NON-SKILLED
HOME HEALTH AGENCY START-UP CONSULTATION SERVICE

Completion Application and Follow-up with AHCA
Application Package Includes:

INCLUSIONS

- Application and Addendum prepared for submission to AHCA
- AHCA Financials (when applicable)
- AHCA required business plan (not for outside or third-party purposes, i.e.: SBA, financial institution purposes)
- Required Policy and Procedures
- Staff Employment Packages
- Client Admission Packages
- Organizational Structure
- Comprehensive Emergency Management Plan
- On-going consultation until licensure

OWNER's RESPONSIBILITY

- Obtaining office and fees related to the office
- Obtaining zoning and other related local government certificates and fees related
- Application Fee and any other related fees
- Provide bank statement when requested (this is a requirement for the State Agency reviewing your application)
- Corporation Filing and fees (we can refer for services)

Note: Disclaimer for all business: The applicant is responsible for consulting with zoning, fire, health department and all other local government agencies regarding the structural requirements for the location. These local government agencies may need the signature of the applicant to sign off on documents. This type of license type cannot operate in a residence.

____**Initial** ____**Change of Ownership**

Home Health Agency Information: Answer where applicable and write legibly

FACILITY INFORMATION

County: _____ City/Municipality: _____
Name of Agency: _____ 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 _____

Management Company: _____ Yes _____ No

ADMINISTRATIVE INFORMATION – Information is for the Emergency Plan

ADMINISTRATOR INFORMATION

Administrator: _____ Cell: _____
Personal Full Address: _____
Email Address: _____ Telephone_____

ALTERNATE INFORMATION

Alternate Administrator: _____ Cell: _____
Personal Full Address: _____
Email Address: _____Telephone_____

NURSE INFORMATION

Nurse Full Name_____
Personal Full Address: _____
Telephone: _____

SAFETY LIAISON INFORMATION

Full Name_____
Personal Full Address: _____
Email: _____Telephone: _____

Comprehensive Emergency Management Program Mutual Aid

Who will be your mutual aid:

BUSINESS NAME: _____
BUS ADDRESS: _____
TELEPHONE: _____ FAX:_____
CONTACT PERSON: _____TITLE:_____
EMAIL: _____