



APPLICATION CHECKLIST

Health Care Licensing Application

MENTAL HEALTH SERVICES

Crisis Stabilization Unit (CSU), Short-term Residential Treatment Facility (SRT),
Residential Treatment Facility (RTF)

Applicants **must** include the following attachments as stated in Chapters 408, Part II and 394, Florida Statutes (F.S.), and Chapters 59A-35, 65E-4, 65E-5, and 65E-12, 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 **The application will be withdrawn from review if all the required documents and fees are not included with this application or received within 21 days of an omission notice.**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/MCHQ/Corebill/index.shtml>. Send completed applications to: Agency for Health Care Administration, Hospital and Outpatient Services Unit, 2727 Mahan Drive, Mail Stop 31, Tallahassee, FL 32308.

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.

A. Initials, Renewals and Change of Ownership Applications must include:

- The biennial licensure fee (**CSU/SRT = \$197.92 per bed; RTF = \$191.83 per bed**). Please make check or money order payable to the *Agency for Health Care Administration (AHCA)*. All fees are nonrefundable. **Additional fees may apply. Refer to Section 2 of this application.** NOTE: *Starter and temporary checks are not accepted.*
- Health Care Licensing Application, Mental Health Services, AHCA Form 3180-5003. **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).
- Proof of professional liability coverage.
- Program Narrative (not applicable for *accredited* CSU/SRT).
- Table of Organization (not applicable for *accredited* CSU/SRT).
- Resume of onsite Facility Manager (not applicable for *accredited* CSU/SRT).
- Sanitation Inspection Report.
- Fire Safety Inspection Report.
- A copy of the most recent Accreditation Survey Report (if applicable).
- Baker Act Receiving Facility Designation (CSU/SRT Only).
 - Addictions Receiving Facility (ARF) license if applicable (CSUs Only).
- AIDS/HIV Training Affidavit (CSU/SRT Only).

Background Screening:

A Level 2 background screening for the Administrator and Financial Officer is required every 5 years.

All screening results must be sent to the Agency for Health Care Administration for review and employment 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 results, additional screening and fees may be required. For additional information, including finding a LiveScan vendor and screening a person who is out of state, please visit the Agency's background screening website at: <http://ahca.myflorida.com/backgroundscreening>.

The Administrator and/or Financial Officer submitted a new Level 2 screening through a LiveScan vendor.

The Administrator and/or Financial Officer submitted a Level 2 screening within the previous 5 years and results are on file with the Agency for Health Care Administration, 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 to operate a continuing care retirement community). An Affidavit of Compliance with Background Screening Requirements, AHCA Form 3100-0008, is also enclosed.

B. Additional Information needed for INITIAL Applications:

- Proof of compliance with local zoning requirements.
- Department of Children and Family certification of authorized beds (CSU/SRT Only).
- Proof of the licensee's right to occupy the building such as a copy of a lease, sublease agreement, or deed.

C. Additional Information needed for CHANGE OF OWNERSHIP Applications:

- Proof of the licensee's right to occupy the property such as a copy of the lease, sublease agreement, contract or deed.
- Department of Children and Family certification of authorized beds (CSU/SRT Only).
- Closing documents signed and dated by all parties.
- A signed agreement to correct all outstanding licensure and certification deficiencies incurred by the previous owner.
- A signed agreement to pay any outstanding payments owed to the Agency. The agreement must include who will pay and when payment will be made.

D. Change During Licensure Period:

1. Request to increase/decrease number of licensed beds:

- Complete and submit Sections 1, 2 and 9 of the Health Care Licensing Application, Mental Health Services, AHCA Form 3180-5003.
- The appropriate licensure fee (**CSU/SRT = \$197.92 per bed x _____ number of new beds = _____**; **RTF = \$191.83 per bed x _____ number of new beds = _____**). Please make check or money order payable to the *Agency for Health Care Administration*. All fees are nonrefundable.
- Department of Children and Family certification of authorized beds (CSU/SRT Only).

2. Request to change the name or address of provider:

- Complete and submit Sections 1, 2 and 9 of the Health Care Licensing Application, Mental Health Services, AHCA Form 3180-5003.
- 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 license/reissue of license due to change during licensure period. Please make check or money order payable to the *Agency for Health Care Administration*. All fees are nonrefundable.

3. Request to add/delete integrated crisis stabilization unit and addiction receiving facility (CSU/ARF) services:

- Complete and submit Sections 1, 2 and 9 of the Health Care Licensing Application, Mental Health Services, AHCA Form 3180-5003.
- \$25.00 fee for replacement license/reissue of license due to change during licensure period. Please make check or money order payable to the *Agency for Health Care Administration*. All fees are nonrefundable.
- If the addition of integrated CSU/ARF services results in the addition of licensed beds the CSU per bed fee will also apply.

4. Request to change Administrator or Financial Officer:

- Complete and submit Sections 1A, 2, 8 and 9 of the Health Care Licensing Application, Mental Health Services, AHCA Form 3180-5003.
- Complete and submit Section 1A of the Health Care Licensing Application Addendum, AHCA Form 3110-1024, sign, date and send with application.
- No fee required.

