FACILITY APPLICATION FORM (APD 2014-01)

### Instructions: Please ensure that all applicable parts of this form are completed legibly and in their entirety. If you have questions regarding this form or the application process, please contact your area APD office for assistance.

Indicate in the space below whether this an application for an initial license or an application for renewal of an existing license.

\_\_\_\_\_ Initial \_\_\_\_\_ Renewal

This application must be completed by the prospective licensee or the designated representative of a partnership, corporation or association. A letter of designation should accompany the application if the applicant is not a member of the partnership, association or corporation. When provider organizations subcontract with individual live-in caregivers for the provision of residential services within those caregivers’ homes, a representative of the contracting provider organization and the live-in caregivers should complete and sign this application. Print or type name, address, telephone number, and e-mail address below of person completing this application and indicate their role in the operation of the facility (licensee, supervisor, manager, board member, etc.):

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Applicant Name:
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant Telephone Number (including cell phone) and E-mail Address:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PRINT NAME OF RESIDENTIAL FACILITY**: Note: When provider organizations subcontract with individual live-in caregivers for the provision of residential services within those caregivers’ homes, the names of both the live-in caregivers and the contracting provider organization should appear on the facility license.

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Physical Address of Licensed Facility:
 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Facility Mailing Address (if different than above):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Facility Telephone Number (including area code)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Section II: Description of Services to be Provided and Types of Residents to be Served:**Requested Capacity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age Range to be Served \_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: \_\_\_\_\_\_\_ Males Only \_\_\_\_\_\_\_\_ Females Only \_\_\_\_\_\_\_\_ Co-ed

This facility would be willing and able to serve individuals with one or more of the following conditions (check all that apply):

\_\_\_\_\_ Mental Retardation

\_\_\_\_\_\_ Autism

\_\_\_\_\_\_ Cerebral Palsy

\_\_\_\_\_\_ Spina Bifida

\_\_\_\_\_\_ Prader-Willi Syndrome

\_\_\_\_\_\_ Hearing Impairments

\_\_\_\_\_\_ Dual Diagnosis (Mental Retardation and Mental Illness)

\_\_\_\_\_\_ Visual Impairments

\_\_\_\_\_\_ Criminal Offenses

\_\_\_\_\_\_ Children in Foster Care

\_\_\_\_\_ Mobility impairments (including those individuals who use wheelchairs, crutches, canes, walkers, or other such devices on an ongoing basis)

\_\_\_\_\_\_ Epilepsy

\_\_\_\_\_ Diabetes

\_\_\_\_\_\_ Chronic medical issues (including those individuals with feeding tubes, tracheostomies, and ostomies)

\_\_\_\_\_\_ Other (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In addition to those categories that were not checked above, please describe any other types of residents whom you would **not** be willing to serve:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Check one or more of the following levels of support which the applicant would be willing and able to provide to residents (in consideration of the resident characteristics described below):

\_\_\_\_\_ Basic

* Functional: Independent in self-care, daily living activities; or requires supervision, intermittent verbal direction or physical prompts to perform self-care, daily living skills
* Behavioral: No formal behavioral intervention necessary except redirection; may be non-compliant at times
* Physical: Health issues under control through medication or diet. Ambulatory or independent in use of wheelchair/walker. May need staff supervision to self-administer medications.

\_\_\_\_\_ Minimal

* Functional: May require consistent verbal and physical help to complete self care/daily living tasks, including physical assistance and mealtime intervention to eat safely, may require mealtime interventions and/or devices. May require scheduled toileting or use of incontinent briefs. Walks independently or independently uses a manual or power wheelchair. May require assistance to change positions. Needs physical assistance of one person to transfer or to change positions.
* Behavioral: May exhibit behaviors that require formal and informal intervention; requires frequent prompts, instruction or redirection, some environmental modifications or restrictions on movement may be necessary.
* Physical: If has seizures, no interference with functional activities; May require medication for bowel elimination. May require a special diet. May require staff supervision to self-administer medications.

