agency for persons with disabilities
State of Florida

APD USE ONLY:
File #: _____
Application #: _____

License Application

This application for an initial license or license renewal must be completed by the applicant / licensee or the designated representative of a business entity. *Please note, "Change of ~~in~~ Ownership" refers to a facility or program that was acquired through a change of ownership/acquisition from an existing APD licensed provider. If you are pursuing a change of ~~in~~ ownership of an existing licensed APD provider, please complete the form below as "initial" and indicate "Change of ~~in~~ Ownership". Please ensure that all applicable parts of this form are completed legibly and in their entirety. All information completed in this form must comply with s~~S~~ection 393.067, Florida Statutes (F.S) and Chapter 65G-2 *Florida Administrative Code* (F.A.C.). Applications shall be completed under oath and must contain factual and accurate information. If you have questions regarding this form or the application process, please contact your APD regional office for assistance.

1. Application Type

A. License Application	
☐ Initial ☐ Renewal	☐ Change of ~~in~~ Ownership* The intended effective date of the change of ownership is (mm/dd/yyyy): _____
B. License Type	
☐ Group Home Facility ☐ Foster Care Facility ☐ Residential Habilitation Center ☐ Adult Day Training program	

2. Applicant / Licensee Information

Section A. is to be filled in by an individual applicant/licensee or designated representative of a business entity (e.g., a partnership, LLC, professional association, or corporation). If the designated representative is a not a member of the business entity, then a letter of designation must accompany the application.

A. INDIVIDUAL APPLICANT/LICENSEE INFORMATION			
Name of Applicant/Licensee as filed with the Florida Department of State, Division of Corporations. *Only use your individual name if applying as an individual.	Date of Birth (mm/dd/yyyy) *For individual applicants only.	Florida Medicaid Provider Number (if available)	
Description of Applicant/Licensee (check one) ☐ Liability Company (LLC) ☐ Corporation ☐ Professional Association (P.A.) ☐ Partnership Other:	Business Entity Name *If different from applicant/licensee.	Federal Employer Identification Number (FEIN): ~~or SSN~~ Individual Applicant SSN:	
Street Address			
City	County	State	Zip
Telephone Number	Cell Phone Number	Fax Number	
E-mail Address			
Is the application being completed by a designated representative on behalf of a business entity? Yes ☐ No ☐	Designated Representative Name: Email Address: Relation to licensee:		

B. FACILITY OR PROGRAM INFORMATION			
Name of facility or program to be licensed:			
Street Address or ☐ Same as above in Section 2.A. of this application			
City	County	State	Zip
Telephone Number	Fax Number		
E-mail Address			
Provider Website			
Mailing Address or ☐ Same as above			
City	County	State	Zip

~~For Section C. if the applicant or licensee is a business entity such as partnership, professional association, limited liability company, corporation, etc., complete the following.~~

C. BUSINESS ENTITY OWNERSHIP INFORMATION: ~~PARTNERSHIP, LLC, P.A., OR CORPORATION, Etc. APPLICANT/LICENSEE INFORMATION –~~ Please complete the ~~following~~ chart below to list ~~for~~ all current officers, directors, or members of the entity seeking a license for a facility or program ~~if applicable~~.

**If the entity is a Not-for-Profit, do not include unpaid voluntary Board members or ownership percentage.*

~~MEMBERSHIP INFORMATION INSTRUCTIONS~~ (*~~attach additional pages if necessary~~*)
~~For licensees or applicants *other* than an individual or corporate applicant or licensee, please complete the table below.~~

FIRST AND LAST ~~FULL~~ NAME ~~of INDIVIDUAL~~ or ENTITY NAME ~~MEMBER~~	**PERSONAL/PRIMARY ADDRESS**	**TELEPHONE NUMBER**	**FEIN Or SSN**	**Date of Birth (mm/dd/yyyy)**	**POSITION TITLE ~~% of OWNERSHIP~~** (If applicable)	**Percentage of OWNERSHIP** (Not applicable to not-for-profit) This column should total 100% **~~EFFECTIVE DATE~~**

