

**Application Checklist**

#### Hospital

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, Hospital & Outpatient Services Unit, 2727 Mahan Dr, MS 31, Tallahassee, FL 32308-5407.**

**Application Definitions and Payment Information:**

**Initial (I)** – application for an initial license/registration/certification or reinstatement of an expired license.

**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:**

* Provider Name Change
* Provider Address Change
* Number or Utilization of Licensed Beds
* Additional Addresses– Add/Delete
* Addition of Licensed Program
* Change or Request Exemption to ER Services

**No Fee Required:**

* Transfer or assignment of less than 51% ownership, shares, membership, or controlling interest of the licensee
* Management Company Change
* Personnel Change

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

* The biennial Licensure fee is $31.46 per bed (minimum of $1565.13)
* The biennial health care assessment fee is $4 per bed (maximum of $1,000.00)
* Change during licensure period submitted that requires issuance of a new license is assessed a $25.00 fee
* Late fee/fine may be assessed for application not timely submitted pursuant to Section 408.806(2), Florida Statute (F.S.) and Rule Chapter 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, home website, transparency website, and if applicable, Medicaid provider number and National Provider Identifier (NPI)

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

Name, primary address, and telephone number

**Contact Person** **(Application Type: All)**

Name, email address, and telephone number

**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

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

Name, EIN/SSN, primary 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, primary 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, primary address, email address, telephone number, effective and end dates of employment

Financial Officer: Name, SSN, date of birth, primary address, email address, telephone number, effective and end dates of employment

Safety Liaison: Name, SSN, date of birth, primary address, email address, telephone 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)

**Bed Counts (Application Types: Initials, Renewals, CHOWS, and Bed Change)**

Number of types of beds

**General Information (Application Type: All)**

Type of hospital, licensed programs offered at the hospital and clinical laboratory services

**Accreditation (Application Type: Renewal, CHOW, and Changes, if applicable)**

Accreditation organization, accreditation ID, federally deemed status, effective date, expiration date and survey end date

**Additional Addresses (Application Type: All)**

Name, street address for all non-emergency/surgical outpatient facilities

**Hospital Emergency Services (Application Types: All)**

List of services provided and availability

**Professional Liability Coverage (Application Type: All)**

Proof of current coverage through a escrow account, or insurance policy. Hospitals exempted under section 395.1061(3)(b), F.S., are not required to document additional coverage

**CHANGE DURING LICENSURE APPLICATION TYPES:**

**Request to Change the Number or Utilization of Licensed Beds**

Sections 1A, 1C, 2, 10, 17 and 19 of the Health Care Licensing Application, AHCA Form 3130-8001

$25.00 Duplicate License Fee

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

Sections 1A, 1C, 2, and 19 of the Health Care Licensing Application, AHCA Form 3130-8001.

$25.00 Duplicate License Fee

**Request to Change Chief Executive Officer or Financial Officer (Personnel Change)**

Sections 1A, 1C, 2, 6A, 7, and 19 of the Health Care Licensing Application, AHCA Form 3130-8001

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

No fee required

**Request to Change Safety Liaison (Personnel Change)**

Sections 1A, 1C, 2, 6B, and 19 of the Health Care Licensing Application, AHCA Form 3130-8001

No fee required

**Request to Change Management Company**

Sections 1A, 1C, 2, 4, 5, 7, and 19 of the Health Care Licensing Application, AHCA Form 3130-8001

No fee required

**Request to Change Management Company Controlling Interest**

Sections 1A, 1C, 2, 4, 5, 7, and 19 of the Health Care Licensing Application, AHCA Form 3130-8001

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

No fee required

**Request to Add/Delete Additional Addresses except Hospital-Based Off-Campus Emergency Department**

Sections 1A, 1C, 2, 15A, 15B, 15C, and 19 of the Health Care Licensing Application, AHCA Form 3130-8001

$25.00 Duplicate License Fee

**Request to Add/Delete Hospital-Based Off-Campus Emergency Department**

Sections 1A, 1C, 2, 15D, 16, and 19 of the Health Care Licensing Application, AHCA Form 3130-8001

$25.00 Duplicate License Fee

**Request to Change the Emergency Service Inventory or Request Exemption pursuant to section 395.1041(3)(d)3, F.S.**

Sections 1A, 1C, 2, 16, and 19 of the Health Care Licensing Application, AHCA Form 3130-8001

Emergency Service Exemption Application, AHCA Form 3000-1, if applicable

$25.00 Duplicate License Fee

**Request Addition of Licensed Program**

Sections 1A, 1C, 2, 11, 12, and 19 of the Health Care Licensing Application, AHCA Form 3130-8001

$25.00 Duplicate License Fee

**Submit Documentation of Professional Liability Coverage**

Sections 1A, 1C, 2, 17, and 19 of the Health Care Licensing Application, AHCA Form 3130-8001

No fee required.

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

Sections 1A, 1C, 2, 3, 7, 8, and 19 of the Health Care Licensing Application, AHCA Form 3130-8001

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

No fee required

**SUPPORTING DOCUMENTS:**

Accreditation documentation and survey report, if applicable (Application Types: I, R, and CHOW)

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

Documentation signed by the appropriate local government official, which states that the applicant has met local zoning requirements (Application Types: I, Addition of Offsite Emergency Department, and Address Change)

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 (Application Types: I, CHOW, Addition of Offsite Outpatient Facility, Addition of Offsite Emergency Department, and Address Change)

Baker Act Receiving Facility certificate, if applicable

List of Cardiovascular registries in which hospital participates including benchmark data, if applicable

Documentation of compliance with professional liability coverage as provided under section 395.1061, F.S. (Escrow, Professional Liability, or self-insurance) (Application Types: All)

Emergency Service Exemption Application, AHCA Form 3000-1, if applicable (Application Types: Emergency Service Exemption)

License Application Alternate-Site Testing, AHCA Form 3130-8013 (Application Types: All)

Current Stroke Center Certificate (Application Type: Renewal, CHOW and Change of Licensed Programs)

Copy of Comprehensive Emergency Management Plan (CEMP) Approval Letter or Documentation of the CEMP submission for review within the last 365 days (Application Type: Renewal)

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

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

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. |