

**Application Checklist**

#### Adult Day Care Center

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, Assisted Living Unit, 2727 Mahan Dr, MS 30, Tallahassee, FL 32308-5407.**

**Application types and definitions:**

**Initial** – application for an initial license/registration/certification

**Renewal** – 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:**

* Provider Name Change
* Provider Address Change
* Participant Capacity Change

**No Fee Required:**

* Transfer or assignment of less than 51% or more ownership, shares, membership, or controlling interest of the licensee
* Management Company Change
* Management Company Controlling Interest Change
* Personnel Change
* Hours of Operation

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

* The biennial licensure fee is $172.55
* Each Change During Licensure Period that requires issuance of a new certificate is assessed a $25.00 fee
* Late fee/fine may be assed for application not timely submitted pursuant to Section 408.806(2), Florida Statute (F.S.) and Rule Chapter 59A-35.040 (F.A.C.)
* Other amounts due (fines, assessment, fees, etc.) will be detailed in the application

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

**SECTIONS OF THE APPLICATIONS:**

**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 Corporation.

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

[ ]  Name, email address, and telephone number

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

[ ]  Name, email 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, and % ownership interest and effective date for each controlling interest, board member and officer

**Management Company (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 Officers (Application Types: All)**

[ ]  Name, EIN/SSN, date of birth, personal mailing address, email address, telephone number, and % ownership and effective date interest for each controlling interest, board member and officer

**Personnel (Application Types: All)**

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

[ ]  Financial Officer: Name, SSN, date of birth, primary address, email address, telephone number, 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, Medicaid or CLIA (if applicable)

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

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

**Facility Provisions and Services Provided (Application Types: All)**

[ ]  Square footage, total number of participants, and optional services offered

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

[ ]  Regular operating days and hours

**CHANGE DURING LICENSURE APPLICATION TYPES:**

**Request to Change the Name**

[ ]  Sections 1A, 1C, 2, 7, and 13 of the Health Care Licensing Application, AHCA Form 3180-1004

[ ]  $25.00 Duplicate License Fee

**Request to Change the Address**

[ ]  Sections 1, 2, 7 and 13 of the Health Care Licensing Application, AHCA Form 3180-1004

[ ]  $25.00 Duplicate License Fee

**Request to Change Operator or Financial Officer (Personnel Change)**

[ ]  Sections 1A, 1C, 2, 6A, and 13 of the Health Care Licensing Application, AHCA Form 3180-1004

[ ]  Sections 1A, 4, and 5 of the Health Care Licensing Application Addendum, AHCA, Form 3110-1024

[ ]  No fee required

**Request to Change Safety Liaison (Personnel Change)**

[ ]  Sections 1A, 1C, 2, 6B, and 13 of the Health Care Licensing Application, AHCA Form 3130-8001

[ ]  No fee required

**Request to Change Participant Capacity**

[ ]  Sections 1A, 1C, 2, 9, and 13 of the Health Care Licensing Application, AHCA Form 3180-1004

[ ]  $25.00 Duplicate License Fee

**Request to add or remove Specialized Alzheimer’s Services**

[ ]  Sections 1A, 1C, 2, 10, and 13 of the Health Care Licensing Application, AHCA Form 3180-1004

[ ]  No fee required

**Request to Change Hours of Operations**

[ ]  Sections 1A, 1C, 2, 11, and 13 of the Health Care Licensing Application, AHCA Form 3180-1004

[ ]  No fee required

**Request to Change Management Company**

[ ]  Sections 1A, 1C, 2, 4, 7, 8, and 13 of the Health Care Licensing Application, AHCA Form 3180-1004

[ ]  No fee required

**Request to Change Management Company Controlling Interest**

[ ]  Sections 1A, 1C, 2, 4, 5, 7, 8, and 13 of the Health Care Licensing Application, AHCA Form 3180-1004

[ ]  Section 1A, 3, and 5 of the Health Care Licensing Application Addendum, AHCA, Form 3110-1024

[ ]  No fee required

**Request for Stock Transfer of less than 51%**

[ ]  Sections 1A, 1C, 2, 3, 7, 8, and 13 of the Health Care Licensing Application, AHCA Form 3180-1004

[ ]  Section 1A, 2, and 5 of the Health Care Licensing Application Addendum, AHCA, Form 3110-1024

[ ]  No fee required

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

[ ]  Current general liability insurance coverage - (Application Types: All)

[ ]  Fire safety inspection report - (Application Types: All)

[ ]  Financial ability to operate – Form Number 3100-0009. – (Application Types: I and CHOW)

[ ]  Department of Health food inspection report - (Application Types: All)

[ ]  Department of Health septic system or water supply evaluation report - (Application Types: I, C and CHOW)

[ ]  Property occupancy, examples: lease, mortgage, and transfer agreement - (Application Types: ALL)

[ ]  Documentation from the appropriate local government officeshowing that the applicant has met local zoning requirements - (Application Types: I and CHOW)

[ ]  Health Care Licensing Application Addendum, AHCA Form 3110-1024

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

[ ]  Required disclosures related to action taken by Medicare, Medicaid or CLIA, if applicable

[ ]  Approved repayment plan, if applicable

[ ]  Copy of Comprehensive Emergency Management Plan (CEMP) Approval Letter or Documentation of the CEMP submission for

 review within the last 365 days (Application Types: R)

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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:** 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.
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