\_\_\_\_\_\_\_ Moderate

* Functional: Requires substantial prompting and/or physical assistance to perform self-care/daily living activities. May be totally dependent on staff for dressing/bathing. May require mealtime interventions and/or devices OR receives all nutrition through a gastrostomy or jejunostomy tube. Incontinent of bowel or bladder. May require scheduled toileting or use of incontinent briefs. Independently uses a powered wheelchair, may need assistance with a manual chair. May require assistance to change positions. Disability prevents sitting in an upright position, has limited positioning options. Needs physical assistance of one person to transfer or to change position.
* Behavioral: May exhibit behaviors that require frequent planned, informal and formal interventions. Assistance from others may be necessary to redirect the recipient. May require psychotropic medication for control of behavior. Self-injury or aggression towards others or property results in broken skin, major bruising/swelling or significant tissue damage requiring physician/nurse attention. May have threatened suicide in past 12 months. May have required use of reactive strategies 5 or more times per month in last 12 months. May routinely wear protective equipment to prevent injury from self-abusive behavior.
* Physical: May have seizures that interfere with functional activities; receives 2 or more medications to control seizures. May have experienced a pressure sore requiring medical attention in the past 6 months. May require medication and daily management, including enemas, for bowel elimination. May be nutritionally at risk and require a physician/dietitian prescribed special diet.

\_\_\_\_\_\_ Extensive 1

* Functional: Totally dependent on staff for self-care/daily living activities; Disability prevents sitting in an upright position, has limited positioning options. Requires two person lift or lifting equipment to transfer. Independently uses a powered wheelchair, needs assistance with a manual chair. Requires daily monitoring and frequent hands-on assistance to stay healthy. Health issues result in inability to attend outside programs 5-10 days a month; health condition is unstable or becoming progressively worse.
* Behavioral: Frequent planned, informal or formal interventions necessary. Assistance from others may be necessary to redirect the recipient. Requires psychotropic medication for control of behavior. Use of physical/mechanical restraint. Self-injury or aggression towards others or property results in significant tissue damage, scarring, damage to bones that requiring physician attention. May have attempted suicide in past 12 months. May have required the use of reactive strategies 5 or more times per month in last 12 months . May routinely wear protective equipment to prevent injury from self abusive behavior at least 12 hours per day. Has received emergency medication to control behavior in last 12 months. May meet criteria of Intensive Behavioral Residential Habilitation.
* Physical: May have uncontrolled seizures that have required hospital or emergency room intervention during past 12 months; receives medications to control seizures. May have been hospitalized for medication toxicity in past 12 months. May have experienced a pressure sore requiring recurrent medical attention or hospitalization in the past 6 months. May require medication and daily management, including enemas, for bowel elimination. May have been hospitalized for impaction in last 12 months. May be at high nutritional risk and requires intensive nutritional intervention. Has a condition that requires physician prescribed procedures. (Cannot be delegated to a non-licensed staff.)
* Other: If the recipient’s primary need is to receive visual supervision based on a documented history of inappropriate sexual behavior or sexually provocative behavior, assignment to this level is appropriate.

\_\_\_\_ Extensive 2:

* Functional: Requires total physical assistance in self-care, daily living activities. May require mealtime interventions and/or devices OR receives all nutrition through a gastrostomy or jejunostomy tube. Incontinent of bowel or bladder. May require scheduled toileting or use of incontinent briefs. May have indwelling catheter or colostomy managed by staff. Disability prevents sitting in an upright position, has limited positioning options. Requires two person lift or lifting equipment to transfer. Totally dependent on others to stay healthy. Health issues result in inability to consistently attend outside programs; health condition is unstable or becoming progressively worse.
* Behavioral: Frequent planned, formal interventions necessary. Assistance from others necessary to redirect recipient . Receives multiple psychotropic medications for control of behavior, possibly frequent medication changes. Use of physical/mechanical restraint. Meets the criteria of Intensive Behavioral Residential Habilitation.

*Note: Pursuant to Chapter 65G-2, F.A.C., the facility must obtain prior approval from the area*

*APD office for any admissions which vary from the criteria specified within this section.*

In addition to the services which are required to be provided under Chapter 65G-2, F.A.C., check all services below which the applicant intends to provide directly to residents of the facility (through, and in accordance with the requirements of, the Medicaid waiver program):

|  |  |
| --- | --- |
| \_\_\_ Adult Day Training (Life Skills Development Level 3)\_\_\_ Behavior Analysis (Wellness and Therapeutic Supports) \_\_\_ Behavior Assistant (Wellness and Therapeutic Supports) \_\_\_Companion (Life Skills Development Level 1) \_\_\_Consumable Medical Supplies (Supplies and Equipment)\_\_\_Dietician \_\_\_Personal Supports\_\_\_Residential Habilitation (Standard) (Personal Supports)\_\_\_Residential Habilitation (Behavior Focus) (Personal Supports)\_\_\_Residential Habilitation (Intensive Behavioral) (Personal Supports)  | \_\_\_Residential Nursing (Personal Supports)\_\_\_Respite (Personal Supports)\_\_\_Skilled Nursing (Wellness and Therapeutic Supports) \_\_\_Special Medical Home Care (Personal Supports)\_\_\_Specialized Mental Health Services (Wellness and Therapeutic Supports)\_\_\_Supported Living Coaching (Personal Supports\_\_\_Transportation\_\_\_Other (please specify below) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

