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

Datasheets for HHA Proof Financial Ability to Operate

DATE: _____

Referral: This work is being done upon referral from

Consultant Name: _____

Consultant Phone: _____

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

HOME HEALTH AGENCY INFORMATION FOR AHCA FINANCIALS

Facility Name: _____

Address: _____

City: _____ FL. Zip Code_____

Telephone: _____ Fax: _____

Facility Type: Home Health Agency County Where Located: _____

Expected Application Filing Date: _____

Owner's Name _____

Contact Phone: _____ Fax: _____

Contact Email(s): _____

Administrator's Name: _____ Admin an RN _____

IMPORTANT NOTICE

THE PFA DOCS WILL BE DONE IN 2 TO 4 DAYS AFTER THIS FORM IS RETURNED TO US FULLY COMPLETED. WE REQUIRE AT LEAST A 50% DEPOSIT IN ADVANCE. THE 50% BALANCE IS DUE WHEN THE DOCS ARE COMPLETED. FINAL PAYMENT MUST BE MADE BEFORE THE DOCS ARE DELIVERED TO YOU. A CREDIT CARD AUTHORIZATION IS ON THE NEXT PAGE. HOWEVER, OUR PREFERRED PAYMENT METHOD IS BY QUICKPAY OR ZELLE THROUGH THE BUSINESS PHONE NUMBER WHICH IS 786-514-9177. THERE IS A $350.00 CHARGE TO UPDATE THE DOCUMENTS IF YOU KEEP THEM MORE THAN 3 MONTHS BEFORE FILING THE APPLICATION WITH AHCA.

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COST AND CERTIFICATION OF EXPECTED REVENUE AND EXPENSES

Seeking Accreditation with: ___ CHAP ___ ACHC ___ JCAHO (The Commission)

Accreditation Cost? $_____ Amount Already Paid? $_____

ARE YOU APPLYING FOR MEDICARE CERTIFICATION? _____

COST OFSERVICE:	PFA for a Non-Skilled Home Health Agency	$1,500.00
	PFA for a Skilled/Accredited Home Health Agency	$1,750.00
	PFA for a Home Health Agency w/ Medicare Certification	$2,000.00
	Simple Business Plan	$300.00
	HHA Business Plan for SBA Loans	$500.00

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 or Authorized Representative

_____ _____
PRINT NAME Date

Instead of using a credit card, you can make payment electronically using QuickPay or Zelle using Caregiver Consulting, Inc. and phone number which is 786-514-9177.

FILL IN BELOW TO AUTHORIZE 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 digits 4 if Amex)	
Name on Card			[Card billing address ☜ ☜]	
Bill Address				
City		State/Zip Code		
Signature			Date Signed	

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ACTUAL OR EXPECTED MONTHLY REVENUE AND SOURCES

State number of consumers 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	Payment breakdown of the monthly charge by Payer					
			Client	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 (if paid monthly)		
Account/Bookkeeper		
Loan + Interest payments		
Equipment lease payment		
Inventory		
Supplies (office + medical)		
Education/Training		
Repair/Maintenance		
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 BLANK IF YOU WANT US TO ESTIMATE

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:						

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Contracted Service:		
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:		

FACILITY OR OFFICE PREPARATION IF APPLICABLE

Fill in the dollar amounts you paid or expect to pay for each item indicated

EQUIPMENT ALREADY PURCHASED		
Equipment Description	**Amount Already Done**	Amount To be Paid
Handicap (handrails, ramps, etc.)		
Security System		
New Website		
Flyers/Postcards/Brochures		
Print Media (newspapers, etc.)		
Broadcast Media		

NOTE:

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**