# License Data Sheet

Non-Skilled Home Health Agency • AHCA licensure (initial / renewal)

www.pnsystem.com
305.818.5940
info@pnsystem.com

**Service:** ☐ $245.00 Initial license ☐ $195.00 Renewal

*AHCA user and password: existing agencies only.*

**AHCA Site User:** _____

**AHCA Password:** _____

**Do not print or scan this form.** Save it to your computer, type the information using Adobe Reader, and email it to us. Use proper capitalization (e.g., Ana Montanez).
**Required:** the biennial licensure fee ($1,705.00 per license + $300.00 special assessment), and proof of current insurance coverage of not less than $250,000 per claim.

## A PROVIDER INFORMATION

*Home health agency name and location*

**License #:** _____ *(for renewal and change of ownership applications)*

**NPI:** _____

**Medicare # (CMS CCN):** _____

**Medicaid #:** _____

**Name of Home Health Agency:** _____

**DBA (if applicable):** _____

**Street Address:** _____

**City:** _____ **County:** _____ **State:** _____ **ZIP:** _____

*Only if applicable, must match Sunbiz information*

**Mailing Address (if different):** _____

**Mailing City, State, ZIP:** _____

**Telephone:** _____

**Fax:** _____

**Email:** _____

**Website:** _____

**Tax ID (EIN):** _____

## B OWNERSHIP

| | | | | | |
|---|---|---|---|---|---|
| **Owner 1:** | _____ | **SS #:** | _____ | **% Ownership:** | _____ |
| **Owner 2:** | _____ | **SS #:** | _____ | **% Ownership:** | _____ |
| **Owner 3:** | _____ | **SS #:** | _____ | **% Ownership:** | _____ |
| **Owner 4:** | _____ | **SS #:** | _____ | **% Ownership:** | _____ |
| **Owner 5:** | _____ | **SS #:** | _____ | **% Ownership:** | _____ |

## C KEY PERSONNEL

**Administrator** ** must qualify*

**Name:** _____ **Prof. License #:** _____ **SS #:** _____
**Home Address:** _____ **Last Criminal Background:** _____
**Email:** _____ **Phone:** _____ **DOB:** _____
☐ Full Time ☐ Part Time

**Alt. Administrator** ** must qualify*

**Name:** _____ **Prof. License #:** _____ **SS #:** _____
**Home Address:** _____ ☐ Full Time ☐ Part Time
**Email:** _____ **Phone:** _____ **DOB:** _____

**RN**

**Name:** _____ **Prof. License #:** _____ **SS #:** _____
**Home Address:** _____ ☐ Full Time ☐ Part Time
**Email:** _____ **Phone:** _____ **DOB:** _____

**Alt. RN**

**Name:** _____ **License #:** _____ **SS #:** _____
**Home Address:** _____ ☐ Full Time ☐ Part Time
**Email:** _____ **Phone:** _____ **DOB:** _____

**CFO (owner)**

**Name:** _____ **SS #:** _____ ☐ Full Time ☐ Part Time
**Home Address:** _____ **Last Criminal Background:** _____
**Email:** _____ **Phone:** _____ **DOB:** _____

## D SERVICES

Planning to provide staffing services to other facilities? ☐ Yes ☐ No

** Must qualify: must be a physician, RN, or a person with more than 1 year of experience as a supervisor in home health, a hospital, or an ALF.*

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## E PERSONNEL

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). Direct employees are those for whom the agency pays withholding taxes.

| PERSONNEL | DIRECT EMPLOYEES (W-2) (total of staff) | CONTRACTED (1099) (total of staff) |
|---|---|---|
| HHA / CNA* | _____ / _____ | _____ / _____ |
| Homemaker/Companion | _____ | _____ |
| Other | _____ | _____ |

*HHA / CNA: enter the number of HHAs / the number of CNAs. * Qualifying services.*

## F OPERATIONS

*For existing agencies only*

**Patients admitted in the most recent fiscal year, last calendar year or most recent 12-month period:** _____

**Hours of Operation:** _____ to _____ **Date of Last Survey:** _____

## G OWNERS / CORPORATION INFORMATION

*Title: President, Vice-President, Secretary, CFO*

| # | Name / Title | DOB | Personal Address / Email | Telephone | Begin Date |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |

## H INSURANCE, BANK AND COUNTIES

**Insurance Company:** _____ **Policy #:** _____

**Coverage Dates:** _____ to _____

**Amount:** _____ **Aggregate:** _____

**Bank Routing #:** _____

**Account #:** _____

**Counties Licensed:**

☐ Miami-Dade ☐ Monroe

**Other:** _____

*Use AHCA area counties.*

**FOR RENEWAL, email:**
*(See documents needed page attached)*

☐ Insurance
☐ Emergency Plan current-year submission or previous-year approval letter
☐ License worksheet completed

Email Form

*Save this document, type the information using Adobe Reader, and then email it to us.*