

Provider:
Test TLF

Provider Type:
Transitional Living Facility

File#: 25950888
License #: 70090987
Expires: 10/30/2023

Logged in as : happyfeet20

[Dashboard](#) [OL Help](#) [Documents](#) [Logout](#)

Provider/Facility Information

Under the authority of Chapters [408, Part II](#) and [400, Part V](#), Florida Statutes (F.S.), and Chapters [59A-35](#) and [59A-17](#), Florida Administrative Code (F.A.C.), an application is hereby made to operate a transitional living facility as indicated below.

Pursuant to section [408.808 \(1\)\(a\) 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>).

= Entered
 = Entry Required

Provider/Facility Information 


Details


Property Ownership

Contact Person

Licensee Information 


Controlling Interests 

Management Company Information 


Personnel 

Required Disclosure 

Accreditation 

Bed Count 

Supporting Documents 

Finalize Submission 

Changes have been saved.

Provider/Facility Information

License #

National Provider Identifier

None Pending

Medicaid #

Medicare # (CMS CCN)

Name of Transition Living Facility (If operated under a fictitious name, enter as it appears in 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

Health Care Licensing Online
Application
Transitional Living Facility,
AHCA Form 3110-9001OL,
August 2023
59A-35.060, Florida
Administrative Code

Property Ownership

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

- Own
 Lease

To **add** a property owner(s) -

Utilizing the picklist below, either choose an individual/entity that is already associated with this application or select 'New Property Owner - Individual' or 'New Property Owner - Entity' .

To **edit** Property Owner's information -
Select "Edit/View" and edit as needed.

To **remove** an existing Property Owner -
Select "Remove" and enter the applicable end date.

No Property Owner!

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


Licensee Information


Changes have been saved.

Description of Licensee (select only one option below) 

For Profit Not for Profit Public

Ownership Types

Sole Proprietorship 

Entity Licensee Details 

Licensee Name (may be same as provider name)

Example Business

Federal Employer Identification # (EIN)

08-0808080

Mailing Address 

[Edit Address](#)

Address

301 OAK ST
MELBOURNE, FL 32951-2035
US - United States
County - BREVARD

Telephone

(303) 030-3030

Ext

Fax #

() - -

None

Email Address

None

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

To **add** a controlling interest -

Utilizing the picklist below, either choose an individual/entity that is already associated with this application or select 'New Controlling Interest - Individual' or 'New Controlling Interest - Entity'.

If the percentage of ownership interest indicated above does not equal 100%, please explain why in the space below:

Management Company Information

- *Select either Yes or No option.*

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

Yes No

Management Company Controlling Interest

- **Add at least one Management Company Controlling Interest.**

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.

To **add** a controlling interest -

Utilizing the picklist below, either choose an individual/entity that is already associated with this application or select 'New Controlling Interest - Individual' or 'New Controlling Interest - Entity'.

Personnel

Changes have been saved.

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
- 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'.

To **edit** an existing individual -

Select "Edit/View" and edit as needed.

To **remove** an existing individual -

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

		<u>Full Name of Individual</u>	<u>Type</u>	<u>Tax ID</u>	<u>Roles</u>	<u>Effective Date</u>	<u>End Date</u>
Remove	Edit/View	DEWEY DUCK	SSN	XXX-XX-3032	Financial Officer	09/01/2023	
Remove	Edit/View	LOUIE DUCK	SSN	XXX-XX-3033	Administrator	09/01/2023	

Removed: (-) Added: (+)

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!

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

Select an individual from this list

No individual exists!

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

Select an individual/entity from this list

No individual/entity exists!

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

Accreditation

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

If this TLF is currently accredited with deemed status through one or more of the accrediting organizations recognized by the Agency for Health Care Administration, make the appropriate selection(s), and provide the requested information.

Otherwise, select "Not Accredited with Deemed Status".

Not Accredited with Deemed Status

<u>Accrediting Organization</u>	<u>Accreditation ID</u>	<u>Accreditation with Deemed Status Effective Date</u>	<u>Accreditation with Deemed Status End Date</u>	<u>Survey End 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"/> Joint Commission (JC)	<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.

Bed Count

Review and revise the bed count, if needed.

Number of Beds

Supporting Documents

Applicants **MUST** include the following attachments as stated in Chapters [408, Part II](#), and [400 Part XI](#), Florida Statutes (F.S.) and Chapters [59A-35](#) and [59A-17](#), Florida Administrative Code (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.

Changes have been saved.

Proof of General Liability Insurance Coverage

Carrier	<input type="text" value="A"/>	Expiry Date	<input type="text" value="9/1/2024"/>
Policy #	<input type="text" value="A"/>		
Effective Date	<input type="text" value="9/1/2023"/>		
Aggregate Policy Amount	<input type="text" value="\$1.00"/>	Occurrence Policy Amount	<input type="text" value="\$2.00"/>

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.

Sanitation 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.

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.

Evidence of a Surety 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.

Documentation of Having Met Local Zoning for a Community Residential Home

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.

- ❌ 1. Provider/Facility Information
 - a. Details
 - b. [Property Ownership](#)
 - c. [Contact Person](#)
- ✅ 2. Licensee Information
 - a. Licensee Details
- ❌ 3. Controlling Interests
 - a. [Controlling Interests](#)
- ❌ 4. Management Company Information
 - a. Management Company Information
 - b. [Management Company Controlling Interest](#)
- ✅ 5. Personnel
 - a. Administration
 - b. Safety Liaison
- ❌ 6. Required Disclosure
 - a. [Convictions](#)
 - b. [Exclusions](#)
 - c. [Felonies/Terminations](#)
- ❌ 7. Accreditation
 - a. [Accreditation](#)
- ✅ 8. Bed Count
 - a. Bed Count
- ❌ 9. Supporting Documents
 - a. [Supporting Documents](#)

I **MANDI MANZIE**, 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.

MANDI MANZIE

09/21/2023

Signature of Licensee or Authorized Representative

Title

Date

I agree

