FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Community Residential Home Affidavit of Compliance with Chapter 419, Florida Statutes

Name of Facility: _____

Address: _____ Telephone: (_____)_____

City: _____ State: _____ Zip: _____

Number of Licensed Beds: _____
Is the facility located in an area zoned single-family or multi-family? Yes ❑ No ❑

If YES, please check appropriate zoning: ❑ single family; ❑ multi-family.
Compliance with the following is also required:

- I have provided the local zoning authority with the most recently published data compiled by the Agency for Health Care Administration, Department of Children and Families, Department of Elder Affairs and the Agency for Persons with Disabilities, identifying all community residential homes within the jurisdiction of the local zoning authority.
- I certify that this facility is not located within a 1,000 foot radius of another community residential home, or has an approved variance* from the local zoning authority.
- I further certify that notification of intent to establish this facility has been made to the local zoning authority (copy of dated letter attached).
- At the time of home occupancy, I will notify local government that the facility is licensed.
- I understand that the Agency for Health Care Administration assumes no financial or other liability in the event an error has been made in calculating, measuring or certifying that this facility meets these dispersion requirements.

❑ *Check if you have an approved variance and attach a copy of approval.

The undersigned affirms that the information submitted herein is true and correct.

BY: _____ _____
Printed or Typed Name Title

_____ _____
Signature Date