License Data Sheet

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): _____
Only if applicable, must match Sunbiz information

Address: _____

Mailing Address (if different): _____

City, ZIP: _____ **County:** _____

Mailing City, 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:**	_____

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:** _____

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

Alt. DON ** must qualify*
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

Does your agency provide services to minors under 21 years of age?	☐ Yes	☐ No
Planning to provide non-skilled services only?	☐ Yes	
Does your agency plan to provide staffing services to a health care facility, school, or other business?	☐ Yes	☐ No
Does your agency participate, or plan to participate, in the home health aide for medically fragile children program?	☐ Yes	☐ No

** **Administrator and Alternate Administrator** 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. The **DON and Alternate DON** must have **2 years** of supervisory experience in home health.*

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)
Nursing*		
PT*		
ST*		
OT*		
RT		
IV Therapy		
HHA / CNA*	/	/
Homemaker/Companion		
Nutritional Guidance		
Medical Equipment		
MSW*		
Other		

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

F OPERATIONS AND ACCREDITATION

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:** _____

Accreditation with: _____ **Accreditation dates (from–to):** _____

Counties Licensed: _____

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 ☐ Accreditation proof and accreditation survey report
☐ Emergency Plan current-year submission or previous-year approval letter
☐ License worksheet completed

Email Form