

**APPLICATION CHECKLIST**

#### PRESCRIBED PEDIATRIC EXTENDE

**PRESCRIBED PEDIATRIC EXTENDED CARE CENTERS**

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
* Replacement License

**No Fee Required:**

* Stock Transfer of less than 51%
* Management Company Change
* Personnel Change
* Property Owner

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

**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, address, and telephone number

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

[ ]  Name, personal/primary 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, % 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, name: email address and phone number of contact person

**Management Company Controlling Interests, Board Members, and Officer (Application Types: All)**

[ ]  Name, EIN/SSN, date of birth, personal mailing address, email 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, 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

[ ]  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 of CLIA if applicable

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

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

**Bed Counts (Application Types: All)**

[ ]  Bed type information

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

[ ]  Sections 1A, 1B, 1C, 2, 6 and 11 of the Health Care Licensing Application, AHCA Form 3110-8002

**Request to Change Administrator or Financial Officer**

[ ]  Sections 1A, 1B, 1C, 2, 5 and 11 of the Health Care Licensing Application, AHCA Form 3110-8002

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

[ ]  No fee required

**Request to Change the Number Beds**

[ ]  Sections 1A, 1B, 1C, 2, 8, and 11 of the Health Care Licensing Application, AHCA Form 3110-8002

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

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

[ ]  Fire Safety Inspection Report- (Application Types: All)

[ ]  Department of Health Food Service Inspection Report - (Application Types: All – *for providers with 11 beds or more only*)

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

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

[ ]  Financial Ability to Operate, AHCA Form 3100-0009 - Evidence of sufficient funds to operate such as bank statements, net worth statements or financial reports. – (Application Types: I and CHOW)

[ ]  Proof of legal right to occupy property may include but not limited to, copies of warranty deeds, lease or rental

 agreements,contracts for deeds, quitclaim deeds, or other such documentation (if applicable)

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

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

[ ]  Approved repayment plan (if applicable)

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

[ ]  The biennial licensure fee is $1,512.35

[ ]  Each change during licensure period that requires issuance of a new certificate is assessed a $25.00

[ ]  Other amounts due (fines, assessment, fees, etc.) will be detailed in the application

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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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