FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

APPLICATION CHECKLIST
Health Care Licensing Application
RESIDENTIAL TREATMENT CENTERS
For CHILDREN AND ADOLESCENTS

Applicants **must** include the following attachments as stated in Chapters 408, Part II, and 394, Florida Statutes (F.S.), and Chapters 59A-35 and 65E-9, 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 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. ***The application will be withdrawn from review if all the required documents and fees are not included with this application or received within 21 days of an omission notice.***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 **($240.00 per bed x _____ = $_____)** - 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, Residential Treatment Centers for Children and Adolescents, AHCA Form 3180-5004. **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).

☐ 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.

☐ Proof of liability insurance coverage (minimum coverage is $300,000 per occurrence/$1,000,000 annual aggregate).

☐ AIDS/HIV affidavit assuring required facility staff will be trained (Section 381.0035, F.S.).

☐ Satisfactory fire safety inspection report completed in the last 365 days.

☐ Satisfactory Department of Health sanitation inspection report completed in the last 365 days.

☐ For all RTCs (except Community Residential Homes), a report or letter from the zoning authority dated within the last 6 months indicating the street location is zoned appropriately for its use.

☐ Facilities considered to be a Community Residential Home under Chapter 419, F.S., must provide a completed Community Residential Home Affidavit of Compliance form.

☐ Copy of the occupational license.

☐ If accredited, a copy of the accreditation letter, survey report and any follow up reports to or from the accrediting organization.

NOTE: for renewals, provide copies of any correspondence to or from the accrediting organization that have not been submitted previously to the Agency since the current accreditation was awarded. A copy of the accreditation award letter, accreditation certificate, and accreditation report (survey report) must be submitted only if a new accreditation period has been awarded since the initial application or last renewal application was filed

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B. Additional Information needed for INITIAL Applications:

☐ Proof of the applicant's legal right to occupy the property for the principal office and each satellite office such as a copy of a lease, rental agreement, contract or deed.

C. Additional Information needed for CHANGE OF OWNERSHIP Applications:

☐ Proof of applicant's legal right to occupy the property for the principal office and each satellite office such as a copy of a lease, rental agreement, contract or deed.

☐ Documented evidence of change of ownership such as an asset purchase agreement, bill of sale, stock transfer/sale agreement and/or proof of corporate reorganization.

☐ Signed agreement to correct any existing licensure deficiencies.

D. Change During Licensure Period:

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

☐ Complete and submit Sections 1, 2, 7 and 11 of the Health Care Licensing Application, Residential Treatment Centers for Children and Adolescents, AHCA Form 3180-5004.

☐ Applicable Community Residential Home Affidavit of Compliance form or zoning documentation.

☐ The appropriate licensure fee (**$240.00 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.

☐ For capacity decrease, $25.00 fee for replacement/reissue of license due to change during licensure period. Please make check ormoney order payable to the *Agency for Health Care Administration.* All fees are nonrefundable.

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

☐ Complete and submit Sections 1, 2 and 11 of the Health Care Licensing Application, Residential Treatment Centers for Children and Adolescents, AHCA Form 3180-5004.

☐ Applicable Community Residential Home Affidavit of Compliance form or zoning documentation.

☐ 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 change Administrator or Financial Officer:***

☐ Complete and submit Sections 1A, 2, 8 and 11 of the Health Care Licensing Application, Residential Treatment Centers for Children and Adolescents, AHCA Form 3180-5004

☐ 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.

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

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

Health Care Licensing Application
RESIDENTIAL TREATMENT CENTERS
FOR CHILDREN AND ADOLESCENTS

Under the authority of Chapters 408, Part II and 394, Florida Statutes (F.S.), and Chapters 59A-35 and 65E-9, Florida Administrative Code (F.A.C.), an application is hereby made to operate a residential treatment center as indicated below:

1. Provider / Licensee Information

A. Provider Information – please complete the following for the residential treatment center name and location.
Provider name, address and telephone number will be listed on http://www.floridahealthfinder.gov/

License # (for renewal & change of ownership applications)	**National Provider Identifier** (NPI) (if applicable)	**Medicare #** (CMS CCN)	**Medicaid #**

Name of Residential Treatment Center (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 address)

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 residential treatment center.

Licensee Name (maybe 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	Not for Profit	Public
☐ Corporation	☐ Corporation	☐ State
☐ Limited Liability Company	☐ Religious Affiliation	☐ City/County
☐ Partnership	☐ Other	☐ Hospital District
☐ Individual		
☐ Sole Proprietor		
☐ Other		

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.

☐ 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/replacement license, proposed effective date: _____

- ☐ Name/address change
- ☐ Increase/decrease in number of licensed beds from _____ to _____
- ☐ Change of service
- ☐ Change in Administrator or Financial Officer (No fee required)

Action	Fee	TOTAL FEES
License Fee (Initial, Renewal and Change of Ownership):	**$240.00 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 Section 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 SSNs)	Telephone Number / Fax
Street Address		E-mail Address	
City	County	State	Zip
Mailing Address or ☐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			

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. Capacity / Services

A. Number of beds to be licensed: _____ (There is a maximum capacity of 12 beds for Therapeutic Group Homes)

B. Residential Treatment Center is for (check all that apply)

☐ Children through age 12
☐ Adolescents ages 13 through 17

C. ☐ Center is to be licensed as a Therapeutic Group Home

D. Are restraints used by the facility? ☐ YES ☐ NO

NOTE: Any facility using restraints must comply with standards established by the Centers for Medicare and Medicaid Services (CMS). The Agency for Health Care Administration will monitor the facility's use of restraints.

8. Personnel

Administrative Personnel:

TITLE	NAME	TELEHPONE NUMBER	E-MAIL
Administrator/Managing Employee			
Financial Officer			

9. Co-Location of Other Programs

List any other programs that are to be co-located with the RTC:	

NOTE: Advance written approval must be received from the local DCF Children's Mental Health Office and from the Agency for Health Care Administration's Hospital and Outpatient Services Unit prior to co-locating any other program with the RTC. Children from another program are not permitted to co-mingle or share common spaces at the same time as the children residing in the RTC.

10. 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.

11. 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