*Note: The Agency will verify that the applicant is capable of serving the intended clientele and rendering the services indicated above (pursuant to Agency review of staff qualifications and facility characteristics).*

**Section III: Ownership and Management Information**

**OWNER OF THE PROPERTY (AS THE NAME APPEARS ON THE DEED OF PROPERTY)**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address of Property Owner:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Complete the following section only if applicant for licensure is an individual.***

Provide full name and address below (indicating previous or maiden names as well):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Telephone Number (including area code): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number\*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*The collection of social security numbers is used for the licensing of residential facilities and is imperative to the agency's duties and responsibilities as prescribed by law. The social security numbers collected will not be available to the general public.

***Complete the following section only if applicant for licensure is a partnership.***

Provide the name, address, social security number\*, and date of birth of each member of the partnership (attach additional sheets if necessary):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\*The collection of social security numbers is used for the licensing of residential facilities and is imperative to the agency's duties and responsibilities as prescribed by law. The social security numbers collected will not be available to the general public.

## *Complete the following section only if applicant for licensure is a corporation, firm or association.*

Provide the name, address, social security number\*, and date of birth of each member of the Board of Directors (excluding volunteer board members as well as those board members who do not reside within the State of Florida). Attach additional sheets if necessary.

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\*The collection of social security numbers is used for the licensing of residential facilities and is imperative to the agency's duties and responsibilities as prescribed by law. The social security numbers collected will not be available to the general public.

##  *INDIVIDUAL Responsible for on-site management/supervision of facility*

Name of Primary On-Site Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Telephone Numbers (including cell phone number):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provide details on education and experience of person identified above:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Provide name and telephone number of back-up manager/supervisor(s):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 **Section IV: Additional Documentation**

The following documents must be attached to this application:

1. If applicant for licensure is a corporation, firm or association. Provide a copy of the Articles of Incorporation and names and telephone numbers of all members of the Board of Directors.

2. Information relating to the number, experience, and training of the employees of the facility or program.

### 3. Any promotional materials (in electronic or print format) which will be used to market the services offered by the facility.

1. Documentation that the facility has been inspected by the local fire safety authority or the State Fire Marshal and determined to be in compliance with applicable statutes and rules.
2. The facility’s current and approved comprehensive emergency management plan.

6. A copy of the lease signed by the applicant and lessor, if the facility is located in a leased building or on leased property.

7. Individuals or entities applying for licensure as a Comprehensive Transitional Education Program shall provide the number and location of the component centers or units which will compose the comprehensive transitional education program.

8. Applicants for initial licensure shall attach the approved variance from local zoning officials (if one is required as described within Section V of this application). Some local governments may choose to provide the applicant with written verification that the home is in compliance with zoning requirements; in those instances, the applicant should attach a copy of such documentation to this application as well.

9. A copy of the applicants written policy regarding sexual activity involving residents of the facility as required under Rule 65G-2.009, F.A.C.

10. A floor plan of the facility.

11. Name(s) of any controlling entity of the applicant.

12. Disclosure of any financial or ownership interest that the controlling entity of the applicant has held in the last 5 years in any entity licensed by the State of Florida to provide residential care which has closed voluntarily or involuntarily, has filed for bankruptcy, has had a license denied, suspended, or revoked, or has had an injunction issued against it by a regulatory agency. The applicant must disclose the reason each licensed entity was closed, and whether the closure was voluntary or involuntary.

13. Copies of any known sanctions, fines, or recoupments related to the receipt or use of federal or state funds by all controlling entities of the applicant within the preceding twelve month period. These include the results of any investigations into Medicaid or Medicare fraud.

14. Evidence of financial ability to operate the facility in accordance with Chapter 65G-2 for up to 60 days without dependence upon payment from the state or other third party fees from facility residents. Such evidence shall include bank account statements, pay stubs, documentation of a line of credit, or any other documents which would demonstrate the expected ability of the licensee to continue operations for that time period and under those conditions.

