Provider:

Provider Type:
Intermediate Care Facility

File#:
License #:
Expires:

Application:
Type:
Status:
Application Received Date:

= Entered
= Entry Required

- **Provider/Facility Information**
  - Details
  - Property Ownership
  - Contact Person
- **Licensee Information**
- **Controlling Interests**
- **Management Company Information**
- **Personnel**
- **Required Disclosure**
- **Bed Count**
- **Supporting Documents**
- **Finalize Submission**

Health Care Licensing Online Application
Intermediate Care Facility for the Developmentally Disabled
AHCA Form 3110-5003 OL,
April 2021
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Provider/Facility Information

Under the authority of Chapters 408, Part II and 400, Part VIII, Florida Statutes (F.S.), and Chapters 59A-35 and 59A-26, Florida Administrative Code (F.A.C.), an application is hereby made to operate a intermediate care facility as indicated below.

Pursuant to section 408.806 (1)(a) and (b), F.S., an application for licensure must include: the name, address and social security number of the applicant, administrator or similarly titled person who is responsible for the day to day operation of the provider, financial officer or similarly titled person who is responsible for the financial operation of the licensee or provider and each controlling interest, if the applicant or controlling interest is an individual; and the name, address, and federal employer identification number (EIN) of the applicant and each controlling interest, if the applicant or controlling interest is not an individual. Disclosure of social security number(s) is mandatory. The Agency for Health Care Administration (AHCA) shall use such information for purposes of securing the proper identification of persons listed on this application for licensure.

Please complete the following for the intermediate care facility name and location. Provider/Facility name, address and telephone number will be listed on http://www.floridahealthfinder.gov

Provider/Facility Information

License #

National Provider Identifier
☐ None ☐ Pending

Medicaid #

Medicare # (CMS CCN)

Name of Intermediate Care Facility (If operated under a fictitious name, enter as it appears in Florida Division of Corporations.)

Provider/Facility Location Address

Edit Address

Provider Location Address

Telephone | Ext | Fax #
☐ None

Email Address *Note: By providing your email address, you agree to accept email correspondence from the Agency.*
☐ None

Provider/Facility Website
☐ None

Provider/Facility Mailing Address (All mail will be sent to this address.)

☐ Check if same as Provider/Facility Location Address

Edit Address

Address

Telephone | Ext | Email Address
☐ None

Undo | Save | Next >>

Provider:

Provider Type:
Intermediate Care Facility

File#:
License #:
Expires:

Application:
Type:
Status:
Application Received Date:

= Entered
= Entry Required

Provider/Facility Information
- Details
- Property Ownership
- Contact Person

Licensee Information

Controlling Interests

Management Company Information

Personnel

Required Disclosure

Bed Count

Supporting Documents

Finalize Submission

Property Ownership

Does the licensee own or lease this facility? If leased, you may provide the name of the property owner by following the instructions below.

◯ Own
◯ Lease

To **add** a property owner(s) -
Utilizing the picklist below, either choose an individual/entity that is already associated with this application or select 'New Property Owner - Individual' or 'New Property Owner - Entity' .

To **edit** Property Owner's information -
Select "Edit/View"and edit as needed.

To **remove** an existing Property Owner -
Select "Remove" and enter the applicable end date.

	Full Name of Individual/Entity	Effective Date	End Date
Remove View			

Removed: (-) Added: (+)

Undo Save << Back Next >>

Provider:

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License #:
Expires:

Application:
Type:
Status:
Application Received Date:

= Entered
= Entry Required

- **Provider/Facility Information**
  - Details
  - Property Ownership
  - Contact Person
- **Licensee Information**
- **Controlling Interests**
- **Management Company Information**
- **Personnel**
- **Required Disclosure**
- **Bed Count**
- **Supporting Documents**
- **Finalize Submission**

Provider/Facility Information

Provider/Facility Contact Person for this Application

First Name | Middle Name | Last Name | Suffix

Telephone (___) ___-____ | Ext | Fax # (___) ___-____

☐ None

Contact Email Address (By providing your email address, you agree to accept email correspondence from the Agency.)

