APPLICATION CHECKLIST
Health Care Licensing Application
HEALTH CARE SERVICES POOL

Applicants must include the following attachments as stated in Chapters 408, Part II, and 400, Part IX, Florida Statutes (F.S.), and Chapters 59A-35 and 59A-27, Florida Administrative Code (F.A.C.). Applications must be received at least 60 days prior to the expiration of the current license or effective date of a change of ownership to avoid a late fee. 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. The application will be withdrawn from review if all the required documents and fees are not included with this application or received within 21 days of an omission notice.

All forms listed below may be obtained from the website: http://ahca.myflorida.com/HQAshares/forms. Send completed applications to: Agency for Health Care Administration, Home Care Unit, 2727 Mahan Drive, Mail Stop 34, Tallahassee, FL 32308.

A. Initial, Renewal and Change of Ownership applications must include:

- **NOTE TO ALL APPLICANTS:** The Agency will verify that all applicants, licensees and controlling interests subject to Chapters 607, 608 or 617, Florida Statutes related to Business Organizations have complied with applicable Department of State registration and filing requirements. The principal and mailing addresses submitted with any application must be the same as the addresses that appear as registered with the Department of State, Division of Corporations.

- The $616.00 biennial registration fee - Please make check or money order payable to the Agency for Health Care Administration (AHCA). All fees are nonrefundable. **NOTE:** Starter and temporary checks are not accepted.

- Health Care Licensing Application, Health Care Services Pool, AHCA Form 3110-1010. **NOTE:** All Agency correspondence will be sent to the mailing address provided in Section 1A of the application. If an applicant or licensee is required to register or file with the Florida Secretary of State Division of Corporations, the principal, fictitious name and mailing address provided in Section 1 of this application must be the same as the information registered with the Division of Corporations as provided in section 59A-35.060(4), Florida Administrative Code.

- Health Care Licensing Application Addendum, AHCA Form 3110-1024 - Complete the information that is applicable, write “NA” on the items that are not applicable, sign, date and send with the application (refer to Sections 3 & 4 of the application for further details).

- Demonstrate financial responsibility to pay claims and costs ancillary thereto, arising out of the rendering of services or failure to render services by the Pool or its employees (see Section 8 Financial Responsibility of this application).

- **Proof of Background Screening:**
  
  **NOTE:** All initial applicants to the Agency must first submit their application to the Agency prior to completing the background screening requirement. Once the application is received a letter will be generated and mailed to the applicant with the AHCA number and information on completing the new user registration agreement on the Background Screening results website. Once this letter is received, the applicant may register on the results website to initiate the screening and select a LiveScan service provider to perform the screening. All LiveScan service providers will require the AHCA number and the agency’s ORI number to complete the screening process. Please visit the Agency’s background screening website for additional information: http://ahca.myflorida.com/backgroundscreening.

  - A Level 2 background screening for the Managing Employee and Financial Officer is required every 5 years. Please check all boxes below that apply to this application:

    - The ☐ Managing Employee and/or ☐ Financial Officer submitted a Level 2 screening through a LiveScan service provider approved to submit fingerprint requests through the Florida Department of Law Enforcement (FDLE). For more information regarding LiveScan service providers please see the Agency’s background screening website at: http://ahca.myflorida.com/backgroundscreening.

All screening results must be sent to the Agency for Health Care Administration (Agency) for review and eligibility determinations. If you choose to use a LiveScan source other than the Agency’s contracted vendor you must identify the Agency for Health Care Administration as the recipient of the screening results to ensure the results are reviewed by the Agency. If the Agency does not receive the result, additional screening and fees may be required.
If the service provider you choose does not have an online registration or appointment system, we ask that you please use the "LivesSan Screening Form" available on the Background Screening Results Website (https://apps.ahca.myflorida.com/SingleSignOnPortal/). The form is created after the screening is initiated on the Background Screening Results Website.

☐ The ☐ Managing Employee and/or ☐ Financial Officer are out of state and do not have access to a Florida Livescan service provider and will submit a fingerprint card (you must obtain a fingerprint card from the Agency). To request a fingerprint card please contact the Agency's Background Screening Section at (850) 412-4503 or email bgoscreen@ahca.myflorida.com. The completed fingerprint card must then be submitted to:

☐ The Agency’s contracted vendor is Cogent Systems. The fingerprint card must be filled out completely and the fingerprints taken by law enforcement personnel or an individual trained in processing fingerprints. Return the completed card to:
Cogent Systems
Attn: Fingerprint Card Scan Florida
5025 Bradenton Ave Suite A
Dublin, OH 43017
Website: http://www.cogentid.com/fl/index_ahca.htm