Section V: AFFIDAVIT

1. Have you or a controlling entity affiliated with this application ever had a license denied, revoked, or suspended in any county in Florida, or any other state or jurisdiction OR been the subject of disciplinary action, or the party responsible for a licensed facility receiving an administrative fine?

\_\_\_\_\_ Yes \_\_\_\_\_\_ No
2. Have you or ownership controlling entity affiliated with this application ever been identified as responsible for the abuse, neglect, or abandonment of a child or the abuse, neglect, or exploitation of a vulnerable adult?

 \_\_\_\_\_ Yes \_\_\_\_\_\_ No

3. Have you or a controlling entity affiliated with this application ever had prior adverse action taken against you by the Medicare or Medicaid program (including, but not limited to, the involuntary termination of a Medicaid/Medicare provider agreement, recoupment, or fraud conviction)?

 \_\_\_\_\_ Yes \_\_\_\_\_\_ No

4. Have you ever held a license to operate a residential facility that was revoked or denied by the Agency for Persons with Disabilities, the Department of Children and Family Services, or the Agency for Health Care Administration?

\_\_\_\_\_ Yes \_\_\_\_\_\_ No

If any of the above four questions were answered with “yes”, please provide additional information regarding such situation(s) on the following lines and attach all relevant documents:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Questions 6 through 10 below only apply to applicants for initial licensure. Applicants for licensure renewal should leave those items blank and proceed to Question 11 within this section.

5. Will this home be a foster care facility (3 beds or less) with a live-in caregiver?

\_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_ No

Note: If the answer to the preceding question is “yes”, then the following statements (items 6 through 10) are not applicable and those applicants should therefore proceed to Question 11.

6. I have provided the local zoning authority with the most recently published data compiled by the Agency for Health Care Administration, Agency for Persons with Disabilities, and Department of Children and Families identifying all community residential homes within the jurisdiction of the local zoning authority. \_\_\_\_\_ (Initial here)

7. I further certify that notification of intent to establish this facility has been made to the local zoning authority. \_\_\_\_\_ (Initial here)

8. At the time of home occupancy, I will notify local government that the facility is licensed. \_\_\_\_\_\_ (Initial here)

9. I understand that the Agency for Persons with Disabilities assumes no financial liability or other liability in the event an error has been made in calculating, measuring or certifying that this facility meets Chapter 419 requirements. \_\_\_\_ (Initial here)

10. Please check only one of the following three items:

\_\_\_\_\_(6 or fewer beds): I certify that the proposed facility is not located within a 1,000 foot radius of another community residential home or has an approved variance\* from the local zoning authority. \_\_\_\_ (Initial here)

\_\_\_\_\_(7-14 beds): I certify that this facility is not located within a 1,200 foot radius of another community residential home or within 500 feet of an area zoned single-family or has an approved variance\* from the local zoning authority. \_\_\_\_ (Initial here)

 \_\_\_\_\_ I have an approved variance from local zoning officials. (Attach copy of variance document to this application). \_\_\_\_ (Initial here)

1. Are any individuals identified as a party of ownership (i.e. officer or member of corporation) either a current employee of the Agency for Persons with Disabilities or married to an employee of the Agency?

\_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_ No

If “yes” was checked, provide names of those individuals:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. Have you or anyone identified as a board member or a party to ownership, been convicted of a misdemeanor or felony?

\_\_\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_\_ No

If “yes” was checked, provide details in the following space (names, dates, etc.):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. As the applicant, I hereby attest that myself and all managers, supervisors, and direct service providers associated with the proposed facility are in full compliance with all requirements for background screening as delineated within s. 393.0655, F.S.
\_\_\_\_ **(Initial here)**

14. I hereby attest that all employees of this facility shall receive training to detect and prevent abuse (including sexual abuse), neglect, and financial exploitation of residents and clients.
**\_\_\_\_ (Initial here)**

Under penalty of perjury, I hereby attest that all information contained in and submitted with application is true and accurate to the best of my knowledge and by submitting same I am requesting a license to operate a facility in accordance with Chapter 393, F.S. I also attest that I have the authority to attest to such information on behalf of the above-named applicant for licensure or license renewal.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Applicant or Representative of Applicant Printed Name

State of \_\_\_\_\_\_\_\_\_\_\_\_\_\_ County of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sworn and subscribed to before me

This \_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOTARY PUBLIC

## IMPORTANT NOTICE

**RE:**  **ZONING REQUIREMENTS FOR APPLICANTS SEEKING INITIAL LICENSURE THROUGH APD**

Dear License Applicant:

Chapter 419, Florida Statutes require that persons seeking to establish APD-licensed foster care facilities\* or group home facilities (meeting the definition of a “community residential homes” within the law) must provide local zoning officials with certain information as part of the license application process.

