

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



## 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 \$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](mailto:AL@arrendells.com)

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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](mailto:AL@arrendells.com)