☐ Another Livescan service provider authorized to provide services in Florida that is equipped to transmit the images of the fingerprints from the fingerprint card electronically. This requires special equipment and not all Livescan service providers have this ability. You may find Livescan service provider contact information on the FDLE website: http://www.fdle.state.fl.us/Content/Criminal-History/Livescan-Service-Providers-and-Device-Vendors.aspx

☐ Proof of Level 2 screening within the previous 5 years for the ☐ Managing Employee and/or ☐ Financial Officer from the Agency, the Department of Children and Families, Department of Health, Department of Elder Affairs, Agency for Persons with Disabilities or Department of Financial Services (if the applicant has a certificate of authority or provisional certificate of authority to operate a continuing care retirement community) is included with this application. An Affidavit of Compliance with Background Screening Requirements, AHCA Form 3100-0008, is also enclosed.

B. Additional Information needed for INITIAL Applications:

☐ Partnership Agreement (Partnerships)
☐ Company Organizational Papers (Limited Liability Companies, Other)

C. Additional Information needed for CHANGE OF OWNERSHIP Applications:

☐ Partnership Agreement (Partnerships)
☐ Company Organizational Papers (Limited Liability Companies, Other)
☐ Copy of signed and dated asset purchase agreement indicating that a change of ownership is pending
☐ Copy of signed closing document (bill of sale) showing the date of the transfer of ownership. This document is not required initially and may be submitted after the date of the transfer.

D. Change During License Period: Request to change the name or address of provider:

☐ Complete and submit sections 1, 2 and 10 of the Health Care Licensing Application, Health Care Services Pool, AHCA Form 3110-1010
☐ Proof of professional liability coverage in the new name or address of the provider
☐ For address changes, proof of the applicant's legal right to occupy the property such as a copy of a lease, sublease agreement, contract or deed.
☐ $25.00 fee for replacement registration/reissue of registration due to change during registration period. Please make check or money order payable to the Agency for Health Care Administration (AHCA). All fees are nonrefundable.
NOTE: 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.

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The Agency for Healthcare 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.
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Health Care Licensing Application
HEALTH CARE SERVICES POOL

Under the authority of Chapters 408, Part II, and 400, Part IX, Florida Statutes (F.S.), and Chapters 59A-35 and 59A-27, Florida Administrative Code (F.A.C.), an application is hereby made to operate a health care services pool as indicated below:

1. Provider / Licensee Information

A. Provider Information – please complete the following for the health care services pool name and location.

<table>
<thead>
<tr>
<th>License # (for renewal &amp; change of ownership applications)</th>
<th>National Provider Identifier (NPI) (if applicable)</th>
<th>Medicare # (CMS CCN)</th>
<th>Medicaid #</th>
<th>N/A</th>
<th>N/A</th>
</tr>
</thead>
</table>

Name of Health Care Services Pool (include fictitious name, if applicable)

Street Address

City

County

State

Zip

Telephone Number

Fax Number

E-mail Address

Provider Website

Mailing Address or ☐ Same as above (All mail will be sent to this location)

City

State

Zip

Contact Person for this application

Contact Telephone Number

Contact e-mail address or ☐ Do not have e-mail

NOTE: By providing your e-mail address you agree to accept e-mail correspondence from the Agency

B. Licensee Information – please complete the following for the entity seeking to operate the health care services pool.

Licensee Name (may be same as provider name above)

Federal Employer Identification Number (EIN)

Mailing Address or ☐ Same as above

City

State

Zip

Telephone Number

Fax Number

E-mail Address

Description of Licensee (check one):

For Profit
☐ Corporation
☐ Limited Liability Company
☐ Partnership
☐ Sole Proprietorship
☐ Individual
☐ Other

Not for Profit
☐ Corporation
☐ Religious Affiliation
☐ Other

Public
☐ State
☐ City/County
☐ Hospital District

AHCA Form 3110-1010, July 2014
APPLICATION Page 1 of 7

Section 59A-27.002(1), Florida Administrative Code
Form available at: http://www.ahca.myflorida.com/HQAllicensureforms
2. Application Type and Fees

Indicate the type of application with an “X.” Applications will not be processed if all applicable fees are not included. All fees are nonrefundable per 408.805(4), Florida Statutes. Renewal and Change of Ownership 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.

