

Provider:  
Hope House

Provider Type:  
Residential Treatment Facility

File#: 32960526  
License #:  
Expires:

✓ = Entered  
✗ = Entry Required

Provider/Facility Information

- Details
- Property Ownership
- Contact Person

Licensee Information

Controlling Interests

Management Company Information

Personnel

Required Disclosure

Accreditation

Bed Count and Classification

Additional Street Addresses

Supporting Documents

Finalize Submission

Health Care Licensing Online Application  
Residential Treatment Facility  
AHCA Form 3180-5005 OL,  
August 2023  
59A-35.060, Florida  
Administrative Code

Logged in as : kelli.fillyaw

Dashboard OL Help Documents Logout

### Provider/Facility Information

Under the authority of Chapters [408, Part II](#) and [394, Part IV](#), Florida Statutes (F.S.), and Chapters [59A-35](#) and [66E-4](#), Florida Administrative Code (F.A.C.), an application is hereby made to operate a residential treatment facility 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 Website information cannot be blank. Please enter a website or check None checkbox below the field.

#### Provider/Facility Information

License #  National Provider Identifier

None  Pending

Medicaid #  Medicare # (CMS CCN)

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

#### Provider/Facility Location Address

Provider Location Address  
2727 MAHAN DR  
TALLAHASSEE, FL 32308  
US - United States  
County - LEON

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

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

Telephone  Ext  Email Address

None

## 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

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

Description of Licensee (select only 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)

Federal Employer Identification # (EIN)

## Mailing Address ?

Edit Address

Address

Telephone

( ) -

Ext

Fax #

( ) -

None

Email Address

None

Undo

Save

<< Back

Next >>

## Controlling Interests of Licensee

- *Select either Yes or No option.*

**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.

**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.

Yes  No

Undo

Save

<< Back

Next >>

## Management Company Information

- *Select either Yes or No option.*

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

Yes  No

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 occurred at least 20 years before the date of the application?

Yes  No

Undo

Save

<< Back


Next >>

## Accreditation

- *Either select an Accrediting Organization or check the Not Accredited check box.*

Please check the appropriate accrediting organization(s) below. If accredited, provide a copy of the full accreditation survey, award letter, and any follow up letters to or from the accrediting body in the Supporting Documents section of this application. Please review Chapter [394.741](#), F.S. for additional information.

Not Accredited

<u>Accrediting Organization</u>	<u>Accrediting Org ID</u> 	<u>Accreditation Effective Date</u>	<u>Accreditation Expiration Date</u>	<u>Survey Date</u>
<input type="checkbox"/> Commission on Accreditation of Rehabilitation Facilities (CARF)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Commission of Accreditation (COA)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> The Joint Commission (JC)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> National Committee for Quality Assurance (NCQA)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**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.

**Note:** If accredited, provide a copy of the full accreditation survey, award letter and any follow up letters to or from the accrediting organization.

Undo

Save

<< Back

Next >>



## Bed Count and Classification

- *BEDS capacity is required.*

### 1. Number of Beds

- Provide the number of licensed beds.
- Initial applications - Enter your bed count in the 'Increase' column.

LICENSED CAPACITY	CURRENT CAPACITY	INCREASE	DECREASE	FINAL CAPACITY
BEDS	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

### 2. Classification

- Select only one option:

- Level IA
- Level IB
- Level II
- Level III
- Level IV
- Level V

Undo

Save

<< Back

Next >>

## Additional Street Addresses

- *Provide an answer to the question below.*

Are there any additional street addresses associated with this license?

- Yes  No

Undo

Save

<< Back

Next >>

## Supporting Documents

Applicants **MUST** include the following attachments as stated in Chapters [408, Part II](#) and [394, Part IV](#), F.S. and Chapter [59A-35](#) and [65E-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 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.*
- **Fire Safety Inspection Report**
  - *Upload document is required/check the document mailed checkbox.*
- **Department of Health Sanitation Report**
  - *Upload document is required/check the document mailed checkbox.*
- **Documentation signed by the appropriate local government official, which states that the applicant has met zoning requirement**
  - *Upload document is required/check the document mailed checkbox.*
- **Program Narrative**
  - *Upload document is required/check the document mailed checkbox.*

### Proof of Professional Liability Insurance Coverage

Carrier	<input type="text"/>	Expiry Date	<input type="text"/>
Policy #	<input type="text"/>	Occurrence Policy Amount	<input type="text"/>
Effective Date	<input type="text"/>		
Aggregate Policy Amount	<input type="text"/>		

- 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.

### Department of Health Sanitation 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.

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

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.

**Department of Health Septic System or Water Supply Evaluation 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.

**Organizational Chart**

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.

**Accreditation 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.

**Program Narrative**

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.

**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.

**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.

**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.

**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.

## 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.

- ❶. Provider/Facility Information
  - a. [Details](#)
  - b. [Property Ownership](#)
  - c. [Contact Person](#)
- ❷. Licensee Information
  - a. [Licensee Details](#)
- ❸. Controlling Interests
  - a. [Controlling Interests](#)
- ❹. Management Company Information
  - a. [Management Company Information](#)
  - b. Management Company Controlling Interest
- ❺. Personnel
  - a. [Administration](#)
  - b. Safety Liaison
- ❻. Required Disclosure
  - a. [Convictions](#)
  - b. [Exclusions](#)
  - c. [Felonies/Terminations](#)
- ❼. Accreditation
  - a. [Accreditation](#)
- ❽. Bed Count and Classification
  - a. [Bed Count and Classification](#)
- ❾. Additional Street Addresses
  - a. [Additional Street Addresses](#)
- ❿. Supporting Documents
  - a. [Supporting Documents](#)

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

- (1) Pursuant to section [837.08](#), 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.

**KELLI FILLYAW**

**GOC III**

**09/26/2023**

Signature of Licensee or Authorized Representative

Title

Date

I agree

### Biennial Licensure Fee and Other Amounts Due Upon Submission of Application

- The license fee is \$191.83 per bed
- 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.