



# 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 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 **The application will be withdrawn from review if all the required documents and fees are not included with this application or received within 21 days of an omission notice.**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/Publications/Forms/HQA.shtml>. Send completed applications to: Agency for Health Care Administration, Hospital and Outpatient Services Unit, 2727 Mahan Drive, Mail Stop 31, Tallahassee, FL 32308.

#### A. Initials, Renewals 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 biennial licensure fee (**CSU/SRT = \$195.00 per bed; RTF = \$184.00 per bed**). Please make check or money order payable to the *Agency for Health Care Administration (AHCA)*. All fees are nonrefundable
- 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 1 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 2 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
- Accreditation Survey Report (if applicable)
- Baker Act Receiving Facility Designation (CSU/SRT Only)
- AIDS/HIV Training Affidavit (CSU/SRT Only)
- A Level 2 background screening for the Administrator and Chief Financial Officer is required every 5 years.
  - The  Administrator and/or  Chief Financial Officer submitted a Level 2 screening through a **LiveScan vendor** approved to submit fingerprint requests through the Florida Department of Law Enforcement (FDLE). For more information regarding LiveScan vendors please see the Agency's background screening website at: [http://ahca.myflorida.com/MCHQ/Long\\_Term\\_Care/Background\\_Screening/index.shtml](http://ahca.myflorida.com/MCHQ/Long_Term_Care/Background_Screening/index.shtml).
  - The  Administrator and/or  Chief Financial Officer are out of state and do not have access to a Florida LiveScan vendor. (**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 [bgscreen@ahca.myflorida.com](mailto:bgscreen@ahca.myflorida.com)). A fingerprint card and fee will 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 individual trained in processing fingerprints. Return the completed card to:  
3M Cogent  
Attn: FL Cardscan  
5025 Bradenton Ave, Ste A  
Dublin, OH 43017  
Website: [www.cogentid.com](http://www.cogentid.com)
- The fingerprint card may also be sent to other LiveScan vendors authorized to provide services in Florida as long as they are equipped to transmit the images of the fingerprints from the fingerprint card electronically. This requires special equipment and not all LiveScan vendors have this ability. For more information you may find LiveScan vendor contact information on the FDLE website: <http://www.fdle.state.fl.us/Content/Criminal-History/Livescan-Service-Providers-and-Device-Vendors.aspx>.

All screening results must be sent to the **Agency for Health Care Administration** (Agency) for review and employment determinations. If you choose to use a LiveScan source other than the Agency's contracted vendor you **must provide** the following **ORI FL922020Z** and 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.

The Agency created a form that you may use to take to the vendor. You may access this form on the Agency's website at: [http://ahca.myflorida.com/MCHQ/Long\\_Term\\_Care/Background\\_Screening/index.shtml](http://ahca.myflorida.com/MCHQ/Long_Term_Care/Background_Screening/index.shtml).

- Proof of Level 2 screening within the previous 5 years for the  Administrator and/or  Chief Financial Officer from the Agency for Health Care Administration, Department of Children and Families, Department of Health, 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) is included with this application. An Affidavit of Compliance with Background Screening Requirements, AHCA Form 3100-0008, is also enclosed.

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#### **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

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#### **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

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#### **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 = \$195.00 per bed x \_\_\_\_\_ number of new beds = \_\_\_\_\_**; **RTF = \$184.00 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
- 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

The Agency for Health Care Administration scans all documents for electronic storage. In an effort to facilitate this process, we ask that you **please place checks, money orders and fingerprint cards on top of the application and paperclip** everything together. Please **do not staple or bind 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

<b>A. Provider Information – please complete the following for the CSU, SRT or RTF name and location.</b> <i>Provider name, address and telephone number will be listed on <a href="http://www.floridahealthfinder.gov/">http://www.floridahealthfinder.gov/</a></i>			
License # (for renewal & change of ownership applications)	National Provider Identifier (NPI) (if applicable)	Medicare # (CMS CCN)	Medicaid #
Name of CSU, SRT or RTF (if operated under a fictitious name, list that here)			
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		<b>NOTE:</b> By providing your e-mail address you agree to accept e-mail correspondence from the Agency	

<b>B. Licensee Information – please complete the following for the entity seeking to operate the CSU, SRT or RTF.</b>			
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):			
<b>For Profit</b> <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Partnership <input type="checkbox"/> Individual <input type="checkbox"/> Other	<b>Not for Profit</b> <input type="checkbox"/> Corporation <input type="checkbox"/> Religious Affiliation <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Other	<b>Public</b> <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. All 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  
 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

Was this entity previously licensed as a CSU/SRT or Residential Treatment Facility in Florida?

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:
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- Renewal Licensure  
 Change of Ownership  
 Change During License Period:

Proposed Effective Date: \_\_\_\_\_

Proposed Effective Date: \_\_\_\_\_

- Name change of the facility  
 Increase/Decrease in number of licensed beds from \_\_\_\_\_ to \_\_\_\_\_

### 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	\$195.00 per bed x _____ number of beds \$184.00 per bed x _____ number of beds	\$
Change During Licensure Period/Replacement License	\$ 25.00	\$
Other: _____		\$
Other: _____		\$
<b>TOTAL FEES INCLUDED WITH APPLICATION:</b>		<b>\$</b>
<i>Please make check or money order payable to the Agency for Health Care Administration (AHCA)</i>		

### 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.

**Voluntary Board Member**, as defined in subsection 408.803(13), Florida Statutes, means a board member or officer of a not-for-profit corporation or organization who serves solely in a voluntary capacity, does not receive any remuneration for his or her services on the board of directors, and has no financial interest in the corporation or organization.

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**

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

**C. Voluntary Board Members and Officers of Licensee**

If the licensee is a not-for-profit corporation/organization, provide the requested information for **each individual that serves as a voluntary board member**. Attach additional sheets if necessary.

FULL NAME	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER

**D. Administration**

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

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**4. Management Company Controlling Interests**

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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**

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

**C. Voluntary Board Members and Officers of Management Company**

If the management company is a not-for-profit corporation/organization, provide the requested information for **each individual that serves as a voluntary board member**. Attach additional sheets if necessary.

FULL NAME	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER

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**5. Required Disclosure**

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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

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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.

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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, within the previous 15 years prior to the date of this application;
- YES  NO  Terminated for cause from the Florida Medicaid program pursuant to s. 409.913, and not been in good standing with the Florida Medicaid program for the most recent 5 years;
- YES  NO  Terminated for cause, pursuant to the appeals procedures established by the state or federal government, from the federal Medicare program or from any other state Medicaid program, have not been in good standing with a state Medicaid program or the federal Medicare program for the most recent 5 years and the termination was less than 20 years prior to the date of this application.

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## 6. Provider Fines and Financial Information

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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.**

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## 7. Accreditation

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The applicant participates in:

Not accredited  The Joint Commission  CARF  COA  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.

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## 8. Personnel

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Provide the requested information for all licensed personnel (medical staff, nurses, technicians, therapists, and consultants). Attach additional pages if needed.

FULL NAME	PROFESSION TYPE	JOB TITLE	FLORIDA LICENSE OR REGISTRATION NUMBER

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## 9. Affidavit

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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 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

**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