Health Care Clinic Data Sheet

All persons who will be on the application and providing direct care services must conduct a LEVEL II (FBI) Background. The results MUST be ELIGIBLE

Today's Date: _____

Clinic's Legal Name: _____

d/b/a: _____

Clinic's Physical Address: _____

FEIN: _____

Owners:

1. _____ % _____
   Full address: _____
   Telephone: _____ Email: _____
   Social Security: _____ DOB: _____
2. _____% _____
   Full address: _____
   Telephone: _____ Email: _____
   Social Security: _____ DOB: _____
3. _____% _____
   Full address: _____
   Telephone: _____ Email: _____
   Social Security: _____ DOB: _____
4. _____%_____
   Full address: _____
   Telephone: _____ Email: _____
   Social Security: _____ DOB: _____

CITY PROCESS

1. Establish Zoning from your city or municipality.
2. Obtain business tax receipt (You may have to put doctor's name on BTR)
3. Fire Inspection, depending on license type.
4. Health Inspection, depending on the license type.

APPLICATION PROCESS

1. Prepare Application AHCA
2. Prepare Financials (2 weeks before sending application)
3. Prepare for Accreditation
4. Usually takes about 3 months

INSPECTION PROCESS

1. After the application is approved by Tallahassee, the local government usually makes your initial appointment within 30 days.
2. Your initial inspection will be the only time you are aware of the Agency showing up.
3. Owner must be present
4. Medical Director must be present or available by phone
5. All equipment and paperwork are reviewed.
6. Process usually take between 2 to 4 hours depending on the applicant's readiness.
7. License issued within 21 days after a deficiency free inspection.

QUESTIONS

1. Medical Director Name: _____
    a. DOB: _____ Social Security: _____
    b. Home Ph: _____Cell: _____
    c. Full Address: _____
    d. Email: _____

    Hrs. per wk.: _____ Attendance: ___ Daily ___ Wkly. ___ Monthly
    Medical license number: _____
    Signed Agreement? ____Yes ____No
    Is MD a Medical Director for another facility? _____ Yes _____ No, if so, which one:
    _____

2. Who is responsible for the day to day administration: _____
3. Clinic records owner / reviewer: _____

4. Who is financial director? _____
    a. DOB: _____ Social Security: _____
    b. Email: _____
5. Where is billing done? _____On-site _____Off-site
6. Who conducts billing? ___Company ___Offsite ____Other: _____

A. SERVICES PROVIDED FOR THE CLINIC: (check all that apply)

☐	Acupuncture	☐	Hyperbaric Medicine	☐	Physical Therapy
☐	Advanced Practice Registered Nursing	☐	Induced Termination of Pregnancy	☐	Physician Services (MD/DO, including PA), excluding office surgery
☐	Athletic Training	☐	Infusion Therapy	☐	Physician Services (MD/DO, including PA), including office surgery
☐	Audiology	☐	Mammography	☐	Podiatry
☐	Behavior Analysis	☐	Massage Therapy	☐	Psychology
☐	Cardiac Catheterization Laboratory	☐	Medication Therapy Management/ Pharmaceutical Counseling	☐	Radiation Therapy
☐	Chemotherapy	☐	Mental Health, Counseling & Clinical Social Work Services	☐	Renal Dialysis
☐	Chiropractic Medicine	☐	Naturopathy	☐	Research/Clinical Trials
☐	Clinical Laboratory	☐	Nuclear Medicine	☐	Respiratory Care
☐	Dentistry	☐	Nursing Services (RN, LPN, CNA)	☐	Sleep Disorders/Studies
☐	Diagnostic Imaging including MRI (Magnetic Resonance Imaging)	☐	Obstetrics/Midwifery	☐	Speech Therapy
☐	Diagnostic Imaging excluding MRI (Magnetic Resonance Imaging)	☐	Occupational Therapy	☐	Sports Medicine
☐	Dietetic/Nutrition Services/Weight Loss	☐	Optometry	☐	Substance/Alcohol Abuse Treatment
☐	Electrolysis	☐	Orthotics/Prosthetics / Pedorthic	☐	Other:
☐	Hearing Aid Dispensing	☐	Pharmacy	☐	Other:

SERVICE COST

$6,500.00 includes

Consultation until license is received
2 site inspections included if residing within Miami-Dade or Broward
Monroe and Palm Beach County $950.00 additional per visit.
AHCA Application and follow-up
AHCA policy and procedures
AHCA required log-books
Required Wall mural(s)

Does not include

Accreditation and AHCA financials **(we can assist with referral for AHCA financial, if needed)**

All information is true and correct to the best of my ability:

Print Name: _____

Signature: _____ Date: _____