☐ None

Undo | Save | << Back | Next >>

Provider:

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License #:
Expires:

Application:
Type:
Status:
Application Received Date:

= Entered
= Entry Required

- Provider/Facility Information
- Licensee Information
  - Licensee Details
- Controlling Interests
- Management Company Information
- Personnel
- Required Disclosure
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- Supporting Documents
- Finalize Submission

Licensee Information

Description of licensee (select only one option below)

○ For Profit ○ Not for Profit ○ Public

Ownership Types

Entity Licensee Details

Licensee Name (may be same as provider name)

Federal Employer Identification # (EIN)

Mailing Address

Edit Address

Address

Telephone | Ext | Fax # | Email Address

☐ None ☐ None

Undo | Save | << Back | Next >>

Provider:

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Expires:

Application:
Type:
Status:
Application Received Date:

= Entered
= Entry Required

- Provider/Facility Information
- Licensee Information
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Controlling Interests of Licensee

Controlling Interests, as defined in Section 408.803(7), F.S., are the applicant or licensee; a person or entity that serves as an officer of, is on the board of directors of, or has a 5% or greater ownership interest in the applicant or licensee; or a person or entity that serves as an officer of, is on the board of directors of, or has a 5% or greater ownership interest in the management company or other entity, related or unrelated, with which the applicant or licensee contracts to manage the provider. The term does not include a voluntary board member.

Note: For each controlling interest, an AHCA Screening through the Care Provider Background Screening Clearinghouse is needed, or the Attestation of Compliance with the Background Screening Requirements, AHCA Form 3100-0008 if background screening was conducted by the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S. To verify who must be screened, visit the Background Screening site.

Do any individuals or entities possess 5% or greater ownership interest in the licensee, or, function as a board member or officer?

◯ Yes ◯ No

To **add** a controlling interest -
Utilizing the picklist below, either choose an individual/entity that is already associated with this application or select 'New Controlling Interest - Individual' or 'New Controlling Interest - Entity' .

To **edit** an existing controlling interest -
Select "Edit/View"and edit as needed.

To **remove** an existing controlling interest -
Select "Remove" and enter the date the controlling interest's relationship with the licensee ended.

			Full Name of Individual/Entity	Type	Tax ID	Effective Date	End Date	%
Remove	View							0.00
Remove	View							0.00

Total 0.00

Removed: (-) Added: (+)

If the percentage of ownership interest indicated above does not equal 100%, please explain why in the space below:

Undo Save << Back Next >>

Provider:

Provider Type:
Intermediate Care Facility

File#:
License #:
Expires:

Application:
Type:
Status:
Application Received Date:

◌ = Entered
◌ = Entry Required

- **Provider/Facility Information** »
- **Licensee Information** »
- **Controlling Interests** »
- **Management Company Information** «
  - ◌ Management Company Information
  - ◌ Management Company Controlling Interest
- **Personnel** »
- **Required Disclosure** »
- **Bed Count** »
- **Supporting Documents** »
- **Finalize Submission** »

Management Company Information

Controlling Interests, as defined in Section 408.803(7), F.S., are the applicant or licensee; a person or entity that serves as an officer of, is on the board of directors of, or has a 5% or greater ownership interest in the applicant or licensee; or a person or entity that serves as an officer of, is on the board of directors of, or has a 5% or greater ownership interest in the management company or other entity, related or unrelated, with which the applicant or licensee contracts to manage the provider. The term does not include a voluntary board member.

Note: For each controlling interest, an AHCA Screening through the Care Provider Background Screening Clearinghouse is needed, or the Attestation of Compliance with the Background Screening Requirements, AHCA Form 3100-0008 if background screening was conducted by the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S. To verify who must be screened, visit the Background Screening site.

Do any individuals or entities possess 5% or greater ownership interest in the licensee, or, function as a board member or officer?

◯ Yes ◯ No

Undo | Save | << Back | Next >>

Add Management Company

Add Management Company

Name of Management Company

Federal Employer Identification # (EIN)

Effective Date

End Date

Location Address

Edit Address

Location Address

Telephone #

(___)___-____

Ext

Fax

(___)___-____

None

Email Address

None

Mailing Address

Check if same as Management Company Location Address

Edit Address

Mailing Address

Contact Person

Edit Individual

Contact Person:

Telephone #

(___)___-____

Ext

Email Address

None

Done Cancel

Provider:

Provider Type:
Intermediate Care Facility

File#: _ _ _ _
License #:
Expires:

Application:
Type:
Status:
Application Received Date:

