ALL DOCUMENTS MUST BE IN THE EXACT NAME OF THE BUSINESS. ALL DOCUMENTS MUST ALIGN. PLEASE INCLUDE LLC, INC, CORP, AS IT APPLY

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Medicaid Application Data Sheet

Business Type: __ALF __Nurse Registry __HME __Other: _____

	INITIAL APPLICATION		CHOW APPLICATION
	AHCA license (copy)		AHCA license (copy)
	Voided check (needed for direct deposit)		Voided check (needed for direct deposit)
	IRS (SS4 Form)		IRS (SS4 Form)
	NPI: _____ (if you do not have one, we can create $75.00)		Bill of Sale
			Old Business Name: (if applicable) _____
			Old Medicaid Provider Number: _____
			NPI: _____ (if you do not have one, we can create for $75.00)
			Notes: if there is a name change, a new NPI is required
	Background Login In:		Background Login In:
	Background Password:		Background Password:

I. Contact Information

Contact Person for application: _____

Contact Cell Number: _____ Contact Email: _____

II. Facility Information

Facility Name: _____

Facility Full Address: _____

Facility Phone: _____ Facility Fax: _____

Facility Email: _____

III. Owner Information

Name of Owner #1: _____

Phone: _____ Email: _____

Social Security #: _____ D.O.B.: _____

Please return the information to
Email: AL@arrendells.com

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Arrendell's Training & Consulting

Home Full Address: _____

Contact Phone #: _____ Email: _____

Name of Owner #2: _____

Phone: _____ Email: _____

Social Security #: _____ D.O.B.: _____

Home Full Address: _____

Contact Phone #: _____ Email: _____

Name of Owner #3: _____

Phone: _____ Email: _____

Social Security #: _____ D.O.B.: _____

Home Full Address: _____

Contact Phone #: _____ Email: _____

IV. Administrator Information

Name of Administrator: _____

Full Address: _____

Administrator Phone: _____ Email: _____

Social Security #: _____ D.O.B.: _____

V. Execute

I hereby agree that the information provided is true and correct to the best of my ability. I understand that the information submitted, is for the purpose to obtain a Medicaid number to be used solely for the purpose intended. I understand that additional information may be needed and I will provide correct and true information when requested.

Signature: _____ Date: _____

The process can take *within* 3 to 6 months or sooner.

Reminders:

1. If you change your bank account this will disrupt the direct deposit.
2. If you change your contact information, this could mis route mail for AHCA Medicaid to contact or verify your identity.
3. If you change your email, you may not receive notices.

Please return the information to
Email: AL@arrendells.com