

**Application Checklist**

#### Adult Family Care Home

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 renew 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 (I)** – application for an initial license

**Renewal (R)** – biennial renewal of existing license

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

**Fee Required:**

* Name Change
* Address Change

**No Fee Required:**

* Personnel Change

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

* The biennial licensure fee is $226.34
* 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 APPLICATION:**

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

[ ]  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

**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, effective and end dates of employment

[ ]  Designated Relief Person; Name SSN, date of birth, personal/primary address, email address, telephone number, effective and end dates of employment and Florida healthcare license number (if applicable)

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

[ ]  Other Household Member(s): name, SSN date of birth, personal/primary address, email address, telephone number effective and end dates of employment

**Disclosures (Application Types: All)**

[ ]  Legal information for licensee and licensee 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).

**Number of Residents (Application Types: All)**

[ ]  Total number of residents

**CHANGE DURING LICENSURE APPLICATION TYPES:**

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

[ ]  Sections 1A, 2, and 8 of the Health Care Licensing Application, AHCA Form 3180-1022

[ ]  $25.00 Duplicate License Fee

**Request to Change Personnel**

[ ]  Sections 1A, 2, 3, and 8 of the Health Care Licensing Application, AHCA Form 3180-1022

[ ]  Section 1A, 3, and 5 of the Health Care Licensing Application Addendum, AHCA, Form 3180-1024

[ ]  No fee required

**Request to Change the Number of Residents**

[ ]  Sections 1A, 2, 6, and 8 of the Health Care Licensing Application, AHCA Form 3180-1022

[ ]  $25.00 Duplicate License Fee

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

[ ]  Fire safety inspection report – (Application Types: I, R, Change of Address and Capacity Increase)

[ ]  Documentation from the appropriate local government office showing that the applicant has met local zoning requirements - (Application Types: I, Change of Address and Capacity Change)

[ ]  Documentation proving compliance with the community residential homes site selection requirements specified pursuant to

 Chapter 419, Florida Statutes, if applicable – (Application Types: I, Change of Address and Capacity Increase)

[ ]  Department of Health residential group care inspection report - (Application Types: All)

[ ]  Income and Expenses Report, AHCA Form 3108-1017 - (Application Types: I)

[ ]  Documentation of homestead exemption or lease or rental agreement accompanied by corresponding utility bill and telephone

bill, or personal identification issued by a state or federal agency (Application Types: I and Change of Address)

[ ]  Documentation from the appropriate local government office showing that the applicant has met local zoning requirements – Application Types: I and Capacity Change)

[ ]  Health Care Licensing Application Addendum, AHCA Form 3110-1024 – (Application Types: I, R and Change of Address)

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

[ ]  Approved repayment plan (if applicable)

|  |
| --- |
| *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.
 |