

**LICENSE DATA SHEET:** AHCA site user: \_\_\_\_\_ **www.pnsystem.com**

Password: \_\_\_\_\_

REQUIRED:

(existing agencies only)

305.818.5940

The biennial licensure fee (**\$1,705.00 per license+300 special assessment**)

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

**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 # : _____	% ownership: _____
_____	SS # : _____	% ownership: _____
_____	SS # : _____	% ownership: _____
_____	SS # : _____	% ownership: _____

**Administrator:** \_\_\_\_\_ Prof. License: \_\_\_\_\_ SS #: \_\_\_\_\_

Home Address: \_\_\_\_\_ Date Last Criminal Background \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_ DOB: \_\_\_\_\_  
Full Time Part Time

**Alt. Administrator:** \_\_\_\_\_ Prof. License: \_\_\_\_\_ SS#: \_\_\_\_\_

Home Address: \_\_\_\_\_ Full Time Part Time

Email: \_\_\_\_\_ Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

**DON:** \_\_\_\_\_ Prof. License: \_\_\_\_\_ SS#: \_\_\_\_\_

Home Address: \_\_\_\_\_ Full Time Part Time

Email: \_\_\_\_\_ Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

**Alt. DON:** \_\_\_\_\_ License: \_\_\_\_\_ SS#: \_\_\_\_\_

Home Address: \_\_\_\_\_ Full Time Part Time

Email: \_\_\_\_\_ Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

**CFO:** \_\_\_\_\_ SS #: \_\_\_\_\_ Full Time Part Time

Home Address: \_\_\_\_\_ Date Last Criminal Background: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

Your Agency Provide service to minor of 21 years old: Yes No

Planning to provide Non Skilled services only? Yes

NOTE: If providing nursing services, some of the service must be provided by a direct employee as required in state law, section 400.487(5), F.S Medicare and Medicaid certified agencies must also provide one of the qualifying services (\* below) totally by "direct employees" (Medicaid does not include Medical Social Services as a home health agency service) the direct employees are those for whom the agency pays withholding taxes.

PERSONNEL	TOTAL DIRECT Employees (W2)	Total CONTRACTED Independent (1099)	EMPLOYEES IF SUB-CONTRACT FROM ANOTHER AGENCY, WRITE AGENCY NAME
Nursing*	_____	_____	_____
PT*	_____	_____	_____
ST*	_____	_____	_____
OT*	_____	_____	_____
RT	_____	_____	_____
IV Therapy	_____	_____	_____
HHA/ CNAs*	_____/_____	_____/_____	_____
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: \_\_\_\_\_ From-to: \_\_\_\_\_  
(Accreditation dates)

Date of Last Survey: \_\_\_\_\_

Counties License: \_\_\_\_\_

**Owners Information:**

Name	Title	Personal Address	Telephone	Begin Date
1				
2				
3				
4				
5				

(Title: President, Vice-President, Secretary, CFO)

Insurance Company: \_\_\_\_\_  
(existing, renew agencies only)

Dates: \_\_\_\_\_ to \_\_\_\_\_

Amount: \_\_\_\_\_ Aggregate: \_\_\_\_\_

Bank routing number: \_\_\_\_\_  
(existing, renew agencies only)

Counties License: Miami Dade Monroe

Other: \_\_\_\_\_

Account Number: \_\_\_\_\_

(use AHCA areas counties)