



Assisted Living Application Data Sheet

Further inclusions may exist depending on facility size and state requirements

Facility Information: Answer where applicable and write legibly.

1. Things needed for owner / operator to establish.

- Obtain zoning from the jurisdiction (county, municipality) where the home will be licensed.
- Corporation, EIN (tax identification number) – Our department can help with this.
- Facility
- Facility furnishings
- CEMP mutual aid
- Licensing application fee to AHCA
- Any additional fees to the Agency, local government, city, or any other jurisdiction
- Staff and operators
- Other tangible and non-tangibles as needed.

2. Arrendell's will do the following:

- Completion of AHCA Application
- Completion of AHCA Addendum
- AHCA Financials (for small beds only (0 to 8 beds))
- On-going consultation throughout license process
- Compliant Policy & Procedures (standard related to the license type)
- Specialty license policy and procedure
- Resident Folder
- Staff Folder
- Compliant Admission Package
- Required forms
- Background portal registration
- Organized operational binder
- CEMP (Comprehensive Emergency Management Plan) and follow-ups

_____ Initial _____ Change of Ownership

County: _____
Name of Business: _____ License # _____
DBA: if applicable: _____
Full ALF Address: _____
Full Mailing Address: _____
EIN: _____ NPI: _____
Medicaid Number, if applicable: _____ / Medicaid waiver: _____
Business Telephone: _____ Business Fax: _____
Email: _____ Website: _____
Capacity: _____ - ___OSS ___ Private Specialty License: ___LNS ___ECC ___LMH
Nurse On Site: ___ Full Time ___ Part Time ___ Third Party ___ None
Management Company: ___ Yes ___ No?

Administrator: _____
Cell: _____
Full Address: _____
Email Address: _____
Administrator social security number: _____ DOB: _____
Education: _____ Highschool Diploma _____ GED
Are you administering to any other facilities: ___ Yes ___ No

Chief Financial Officer: _____ D.O.B.: _____
Telephone: _____ Email: _____
Personal Address: _____

Safety Liaison: _____ D.O.B.: _____
Full Address: _____
Telephone: _____ Email: _____

Who owns the property? ___ Business ___ You ___ Other: _____
Name: _____ Phone _____
Full Address: _____

OWNERSHIP

Owner #1: Full Name: _____ %: _____
Personal Address: _____
Telephone Number: _____ Email: _____
Social Security Number: _____ D.O.B.: _____

Owner #2: Full Name: _____ %: _____
Personal Address: _____
Telephone Number: _____ Email: _____
Social Security Number: _____ D.O.B.: _____

Owner #3: Full Name: _____ %: _____
Personal Address: _____
Telephone Number: _____ Email: _____
Social Security Number: _____ D.O.B.: _____

Owner #4: Full Name: _____ %: _____
Personal Address: _____
Telephone Number: _____ Email: _____
Social Security Number: _____ D.O.B.: _____

BOARD MEMBERS

BM #1: Full Name: _____ Telephone: _____
Personal Address: _____
Social Security Number: _____

BM #2: Full Name: _____ Telephone: _____
Personal Address: _____
Social Security Number: _____

BM #3: Full Name: _____ Telephone: _____
Personal Address: _____
Social Security Number: _____

BM #4: Full Name: _____ Telephone: _____
Personal Address: _____
Social Security Number: _____

1. Are you willing to hold a bed for a resident if, for example, they went to the hospital, rehab temporarily?
___ Yes ___ No
2. Are you affiliated with any religion / religious group? ___ Yes ___ No, if yes, please list here;

3. What forms of payment(s) do you accept? ___ Private Pay ___ Medicaid ___ SSI Other:

4. Will you provide day service to adults who will not residing on the premises? _____
5. Languages spoken at the facility by administrator and staff?

Emergency Power Plan (EPP):

1. Generator: Portable _____ or Fixed _____ Other: _____
2. Make: _____ Model: _____ Size: _____
3. Type of Fuel: ___ Diesel ___ Propane ___ Piped Gas ___ Gasoline
4. Hours of runtime with fuel: _____ hours
5. Are there local restrictions as to how much fuel is stored: ___ Yes ___ No
6. How and where will fuel be stored: _____
7. The power source can power: _____

- a. _____ Entire facility
 - b. _____ Lights
 - c. _____ A/C
 - d. _____ Heating System
 - e. _____ Refrigerator
 - f. _____ Life Safety Systems
 - g. _____ Other: _____
8. Square footage of the area to be cooled? _____
9. How many people will be in the cooled area? _____
10. Will there be beds in the cooled area? _____ Are the beds on site? _____
11. Where is the carbon monoxide located in the facility? _____
12. Maintenance schedule for the carbon monoxide? _____

Please send the following:

- Facility floor plan
- Letter stating that the power source (alternate power) is sufficient to operate the equipment necessary to maintain the indoor temperature
- Fuel agreement

Attestation: Please sign certifying that all information is correct and true

Print

Signature

Date

Note: Additional Information may be required, as each location is different.