

LICENSE DATA SHEET:

www.pnsystem.com

REQUIRED:

305.818.5940

The biennial licensure fee (**\$1,705.00 per license**)

Proof of current insurance coverage in an amount of not less than \$250,000 per claim

Proof of Level 2 screening within the previous 5 years for the Administrator and/or Chief Financial Officer

INITIAL Applications:

Evidence that the applicant has sufficient funds to operate the facility such as bank statements, net worth statements or financial reports. Please complete and submit the Proof of Financial Ability to Operate, AHCA Form 3100-0009 Business Plan

Proof of Organization: Certificate of Status; Articles of Incorporation

A report or letter from the local government zoning office

Signed and notarized Distance Attestation form

Copy of a lease, sublease or rental agreement, or deed

Proof of federal employer identification number from the Internal Revenue Service

A. Provider Information – please complete the following for the home health agency name and location.

License # (for renewal & change of ownership applications) _____

National Provider Identifier (NPI) (if applicable) _____

Medicare # (CMS CCN) _____

Medicaid # _____

Name of Home Health Agency _____

Street Address _____

City _____ County _____ State _____ Zip _____

Telephone Number _____ Fax Number _____

E-mail Address _____

Provider Website _____

Federal Employer Identification Number (EIN) _____

Ownership Names: _____ SS # : _____

_____ SS # : _____

_____ SS # : _____

Administrator: _____ License: _____

Home Address: _____

Alt. Administrator: _____ License: _____

Home Address: _____

DON: _____ License: _____

Home Address: _____

Alt. DON: _____ License: _____

Home Address: _____

CFO: _____ License: _____

Home Address: _____

Other Providers Relations ?

PERSONNEL # DIRECT	EMPLOYEES	# CONTRACTED	EMPLOYEES IF SUB-CONTRACT FROM ANOTHER AGENCY, WRITE AGENCY NAME
Nursing*	_____	_____	_____
PT*	_____	_____	_____
ST*	_____	_____	_____
OT*	_____	_____	_____
RT	_____	_____	_____
IV Therapy	_____	_____	_____
HHA*	_____	_____	_____
Homemaker/Companion	_____	_____	_____
Nutritional Guidance	_____	_____	_____
Medical Equipment	_____	_____	_____
MSW*	_____	_____	_____
Other	_____	_____	_____

Provide the number of patients admitted by your Home Health Agency's most recent fiscal year, last calendar year or most recent 12 month period: _____

Hours Operations: _____ to _____

Accreditation with: _____ Expired on: _____