CAREGIVER CONSULTING, INC.
P: 786-514-9177 F: 1-866-209-0444
www.caregiverconsulting.com
E-mail: caregiverconsulting@hotmail.com

Data Collection Sheet for AHCA's Proof of Financial Ability to Operate

DATE: _____

Consultant Name: _____

Consultant Phone: _____

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

NURSE REGISTRY INFORMATION FOR AHCA FINANCIALS

Facility Name: _____

Address: _____

City: _____ FL. Zip Code_____

Telephone: _____ Fax: _____ County: _____

Facility Type: NURSE REGISTRY; Total Clients expected in Year 1: _____

Expected Application Filing Date: _____

Owner's Name _____

Administrator's Name _____

Is Admin an RN? _____ Is Admin the Financial Officer for the Registry? _____

Contact Phone: _____ Fax: _____

Contact Email(s): _____

IMPORTANT NOTICE

You will not know how much Working Capital and Contingency Funding AHCA requires you to have until the financial forms are prepared.

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 AND CERTIFICATION OF INFORMATION PROVIDED

COST OFSERVICE: **Nurse Registry Financials + Notes & Assumptions** **$650.00**

OPTIONAL SERVICES: AHCA usually require the following optional documents. Check any you want us to provide according to what AHCA will approve.

Letters of Commitment for Contingency or Salary Waiver	$0.00
Nurse Registry Lease	$50.00 ☐
Bill of Sale + Seller's Affidavit (if Change of Ownership)	$50.00 ☐
Furniture Donation Affidavit	$0.00 ☐
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

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 FOR 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: (3/4 digits)**	
Name on Card		**[Card billing address ⇘⇘]**	
Bill Address			
City	**State/Zip Code**		
Signature		**Date Signed**	

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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 (if paid monthly)		
Account/Bookkeeper		
Loan + Interest payments		
Equipment lease payment		
Inventory		
Supplies (office + medical)		
Education/Training		
Repair/Maintenance		
Other		

WRITE A STATEMENT DESCRIBING HOW YOU INTEND TO GET CLIENTS

_____

_____

_____

MARKETING & ADVERTISING		
M&A	**Expected Cost**	Comments if any
New Website		
Flyers/Postcards/Brochures		
Print Media (newspapers, etc.)		
Broadcast Media		
Other		
Other		

IF THIS IS A CHOW PUT THE PURCHASE PRICE HERE $_____ AND SKIP TO THE NEXT SECTION. DON'T FILL IN ANY EQUIPMENT PRICES.

Fax the completed datasheets to us at 1-866-209-0444

OR you can email it to **caregiverconsulting@hotmail.com**

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FILL IN THE AMOUNTS YOU PAID EXACTLY AS THEY APPEAR ON THE RECEIPTS (E.G. 245.86). DON'T LIST ITEMS THAT YOU DON'T HAVE RECEIPTS FOR

EQUIPMENT PURCHASES		
Office Renovations (Describe each)	**Amount Paid if Work Already Done**	Amount To be Paid if work not already done
Office Equipment (Describe each)	**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 Expenses	**Amount Paid if Already Paid**	Amount To be Paid if not Purchased

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COMPLETE THESE SECTIONS ONLY IF THIS IS A CHANGE OF OWNERSHIP

ACTUAL OR EXPECTED MONTHLY REVENUE AND SOURCES

State number of patients the registry has currently and their monthly payment breakdown. Add additional sheets if needed.

Patient	No. of Clients	Charge/ Client/Mo	Payment breakdown of the monthly charge by Payor					
			Client	Medicare	Medicaid	Insurance	HMO	Other
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
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26								
27								
28								

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STAFFING AND SALARY

State the number and type of staff and the salaries that you pay currently.
:

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:						