= Entered
= Entry Required

- **Provider/Facility Information**
- **Licensee Information**
- **Controlling Interests**
- **Management Company Information**
  - Management Company Information
  - Management Company Controlling Interest
- **Personnel**
- **Required Disclosure**
- **Bed Count**
- **Supporting Documents**
- **Finalize Submission**

Management Company Controlling Interest

Controlling interests, as defined in section 408.803(7), F.S., are the applicant or licensee; a person or entity that serves as an officer of, is on the board of directors of, or has a 5% or greater ownership interest in the applicant or licensee; or a person or entity that serves as an officer of, is on the board of directors of, or has a 5% or greater ownership interest in the management company or other entity, related or unrelated, with which the applicant or licensee contracts to manage the provider. The term does not include a voluntary board member.

Note: For each controlling interest, an AHCA Screening through the Care Provider Background Screening Clearinghouse is needed, or the Attestation of Compliance with the Background Screening Requirements, AHCA Form 3100-0008 if background screening was conducted by the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S. To verify who must be screened, visit the Background Screening site.

To add a controlling interest -
Utilizing the picklist below, either choose an individual/entity that is already associated with this application or select 'New Controlling Interest - Individual' or 'New Controlling Interest - Entity' .

Undo | Save | << Back | Next >>

Add Individual

Individual Ownership of Management Company

Edit Individual

Board Member/Officer

% Ownership Interest

Owner/Board Member

Effective Date

End Date

Personal Mailing Address

Edit Address

Mailing Address

Telephone #

(___)___-____

Ext

Email Address

None

Done

Cancel

Provider:

Provider Type:
Intermediate Care Facility

File#:
License #:
Expires:

Application:
Type:
Status:
Application Received Date:

= Entered
= Entry Required

- **Provider/Facility Information**
- **Licensee Information**
- **Controlling Interests**
- **Management Company Information**
- **Personnel**
  - Administration
  - Safety Liaison
- **Required Disclosure**
- **Bed Count**
- **Supporting Documents**
- **Finalize Submission**

Personnel

Personnel

Note: The administrator and financial officer are required pursuant to section 408.809, F.S. to have an Agency screening through the Care Provider Background Screening Clearinghouse or submit the Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, if background screening was conducted by the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S. To verify who must be screened, visit the Background Screening site.

Provide the information for the individual(s) who perform the following roles:

- Administrator
- Financial Officer

To **add** an individual -
Utilizing the picklist below, either choose an individual that is already associated with this application or select 'New Individual'.

To **edit** an existing individual -
Select "Edit/View"and edit as needed.

To **remove** an existing individual -
Select "Remove" and enter the date the individual's relationship with the licensee ended.

		Full Name of Individual	Type	Tax ID	Roles	Effective Date	End Date
Remove	View				Financial Officer		
Remove	View				Administrator		

Removed: (-) Added: (+)

Undo Save << Back Next >>

Provider:

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File#:
License #:
Expires:

Application:
Type:
Status:
Application Received Date:

= Entered
= Entry Required

- **Provider/Facility Information**
- **Licensee Information**
- **Controlling Interests**
- **Management Company Information**
- **Personnel**
  - Administration
  - Safety Liaison
- **Required Disclosure**
- **Bed Count**
- **Supporting Documents**
- **Finalize Submission**

Personnel

B. Safety Liaison

Please provide the requested information for the individual who will serve as primary contact during emergency operation pursuant to section 408.821, F.S.

Safety Liaison

To **add** an Individual -
Utilizing the picklist below, either choose an individual that is already associated with this application or select 'New Individual'.

To **verify** Individual's information -
Select "Edit/View"and edit as needed.

To **remove** an existing Individual -
Select "Remove" and enter the applicable end date.

No Individuals exist!

Undo | Save | << Back | Next >>

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License #:
Expires:

Application:
Type:
Status:
Application Received Date:

= Entered
= Entry Required

- Provider/Facility Information
- Licensee Information
- Controlling Interests
- Management Company Information
- Personnel
- Required Disclosure
  - Convictions
  - Exclusions
  - Felonies/Terminations
- Bed Count
- Supporting Documents
- Finalize Submission

Required Disclosure

Convictions

Pursuant to section 408.809, F.S., the applicant shall submit to the agency a description and explanation of any convictions or offenses prohibited by sections 435.04 and 408.809(4), F.S., for each controlling interest.

Has the applicant or any individual listed in the Controlling Interests or Management Company Controlling Interests sections of this application been convicted of any level 2 offense pursuant to subsection 408.809, Florida Statutes?

