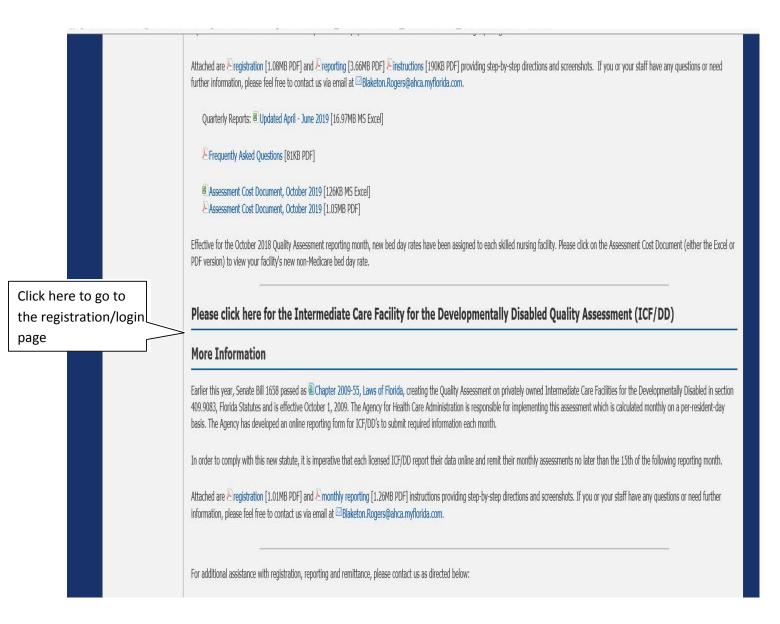
In order to comply with s. 409.9083, F.S., all Intermediate Care Facilities for the Developmentally Disabled licensed under part VIII of chapter 400, F.S. shall report resident day data. Facilities must register prior to reporting. Registration is a two-part process initiated by the ICF/DD and finalized by the Agency. To register, the ICF/DD must first complete the registration form online at: https://apps.ahca.myflorida.com/nfqa/. The link, Please click here for the ICF/DD Assessment, takes you to the registration home page. *Registration will not be available until 10/26/2009*.

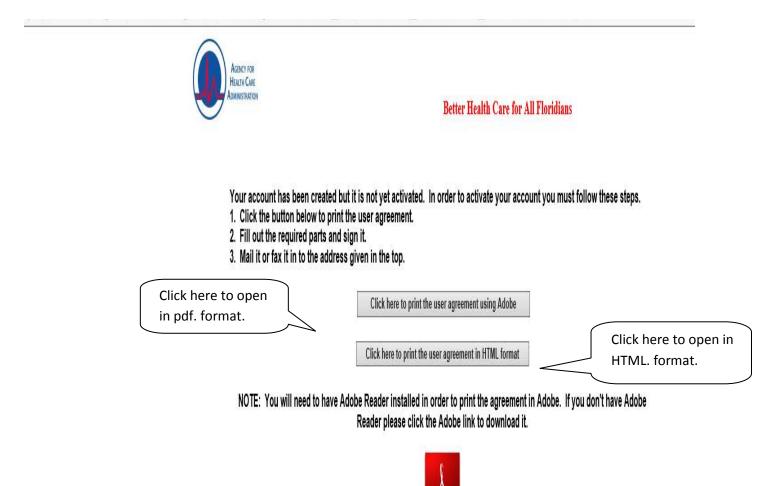


Click on New Users Register Here.

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© 2017 Florida Agency for Health Care Administration	Privacy Policy Doing Business	; with AHCA Refun	d Policy Disclaimer Contact We	bmaster Find a Facility	Download Adobe Reader		mut
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Create a User ID and password that meets criteria and complete the registration form data. If you are reporting for more than one facility, you must create a separate User ID for each facility. Your password must have 6-10 characters. Please do not include special characters (!@#\$%^ etc...) when creating your user id and password. Once the form is complete click **SUBMIT.** All data must be complete and meet criteria. If not, the website will inform you of any errors before acceptance.

Upon completion of the registration form, a User Agreement Form must be printed out for signature. You are able to view and print in either pdf. or HTML format.



The User Agreement Form should automatically open. If the form does not open, save the file to your desktop and then open. This form includes all the data you just submitted on the registration form. Print and return the signed User Agreement Form by fax to (850) 922-3659 or e-mail to NFQA@ahca.myflorida.com. The form must be signed and dated by the user and Administrator. The User and Administrator may be the same person. If that is the case, please sign both signature lines. Upon receipt of the nursing home facility's User Agreement Form, the Agency will approve the nursing home facility will then have the ability to log in and report net patient revenue and patient day data to the Agency.

	\bigcirc	Facility Quality Assessment System Provider User Account Agreement					
	AGENCY FOR						
	HEALTH CARE ADMINISTRATION	Print Date: 10/7/2019					
		Thin bate. Tom2010					
	Mail To:						
	Agency for Health Care Administration	Provider Name: Abbey Delray					
	2727 Mahan Dr, MS #14	User Type: Health Care Provider					
	Tallahassee, FL 32308 Finance & Accounting - NFQAF/ICFDD						
	Memo: NEOA/ICEDD Eacility User Agreement						
	Phone: (850) 412-3858 Fax: (850) 4						
User Name	> User Name: Street Second	User ID: MPFSTREET					
	Phone#: (888)888-8888	License#: 1201096					
	Email Address: MPFStree@ahca.myflorida.com						
	Address: 2105 SW 11TH COURT	DELRAY BEACH, FL 33445					
	As an NFQA/ICFDD Facility Quality Assessment System user I agree to abide by the following:						
The user of this account sign here	 I will not disclose or lend my USER CODE AND/OR PASSWORD to anyone. These are for my use only and will serve as my "electronic signature". This means that I may be held responsible for the consequences of unauthorized or illegal transactions. I will not browse or use this information for unauthorized or illegal purposes. I will not index any disclosure of this data that is not specifically authorized. I will not intentionally cause corruption or disruption of data. If I become aware of any violation of these security requirements or suspect that someone may have used my user code or password, I will immediately contact Agency for Health Care Administration Security Officer at (850) 412-4849. I understand that Florida has a very broad public records law. Most information entered into this Application or otherwise in the possession of the Agency for Health Care Administration is available to the public upon request. I understand that as a User, I can submit information electronically on behalf of this Provider. By accessing this system, I am agreeing to follow the Agency for Health Care Administration policies regarding acceptable use and protection of confidential information. By submitting electronic information, I affirm that the information submitted is true. By agreeing I acknowledge that I have read and understand the terms of this User Account Agreement. Failure to submit this signed agreement to the Agency shall result in termination of my user account.						
	User Signature	Date					
Facility	Administrator Signature	Date					
Facility	/ within otracor orginature	Daw					
Administrator	AHCA USE ONLY						
sign here	DATE AUTHENTICATED:	DATE ACTIVATED:					
	STAFE SIGNATURE:	STAFF SIGNATURE:					

THE REGISTRATION PROCESS IS COMPLETE!