

**Application Checklist**

**Hospice**

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
* Satellite Location Change
* Freestanding Inpatient Facilities Change
* Residential Units Change
* Geographic Service Area Change
* Bed Capacity 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
* Governing Body
* Services Change

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

* The biennial licensure fee is $ 1,218.00
* The biennial health care assessment fee is $ 300.00
* 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 Type: All)**

[ ]  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 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

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

[ ]  Name, email address, and telephone number

**Licensee Controlling Interests, Board Members, and Officers** **(Application Type: 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 Type: 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 Type: All)**

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

**Personnel (Application Type: 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

[ ]  Medical Director: Name, Florida Medical License Number and hospital with admitting privileges and/or transfer agreement

[ ]  Nursing Supervisor: Name, SSN, date of birth, personal/primary address, email address, telephone number, Florida health care professional license number, effective and end dates of employment

**Disclosures (Application Type: 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 Type: All)**

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

**Accreditation with Deemed Status (Application Types: I, R & CHOW)**

[ ]  Name of accrediting organization, accreditation ID (if applicable), deemed status begin and end date, and survey end date

**Geographic Service Area (Application Types: I, R, CHOW & some C)**

[ ]  Counties where services will be provided

**Satellite Offices (Application Types: I, R, CHOW & some C)**

[ ]  Street address, phone number, date opened, and date closed (if applicable) of each office

**Freestanding Inpatient Facilities and Residential Units (Application Types: I, R, CHOW & some C)**

[ ]  Street address, phone number, number of beds, date opened, and date closed (if applicable) of each location

**Governing Body Members (Application Types: I, R & CHOW)**

[ ]  Name, personal or primary address including county, and telephone number of each member

**Services (Application Types: I, R & CHOW)**

[ ]  Number of employees providing each required direct service – nursing, medical social work, dietary counseling, pastoral or counseling, bereavement counseling and volunteer coordination

**CHANGE DURING LICENSURE APPLICATION TYPES:**

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

[ ]  Sections 1A, 1C, 2, 7 and 17 of the Health Care Licensing Application, AHCA Form 3110-4001

[ ]  $25.00 Duplicate License Fee

**Request to Change Personnel**

[ ]  Sections 1A, 1C, 2, 6 and 17 of the Health Care Licensing Application, AHCA Form 3110-4001

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

[ ]  No fee required

**Request to Change Geographic Service Areas**

[ ]  Sections 1A, 1C, 2, 10 and 17 of the Health Care Licensing Application, AHCA Form 3110-4001

[ ]  $25.00 Duplicate License Fee

**Request to Change Freestanding Inpatient Facilities and Residential Units**

[ ]  Sections 1A, 1C, 2, 12 or 13 and 17 of the Health Care Licensing Application, AHCA Form 3110-4001

[ ]  $25.00 Duplicate License Fee

**Request to make changes to Satellite Office (Change/Close/New)**

[ ]  Sections 1A, 1C, 2, 11 and 17 of the Health Care Licensing Application, AHCA Form 3110-4001

[ ]  $25.00 Duplicate License Fee

**Request for Bed Capacity Change**

[ ]  Sections 1A, 1C, 2, and 17 of the Health Care Licensing Application, AHCA Form 3110-4001

[ ]  $25.00 Duplicate License Fee

**Request to Change Services**

[ ]  Sections 1A, 1C, 2, 15 and 17 of the Health Care Licensing Application, AHCA Form 3110-4001

[ ]  No fee required

**Request for Management Company Change**

[ ]  Sections 1A, 1C, 2, 4 and 17 of the Health Care Licensing Application, AHCA Form 3110-4001

[ ]  No fee required

**Request for Management Company Controlling Interest Change**

[ ]  Sections 1A, 1C, 2, 5 and 17 of the Health Care Licensing Application, AHCA Form 3110-4001

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

[ ]  No fee required

**Request to make changes to the Governing Body**

[ ]  Sections 1A, 1C, 2, 14 and 17 of the Health Care Licensing Application, AHCA Form 3110-4001

[ ]  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, 6, 7 and 17 of the Health Care Licensing Application, AHCA Form 3110-4001

[ ]  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)**

[ ]  Accreditation report, if applicable (Application Types: I, R, CHOW & addition of new inpatient facility)

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

[ ]  Property Occupancy documentation, examples: facility ownership/lease documentation (if applicable), for principal office and each satellite office, inpatient facility, and residential unit (Application Types: I, CHOW & C-F/A)

[ ]  Documentation from local government proving compliance with local zoning requirements for principal office and addition/renovation of inpatient facility or residential unit (Application Type: I, CHOW & C-F/A)

[ ]  Plan for delivery of services per section 400.606(1), Florida Statutes (Application Types: I & CHOW)

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

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

[ ]  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)

[ ]  Medical director’s proof of hospital admitting privileges, if not previously reported (Application Types: I, R & CHOW)

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

[ ]  Required disclosures related to actions taken by Medicare, Medicaid or CLIA, if applicable (Application Types: I, R & CHOW)

[ ]  Approved repayment plan, if applicable (Application Types: I, R & CHOW)

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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 you please to remember the following:* Place checks or money orders on top of the application
* Include license number, AHCA file 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
* **Do not bind any** documents submitted to the Agency
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