PEDIATRIC PRESCRIBED EXTENDED CARE

____Initial ____Renewal ____Change of Ownership

Instructions: If you have another business(es), please do not put the Medicaid, NPI or EIN for that business(es), only the business for this application. If it is a new application, you will not have a Medicaid or NPI number.
Social security numbers are required for both application and the background.
Answer where applicable and write legibly.

PPEC: Solutions for parents who have children with challenges and will not thrive in a traditional daycare center due to their immediate medical needs. As a PPEC you cannot bill Medicare, however you can bill the State Medicaid program, private insurance and direct pay. PPEC's offer direct care, medical, and educational services that children throughout their development.

Note: ***The applicant is responsible for contacting zoning, fire, health department and all other applicable local government agencies regarding the requirements for the business location. These local government agencies will require the signature of the applicant to sign off on documents, for this reason Arrendell's cannot obtain these documents.***

Content Subject to change without notice

COMPLETE ALL AREAS APPLICABLE

FACILITY INFORMATION

County: _____
Name of PPEC: _____ License #_____
DBA: if applicable: _____
Full Physical Address: _____
Full Mailing Address: _____
Telephone: _____Fax: _____
Email: _____ Website: _____
EIN: _____ NPI: _____
Medicaid Number, if applicable: _____ / Medicaid waiver: _____
Days and Hours of operation: Days _____ to _____ Hours _____ to _____
Bed capacity: _____

Management Company: _____ Yes _____ No, IF YES
Name: _____
Full Address: _____
Email Address: _____
Telephone: _____ Fax: _____
Contact Person: _____
EIN: _____

ADMINISTRATIVE INFORMATION

Medical Director: _____Cell: _____
Personal Full Address: _____
Email Address: _____
Administrator social security number: _____ DOB: _____
___ Full Time ___Part Time
_____ License Number: _____
_____ Please send Resume

Administrator/Director: _____ Cell: _____
Personal Full Address: _____
Email Address: _____ Telephone_____
Administrator social security number: _____ DOB: _____
_____ at least 2 year experience ___ Full Time ___Part Time
_____ RN: License Number: _____
_____ Please send Resume

Financial Officer: _____ Cell: _____
Personal Full Address: _____
Email Address: _____
Social security number: _____ DOB: _____
_____ Please send Resume

Safety Liaison: _____ Cell: _____
Personal Full Address: _____
Email Address: _____
Social security number: _____ DOB: _____
_____ Please send Resume

REGISTERED NURSE INFORMATION

Nurse Full Name_____ DOB: _____
Personal Full Address: _____
Email Address: _____ Telephone: _____
_____ at least 2 year experience ___ Full Time ___Part Time ___Contractor
_____ RN: License Number: _____
___ Full Time ___Part Time ___Contractor
_____ Please send Resume and Copy of License

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: _____

Items required for Application (Legible Copies)

__Zoning Form
__Local Occupancy License/Certificate with Medical Doctor as Medical Director of facility, if required.
__Fire Department Satisfactory Sheet (within 3 months of submitting application)
__Health Department Satisfactory Sheet (for meals to be served)
__Biomedical Waste Certificate
__Financials
__Level II Background (all owners) and (staff, including the Medical Director)
__Liability Insurance (*Recommendation: Purchase 2 weeks prior to application submittal*)
__Lease / Sub-lease / Deed
__Floor Plan
__Medical Doctor's License
__All other items will be prepared by Arrendell's (applicant's signature will be required)
AHCA Application Fee: $$$$$ (at cost to PPEC owner) AHCA can require additional paperwork at their discretion (ex: pictures, financial support beyond listed)

Facility Check List:

__Square Footage _____
__Administrative Offices
__Kitchen
__Bathrooms (children and staff)
__Medical Doctor's office w/ supplies
__Rooms (with doors, where applicable)
Isolation Room _____
Play / Social Room _____
Nurse Station _____
Classroom(s) _____
Nap room _____
Physical Therapy _____
Area for children to eat_____
Outdoor play area _____

Items Needed to demonstrate proficiency as a director/nurse

__Director: Degree in business or related area of license (social service, medical staff assistant, social worker, pediatric service), resume
__Director of Nursing
At least 2 years of pediatric experience (resume)
License
In-services
Liability Insurance
Level II Background
Physical – Free of Communicable disease and TB

Menu

Alvarez, Ana: Licensed Registered Dietician: American, Latin, Kosher and Specialty menu plans (diabetic, fiber, etc.): 954- 328-4506 - email: anaalvarezrd@bellsouth.net / website: www.alfmenus.com
Castro, Mayda: Licensed Registered Dietician: American, Latin, Kosher Specialty menu plans (diabetic, fiber, etc.)786-390-6108 - email: MaCastro@selectmedicalcorp.com

Things Needed in the facility(not limited to the following list)

__Battery Power Generator / Power inverter (no gasoline)
__Generator
__Cribs (lining, etc)
__Cots
__Hospital Beds
__Medical machines / devices per prescription order(s)
__Medical Emergency Cart
__OTHER ITEMS NEED

Applicants must include the following attachments as stated in Chapter 408, Part II and Chapter 400, Part VI, F.S. and Chapters 59A-35 and 59A-13, F.A.C. **Note: Required documents listed below are dependent on the type of application submitted. (Initial, Renewal, Change of Ownership, Change during licensure period)**

Documents to be Provided:	Required For:
General and Professional Liability Insurance	Initial, Renewal, Change of Ownership and Capacity Increase application types
Fire Safety Inspection Report	Initial, Renewal, Change of Ownership and Capacity Increase application types
Department of Health Food Service Inspection Report	All application types
Documentation from the appropriate local government office-showing that the applicant has met local zoning requirements	Initial, Change of Ownership and Capacity Increases application types
Signed agreement to correct all outstanding licensure deficiencies incurred by the previous owner.	Change of Ownership
Closing documents, signed and dated by all parties	Change of Ownership
Financial Ability to Operate, AHCA Form 3100-0009	Initial and Change of Ownership application types
Proof of Property Occupancy, Examples: Lease, Mortgage, and Transfer Agreement.	Initial, Renewal, Change of Ownership, Request to Change Name or Address of Provider application types
Health Care Licensing Application Addendum, AHCA Form 3110-1024	Initial, Renewal and Change of Ownership application types
Required disclosures related to actions taken by Medicare, Medicaid or CLIA, if applicable	All application types, if documentation is required due to responses provided in application
Approved repayment plan, if applicable	All application types