~~**Board Members and Officers of Licensee –** If a Licensee is a corporation, provide the information for each individual that serves as~~

~~an officer or is on the Board of Directors. Do not include voluntary Board members.~~

~~TITLE~~	~~FULL NAME~~	~~PERSONAL/PRIMARY ADDRESS~~	~~TELEPHONE NUMBER~~	~~EFFECTIVE DATE~~

D~~E~~. **PROPERTY OWNER INFORMATION –** Complete this subsection if the owner of the property is different from the licensee.		
Does the applicant/licensee own the property where the facility or program is located? If ☐ YES, proceed to Section 3. If ☐ NO, provide the following information for the property owner:		
Full Name of Property Owner		
Address	Telephone Number	
City	State	Zip
E-Mail Address		

3. Facility or Adult Day Program Operator, Manager, or Program Director

A. Provide the following information for the Operator or Program Director responsible for on-site management and/or supervision of the facility or program ~~pursuant to 65G-2.0072 and 65G-2.0074, F.A.C.~~

INFORMATION	Facility Operator or Program Director
Full Name	
Date of Birth	
Telephone Number	
Alternative Contact Number	
Email Address	

Provide a description of the training, education, and experience of the Facility Operator or Program Director.

B. **Back-up Facility Operator(s) or P~~p~~rogram D~~d~~irector~~)~~ –** Provide the requested information for the individual who will serve as the back-up facility operator or program director

INFORMATION	Back-up operator
Full Name	
Date of Birth	
Telephone Number	

Alternative Contact Number	
Email Address	

Provide a description of the education, training, and experience of the Back-up Facility Operator (documentation of any and experience must be attached to this application).

4. Employee Information

For license renewal applications, please provide the staffing information below. If this application is for an initial license and there is no staff available at the time of application, this information must be provided to the Agency prior to serving residents or program participants. (Additional employees can be added on a separate page as needed~~,~~)

Employee Name	Date of Birth	Describe the Employee's Experience	Employee's ~~Training and~~ Education

As the applicant, I hereby attest that I 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 section ~~s.~~ 393.0655, F.S.

(Initial here)

I hereby attest that all employees of this facility or program shall receive training to detect and prevent abuse (including sexual abuse), neglect, and financial exploitation of residents, participants, and clients prior to direct client contact.

(Initial here)

5. Individuals to be Served

Pursuant to Rule 65G-2.009(34), F.A.C., licensees must obtain approval from the Agency for Persons with Disabilities prior to receiving any resident that would deviate from the application for licensure.

REQUESTED CAPACITY (Number of residents or participants to be served)	**SEX OF INDIVIDUALS TO BE SERVED:**	**AGE OF INDIVIDUALS TO BE SERVED (prior approval from APD is required to serve both adults and minors):**
_____ Residents/Participants	☐ Male and Female ☐ Male Only ☐ Female Only	☐ 3 - 5 (High-Risk) ☐ 6 – 17 ☐ 8 - 2122 ☐ 2223 - 45 ☐ 46 - 65 ☐ 66 and over

THIS FACILITY OR PROGRAM WILL SERVE INDIVIDUALS WITH ANY OF THE FOLLOWING DIAGNOSIS (check all that apply):

☐ Intellectual Disability
☐ Autism
☐ Cerebral Palsy
☐ Spina Bifida
☐ Prader-Willi Syndrome
☐ Down Syndrome
☐ Phelan-McDermid Syndrome

Behavior Level:
☐ Standard
☐ Behavior Focus
☐ Intensive Behavior

☐ Visual Impairments
☐ Hearing Impairments
☐ Children in Foster Care
☐ Criminal Offenses
☐ Diabetes
☐ Seizures or epilepsy
☐ Mobility Impairments (Wheelchairs, Walker, Hoyer Lifts, etc.)

