the type(s) of specialty licenses currently held or being pursued with this application.

- [ ] None
- [ ] Limited Mental Health (LMH)
- [ ] Limited Nursing Services (LNS)
- [ ] Extended Congregate Care (ECC)

Undo | Save | << Back | Next >>


Direct Care Workforce
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
Undo
Save
<< Back
Next >>

Direct Care Workforce

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 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: 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
- [x] Registered Nurse
- [ ] Licensed Practical Nurse
- [x] Certified Nursing Assistant
- [ ] Home Health Aide
- [x] Paid Feeding Assistant trained under s. 400.141, F.S.
- [ ] Personal Care Assistant
- [ ] Homemaker/Companion Service Provider
- [x] Other B
- [x] Other A

Add Worker Category

Direct Care Workforce

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:

Start Date: 4/18/2022 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
- [x] Registered Nurse
- [ ] Licensed Practical Nurse
- [x] Certified Nursing Assistant
- [ ] Home Health Aide
- [x] Paid Feeding Assistant trained under s. 400.141, F.S.
- [ ] Personal Care Assistant
- [ ] Homemaker/Companion Service Provider
- [x] Other B
- [x] Other A

Add Worker Category

Direct Care Workforce

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	0.19	0.15
Certified Nursing Assistant	65	12	50	5	12	34	8	0.18	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	2	19	4	0.00	0.30
Other A	10	1	10	0	1	11	2	0.10	0.00

Direct Care Workforce

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

Direct Care Workforce

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

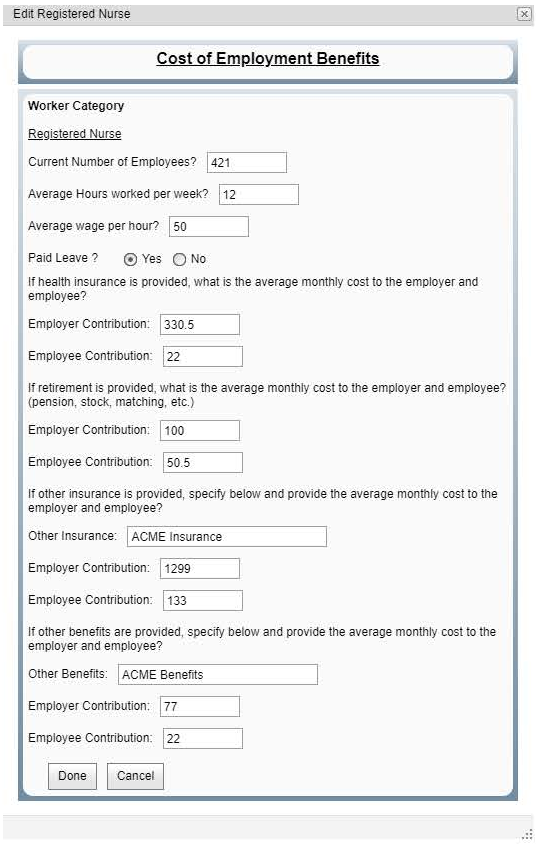
Cost of Employment Benefits

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	


Edit Registered Nurse
Cost of Employment Benefits
Worker Category
Registered Nurse
Current Number of Employees? 421
Average Hours worked per week? 12
Average wage per hour? 50
Paid Leave ? Yes No
If health insurance is provided, what is the average monthly cost to the employer and employee?
Employer Contribution: 330.5
Employee Contribution: 22
If retirement is provided, what is the average monthly cost to the employer and employee? (pension, stock, matching, etc.)
Employer Contribution: 100
Employee Contribution: 50.5
If other insurance is provided, specify below and provide the average monthly cost to the employer and employee?
Other Insurance: ACME Insurance
Employer Contribution: 1299
Employee Contribution: 133
If other benefits are provided, specify below and provide the average monthly cost to the employer and employee?
Other Benefits: ACME Benefits
Employer Contribution: 77
Employee Contribution: 22
Done
Cancel

Direct Care Workforce

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

Direct Care Workforce

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

Direct Care Workforce

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 ( ) No

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.	☐	☐	☐	☐	☐	☐	☐
Other B	☐	☐	☐	☐	☐	☐	☐
Other A	☐	☐	☐	☐	☐	☐	☐

Supporting Documents

Applicants **MUST** include the following attachments as stated in Chapters 408, Part II and 429, Part I F.S. and Chapters 59A-35 and 59A-36, 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 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.*
- *Fire Safety Inspection Report*
  - *Upload document is required/check the document mailed checkbox.*
- *Residential Group Care Inspection Report*
  - *Upload document is required/check the document mailed checkbox.*
- *Documentation from the appropriate local government office showing that the applicant has met local zoning requirements*
  - *Upload document is required/check the document mailed checkbox.*
- *Proof of Financial Ability to Operate*
  - *Upload document is required/check the document mailed checkbox.*
- *Copy of Administration's high school diploma or GED certificate*
  - *Upload document is required/check the document mailed checkbox.*
- *Emergency Environmental Control Plan Approval Letter and Consumer Friendly Summary*
  - *Upload document is required/check the document mailed checkbox.*

Proof of General Liability Insurance Coverage

Carrier

Policy #

Effective Date

Expiry Date

Aggregate Policy Amount $0.00

Occurrence Policy Amount $0.00

☐ 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...

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.

Browse...

Residential Group Care 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.

Browse...

Department of Health Food Service 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.

Browse...

Evidence of a Surety Bond or 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.

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...

Department of Health septic system or water supply evaluation report (if facility is on a septic system)

☐ 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...

Documentation from the appropriate local government office showing that the applicant has met local 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.

Browse...

Documentation proving compliance with the community residential Homes site selection requirements specified pursuant to Chapter 419, F.S.

☐ 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...

Proof of 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.

Browse...

Copy of Administration's high school diploma or GED certificate

☐ 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...

Emergency Environmental Control Plan Approval Letter and Consumer Friendly Summary

☐ 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...

Certificate of Authority, if part of a continuing care retirement community (CCRC)

☐ 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...

Undo | Save | << Back | Next >>

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/Managing Employee*
  - b. Safety Liaison
- 6. Required Disclosure
  - a. *Convictions*
  - b. *Exclusions*
  - c. *Felonies/Terminations*
  - d. *Health and Residential Care*
  - e. *Miscellaneous*
- 7. Bed Count
  - a. *Bed Count*
- 8. Consumer Information
  - a. Consumer Information
- 9. Qualifications
  - a. *Qualifications*
- 10. Supporting Documents
  - a. *Supporting Documents*

I **ANGEL STOCK**, 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.

ANGEL STOCK	ANALYST	09/22/2023
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 $387.73 plus $64.96 per private pay bed fee (not to exceed $14,253.64)
- The extended congregate care fee is $546.07 plus $10.15 per bed fee times total bed capacity
- The limited nursing service fee is $322.77 plus $10.15 per bed fee times total bed capacity
- The biennial assessment fee is $2 per bed (annual fee of $1 per bed x 2 years) not to exceed $300 per facility (annual cap of $150 x 2 years)
- 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