◯ Yes ◯ No

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Provider:

Provider Type:
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License #:
Expires:

Application:
Type:
Status:
Application Received Date:

= Entered
= Entry Required

- Provider/Facility Information
- Licensee Information
- Controlling Interests
- Management Company Information
- Personnel
- Required Disclosure
  - Convictions
  - Exclusions
  - Felonies/Terminations
- Bed Count
- Supporting Documents
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Required Disclosure

Exclusions

Pursuant to section 408.810(2), F.S., the applicant must provide a description and explanation of any exclusions, suspensions, or terminations from the Medicare, Medicaid, or federal Clinical Laboratory Improvement Amendment (CLIA) programs.

Has the applicant or any individual/entity listed in the Controlling Interests or Management Company Controlling Interests sections of this application been excluded, suspended, terminated or involuntarily withdrawn from participation in Medicare or Medicaid in any state?

◯ Yes ◯ No

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Provider:

Provider Type:
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File#:
License #:
Expires:

Application:
Type:
Status:
Application Received Date:

= Entered
= Entry Required

- Provider/Facility Information
- Licensee Information
- Controlling Interests
- Management Company Information
- Personnel
- Required Disclosure
  - Convictions
  - Exclusions
  - Felonies/Terminations
- Bed Count
- Supporting Documents
- Finalize Submission

Required Disclosure

Felonies/ Terminations

Pursuant to section 408.815(4), F.S., has the applicant or a controlling interest in the applicant, or any entity in which a controlling interest of the applicant was an owner or officer when the following actions occurred ever been:

1. Convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, chapter 893, 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396, Medicaid fraud, Medicare fraud or insurance fraud, within the previous 15 years prior to the date of this application;

◯ Yes ◯ No

2. Terminated for cause from the Medicare program or a state Medicaid program.

◯ Yes ◯ No

If yes, has applicant been in good standing with the Medicare program or a state Medicaid program for the most recent 5 years and the termination occured at least 20 years before the date of the application.

◉ Yes ◉ No

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Provider:

Provider Type:
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Expires:

Application:
Type:
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= Entered
= Entry Required

- Provider/Facility Information
- Licensee Information
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- Bed Count
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Bed Count

A. Bed Count and Client Catagories - Review and revise the number of beds and living units if needed.

Total number of beds:
Total number of living units:

Categories of clients served in each living unit:

To **add** a living unit, select "Add".

To **edit** an existing unit, select "Edit".

To **remove** an existing unit, select "Remove".

Add

	Living Unit	# of Beds	Level of Care Provided
Remove Edit			7 8 9

Removed Added

B. Maladaptive Specialty - Please mark one box below:

☐ The Intermediate Care Facility does not provide nor is planning on providing services to persons with severe maladaptive behaviors and co-occurring psychiatric diagnoses.

☐ The Intermediate Care Facility does provide or is planning on providing services to persons with severe maladaptive behaviors and co-occurring psychiatric diagnoses. Provide the following information and a copy of the Certificate of Need Exemption will be required in the Supporting Document section:

1. Does each resident have his/her own bedroom and bathroom? ○ Yes ○ No
2. Total number of beds per home?
3. Is each eight-bed home collated on the same property with two other eight-bed homes? ○ Yes ○ No
4. How many beds are designated for residents with severe maladaptive behaviors?
5. Have the residents been deemed appropriate for a specialized placement in an ICF? ○ Yes ○ No
6. The individuals with severe maladaptive behaviors were assessed by (select all that apply):
   - ○ Agency for Persons with Disabilities Global Behavioral Serviced Need Matrix
   - ○ Agency for Health Care Administration

Undo Save << Back Next >>

Provider:

Provider Type:
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File#:
License #:
Expires:

Application:
Type:
Status:
Application Received Date:

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= Entry Required

- Provider/Facility Information
- Licensee Information
- Controlling Interests
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  - Supporting Documents
- Finalize Submission

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Supporting Documents

Applicants **MUST** include the following attachments as stated in Chapters 408 Part II and 400 Part VIII , Florida Statutes (F.S.) and Chapter 59A-35 and 59A-26, Florida Administrative Code (F.A.C)

The following file types are suggested for uploading and submitting electronic documents to the Agency: .DOC, .PDF, .TIFF, .TXT, .JPG, .XLS, and .PPT.

