

## DATA COLLECTION SHEET

DATE: \_\_\_\_\_

Consultant Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_

FAX WHEN COMPLETED TO: CAREGIVER CONSULTING, INC. 1-866-209-0444

### DATA TO COMPLETE AHCA'S FINANCIALS ALF LICENSING

New Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ FL. Zip Code \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

County Where Facility is Located: \_\_\_\_\_ Generator? \_\_\_\_\_

Facility License Type: \_\_\_ Standard \_\_\_ LNS \_\_\_ LMH \_\_\_ ECC

Total No. of Beds: \_\_\_\_\_ No. Private \_\_\_\_\_ No. of Current Residents: \_\_\_\_\_

**New Owner's Name** \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

New Owner's Email: \_\_\_\_\_

Administrator Name: \_\_\_\_\_

Is the Administrator currently the Administrator of another ALF? \_\_\_\_\_

Is the Administrator the Financial Officer? \_\_\_\_\_

**Old ALF Name (if CHOW)** \_\_\_\_\_

**CHOW Purchase Price:** \_\_\_\_\_ **Payment Method:** \_\_\_\_\_

**If Loan: Amount** \_\_\_\_\_ **Interest Rate** \_\_\_\_\_ % **No. of Years** \_\_\_\_\_

#### 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.

**COST AND CERTIFICATION OF EXPECTED REVENUE AND EXPENSES**

**COST OF SERVICE:**

01-05 Beds	\$600	41-50 Beds	\$1,150	91-100 Beds	\$1,900
06-10 Beds	\$650	51-60 Beds	\$1,300	101-110 Beds	\$2,050
11-20 Beds	\$750	61-70 Beds	\$1,450	111-120 Beds	\$2,300
21-30 Beds	\$850	71-80 Beds	\$1,600	121-130 Beds	\$2,450
31-40 Beds	\$1,000	81-90 Beds	\$1,750	131-140 Beds	\$2,550
141-150 Beds	\$2,650	191-200 Beds	\$3,150	241-250 Beds	\$3,650
151-160 Beds	\$2,750	201-210 Beds	\$3,250	251-260 Beds	\$3,750
161-170 Beds	\$2,850	211-220 Beds	\$3,350	261-270 Beds	\$3,850
171-180 Beds	\$2,950	221-230 Beds	\$3,450	271-280 Beds	\$3,950
181-190 Beds	\$3,050	231-240 Beds	\$3,550	281-290 Beds	\$4,050
291-300 Beds	\$4,150	Call for additional costs			

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.**

AHCA compliant Commercial Lease \$100.00   
 Furniture Donation Affidavit \$50.00   
 CHOW Bill of Sale + Seller's Affidavit \$150.00   
 STOCK TRANSFER DOCS (certificates, transfer agreement, etc.) \$250.00   
 Total: \_\_\_\_\_

**CERTIFICATION**

I, the undersigned, certify that the financial information provided herein 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 Administrator                      PRINT NAME                      Date

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

<b>AUTHORIZATION for payment by Credit Card or Debit Card</b>			<b>Amount:</b>		
<b>Card Type</b>	<input type="checkbox"/> Visa	<input type="checkbox"/> MasterCard	<input type="checkbox"/> Discover	<input type="checkbox"/> Amex	<b>Date Expire</b>
<b>Card Number</b>				<b>CCV: 3 digits 4 digits if Amex</b>	
<b>Name on Card</b>					
<b>Card Zip Code</b>		<b>Phone No.</b>			
<b>Signature</b>				<b>Date Signed</b>	

**BANK STATEMENTS:** The Proof of Financial Ability to Operate will tell you the amount AHCA requires you to show for Working Capital and Contingency Funding. You will have to send BANK STATEMENTS or BANK LETTERS, IN ENGLISH, DATED THE SAME DAY OR DAY BEFORE YOU SEND YOUR APPLICATION TO AHCA.

RESIDENTS MONTHLY PAYMENT							
Resident	Private Pay	Medicaid LTC	ACS	Resident	Private Pay	Medicaid LTC	ACS
1				16			
2				17			
3				18			
4				19			
5				20			
6				21			
7				22			
8				23			
9				24			
10				25			
11				26			
12				27			
13				28			
14				29			
15				30			

COMPENSATION OF OFFICERS & STAFF IF KNOWN, OTHERWISE LEAVE BLANK		
Officer/Administrator	Annual Amt.	Comments (if any)
Administrator		
Financial Officer		
Secretary		

LIST THE FOLLOWING MONTHLY EXPENSES WITH COMMENTS IF ANY		
Item	Monthly Amt.	Comments (if any)
Rent/Mortgage		
Interest if Mortgage		Send amortization schedule for first 2 years
Utilities (phone, water, etc.)		
Insurance (required liability)		AHCA requirement for licensing
Accountant/Bookkeeper		
Supplies (office + medical)		
Menu preparation	\$90.00/Year	
Dietary/Meals/Food		
Repair/Maintenance		
Security Monitoring		
Pool Cleaning		
Lawn Service		
Equipment lease payment		
Contracted service		
Loan + Interest		
<b>Describe Other Expenses Below</b>		

Send us an email to: [caregiverconsulting@hotmail.com](mailto:caregiverconsulting@hotmail.com)

Get more valuable information online at: [www.caregiverconsulting.com](http://www.caregiverconsulting.com)