[](http://ahcaportal/multimediadesign/PNI/Agency%20Logos/Forms/AllItems.aspx)

**APPLICATION CHECKLIST**

#### HEALTH CARE CLINICS

The Agency for Health Care Administration (AHCA) has implemented the **ONLINE LICENSING SYSTEM,** whichallows the electronic submission of renewal and change during licensure period applications and fees, along with the ability to upload supporting documentation.

To submit online please go to:<http://ahca.myflorida.com/onlinelicensure>

**This application checklist is for informational purposes only – to be used as a guide for applicants when completing the licensing application process. All forms listed below may be obtained from the website:** <http://ahca.myflorida.com/HQAlicensureforms>**. Send completed applications to: Agency for Health Care Administration, Hospital and Outpatient Services Unit, 2727 Mahan Drive, MS 53, Tallahassee, FL 32308.**

**Application types and definitions:**

**Initial (I)** – application for an initial license/registration/certification

**Renewal (R)** – biennial renewal of existing license/registration/certification

**Change of Ownership (CHOW)** – licensee sells/transfers ownership to a different individual/entity or change of 51% or more of the ownership (controlling interest of licensee)

**Change During Licensure Period (C)** – request to amend /change provider information

**Fee Required:**

* Name Change
* Address Change
* Clinic Type
* Replacement License

**No Fee Required:**

* Stock Transfer of less than 51%
* Management Company Change
* Personnel Change
* Hours of Operation
* Clinic Services

In order to provide the Agency with a complete application and expedite the licensure process, it may be helpful to gather the following information:

**Provider Information- (Application Types: All)**

Fictitious name (if applicable), street address, mailing address, telephone number, fax number, email address, website

address, and if applicable, Medicare provider number, Medicaid provider number and National Provider Identifier (NPI)

**Licensee (Owner) Information (Application Types: All)**

Organization type, complete legal name, mailing address, EIN/SSN, email address, telephone number, and fax number. Legal name and address submitted with application must be the same that is registered with Department of State, Division of Corporations

**Contact Person** **(Application Types: All)**

Name, email address, and telephone number

**Licensee Controlling Interests, Board Members, and Officers** **(Application Types: All)**

Name, EIN/SSN, mailing address, telephone number, % ownership interest and effective date for each controlling interest, board member and officer

**Management Company, (if applicable)** **(Application Types: All)**

Name, EIN, street address, mailing address, telephone number, fax number; email address, and contact person’s name, email address, and phone number

**Management Company Controlling Interests, Board Members, and Officer (Application Types: All)**

Name, EIN/SSN, mailing address, telephone number, % ownership interest and effective date for each controlling interest, board member and officer

**Personnel - (Application Types: All)**

Administrator: Name, SSN, date of birth, personal/primary address, email address, telephone number, effective and end dates of employment

Financial Officer: Name, SSN, personal/primary address, email address, telephone number, effective and end dates of employment

Medical or Clinic Director: Name, SSN, Florida healthcare license number, telephone number, email address, personal/primary address, business address, employment status, effective and end dates of employment and list additional licensed clinics supervised

Clinic Personnel: Name, SSN, position, and professional license information

**Disclosures - (Application Types: All)**

Legal information (if any) for licensee, licensee controlling interests, management company, and management company controlling interests related to any convictions of criminal offenses and any exclusions, suspensions or terminations from the Medicare or Medicaid programs or CLIA, if applicable

Surety bond for any nonimmigrant aliens

**Provider Fines and Financial Information - (Application Types: All)**

Assessing entities, related case numbers, dates of assessment, final orders, next payment due dates of any monies owed to the Agency (AHCA)

**Hours of Operations (Application Types: All)**

Regular operating days and hours

**Clinic Type and Services (Application Types: All)**

Type of clinic and services provided

**Accreditation for MRI (Application Types: All)**

Accreditation information if clinic provider magnetic resonance imaging services

**Request to Change the Address or Name of Provider**

Sections 1, 2 and 12 of the Health Care Licensing Application, AHCA Form 3110-0013

**Request to Change Administrator, Financial Officer, and Licensed Personnel or Staff**

Sections 1, 2, 5 and 12 of the Health Care Licensing Application, AHCA Form 3110-0013

Health Care Licensing Application Addendum, AHCA Form 3110-1024

No fee required

**Request to Change Medical or Clinic Director**

Sections 1, 2, 5 and 12 of the Health Care Licensing Application, AHCA Form 3110-0013

Health Care Licensing Application Addendum, AHCA Form 3110-1024

Medical /Clinic Director Attestation, AHCA Form 3110-1028

No fee required

**Supporting Documents**

Health Care Licensing Application Addendum, AHCA Form 3110-1024 - (Application Types: I, R, CHOW and Personnel Changes)

Financial Ability to Operate, AHCA Form 3100-0009 - (Application Types: I and CHOW)

Nonimmigrant Alien Surety Bond, if applicable

Medical /Clinic Director Attestation, AHCA Form 3110-1028 - (Application Types: I, R, CHOW and Medical/Clinic Director Changes

Medical/Clinic Director’s contract or agreement with the clinic including the effective date of service

Documentation of change of ownership transaction stating effective date and executed by all parties (Application Type: CHOW)

MRI accreditation, or letter of intent to achieve MRI accreditation within 12 months - (MRI providers only)

Required disclosures related to action(s) taken by Medicare, Medicaid or CLIA, if applicable

Approved repayment plan, if applicable

**Licensure Fee and Other Amounts Due upon Submission of Application (all fees are nonrefundable)**

The biennial licensure fee: $2000.00

The biennial health care assessment fee: $300.00

Fee for changes during licensure period that require issuance of a new license: $25.00

Other amounts due (fines, assessment, fees, etc.) will be detailed in the application

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| *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:*   * 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. |