HEALTH CARE CLINIC START-UP CONSULTNG SERVICE

____Initial **____Change of Ownership**

Instructions: Complete the questions where applicable. If the question does not apply to you, put N/A. Name, Address, Phone and Fax, Email, DOB, Social Security must be completed. There is both an application and an addendum that must be completed, therefore, all information is required.

County: ______________________________
Name of Clinic: ____ License #______________
DBA: if applicable: ____
Full Address: ____
EIN: _______________________________ NPI: __________________________________
If applicable: Medicaid Number: ____________________ / Medicaid waiver: _____________________
Telephone: _______________________________Fax: __________________________________
Email: ________________________________ Website: ________________________________
Hours of Operation: _________ to _________ Days of Week: ____________ to ______________

Medical Director: ____ Lic # _________________
Medical Director's social security number: _____________________________ DOB: __________
Personal Full Address: ____
Telephone Number: _______________________ Email: __________________________________
Will the doctor be an employee or a contractor: ____
Does the doctor serve as a Medical Director at other medical offices? Yes ____ No ____ if yes, please state on another page and list the clinic(s) Name, Address, Phone, Number of Employees, Days and hours at the clinic and license number.

Management Company: _____ Yes _____ No

Administrator: ____ Cell: __________________
Personal Address: ____
Email Address: ____
Administrator social security number: ________________________________ DOB: ____________

Chief Financial Officer: ______________________________ Telephone: ____________________
Chief Financial Officer social security number: _____________________________ DOB: __________
Personal Full Address: ____
Safety Liaison: ______________________________ Telephone: ____________________________

OWNERSHIP

Owner #1: Full Name: ____ %: ________
Full Address: ____
Telephone: ____
Owner #2: Full Name: ____ %: ________
Full Address: ____
Telephone: ____
Owner #3: Full Name: ____ %: ________
Full Address: ____
Telephone: ____
Owner #4: Full Name: ____ %: ________
Full Address: ____
Telephone: ____

BOARD MEMBERS

BM #1: Full Name: ____
Full Address: ____
Telephone: ____

BM #2: Full Name: ____
Full Address: ____
Telephone: ____

BM #3: Full Name: ____
Full Address: ____
Telephone: ____

BM #4: Full Name: ____
Full Address: ____
Telephone: ____

PERSONNEL who will work at the facility. If this is an initial application and you do not have personnel, put N/A. If there is more than 2 staff then list on a separate page.

Full Name	FL License / Registration Type
Position / Title	FL License / Registration Number
Full Name	FL License / Registration Type
Position / Title	FL License / Registration Number

A. CLINIC TYPE: Check all that apply

- ☐ Receives reimbursement from Medicare and/or Medicaid
- ☐ Receives reimbursement from Automobile Personal Injury Protection (PIP) Insurance
- ☐ Mobile Clinic – (movable or detached self-contained health care unit within or from which direct health care services are provided)
- ☐ Portable Equipment Provider – (entity that contracts with or employs persons to provide portable equipment to multiple locations performing treatment or diagnostic testing of individuals)
- ☐ Urgent Care Center – (a facility or clinic that holds itself out to the general public in any manner as a facility or clinic where immediate but not emergent medical care is provided)
- ☐ Pain Management Clinic – (registration with the Florida Department of Health will be required)
- ☐ None apply

