NURSE REGISTRY

____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.

Things needed for owner / operator to establish.

1. Obtain zoning from the jurisdiction (county, municipality) where the home will be licensed.
2. Corporation, EIN (tax identification number)
3. Office
4. Office equipment
5. CEMP mutual aid
6. AHCA PFA (Proof of Financial Ability to Operate) preparer
7. Licensing application fee to AHCA
8. Any additional fees to the Agency, local government, city or any other jurisdiction
9. Staff and operators

2. Arrendell's will do the following:

- Completion of AHCA Application
- Completion of AHCA Addendum
- Completion of supplemental documents as they relate to the application (obtaining supplemental documents could be for discussion at the cost of the client depending on what or if AHCA needs anything additional to support the application). Each applicant could have differences.
- On-going consultation throughout license process
- Compliant Policy & Procedures (standard related to the license type)
- Patient Folder
- Staff Folder
- Compliant Admission Package
- Required forms
- Required documents for submission to third parties
- Background portal registration
- Organized operational binder
- CEMP (Comprehensive Emergency Management Plan) and follow-ups

<u>Note</u>: 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 Registry: ____ 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 (the admin does not have to be a nurse)

Administrator: ____ Cell: ____________________
Personal Full Address: ____
Email Address: ______________________________________ Telephone___________________
Administrator social security number: _____________________________ DOB: ____________
_____ at least 1 year experience ___ Full Time ___Part Time
_____ RN: License Number: ______________________________
_____ Please send Resume

Alternate Administrator: ____________________________________ Cell: ____________________
Personal Full Address: ____
Email Address: ____
Alt. Administrator social security number: __________________________ DOB: ____________
_____ at least 1 year experience ___ Full Time ___Part Time ___Contractor
_____ RN: License Number: ______________________________
_____ Please send Resume

REGISTERED NURSE INFORMATION

Nurse Full Name____ DOB: ____________
Personal Full Address: ____
Email Address: ____ Telephone: __________________
_____ at least 1 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: ____

Comprehensive Emergency Management Program Mutual Aid

Who will be your mutual aid in the event of an emergency? This can be another Nurse Registry or HHA.
BUSINESS NAME: ____
BUS ADDRESS: ____
TELEPHONE: ______________________________ FAX:_______________________________
CONTACT PERSON: ___________________________________TITLE:___________________
EMAIL: ____

County: ______________________________

What you will need to submit with the application

Documents to be Provided:	Required for:
Application Fee	Initial Application
Bank Statement or Letter	Initial Application
Proof of Financial Ability to Operate, AHCA Form 3100-0009	Initial and Change of Ownership application types
Documentation from the appropriate local government office showing that the applicant has met local zoning requirements	Initial, Change of Ownership and Change during license period - Address Change application types
Documentation of change of ownership transaction stating effective date and executed by all parties	Change of Ownership application types
Health Care Licensing Application and Addendum	Initial, Renewal and Change of Ownership application types
Lease	