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: _____

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 Salary _____

Old Owner's Name (if CHOW) _____

Old Business Name (if CHOW) _____

Purchase Price $_____ Payment Method _____

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 & PAYMENT OF PFA, ACCREDITATION AND MEDICAL DIRECTOR

COST OFSERVICE: CPA Certified PFA for HCC + Required Notes & Financial Assumptions
+ Letters of Commitment for Working Capital and/or Contingency Funding

TOTAL **$2,000.00**

☐ Check this box if you are applying for accreditation and Medicare certification.
- State the amount quoted for the accreditation by JCAHO,CHAP or ACHA $ _____
- State the amount already paid for the accreditation $ _____

☐ 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

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 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			CVC: (3 digits, 4 if Amex)	
Name on Card			[Card billing address ☜ ☜]	
Bill Address				
City		State/Zip Code		
Signature			Date Signed	

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LIST SERVICES PROVIDED + % OF PATIENTS THAT WILL RECEIVE THEM MONTHLY			
Services/Treatments Provided	**Cost/Visit**	**Total/Month**	**Comments**
Initial Visits			

THIS IS YOUR ACTUAL OR EXPECTED MONTHLY REVENUE

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		
Supplies (office + medical)		
Repair/Maintenance		
Security Monitoring		
Equipment lease payment		
Contracted service		
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:		

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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**