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

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

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



AHCA USE ONLY:	
File #:	_____
Application #:	_____
Check #:	_____
Check Amt:	_____
Batch #:	_____

Health Care Licensing Application MENTAL HEALTH SERVICES

Crisis Stabilization Unit, Short-term Residential Treatment Facility, Residential Treatment Facility

Under the authority of Chapters 408 Part II, and 394 Florida Statutes (F.S.), and Chapters 59A-35 , 65E-4, 65E-5 and 65E-12, Florida Administrative Code (F.A.C.), an application is hereby made to operate a crisis stabilization unit (CSU), short-term residential treatment facility (SRT) or a residential treatment facility (RTF) as indicated below:

1. Provider / Licensee Information

A. Provider Information – please complete the following for the CSU, SRT or RTF name and location. <i>Provider name, address and telephone number will be listed on http://www.floridahealthfinder.gov/</i>			
License # (for renewal & change of ownership applications)	National Provider Identifier (NPI) (if applicable)	Medicare # (CMS CCN)	Medicaid #
Name of CSU, SRT or RTF (include fictitious name, if applicable)			
Street Address			
City	County	State	Zip
Telephone Number	Fax Number	E-mail Address	Provider Website
Mailing Address or <input type="checkbox"/> 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 <input type="checkbox"/> Do not have e-mail		NOTE: By providing your e-mail address you agree to accept e-mail correspondence from the Agency	

B. Licensee Information – please complete the following for the entity seeking to operate the CSU, SRT or RTF.			
Licensee Name (may be same as provider name above)		Federal Employer Identification Number (EIN)	
Mailing Address or <input type="checkbox"/> Same as above			
City		State	Zip
Telephone Number	Fax Number	E-mail Address	
Description of Licensee (check one):			
For Profit <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Partnership <input type="checkbox"/> Individual <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Other	Not for Profit <input type="checkbox"/> Corporation <input type="checkbox"/> Religious Affiliation <input type="checkbox"/> Other	Public <input type="checkbox"/> State <input type="checkbox"/> City/County <input type="checkbox"/> Hospital District	

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. Pursuant to subsection 408.805(4), Florida Statutes, fees are nonrefundable.** 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.

FACILITY TYPE:

- Crisis Stabilization Unit serving: Children only Adult and children Adults only
 Integrated CSU/ARF Services
- Short-term Residential Treatment Facility
 Residential Treatment Facility
 Level: I.A.
 Level: I.B.
 Level: II
 Level: III
 Level: IV
 Level: V

APPLICATION TYPE:

- Initial licensure
 Is this application to reactivate an expired license? YES NO

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

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

- Renewal licensure
 Change of ownership, proposed effective date: _____
 Change during licensure period, proposed effective date: _____
 Name change of the facility
 Increase/decrease in number of licensed beds from ____ to ____
 Addition/deletion of Integrated CSU/ARF services
 Change in Administrator or Financial Officer (No fee required)

LICENSE FEE (Initial, Renewal and Change of Ownership Applications):

Action	Fee	TOTAL FEES
License Fee (Initial, Renewal and Change of Ownership): <input type="checkbox"/> CSU/SRT <input type="checkbox"/> RTF	\$197.92 per bed x _____ number of beds \$191.83 per bed x _____ number of beds	\$
Change During Licensure Period/Replacement License	\$ 25.00	\$
Late fee, if applicable	Contact licensure unit for details.	\$
Other: _____		\$

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

FULL NAME of INDIVIDUAL or ENTITY	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER	EIN (No SSNs)	% OWNERSHIP INTEREST

B. Board Members and Officers of Licensee (Excludes Voluntary Board Members)

TITLE	FULL NAME	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER
Director/CEO			
President			
Vice President			
Secretary			
Treasurer			
Other:			

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:

Name of Management Company		EIN (No SSN)	Telephone Number / Fax	
Street Address		E-mail Address		
City	County	State	Zip	
Mailing Address or <input type="checkbox"/> Same as above				
City		State	Zip	
Contact Person	Contact E-mail		Contact Telephone Number	

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

FULL NAME of INDIVIDUAL or ENTITY	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER	EIN (No SSNs)	% OWNERSHIP INTEREST

B. Board Members and Officers of Management Company (Excludes Voluntary Board Members)

TITLE	FULL NAME	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER
Director/CEO			
President			
Vice President			
Secretary			
Treasurer			
Other:			

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(5), 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, have not 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 this application.

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. Accreditation

The applicant participates in:

- Not accredited The Joint Commission The Council on Accreditation (COA)
 Commission on Accreditation of Rehabilitation Facilities (CARF) National Committee for Quality Assurance (NCQA)

Accreditation begins _____ **and ends** _____

NOTE: If accredited, provide a copy of the full accreditation survey, award letter and any follow up letters to or from the accrediting body. Please review Ch. 394.741, F.S. for additional information.

8. Personnel

Administrative Personnel:

TITLE	NAME	TELEPHONE NUMBER	E-MAIL
Administrator/Managing Employee			
Chief Financial Officer			
Facility Manager (Required for all RTFs; optional for accredited CSUs and SRTs)			

9. Affidavit

I, _____, hereby swear or affirm, under penalty of perjury, that the statements in this application are true and correct. As administrator or authorized representative of the above named provider/facility, I hereby attest that all employees required by law to undergo Level 2 background screening have met the minimum standards of Sections 435.04, and 408.809(5), Florida Statutes (F.S.) or are awaiting screening results.

In addition, I attest that all employees subject to Level 2 screening standards have attested to meeting the requirements for qualifying for employment and agree to inform me immediately if arrested for or convicted of any of the disqualifying offenses while employed here as specified in subsection 435.04(5), F.S.

Signature of Licensee or Authorized Representative

Title

Date

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

RETURN THIS COMPLETED FORM WITH FEES AND ALL REQUIRED DOCUMENTS TO:

AGENCY FOR HEALTH CARE ADMINISTRATION
HOSPITAL AND OUTPATIENT SERVICES UNIT
2727 MAHAN DR., MS 31
TALLAHASSEE FL 32308-5407

Questions?

Review the information available at <http://ahca.myflorida.com/> or contact the Hospital and Outpatient Services Unit at (850) 412-4549