CAREGIVER CONSULTING, INC.
P: 786-514-9177 F: 866-209-0444
E-mail: caregiverconsulting@hotmail.com
www.caregiverconsulting.com

Datasheets for Home Health Agency Proof Financial Ability to Operate

DATE: _____

Referral: This work is being done upon referral from

Consultant Name: _____

Consultant Phone: _____

FAX WHEN COMPLETED TO: CAREGIVER CONSULTING, INC. (866) 209-0444

HOME HEALTH AGENCY INFORMATION FOR AHCA FINANCIALS

Facility Name: _____

Address: _____

City: _____ FL. Zip Code_____

Telephone: _____ Fax: _____

Facility Type: Home Health Agency County Where Located: _____

Expected Application Filing Date: _____

Owner's Name _____

Contact Phone: _____ Fax: _____

Contact Email(s): _____

Administrator's Name: _____ Admin an RN _____

IMPORTANT NOTICE

The PFA will state the Working Capital and Contingency Funding that AHCA requires for licensing.

THE FINANCIALS WILL BE DONE IN 48 - 72 HOURS, AFTER THIS FORM IS RETURNED TO US FULLY COMPLETED. WE REQUIRE A 50% DEPOSIT IN ADVANCE. THE 50% BALANCE IS DUE WHEN THE FINANCIALS ARE COMPLETED. FINAL PAYMENT MUST BE MADE IN CASH, OR BY CREDIT CARD OR DEBIT CARD. A CREDIT CARD AUTHORIZATION IS ON THE NEXT PAGE. THERE IS NO COST FOR CORRECTIONS. THE DEPOSIT IS FULLY REFUNDABLE IF YOU CANCEL THE SERVICE.

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COST AND CERTIFICATION OF EXPECTED REVENUE AND EXPENSES

Seeking Accreditation with: ___ CHAP ___ ACHC ___ JCAHO (The Commission)

Accreditation Cost? $_____ Amount Already Paid? $_____

ARE YOU APPLYING FOR MEDICARE CERTIFICATION? _____

COST OFSERVICE:	HHA Proof of Financial Ability to Operate only	$2,000.00
	Business Plan only	$850.00
	HHA PFA + Business Plan	$2,500.00

CERTIFICATION

I, the undersigned, certify that the financial information provided above and below in this questionnaire, for the Agency for Health Care Administration (AHCA) and Department of Elder Affairs (DOEA), is true and correct to the best of my knowledge. I understand AHCA might ask for more information or receipts and can deny my application if it determines that any of the information I provide is insufficient or unacceptable.

_____
Signature of Owner or Authorized Representative

_____ _____
PRINT NAME Date

Instead of using a credit card, you can make payment electronically using QuickPay or Zelle using the business email address which is caregiverconsulting@hotmail.com

FILL IN BELOW TO AUTHORIZE PAYMENT BY CREDIT OR DEBIT CARD

PAYMENT AUTHORIZATION TO CAREGIVER CONSULTING, INC.			Amount:	
Card Type	☐Visa ☐MasterCard ☐Discover ☐Amex		Date Expire	
			Phone No.	
Card Number			CCV: (3 digits 4 if Amex)	
Name on Card			[Card billing address]	
Bill Address				
City		State/Zip Code		
Signature			Date Signed	

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ACTUAL OR EXPECTED MONTHLY REVENUE AND SOURCES

State number of consumers you expect to have in each month for Year 1 after licensing and amount each participant will pay monthly. Leave blank if you don't know.

Month	No. of Clients	Charge/ Client/Mo	Payment breakdown of the monthly charge by Payer					
			Client	Medicare	Medicaid	Insurance	HMO	Other
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								

LIST THE FOLLOWING MONTHLY EXPENSES WITH COMMENTS IF ANY

Item	**Monthly Amt.**	**Comments (if any)**
Rent/Mortgage		
Utilities (phone, water, etc.)		
Insurance (if paid monthly)		
Account/Bookkeeper		
Loan + Interest payments		
Equipment lease payment		
Inventory		
Supplies (office + medical)		
Education/Training		
Repair/Maintenance		
Other:		

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STAFFING AND SALARY

State the number and type of staff you intend to have and the salaries you pay or expect to pay.
USE ACTUAL FIGURES IF YOU HAVE THEM

LEAVE BLANK IF YOU WANT US TO ESTIMATE

DIRECT STAFF TO BE HIRED	NUM	Salary/Hr	Salary/Yr	Benefits?	Starting Month	Contracted?
Administrator/General Manager						
Alternate Administrator						
Director of Nursing/Medical Director						
Alternate Director of Nursing						
Financial Officer						
Admissions Director						
Bookkeeper						
Secretary						
Personnel/Complaint Records						
Medical Records Clerk						
Direct Care Staff						
Delivery Staff						
Intake/Receptionist/Information Clerk						
Maintenance/Repair						
Inventory						
Housekeeping						
R.N.s						
L.P.N.s						
Home Health Aides						
Physical Therapist						
Occupational Therapist						
Speech Therapist						
Respiratory Therapy						
Social Services						
Homemaker Services						
Dietary Guidance (Dietitian)						
Other:						

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Contracted Service:		
Nursing Services		
Security Guard		
Security Monitoring		
Recreational/Activities		
Transportation		
Food		
Housekeeping/Cleaning		
Landscaping		
Pool Service		

FACILITY OR OFFICE PREPARATION IF APPLICABLE

Fill in the dollar amounts you paid or expect to pay for each item indicated

EQUIPMENT ALREADY PURCHASED		
Site Construction Improvements	**Amount Paid if Work Already Done**	Amount To be Paid if work not already done
Fire Alarm/Pull Station		
Sprinkler System		
Handicap (handrails, ramps, etc.)		
New/Modified Windows		
Bathroom Renovations		
Security System		
Air Conditioning System		
Commercial Kitchen		
Roof		
Other Facility/Site Renovations		
Advertisement	**Amount Paid if Already Purchased**	Amount To be Paid if not Purchased
New Website		
Flyers/Postcards/Brochures		
Print Media (newspapers, etc.)		
Broadcast Media		

Office and Medical Equipment	**Amount Paid if Already Purchased**	Amount To be Paid if not Purchased
Furniture	**Amount Paid if Already Purchased**	Amount To be Paid if not Purchased
Other Capital Expenses	**Amount Paid if Already Paid**	Amount To be Paid if not Purchased

NOTE:

AS PROOF OF FUNDS FOR WORKING CAPITAL AND CONTINGENCY FUNDS, AHCA REQUIRES YOU TO SEND IN WITH THE APPLICATION AND FINANCIALS BANK STATEMENTS IN ENGLISH, DATED LESS THAN 10 DAYS BEFORE THEY RECEIVE YOUR APPLICATION.

Send datasheets to us by: Fax: 1-866-209-0444

Or email it to **caregiverconsulting@hotmail.com**

Get valuable information online at **http://caregiverconsulting.com**