B. SERVICES PROVIDED AT THE CLINIC: (check all that apply)

☐	Allergy	☐	Ophthalmology	☐	Laboratory
☐	Acupuncture	☐	Optometry	☐	Midwifery
☐	Cardiology	☐	Oral/Maxillo-facial Surgery	☐	Medication Therapy Management
☐	Chiropractic Medicine	☐	Orthopedics		Mental Health Services:
☐	Dentistry	☐	Osteopathy	☐	Clinical Counseling
☐	Dermatology	☐	Otolaryngology (ENT)	☐	Marriage & Family Counseling
	Diagnostic Imaging:	☐	Pain Management	☐	Psychiatry
☐	Angiography	☐	Pediatrics	☐	Substance/Alcohol Abuse
☐	Arteriography	☐	Pharmacy	☐	Mental Health/Other:
☐	Bronchography	☐	Pharmaceutical Counseling		Rehabilitation Services:
☐	CT (Computed Tomography)	☐	Plastic Surgery	☐	Massage Therapy
☐	Digital Vascular Imaging	☐	Podiatry	☐	Physical Therapy
☐	EEG (Electroencephalogram)	☐	Pulmonary Medicine	☐	Speech Therapy
☐	EKG/ECG (Electrocardiogram)	☐	Radiation Therapy	☐	Occupational Therapy
☐	Evoked Potentials	☐	Radiology	☐	Research/Clinical Trials
☐	Lymphangiography	☐	Electrolysis	☐	Sleep Disorders
☐	Mammography	☐	Emergency Medicine	☐	Sleep Studies
☐	MRI (Magnetic Resonance Imaging)	☐	Endocrinology	☐	Sports Medicine
☐	Nerve Conduction Studies	☐	End-stage Renal Disease	☐	Termination of Pregnancy
☐	Nuclear Medicine	☐	Family Medicine	☐	Thoracic Surgery
☐	PET (Positron Emission Tomography)	☐	Gastroenterology	☐	Urgent Care
☐	Splenography	☐	General Surgery	☐	Urology
☐	Ultrasound	☐	Geriatrics	☐	Vascular Surgery
☐	Dietetic/Nutrition Services	☐	Gynecology	☐	Weight Loss
☐	Naturopathy	☐	Hematology	☐	
☐	Nephrology	☐	Hyperbaric Medicine	☐	Other:
☐	Neurology	☐	Immunology	☐	1.
☐	Neurosurgery	☐	Infectious Disease	☐	2.
☐	Obstetrics	☐	Infusion Treatment	☐	3.
☐	Oncology	☐	Internal Medicine	☐	4.

Documents to be Provided	Required For

Health Care Licensing Application Addendum, AHCA Form 3110-1024	Initial, Renewal, Change of Ownership, and Personnel Changes application types
Proof of Financial Ability to Operate (AHCA Form 3100-0009)	Initial and Change of Ownership application types
Surety Bond, if required per section 408.8065, F.S.	Initial, Renewal, Change of Ownership, and Personnel Changes application types
Medical/Clinic Director Attestation, AHCA Form 3110-1028	Initial, Renewal, Change of Ownership, and Change of Medical/Clinic Director application types
Medical/Clinic Director's contract or agreement wit the clinic including the effective date of service	Initial, Change of Ownership, and change of Medical/Clinic Director application types
Copy of the Medical/Clinic Director's Florida health care practitioner's license and any other specialty certifications necessary for supervision of services provided	Initial, Change of Ownership, and change of Medical/Clinic Director application types
Documentation of change of ownership transaction stating effective date and executed by all parties	CHOW application type
Proof of new or continued MRI accreditation, or letter of intent to achieve MRI accreditation within 12 month (MRI providers only)	Initial, Renewal, Change of Ownership, adding Clinic Services 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

Health Care Clinic licensing package Includes

- Completion of AHCA Application and addendum and Follow-up with Agency
- On-going consultation throughout license process
- One visit to the facility and present during initial inspection (depending on location; additional cost may incur)
- Licensing required documentation

***Note*: 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 can need the signature of the applicant to sign off on documents for this reason Arrendell's cannot obtain these documents. If this is a home business, it is recommended to consult with your local government to satisfy their requirements related to a home business).**

***Disclaimer*: Policy and Procedures will meet the requirements upon inspection, thereafter, it is the responsibility of the Health Care Clinic to maintain policies and procedures current.**

My Signature states that the information is presented in truth to by best ability.

Signature: ____ Date: ______________