☐ Physical Support Needs (individuals who require crutches, canes, or other additional support due to balance and gait issues) *Ramps, doorways, hallways, toileting and bathing facilities, furnishings, and equipment shall be designed to accommodate resident needs.
☐ Chronic medical needs (feeding tubes, tracheostomies, and ostomies)

☐ Other:

6. Services to be Provided

The Agency will verify that the applicant is capable of serving the intended clientele and rendering the services indicated below following Agency review of staff qualifications and facility characteristics.

A. For Residential Facilities:

Indicate what level of Residential habilitation services that you will be able to provide to residents of your facility. The licensee or applicant must be able to demonstrate that it is capable of providing the service level indicated. Failure to do so may result in disciplinary action, including revocation of license. Select all that apply.

☐ **Basic** ☐ **Moderate** ☐ **Minimal** ☐ **Extensive 1** ☐ **Extensive 2**

B. For Adult Day Training Programs:

Indicate what staffing ratios will be provided. Failure to render services with the approved staffing ratio may result in disciplinary action, including revocation of license. Select all that apply.

☐ 1:6-1:10 ~~1:1~~ ☐ 1:5 ~~1:3~~ ☐ 1:3 ~~1:5~~ ☐ 1:1 ~~1:6-1:10~~

In addition to the services which are required to be provided under Chapter 65G-2, F.A.C., check all services below that ~~which~~ the applicant intends to provide directly to residents or participants of the facility or adult day training program (through and in accordance with the requirements and limitations of the Medicaid waiver program) The licensee or applicant must be able to demonstrate that it is capable of providing the services indicated. Failure to do so may result in disciplinary action, including revocation of license.			
I. Residential Facilities and Adult Day Training Programs			
Behavior Analysis services	☐	Specialized Mental Health Counseling	☐
Behavior Assistant services	☐	Speech Therapy	☐
Dietician Services	☐	Occupational Therapy	☐
Skilled Nursing	☐	Physical Therapy	☐
Transportation	☐	Other:	

II. Residential Facilities Only			
Companion (Life Skills Development Level 1)	☐	Residential Nursing Services	☐
Residential Habilitation (Standard)	☐	Respite Care Services	☐
Residential Habilitation (Behavior Focus)	☐	Special Medical Home Care	☐
Residential Habilitation (Intensive Behavioral)	☐	Personal Supports	☐

7. Disciplinary Background Information

If any of the questions below is answered with "yes," please provide additional information regarding such situation(s) and attach all relevant documents. Failure to provide relevant documentation may result in denial of the application.

Have you or a controlling interest as defined in Rule 65G-2.001(8), F.A.C., ~~§ 393.063, Florida Statutes,~~ affiliated with this application ever had a license denied, revoked, or suspended in any county in Florida, or any other state or jurisdiction, or ~~has~~ been the subject of disciplinary action, or the party responsible for a licensed facility receiving an administrative fine?

☐ Yes ☐ No

Have you or a controlling interest 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

Have you or a controlling interest 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

Have you or a controlling interest 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

Have you or anyone identified as having a controlling interest been convicted of a misdemeanor or felony?

☐ Yes ☐ No

Are ~~Is~~ the owner(s), all managers, supervisors, and direct service providers associated with the proposed facility in full compliance with all requirements for background screening as delineated within section ~~s.~~ 393.0655, F.S.

☐ Yes ☐ No

8. Zoning (Initial Applications for Residential Facilities, Only)

1. Is ~~Please indicate whether the following zoning requirements have been completed. If~~ this an application ~~is~~ for a license to operate a foster care facility with a live-in caregiver~~, the following are not applicable~~? ~~.~~ Yes ___ No ___ If yes, the following are not applicable.

2. The local zoning authority has been provided 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)

3. Notification of intent to establish this facility has been made to the local zoning authority. _____ (Initial here)

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

5. 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 c~~C~~hapter 419, F.S., requirements. _____ (Initial here)

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

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

   ☐ (7-14 beds): 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)

9. Supporting Documents

Applicants must include the following documents or attachments as applicable.

