** Please save the document in your computer, using Adobe Reader type the info, and then email to us*

AHCA Site User:

Password:

LICENSE DATA SHEET: ** do not print or scan the form please*

www.pnsystem.com

NON-SKILLED

REQUIRED: ** please use proper capitalization*

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

☐ $ 195.00 (renew)

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** please use proper capitalization*

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 _____ ** (existing agencies only, if applicable)*

Federal Employer Identification Number (EIN) _____

Ownership Names: _____ SS # : _____ % ownership:

please use proper capitalization

_____ SS # : _____ % ownership:

_____ SS # : _____ % ownership:

Administrator: _____ Prof. License: _____ SS #: _____
** must qualify*
Home Address: _____ Date Last Criminal Background _____

Email: _____ Phone: _____ DOB: _____
☐ Full Time ☐ Part Time

Alt. Administrator: _____ Prof. License: _____ SS#: _____
** must qualify*
Home Address: _____ ☐ Full Time ☐ Part Time

Email: _____ Phone: _____ DOB: _____

RN: _____ Prof.License: _____ SS#: _____
Home Address: _____ ☐ Full Time ☐ Part Time

Email: _____ Phone: _____ DOB: _____

Alt. RN: _____ 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: _____

please use proper capitalization

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

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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
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
HHA/ CNAs*	_____/_____	_____/_____	_____
Homemaker/Companion	_____	_____	_____
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 _____

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please use proper capitalization

Date of Last Survey: _____

Owners Information:

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

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

Counties License: ☐ Miami Dade ☐ Monroe

Other: _____

_____

(use AHCA areas counties)

Bank routing number: _____

Account Number: _____

Insurance Company: _____ Policy #: _____
(existing, renew agencies only)

Dates: _____ to _____
Amount: _____ Aggregate: _____

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FOR RENEW: email ☐ Insurance ☐ Emergency Plan current year submission or previous year approval letter

Email form