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

## DATA COLLECTION SHEET Health Care Clinic

**DATE:** ______________________

Consultant Name: _________________________

Consultant Phone: _________________________

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Call 786-514-9177 if you have questions.

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

## HEALTH CARE CLINIC INFORMATION FOR AHCA'S FINANCIALS

Facility Name: __________________________________________________________

Address: _______________________________________________________________

City: _________________________________ FL. Zip Code_______________________

Telephone: ____________________________ Fax: ______________________________

Facility Type: HEALTH CARE CLINIC: __ PHP/CMH __PMC __ Other: _____________

Max No. Patients: ______ Applying for Medicare + Medicaid Certification _____

**Owner's Name** ____________________________________________________________

Phone: __________________________________ Fax: __________________

Owner's Email: __________________________________________________

Medical Director's Monthly Salary __________________________________

**Old Owner's Name (if CHOW)** ______________________________________________

**Old Business Name (if CHOW)** ______________________________________________

**Purchase Price** $________________ Payment Method ________________________

**IMPORTANT NOTICE**

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.

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## COST & PAYMENT OF PFA, ACCREDITATION AND MEDICAL DIRECTOR

SERVICE: This service is for a CPA Certified PFA for a Health Care Clinic + the Required Notes, Financial Assumptions & Explanations

COST OF SERVICE: **$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**

☐ Check this box if you are applying for accreditation and Medicare certification.
- Accreditation by _ JCAHO,_ CHAP or __ACHA.
- Accreditation Cost: $ ____________ Amount already paid: $ __________

☐ Check this box if you have a fee agreement with a Medical Doctor and state $_________/month

**CERTIFICATION**

I, the undersigned, understand that the information provided above and below in this questionnaire is for the Agency for Health Care Administration (AHCA) and Department of Elder Affairs (DOEA). I hereby certify that is true and correct to the best of my knowledge. I understand also that 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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| LIST SERVICES PROVIDED + % OF PATIENTS THAT WILL RECEIVE THEM MONTHLY | | |
|---|---|---|
| **Services/Treatments Provided** | **Cost/Visit** | **Comments** |
| Initial Visits | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| REVENUE DISTRIBUTION | | | | | |
|---|---|---|---|---|---|
| What %-age of you expected revenue will come from the following sources | | | | | |
| Patient | Medicare | Medicaid | Insurance | HMO | Other |
| | | | | | |

| THIS IS YOUR ACTUAL MONTHLY REVENUE<br>**For Change of Ownership Only**<br>State number of patients you expect to have in each month for Year 1 after licensing and amount they will pay monthly. Leave blank if you don't know and we will estimate. | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Month | No. of Patients | Monthly Charge | Breakdown of the monthly charge payments by %-age | | | | | |
| | | | Patient | Medicare | Medicaid | Insurance | HMO | Other |
| 1 | | | | | | | | |
| 2 | | | | | | | | |
| 3 | | | | | | | | |
| 4 | | | | | | | | |
| 5 | | | | | | | | |
| 6 | | | | | | | | |
| 7 | | | | | | | | |
| 8 | | | | | | | | |
| 9 | | | | | | | | |
| 10 | | | | | | | | |
| 11 | | | | | | | | |
| 12 | | | | | | | | |

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| LIST THE FOLLOWING MONTHLY EXPENSES WITH COMMENTS IF ANY | | |
|---|---|---|
| **Item** | **Monthly Amt.** | **Detailed Description** |
| Rent/Mortgage | | |
| Utilities (phone, water, etc.) | | |
| Insurance (required liability) | | AHCA requirement for licensing |
| Accountant/Bookkeeper | | |
| Office Supplies | | |
| Medical Supplies | | |
| Repair/Maintenance | | |
| Security Monitoring | | |
| Equipment lease payment | | |
| Other (describe): | | |
| Other: | | |
| Other: | | |
| Other: | | |
| | | |

**PUT THE EXACT AMOUNT ON THE RECEIPTS FOR ITEMS "ALREADY PAID"**
**MAKE COPIES OF THE RECEIPTS TO SEND TO AHCA. DO NOT SEND THEM TO ME.**

| EQUIPMENT OR PROPERTY IMPROVEMENTS ALREADY PURCHASED | | |
|---|---|---|
| **Site Equipment** | **Amount you Already Paid for items purchased** | Amount To be Paid for items you did not buy yet |
| Fire Alarm/Pull Station | | |
| Sprinkler System | | |
| Handicap (handrails, ramps, etc.) | | |
| New/Modified Windows | | |
| Bathroom renovations | | |
| Security System | | |
| Air Conditioning System | | |
| Other: | | |
| Other: | | |
| Other: | | |
| Other: | | |
| | | |
| | | |
| | | |

| **Clinic Equipment and Furniture** | **Amount you Already Paid for items purchased** | Amount To be Paid for items you did not buy yet |
|---|---|---|
| Computer | | |
| Phone and Fax | | |
| Printer and Copier | | |
| Desk | | |
| Chairs | | |
| Examining Table | | |
| Safe | | |
| Filing Cabinet | | |
| Other: | | |
| Other: | | |
| Other: | | |
| Other: | | |
| | | |
| | | |
| ***Attach a detailed list of equipment and the actual or projected cost of each in necessary*** | | |
| **Advertisement** | **Amount you Already Paid for items purchased** | Amount To be Paid for items you did not buy yet |
| New Website | | |
| Flyers/Postcards/Brochures | | |
| Print Media (newspapers, etc.) | | |
| Broadcast Media | | |

**AS PROOF OF FUNDS FOR WORKING CAPITAL AND CONTINGENCY FUNDS, AHCA REQUIRES YOU TO SEND IN WITH THE APPLICATION AND PFA BANK STATEMENTS IN ENGLISH, DATED LESS THAN 10 DAYS BEFORE THEY RECEIVE YOUR APPLICATION. YOU COULD ALSO SEND A SCREEN PRINTOUT OF YOU ONLINE BANKING INFO. HOWEVER, AHCA WILL NOT ACCEPT A LETTER FROM A TELLER AT THE ABNEK**

## Send datasheets to us by:

Fax: 1-866-209-0444 — This is a secured, confidential fax. Your information will not be available to regular employees.

Or you can send it by email it to **caregiverconsulting@hotmail.com**

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