

**Application Checklist**

**Nurse Registry**

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%20)

**Send completed applications to: Agency for Health Care Administration, Laboratory and In-Home Services Unit, 2727 Mahan Drive, MS 32, 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 information that displays on the license

**Fee Required:**

* Name Change
* Address Change
* Satellite Address Change
* Geographic Service Area 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
* Service Change

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

* The biennial licensure fee is $2,000
* The replacement license certificate fee is $25
* 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 Type: All)**

[ ]  Name (or 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 Type: 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 Type: All)**

[ ]  Name, email address, and telephone number

**Licensee Controlling Interests, Board Members, and Officers** **(Application Types: I, R, CHOW, C, if applicable)**

 [ ]  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: I, R, CHOW, C, if applicable)**

 [ ]  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: I, R, CHOW, C, if applicable)**

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

**Personnel (Application Types: I, R, CHOW, C, if applicable)**

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

[ ]  Alternator Administrator: SSN, date of birth, personal/primary address, email address, telephone number, florida license number, experience, effective and end dates of employment

[ ]  Registered Nurse: SSN, date of birth, personal/primary address, email address, telephone number, florida license number, experience, 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

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

**Required 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: I, R, CHOW, C, if applicable)**

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

**Days and Hours of Operations Types: I, R, CHOW, C, if applicable)**

[ ]  Regular operating days and hours

**Geographic Service Area (Application Types: I, R, CHOW, C, if applicable)**

[ ]  Counties served

**Services (Application Types: I, R, CHOW, C, if applicable)**

[ ]  Health care personnel provided

**Other Associated Locations (Application Types: I, R, CHOW, C, if applicable)**

[ ]  Street address, city zip, county, telephone number

**CHANGE DURING LICENSURE APPLICATION TYPES:**

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

[ ]  Sections 1A, 1B, 1C, 2, and 13 of the Health Care Licensing Application, AHCA Form 3110-7004

[ ]  $25.00 Duplicate License Fee

**Request to Change the Satellite/Drop-Off Site**

[ ]  Sections 1A, 1B, 1C, 2, 11, and 13 of the Health Care Licensing Application, AHCA Form 3110-7004

[ ]  $25.00 Duplicate License Fee

**Request to Change the Geographic Service Area**

[ ]  Sections 1A, 1B, 1C, 2, 9, and 10 of the Health Care Licensing Application, AHCA Form 3110-7004

[ ]  $25.00 Duplicate License Fee

**Request to Change in Services Provided**

[ ]  Sections 1A, 1C, 2, 10, and 13 of the Health Care Licensing Application, AHCA Form 3110-7004

[ ]  No fee required

**Request to Change Personnel**

[ ]  Sections 1A, 1C, 2, 5, and 13 of the Health Care Licensing Application, AHCA Form 3110-7004

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

[ ]  No fee required

**Request for Change Management Company**

[ ]  Sections 1A, 1C, 2, 4, and 13 of the Health Care Licensing Application, AHCA Form 3110-7004

[ ]  No fee required

**Request for Change Management Company Controlling Interest**

[ ]  Sections 1A, 1C, 2, 4, and 13 of the Health Care Licensing Application, AHCA Form 3110-7004

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

[ ]  No fee required

**Request for Hours of Operation**

[ ]  Sections 1A, 1C, 2, 8, and 13 of the Health Care Licensing Application, AHCA Form 3110-7004

[ ]  No fee required

**Request for Transfer or assignment of less than 51% or more ownership, shares, membership, or controlling interest of the licensee**

[ ]  Sections 1A, 1C, 2, 3, and 13 of the Health Care Licensing Application, AHCA Form 3110-7004

[ ]  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)**

[ ]  Financial Ability to Operate, AHCA Form 3110-7004A – (Application Types: I and CHOW)

[ ]  Documentation from local government proving compliance with local zoning requirements – (Application Types: I, CHOW, C)

[ ]  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)

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

[ ]  A signed agreement to pay any outstanding payments owed to the Agency. The agreement must include who will pay and when payment will be made – (Application Type: CHOW)

[ ]  Health Care Licensing Application Addendum, AHCA Form 3110-1024 – (Application Types: I, R, CHOW, C-Personnel)

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

[ ]  Approved repayment plan (if applicable)

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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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