



NOTIFICATION OF CHANGE OF ADMINISTRATOR

Name of Assisted Living Facility License # (____) _____
Telephone

Facility Street Address City County Zip Code

Signature of Owner/Authorized Agent

Date

Please provide the following information for the person to be designated as administrator:

Effective Date: _____

Name: _____ Date of Birth: _____ SSN: _____

The Agency for Health Care Administration is required to obtain your social security number pursuant to section 429.11(3), Florida Statutes. Disclosure of your social security number is mandatory. Your social security number will be used to secure the proper identification of the person listed on this notification.

Mailing Address: _____ Phone (____) _____

Do you have a high school diploma ? Yes No G.E.D.?

Are you a licensed nursing home administrator pursuant to part II of chapter 468, F.S.?
 Yes No License Number: _____.

Will you be serving as the administrator of more than this ALF ? Yes No.
[Note: An administrator may manage a maximum of 3 ALFs.]

Name of Facility: _____ License Number: _____

Name of Facility: _____ License Number: _____

Affiliations –

Please list the name(s) of any entity licensed by this state or another state to provide health or residential care with which the administrator has been affiliated through ownership or employment within the last 5 years. [Attach additional sheets if necessary.]

Name & Type of Facility/Service Entity:

Address:

Dates of Affiliation: _____ Employee? ___ Owner? ___ If owner, % of ownership? _____

If the entity has closed or ceased to operate due to financial problems; had a receiver appointed; had its license denied, suspended, or revoked; was subject to a moratorium on admissions; or had an injunctive proceeding initiated against it, please provide a detailed description and explanation of the occurrence. [Attach additional sheets if necessary.]

Adverse Action: ___ Yes? ___ No? If yes, description, explanation, and date of occurrence _____

References - Please provide two references of whom the agency may inquire as to the administrator's character, reputation, and financial responsibility:

Name

Address

Phone

Background Screening - Pursuant to § 429.174, F.S., and rule 58A-5.019, F.A.C., all facility administrators are subject to Level 2 background screening. Please attach required screening form and fee.

AHCA Form 3180-1006, Jan. 06 AHCA ALU, 2727 Mahan Drive, MS 30, Tallahassee, FL 32308 (850) 487-2515 Fax: (850) 410-1476
Form available at: http://ahca.myflorida.com/MCHQ/Long_Term_Care/Assisted_living/alf.shtml