

**APPLICATION CHECKLIST**

#### INTERMEDIATE CARE FACILITIES for the DEVELOPMENTALLY DISABLED

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**](http://ahca.myflorida.com/HQALicensureForms)**. Send completed applications to: Agency for Health Care Administration, Long-Term Care Services Unit, 2727 Mahan Dr, MS 33, Tallahassee, FL 32308-5407.**

**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
* Bed Capacity Change
* Replacement License

**No Fee Required:**

* Stock Transfer of less than 50%
* Management Company Change
* Personnel Change
* Property Owner

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, Florida 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

**Property Owner** **(Application Types: All)**

[ ]  Name, personal/primary address, and telephone number

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

[ ]  Name, EIN/SSN, date of birth, personal mailing address, email 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, name: email address and phone number of contact person

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

[ ]  Name, EIN/SSN, date of birth, personal mailing address, email 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, Florida healthcare license number (if applicable), effective and end dates of employment

[ ]  Financial Officer: name, SSN, date of birth, personal/primary address, email address, telephone number, Florida healthcare license number (if applicable), effective and end dates of employment

[ ]  Safety Liaison: name, SSN, date of birth, personal/primary address, email address, telephone number, effective and end dates of employment

**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

**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)

**Bed Counts (Application Types: All)**

[ ]  Bed type information

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

[ ]  Sections 1A, 1C, 1D, 2, 6 and 10 of the Health Care Licensing Application, AHCA Form 3110-5003

**Request to Change Administrator or Financial Officer**

[ ]  Sections 1, 1C, 5 and 10 of the Health Care Licensing Application, AHCA Form 3110-5003

[ ]  Section 1A and 4 of the Health Care Licensing Application Addendum, AHCA, Form 3110-1024

[ ]  No fee required

**Request to Change the Number Beds**

[ ]  Sections 1A, 1C, 1D, 2, 8, and 10 of the Health Care Licensing Application, AHCA Form 3110-5003

**Supporting Documents (Application Types: All, unless otherwise specified)**

[ ]  Description of the clients to be served including age range, level of care, sex, health status, ambulation status, medical diagnosis, presence of challenging behaviors, and special training or treatment needs (Application Types: I)

[ ]  Letter of intent or contract/agreement as appropriate for provisions of off-site programs (Application Types: I and CHOW)

[ ]  Copies of any civil verdict or judgment involving the applicant within the ten years preceding the application relating to medical negligence, violation of resident’s rights, or wrongful death (Application Types: I and CHOW)

[ ]  Evidence of application to Medicaid. Contact the Medicaid fiscal intermediary, ACS State Healthcare, at (800) 377-8216 or at the website <http://mymedicaid-florida.com> in order to obtain an application for enrollment in Medicaid. (Application Types: I and CHOW)

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

[ ]  Department of Health Food Service Inspection Report (Application Types: Renewal)

[ ]  Documentation from the appropriate local government officeshowing that the applicant has met local zoning requirements

[ ]  Fire Safety Inspection Report - (Application Types: All)

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

[ ]  Property Occupancy documentation, examples: facility ownership/lease documentation (if applicable) (Application Types: I, R, C, CHOW)

[ ]  Health Care Licensing Application Addendum, AHCA Form 3110-1024 (Application Types: All)

[ ]  Required disclosures related to action(s) taken by Medicare, Medicaid or CLIA (if applicable) (Application Types: All)

[ ]  Approved repayment plan (if applicable) (Application Types: All)

**Biennial Licensure Fee and Other Amounts Due Upon Submission of Application**

[ ]  The biennial licensure fee is $262.88 per bed

[ ]  The biennial assessment fee is $300

[ ]  Each change during licensure period that requires issuance of a new certificate is assessed a $25.00 fee

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

|  |
| --- |
| *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.
 |