HOME HEALTH AGENCY START-UP CONSULTATION SERVICE

Completion of AHCA Application and Follow-up with Agency
On-going consultation throughout license process
Two Visits to the facility (additional cost may incur, depending on location)

- State licensing
- Accrediting body standards, when required (Joint Commission, CHAPS, ACHC)
- Identifying Agency Services
- Agency Policy and Procedures
- Accreditation Policy and Procedures, when applicable
- Huma Resources requirement and compliance
- Required Forms
- Organizational Structure

Present during AHCA Initial Inspection (additional cost, pending location)

***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).*

Content subject to change without notice

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Training & Consulting

____**Initial** ____**Change of Ownership**

Home Health Agency Information: Answer where applicable and write legibly.

County: _____
Name of Agency: _____ License #_____
DBA: if applicable: _____
Full Address: _____
Telephone: _____Fax: _____
Email: _____ Website: _____
EIN: _____ NPI: _____
Medicaid Number, if applicable: _____ / Medicaid waiver: _____

Medicare: _____

Management Company: _____ Yes _____ No?
Administrator: _____ Cell: _____
Full Address: _____
Email Address: _____ Telephone_____
Administrator social security number: _____ DOB: _____
___ Nurse ____M.D. license # _____ or _____at least 1 year experience ___
Full Time ___Part Time

Alternate Administrator: _____ Cell: _____
Full Address: _____
Email Address: _____
Alt. Administrator social security number: _____ DOB: _____
___ Full Time ___Part Time

Director of Nursing_____ RN License #_____
Full Address: _____
Email Address: _____Telephone: _____
___ Full Time ___Part Time

Alternate DON: _____ DOB: _____
Full Address: _____RN License # _____
Email Address: _____Telephone: _____
___ Full Time ___Part Time ___Contractor

Chief Financial Officer: _____ DOB: _____
Full Address: _____
Email: _____ Telephone: _____

OWNERSHP

Owner #1: Full Name: _____ %: _____
Owner #2: Full Name: _____ %: _____
Owner #3: Full Name: _____ %: _____
Owner #4: Full Name: _____ %: _____

BOARD MEMBERS

BM #1: Full Name: _____ Telephone: _____
BM #2: Full Name: _____ Telephone: _____
BM #3: Full Name: _____ Telephone: _____
BM #4: Full Name: _____ Telephone: _____