The following file types are **NOT** permitted for upload: .ZIP, .EXE, .BIN, .COM, .CMD, .SYS, .BAT, and .JS. The upload and submission process will fail if any of these unpermitted file types are selected.

Department of Health Food Service Inspection Report

☐ An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Browse...

Civil Verdict Documentation

☐ An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Browse...

Required Disclosures Related to Actions Taken by Medicare, Medicaid, or CLIA

☐ An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Browse...

Facility Ownership/Lease Documentation

☐ An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Browse...

Approved Repayment Plan

☐ An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Browse...

Additional Documentation

☐ An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Browse...

Undo | Save | << Back | Next >>

Provider:

Provider Type:
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= Entered
= Entry Required

- **Provider/Facility Information**
- **Licensee Information**
- **Controlling Interests**
- **Management Company Information**
- **Personnel**
- **Required Disclosure**
- **Bed Count**
- **Supporting Documents**
- **Finalize Submission**
  - Finalize Application

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Finalize Application

Any areas marked in red are incomplete and must be completed before the application can be submitted. To submit the application, select the appropriate subsection below, or from the Applications Components list to the left, and provide the missing information.

1. Provider/Facility Information
   a. Details
   b. Property Ownership
   c. Contact Person
2. Licensee Information
   a. Licensee Details
3. Controlling Interests
   a. Controlling Interests
4. Management Company Information
   a. Management Company Information
   b. Management Company Controlling Interest
5. Personnel
   a. Administration
   b. Safety Liaison
6. Required Disclosure
   a. Convictions
   b. Exclusions
   c. Felonies/Terminations
7. Bed Count
   a. Bed Count
8. Supporting Documents
   a. Supporting Documents

I _____, attest as follows:

(1) Pursuant to section 837.06, Florida Statutes, I have not knowingly made a false statement with the intent to mislead the Agency in the performance of its official duty.

(2) Pursuant to section 408.815, Florida Statutes, I acknowledge that false representation of a material fact in the license application or omission of any material fact from the license application by a controlling interest may be used by the Agency for denying and revoking a license or change of ownership application.

(3) Pursuant to section 408.806, Florida Statutes, under penalty of perjury, the applicant is in compliance with the provisions of section 408.806 and Chapter 435, Florida Statutes.

(4) Pursuant to section 408.809 and 435.05, Florida Statutes, every employee of the applicant required to be screened has attested, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to Chapter 408, Part II and Chapter 435, Florida Statutes, and has agreed to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer.

(5) Pursuant to section 435.05, Florida Statutes, the applicant has conducted a level 2 background screening through the Agency on every employee required to be screened under Chapter 408, Part II or Chapter 435, Florida Statutes, as a condition of employment and continued employment and that every such employee has satisfied the level 2 background screening standards or obtained an exemption from disqualification from employment.

(6) Pursuant to section 408.810(12), Florida Statutes, the licensee ensures that no person holds any ownership interests, either directly or indirectly, regardless of ownership structure, who has a disqualifying offense pursuant to section 408.809, Florida Statues or in a provider that had a license revoked or application denied pursuant to section 408.815, Florida Statutes.

_____ _____ _____
Signature of Licensee or Authorized Representative | Title | Date

☐ I agree

Biennial Licensure Fee and Other Amounts Due Upon Submission of Application

- The biennial licensure fee is $262.88 per bed
- The biennial assessment fee is $300, regardless of total number of beds
- Other amounts due (fines, assessment, fees, etc.) will be detailed in the application

Selecting the 'Submit Application' you will no longer be able to make changes to your application. Select 'OK' to continue, 'Cancel' to remain in the application.

Submit Application

Online Payments User Name:
Email:

Payment Summary

View Payment History

Provider Name:
City:
License Number:

Below are the provider's outstanding obligations to the Agency.

To make a payment:

1. Choose the items you wish to pay at this time.
2. Select Proceed.
3. When the page refreshes, choose a form of payment.
4. Select Pay Now.

Summary	
Item	**Amount**
	$0.00

Pay Later | Proceed

Fees

Select	Items
☐	Renewal Application Fee Application Number: *Date Due:*
☐	Biennial Assessment Application Number: *Date Due:*

Fines

Select	Items
There are no outstanding fines at this time.	

If you want to send your payment directly to the agency, click the 'Payment Statement' button below.

Payment Statement