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

HOME MEDICAL EQUIPMENT 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 HME LICENSING

Facility Name: _____

Address: _____

City: _____ FL. Zip Code_____

Telephone: _____ Fax: _____

Florida County _____

Facility Type: HME/DHME Expected Licensing Date: _____

Owner's Name _____

Contact Phone: _____ Fax: _____

Contact Email(s): _____

Admin's Name _____

Is Admin the CFO _____

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

COST OF PFA	**HME PFA + Notes & Assumptions**	**$1,500.00**

The completed PFA will be certified by our CPA

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

EXPECTED REVENUE DISTRIBUTION (REQUIRED)

State what percentage (%) of your billing revenue you expect to come from each of the following:

PRIVATE PAY	MEDICARE	MEDICAID	INSURANCE	HMO/PPO	OTHER
%	%	%	%	%	%

IF YOU HAVE A LIST – Attach your list of the equipment and supplies you plan to provide with the cost you will pay the supplier to get each item and the price that the equipment your costPROVIDE WITH YOUR COST THAT YOU WILL PAY FOR EACH ITEM AND THE PRICE THAT YOU WILL SELL THEM FOR TO THE PATIENT OR CLIENT. AHCA REQUIRES THIS.

IF YOU DON'T HAVE A LIST – CREATE ONE HERE:

Equipment or Supply	Your cost	Your Price to Patient

ADD ADDITIONAL PAGES IF NEEDED

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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		
Monthly inventory levels		Estimated monthly inventory (value/cost)
Supplies - office		
Repair/Maintenance		
Security Monitoring		
Lawn Service		
Equipment lease payment		
Special Sub-contract		Explain:
CPA/Accountant		
Payroll (e.g. ADP)		
Loan Principal		
Loan Annual Interest Rate		
Loan Duration (No. of Years)		

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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.

ADMINISTRATIVE STAFF		
Position	**No in Year 1**	**No. in Year 2**
Administrator/General Manager		
Alternate Administrator		
Medical Director		
Financial Officer (not outside CPA)		
Secretary		
Records Clerk		
Other staff (describe below)		
TECHNICAL INDEPENDENT CONTRACTED STAFF		
Position	**Contracted Hrs. in Year 1**	**Contracted Hrs. in Year 2**

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STATE THE $ AMOUNTS YOU PAID OR EXPECT TO PAY FOR FACILITY PREPARATION, FURNITURE AND EQUIPMENT IF APPLICABLE.

AHCA EXPECTS RECEIPTS FOR ITEMS LISTED AS "ALREADY PAID"
MAKE SURE YOU HAVE THEM TO SEND IN

EQUIPMENT ALREADY PURCHASED IF APPLICABLE		
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		
Other		
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
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**