☐ Initial Registration
Was this entity previously registered as a Health Care Services Pool in Florida?
YES ☐ NO ☐

If yes, please provide the name of the agency (if different), the EIN # and the year the prior registration expired or closed:

NAME: ___________________________ EIN #: ___________________________ Year Expired/Closed: ___________________________

☐ Renewal Registration
☐ Change of Ownership
☐ Change during the registration period - Name/address change

Proposed Effective Date: ___________  Proposed Effective Date: ___________

<table>
<thead>
<tr>
<th>Action</th>
<th>Fee</th>
<th>TOTAL FEES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registration fee (Initial, Renewal and Change of Ownership):</td>
<td>$616.00</td>
<td>$</td>
</tr>
<tr>
<td>Change During Licensure Period/Replacement License</td>
<td>$ 25.00</td>
<td>$</td>
</tr>
</tbody>
</table>

TOTAL FEES INCLUDED WITH APPLICATION: $___________________________

Please make check or money order payable to the Agency for Health Care Administration (AHCA)

Note: Starter checks and temporary checks are not accepted

3. Controlling Interests of Licensee

AUTHORITY:

Pursuant to section 408.806(1)(a) and (b), Florida Statutes, an application for licensure must include: the name, address and Social Security number of the applicant 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 shall use such information for purposes of securing the proper identification of persons listed on this application for licensure. However, in an effort to protect all personal information, do not include Social Security numbers on this form. All Social Security numbers must be entered on the Health Care Licensing Application Addendum, AHCA Form 3110-1024.

DEFINITIONS:

Controlling interests, as defined in subsection 408.803(7), Florida Statutes, 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-percent 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-percent 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.
In Sections A and B below, provide the information for each individual or entity (corporation, partnership, association) with 5% or greater ownership interest in the licensee. Attach additional sheets if necessary.

### A. Individual and/or Entity Ownership of Licensee

<table>
<thead>
<tr>
<th>FULL NAME of INDIVIDUAL or ENTITY</th>
<th>PERSONAL OR BUSINESS ADDRESS</th>
<th>TELEPHONE NUMBER</th>
<th>EIN (No SSNs)</th>
<th>% OWNERSHIP INTEREST</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

### B. Board Members and Officers of Licensee (excludes voluntary board members)

<table>
<thead>
<tr>
<th>TITLE</th>
<th>FULL NAME</th>
<th>PERSONAL OR BUSINESS ADDRESS</th>
<th>TELEPHONE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director/CEO</td>
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<tr>
<td>President</td>
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<tr>
<td>Vice President</td>
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<td>Secretary</td>
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<tr>
<td>Treasurer</td>
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<tr>
<td>Other:</td>
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</table>

### 4. Management Company Controlling Interests

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

- If ☐ NO, skip to section 5 – Required Disclosure.
- If ☐ YES, provide the following information:

<table>
<thead>
<tr>
<th>Name of Management Company</th>
<th>EIN (No SSN)</th>
<th>Telephone Number / Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address</td>
<td></td>
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<tr>
<td>E-mail Address</td>
<td></td>
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<tr>
<td>City</td>
<td>County</td>
<td>State</td>
</tr>
<tr>
<td>Mailing Address or ☐ Same as above</td>
<td></td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
<td>Zip</td>
</tr>
<tr>
<td>Contact Person</td>
<td>Contact E-mail</td>
<td>Contact Telephone Number</td>
</tr>
</tbody>
</table>
In Sections A and B below, provide the information for each individual or entity (corporation, partnership, association) with 5% or greater ownership interest in the management company. Attach additional sheets if necessary.

A. Individual and/or Entity Ownership of Management Company

<table>
<thead>
<tr>
<th>FULL NAME of INDIVIDUAL or ENTITY</th>
<th>PERSONAL OR BUSINESS ADDRESS</th>
<th>TELEPHONE NUMBER</th>
<th>EIN (No SSNs)</th>
<th>% OWNERSHIP INTEREST</th>
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</tbody>
</table>

B. Board Members and Officers of Management Company

<table>
<thead>
<tr>
<th>TITLE</th>
<th>FULL NAME</th>
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<td>Treasurer</td>
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<tr>
<td>Other:</td>
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</tbody>
</table>

5. Required Disclosure

The following disclosures are required:

A. Pursuant to subsection 408.809(1)(d), 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, 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 subsection 408.809(1)(d), Florida Statutes? (These offenses are listed on the Affidavit of Compliance with Background Screening Requirements, AHCA Form #3100-0008.)

YES  □  NO  □

If yes, enclose the following information:

□ The full legal name of the individual and the position held

□ A description/explanation of the conviction(s) - If the individual has received an exemption from disqualification for the offense, include a copy

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

□ A description/explanation of the exclusion, suspension, termination or involuntary withdrawal.