\*Note: Foster care facilities (with a maximum capacity of three residents) which intend to utilize live-in caregivers do not meet the statutory definition of “community residential home” as that term is defined in Chapter 419, F.S. and are therefore exempt from the local zoning notification requirements of the law.

In order to ensure compliance with state law, please complete the following steps:

STEP 1: Obtain a list of community residential homes in your area which are licensed by the Agency for Health Care Administration. This information can be found on the Internet via the following link: [http://www.floridahealthfinder.gov/facilitylocator/facloc.aspx](http://www.floridahealthfinder.gov/facilitylocator/facloc.aspx%20%20%20)

Once you reach that website:

1. Choose “Search by Proximity”.

2. Enter the address of the proposed facility and search for each of the following provider types (with 14 or fewer beds) within one mile:

Assisted Living Facilities

Adult Family Care Homes

Residential Treatment Facilities

Intermediate Care Facilities for the Developmentally Disabled

3. Print out the search results for each of the above categories.

STEP 2: Obtain a list of community residential homes in your area which are licensed by Department of Children and Families (DCF). On the Internet, visit: <http://www.myflfamilies.com/contact-us> for the telephone number and address of your local DCF office. Contact the appropriate DCF office to request a list of their currently licensed community residential homes within the vicinity of the proposed facility.

STEP 3: Contact your local APD office to request a current list of APD-licensed community residential homes in your area.

STEP 4: Submit the lists of community residential homes (as described in Steps 1, 2, and 3) to local zoning officials in your area.

STEP 5: After the home is granted an APD license, notify local zoning officials that the home is licensed by APD **as soon as the home receives its first resident**.

If you have any questions, please contact your local APD office.

**Annual Budget Sheet**

(Note: Applicants for initial licensure should only complete the “projected” budget column below while applicants for licensure renewal should complete both columns)

|  |  |  |
| --- | --- | --- |
| **REVENUE** | Past 12 Months | Next 12 months (projected) |
| 1. Income based on existing or proposed licensed capacity.
 |  |  |
| **EXPENDITURES** |  |  |
| 1. **Personnel**
 |  |  |
|  a. Salaries and Wages (FTE’s = ) |  |  |
|  b. Worker’s Comp./ Health Insurance |  |  |
| 1. **Contracted Services:**
 |  |  |
|  a. Fiscal/Legal |  |  |
| 1. **Staff Training (fees & travel costs only)**
 |  |  |
| 1. **Transportation**
 |  |  |
|  a. Loan/Lease Payments |  |  |
|  b. Maintenance/Fuel |  |  |
|  c. Staff travel reimbursements |  |  |
|  d. Auto Insurance |  |  |
| 1. **Liability Insurance**
 |  |  |
| 1. **Marketing/Advertising (incl. Staff recruitment)**
 |  |  |
| 1. **Supplies and Equipment**
 |  |  |
|  a. Consumables (program & consumer) |  |  |
|  b. Equipment repairs/maintenance |  |  |
|  c. Furniture/Equipment Replacement |  |  |
| 1. **Office Expenses:**
 |  |  |
|  a. Postage |  |  |
|  b. Telephone |  |  |
|  c. Printing/Copying |  |  |
| 1. **Facility Cost**
 |  |  |
| a. Mortgage / Rent |  |  |
| b. Utilities |  |  |
| c. Food / consumables |  |  |
| d. Maintenance / repairs |  |  |
| e. Furnishings |  |  |
| **TOTAL EXPENDITURES** |  |  |

I hereby state that I have sufficient capital, income or credit to staff, equip, and operate this facility in accordance with Rule 65G-2 for sixty days without dependence on client fees or payments from the State of Florida.

*Signature of Owner/Sponsor Name of Facility Date*

**Note: The Agency reserves the right to request and obtain from the applicant copies of income tax returns, bank statements, payroll records, and other documentation as necessary in order to substantiate the past or projected revenue/expenditures listed above.**