CAREGIVER CONSULTING, INC.
Phone: 786-514-9177 Fax: 1-866-209-0444
www.caregiverconsulting.com
caregiverconsulting@hotmail.com

ADULT DAY CARE CENTER DATA COLLECTION SHEET

DATE: _____

Consultant Name: _____

Consultant Phone: _____

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

DATA TO COMPLETE AHCA'S FINANCIALS FOR ADCC LICENSING

Facility Name: _____

Address: _____

City: _____ FL. Zip Code_____

Telephone: _____ Fax: _____

Facility Type: ADCC County where located: _____

Capacity (Max No. of Children the ADCC can have): _____

Owner's Name _____

Contact Phone: _____ Fax: _____

Contact Email(s): _____

Admin's Name _____

Is Admin the CFO: _____

If lunches will be catered, attach a copy of the catering agreement.

IMPORTANT NOTICE

THE PFA WILL BE DONE IN 72 - 96 HOURS, AFTER WE RECEIVE THIS COMPLETED FORM. WE REQUIRE A 50% DEPOSIT IN ADVANCE. THE 50% BALANCE IS DUE WHEN THE DOCS ARE COMPLETED, PRIOR TO DELIVERY. PAYMENT BY ZELLE IS PREFERRED, BUT WE ALSO ACCEPT CREDIT AND DEBIT CARD PAYMENTS. A CREDIT CARD AUTHORIZATION IS ON THE NEXT PAGE. THERE IS NO COST FOR CORRECTIONS WITHIN 30 DAYS OF DELIVERY. IT'S $250 FOR UPGRADES AFTER 30 DAYS.

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COST AND CERTIFICATION OF EXPECTED REVENUE AND EXPENSES

UP TO 20 Participants	**ADCC PFA + Notes & Assumptions**	**$850.00**
21-40 Participants	**ADCC PFA + Notes & Assumptions**	**$1,200.00**
41-80 Participants	**ADCC PFA + Notes & Assumptions**	**$1,600.00**
OVER 80 Participants	**ADCC PFA + Notes & Assumptions**	**$2,000.00**

Additional Cost of Addressing Omission for PFA prepared by others **$250.00**
Additional Cost of Addressing NOIDWs for PFA prepared by others **$300.00-$475.00**

OPTIONAL SERVICES: We provide the following documents at an additional charge if needed.

Furniture Donation Affidavit	$50.00 ☐
CHOW Bill of Sale + Seller's Affidavit	$125.00☐
STOCK TRANSFER DOCS (certificates, transfer agreement, etc.)	$250.00☐

TOTAL _____

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, Administrator or Manager PRINT NAME Date

To pay using Zelle, use 786-514-9177 for Caregiver Consulting, Inc.

AUTHORIZATION for payment by Credit Card or Debit Card				**Amount:**	
Card Type	**☐Visa ☐MasterCard ☐Discover ☐Amex**			**Date Expire**	
Card Number				**CCV: 3 digits 4 digits if Amex**	
Name on Card					
Card Zip Code		**Phone No.**			
Signature				**Date Signed**	

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ACTUAL OR EXPECTED MONTHLY REVENUE AND SOURCES

State number of participants 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	Amount of the monthly charge paid by					
			Patient	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 (required liability)		AHCA requirement for licensing
Accountant/Bookkeeper		
Supplies (office + medical)		
Menu preparation		N/A if catering
Dietary/Meals/Food		If catering attach a copy of contract
Repair/Maintenance		
Security Monitoring		
Pool Cleaning		
Lawn Service		
Equipment lease payment		E.g., water dispenser
Contracted service		PT, OT, ST
Loan + Interest payments		
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. Leave a position blank if it does not apply to this facility.

If you wish us to estimate the salaries, write estimate here: :

POSITION	NUM	Salary/Hr	Salary/Yr	Benefits?	Contracted?
Administrator/General Manager					
Alternate Administrator					
Director of Nursing/Medical Director					
Alternate Director of Nursing					
Financial Officer					
Admissions Director					
Bookkeeper					
Secretary					
Direct Care Staff					
Records Clerk					
Other Office/Administrative 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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STATE THE $ AMOUNTS YOU PAID OR EXPECT TO PAY FOR THE ITEMS INDICATED.

COPY THE RECEIPTS TO SEND TO AHCA FOR ITEMS LISTED AS "ALREADY PAID"
PUT THE AMOUNTS BELOW EXACTLY AS THEY APPEAR ON THE RECEIPTS

EQUIPMENT ALREADY PURCHASED		
Site Equipment	**Amount Paid if Already Purchased**	Amount To be Paid if not Purchased
Fire Alarm/Pull Station		
Sprinkler System		
Handicap (handrails, ramps, etc.)		
New/Modified Windows		
Bathroom renovations		
Security System		
Air Conditioning System		
Commercial Kitchen		
Other		
Equipment (Computers, etc.)	**Amount Paid if Already Purchased**	Amount To be Paid if not Purchased
Other Capital Expenses	**Amount Paid if Already Purchased**	Amount To be Paid if not Purchased

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Furniture	**Amount Paid if Already Purchased**	Amount To be Paid if not Purchased
Professional Expenses	**Amount Paid if Already Purchased**	Amount To be Paid if not Purchased
Facility Licensing Fee		
Other		
Other		
Advertisement	**Amount Paid if Already Purchased**	Amount To be Paid if not Purchased
New Website		
Flyers/Postcards/Brochures		
Print Media (newspapers, etc.)		
Broadcast Media		
Other		

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**