C. Pursuant to section 408.815(4), F.S., does the applicant or any controlling interest in an applicant have any of the following:

YES  □  NO  □  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.

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  □
6. Provider Fines and Financial Information

Pursuant to subsection 408.831(1)(a), Florida Statutes, 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):

Amount: $________ assessed by: □ Agency for Health Care Administration Case # ________ □ CMS

Date of related inspection, application or overpayment period if applicable: ________

Due date of payment: ________ Is there an appeal pending from a Final Order? YES □ NO □

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

7. Personnel

Administrative Personnel:

<table>
<thead>
<tr>
<th>TITLE</th>
<th>NAME</th>
<th>TELEPHONE NUMBER</th>
<th>E-MAIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrator/Managing Employee</td>
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<tr>
<td>Financial Officer</td>
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</tbody>
</table>

8. Services

A. Health care personnel provided by the health care services pool (check all that apply):

- □ Audiologist
- □ Audiologist Aide
- □ Certified Nursing Assistants
- □ Clinical Social Worker
- □ Dental Hygienist
- □ Emergency Medical Technician
- □ Nurses – LPN
- □ Nurses – RN
- □ Nurse Aide
- □ Physical Therapist
- □ Other: ________

- □ Paramedic
- □ Pharmacist
- □ Radiology Technician
- □ Medical Director
- □ Pharmacy Technician
- □ Occupational Therapist
- □ Radiology Technician
- □ Medical Technician
- □ Respiratory Therapist
- □ Speech Therapist

B. Types of providers served (check all that apply):

- □ Assisted Living Facility
- □ Hospice
- □ Nursing Home
- □ Clinic
- □ HMO
- □ Dialysis Center

- □ Ambulatory Surgical Center
- □ Hospital
- □ Home Health Agency
- □ Doctor’s Office
- □ Correctional Facility
- □ Other (please specify): ________


As required in section 408.980, Florida Statutes, and 59A-27.009, Florida Administration Code, each Health Care Services Pool must demonstrate financial responsibility to pay claims and costs ancillary thereto, arising out of the rendering of services or failure to render services by the Pool or its employees.

Please check which of the following methods the Health Care Services Pool uses. Submit proof with this application.
Professional liability insurance coverage in an amount of not less than $1,000,000 per claim, with a minimum aggregate of not less than $3,000,000 from one of the following (submit proof of insurance):

- An authorized insurer as defined under section 624.09, F.S.;
- An eligible surplus lines as defined under subsection 626.918(2), F.S.;
- A risk retention group or purchasing group as defined under section 627.942, F.S.; or
- A plan of self-insurance as provided in section 627.357, F.S.
- Escrow account consisting of cash or assets eligible for deposit in accordance with section 625.52, F.S. The cash or assets deposited shall be in an amount not less than $1,000,000 per claim, with a minimum aggregate deposit of not less than $3,000,000. (Provide statement from bank or savings association).

Unexpired irrevocable letter of credit issued by any bank or savings association in this state in an amount not less than $1,000,000 per claim, with a minimum aggregate amount of credit not less than $3,000,000. (Provide statement from bank or financial institution).

10. Other Licenses / Registrations

Please list the name, license number and address of all other health care provider types operated by this owner:

<table>
<thead>
<tr>
<th>Type of Provider</th>
<th>Name of Provider</th>
<th>City</th>
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</thead>
<tbody>
<tr>
<td>Home Health Agency</td>
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<tr>
<td>Hospital</td>
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<tr>
<td>Nursing Home</td>
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<tr>
<td>Laboratory</td>
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<tr>
<td>Home Medical Equipment</td>
<td></td>
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<tr>
<td>Nurse Registry</td>
<td></td>
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<tr>
<td>Other Health Care Services Pools</td>
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<tr>
<td>Other (please specify)</td>
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</tbody>
</table>

11. Attestation

I, ________________________________, under penalty of perjury, 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, 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.

Signature of Licensee or Authorized Representative

Title

Date

AHCA Form 3110-1010, July 2014
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Section 59A-27.002(1), Florida Administrative Code
Form available at: http://www.ahca.myflorida.com/HQALicensureforms
RETURN THIS COMPLETED FORM WITH FEES TO:
AGENCY FOR HEALTH CARE ADMINISTRATION
HOME CARE UNIT
2727 MAHAN DR., MS 34
TALLAHASSEE FL 32308-5407

Questions? Review the information available at http://ahca.myflorida.com/licensing_cert.shtml or contact the Home Care Unit at (850) 412-4403.