A. DOCUMENTS TO BE PROVIDED WITH THIS APPLICATION FOR RESIDENTIAL FACILITIES AND ADULT DAY TRAINING PROGRAMS

- If the applicant for licensure is a corporation or limited liability company, provide a copy of the Articles of Incorporation or Articles of Organization, which may be found at the Department of State, Division of Corporations. If the applicant is a partnership, professional association, or other business entity, please provide the equivalent organizational document(s).
- Information relating to the number, experience, and training of each employee of the facility or program~~.~~
- Any promotional materials (in electronic or print format) which will be used to market the services offered by the facility
- Any current lease or rental agreement must be provided if licensee is renting the property upon which the facility or program will operate
- Current documentation that the facility has been inspected by the local fire safety authority or the State Fire Marshal and determined to be compliant with applicable Fire Safety codes, statutes, and rules

- Copy of Comprehensive Emergency Management Plan (CEMP) and the approval letter if the approval was made from a local authority
- Evidence of financial ability to operate pursuant to 65G-2.002(3) (Such documentation shall include bank account statements, pay stubs, documentation of a line of credit, or any other documents which would demonstrate the current ability of the applicant/licensee to continue operations)
- Completed Annual Budget Sheet (attached below)
- Documentation of prior agency action or any other disciplinary action (65G-2.002)
- Policies and procedures regarding behavioral Interventions and Responses to behavioral Issues Involving residents.
- Applicant's or Licensee's written policy regarding sexual activity involving residents of the facility

B. DOCUMENTS THAT MUST BE PROVIDED WITH GROUP HOME, FOSTER CARE FACILITY, AND RESIDENTIAL HABILITATION CENTER APPLICATIONS, ONLY

- A copy of floor plan of the facility
- Written criteria and procedures in place for the admission or termination of residential services for residents
- Documentation from the appropriate local government office showing that the applicant has met local zoning requirements, including any variances that have been granted
- Written criteria relating to the use of video monitoring equipment if applicant makes use of such devices

Disclosure of social security number(s). The Agency for Persons with Disabilities shall use such information only for purposes of securing the proper identification of persons listed on this application for licensure and is imperative to the agency's duties and responsibilities as prescribed by section 393.0655, Florida Statutes, that requires the Agency to verify level II background screening results. The social security numbers collected will not be available to the public except as authorized under section 119.071, Florida Statutes

UNDER PENALTY OF PERJURY, I HEREBY ATTEST THAT ALL INFORMATION CONTAINED IN AND SUBMITTED WITH APPLICATION, INCLUDING ANY ATTACHMENTS AND SUPPORTING DOCUMENTATION, IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BY SUBMITTING SAME I AM REQUESTING A LICENSE TO OPERATE A FACILITY OR PROGRAM 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 | DATE

~~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: FloridaHealthFinder | Facility/Provider
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		
2. Personnel		
a. Salaries and Wages (FTE's =)		
b. Worker's Comp./ Health Insurance		
3. Contracted Services:		
a. Fiscal/Legal		
4. Staff Training (fees & travel costs only)		
5. Transportation		
a. Loan/Lease Payments		
b. Maintenance/Fuel		
c. Staff travel reimbursements		
d. Auto Insurance		
6. Liability Insurance		
7. Marketing/Advertising (incl. Staff recruitment)		
8. Supplies and Equipment		
a. Consumables (program & consumer)		
b. Equipment repairs/maintenance		
c. Furniture/Equipment Replacement		
9. Office Expenses:		
a. Postage		
b. Telephone		
c. Printing/Copying		
10. Facility Cost		
a. Mortgage / Rent		
b. Utilities		
c. Food / consumables		
d. Maintenance / repairs		
e. Furnishings		
TOTAL EXPENDITURES		

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