

**Application Checklist**

**Nursing 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 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
* Inactive Request

**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
* Personnel Change
* Property Owner Change

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

* The biennial licensure fee is $112.50 per bed
* The biennial licensure fee for sheltered bed is $100.50 per bed
* The biennial assessment fee is $4 per bed (annual fee of $2 per bed x 2 years) not to exceed $500 per facility
* 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 Chanter 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)**

[ ]  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, primary 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, 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

**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

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

[ ]  Information on general bed, payment, religious affiliation, languages spoken by staff, special programs, special services and nurse available that will be provided to consumers

**CHANGE DURING LICENSURE APPLICATION TYPES:**

**Request to Change Administrator or Financial Officer**

[ ]  Sections 1A, 1C, 6A, and 13 of the Health Care Licensing Application, AHCA Form 3110-6001

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

[ ]  No fee required

**Request to Change Bed Count**

[ ]  Sections 1A, 1C, 2, 10, and 13 of the Health Care Licensing Application, AHCA Form 3110-6001

[ ]  Bed fees as applicable

**Request to Change/Update Consumer Information**

[ ]  Sections 1A, 1C, 11, and 13 of the Health Care Licensing Application, AHCA Form 3110-6001

[ ]  No fee required

**Request to Inactive License (partial or full)**

[ ]  Sections 1A, 1C, 2, 10, and 13 of the Health Care Licensing Application, AHCA Form 3110-6001

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

[ ]  Inactive Request letter

[ ]  No fee required

**Request to Reactivate Inactive License (partial or full)**

[ ]  Health Care Licensing Application, AHCA Form 3110-6001

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

[ ]  Reactivate Inactive Request letter

[ ]  Bed fees as applicable

**Request to Change/Update Property Owner**

[ ]  Sections 1A, 1B, 1C, and 13 of the Health Care Licensing Application, AHCA Form 3110-6001

[ ]  No fee required

**Request to Change Management Company**

[ ]  Sections 1A, 1C, 2, 4, and 13 of the Health Care Licensing Application, AHCA Form 3110-6001

[ ]  No fee required

**Request to Change Management Company Controlling Interest**

[ ]  Sections 1A, 1C, 2, 5, and 13 of the Health Care Licensing Application, AHCA Form 3110-6001

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

[ ]  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, 3, 5, 7, 8, and 15 of the Health Care Licensing Application, AHCA Form 3110-6001

☐ 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)**

[ ]  Patient Trust Surety Bond (Application Types: I, R, and CHOW

[ ]  General and Professional Liability Insurance Coverage - (Application Types: All)

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

[ ]  Surety or Continuation Bond (Application Types: All)

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

[ ]  Medicaid Lease Bond, if applicable, (Applications Types: All)

[ ]  Fire Safety Inspection Report - (Application Types: I, CHOW)

[ ]  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, CHOW)

[ ]  Plan for quality assurance and for conducting risk management (Application Types: I, CHOW)

[ ]  Bed change request form for beds certified through the Centers for Medicare and Medicaid Services (Application Type: (Application Types: C)

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

[ ]  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)

[ ]  Copy of Visitation Policy and Procedure (Application Types: Initial, Renewal and CHOW)

[ ]  Change of ownership closing documents signed and dated by all parties (Application Types: CHOW)

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

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

[ ]  Approved repayment plan (if applicable)

[ ]  Inactive Request Letter needs to include:

* + Reason part or all facility will become inactive
	+ Total number of beds affected
	+ Date the beds will become inactive
	+ Partial inactive – describe the intended use (alternative service) for the inactive portion and include a schematic drawing identifying the inactive area
	+ For a full facility inactive license provide a plan for resuming services and the date by which services are expected to resume

[ ]  Reactivation of Inactive license

* + Date the facility anticipates becoming active
	+ The total number of beds that will be reactivated
	+ Submit bed change request forms for beds certified through the Centers for Medicare and Medicaid Services
	+ For partial inactive licenses that utilized the space for a licensed alternative service, return the license issued for the alternative service

**NOTICE:**  If you are a **Medicaid** provider, you may have a separate obligation to notify the Medicaid program of a name/address change, change of ownership or other change of information.  Please refer to your Medicaid handbooks for additional information about Medicaid program policy regarding changes to provider enrollment information.

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| *The Agency for Healthcare 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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**Additional Instructions for New Medicare Provider Agreement for**

**Change of Ownership / Change of Licensed Operator Application**

 Change of Ownership (CHOW) / Change of Licensed Operator where the NEW OWNER requests a NEW Medicare Provider Agreement

* New Owner **must send a letter to the *Centers for Medicare & Medicaid Services Regional Office* 45 days prior** to the effective date of the Change of Ownership (CHOW) **indicating their refusal to accept assignment** of the existing Medicare agreement. **Send copy** of this letter to the Agency for Health Care Administration.

***CMS Regional Office (RO):*** ***AHCA State Agency (SA) Copy to:***

Centers for Medicare & Medicaid Services Agency for Health Care Administration

Division of Medicaid & State Operations Long Term Care Unit

The Atlanta Federal Center 2727 Mahan Drive, MS 33

61 Forsyth Street, Suite 4120 Tallahassee, Florida 32308

Atlanta, Georgia 30303-8909

* Request for a new Medicare Provider Agreement **will require an initial Certification Survey for both Medicare and Medicaid participation** and will result in a period of time that the **provider will not receive Medicare or Medicaid reimbursement** for services.

**MEDICARE STATE OPERATIONS MANUAL (SOM)**

03-98 ADDITIONAL PROGRAM ACTIVITIES 3210.5

 **3210.5. NEW OWNER REFUSES TO ACCEPT ASSIGNMENT OF THE PROVIDER AGREEMENT**

**(Revised 05-21-04)**

A. New Owner Refuses to Accept Assignment of Previous Owner's Provider Agreement. A new owner may refuse to accept assignment of the previous owner's provider agreement, but this means that the existing provider agreement terminated effective with the CHOW date. The refusal to accept assignment should be put in writing by the new owner and forwarded to the RO 45 calendar days prior to the CHOW date to allow for the orderly transfer of any beneficiaries that are patients of the provider. The refusal can take the form of a letter initiated by the prospective owner or can be indicated in response to a letter sent to the new owner by the RO or the SA that is designed to document the new owner’s desire to continue program participation.

In all cases of refusal to accept assignment, all reasonable steps must be taken to ensure that beneficiaries under the care of the provider are aware of the prospective termination of the agreement. In this situation, there may be a period when the facility is not participating, and beneficiaries must have sufficient time and opportunity to make other arrangements for care prior to the CHOW date.

After the CHOW has taken place, the RO acknowledges the refusal to accept assignment in a letter to the new owner, with copies to the SA and the FI (Fiscal Intermediary). The RO completes a Form HCFA-2007 with the date the agreement is no longer in effect, noting that the termination is due to the new owner's refusal to accept assignment of the provider agreement.

It is the responsibility of a prospective purchaser of a Medicare provider to know that it can refuse to accept assignment of the provider agreement and that it should formally indicate its choice in that regard. If, however, the CHOW goes into effect without a refusal or acceptance of assignment on record, the RO concludes that the agreement has been automatically assigned to the new owner and completes processing of the CHOW.

If the new owner refuses to accept assignment after the date the CHOW has taken place, the RO should contact its regional attorney for guidance.

If a new owner refuses to accept assignment and also wishes to participate in the Medicare program, the RO first processes the refusal as indicated above and then treat the new owner as it would any new applicant to the program: obtain and process application documents, have the SA perform an initial survey and, if all requirements for participation are met, assign an effective date of participation based upon the applicable regulation. (See 42 CFR 489.13.)

The earliest possible effective date for the applicant is the date the RO determines that all Federal requirements are met. The Federal requirements include, in addition to the CoP, enrollment as described in §2005, capitalization (HHAs), and any other special requirements such as the special provisions for psychiatric hospitals at 42 CFR 482.60. The aforementioned requirements are the same regardless of whether the new owner operates a non-accredited facility or is seeking Medicare compliance with the CoP via deemed status.

As mentioned above, these requirements include enrollment of the provider in accordance with the instructions in §2005. The Form CMS-855 must be submitted prior to the CHOW date. However, the subsequent survey of the new applicant must be performed (1) after the CHOW, because the provider agreement of the former owner terminates effective with the CHOW date and the new owner must be treated as a new Medicare applicant; and (2) after the FI makes a recommendation to CMS for approval in accordance with the current procedures. If for any reason the accrediting body of the entity seeking deemed status chooses not to conduct or to delay a survey of the new entity, CMS will inform the entity that it will be unable to participate in the Medicare program until a survey is conducted and CMS is assured that the new entity meets all applicable health and safety requirements. In such a circumstance the new applicant may choose to have the SA conduct its survey.

B. Withdrawal After CHOW - Provider. --If, after a CHOW takes place, the RO receives notice that the new owner of a provider desires to withdraw from the program, the RO consults with the new owner to set a withdrawal date designed to protect the health and safety of program beneficiaries who may be patients of the provider. The RO sets a withdrawal date of up to 6 months beyond the provider's notice of intent to withdraw. Under these circumstances, the RO processes a complete CHOW notice and a withdrawal.

C. CHOW and Withdrawal - Supplier. --If the new owner of a supplier declines to participate, the RO negotiates a withdrawal date that does not disadvantage any program beneficiaries the supplier may be serving. The RO processes the supplier withdrawal as usual.