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

DATA COLLECTION SHEET PPEC

DATE: _____

Consultant Name: _____

Consultant Phone:_____

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

PPEC INFORMATION FOR AHCA'S FINANCIALS

Facility Name: _____

Address: _____

City: _____ FL. Zip Code_____

Telephone: _____ Fax: _____

Facility Type: PPEC: __ PHP/CMH __PMC __ Other: _____

Treatment Capacity: _____ Expected Approval Date: _____

Owner's Name _____

Phone: _____ Fax: _____

Owner's Email: _____

Old Owner's Name (if CHOW) _____

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 EXPECTED REVENUE AND EXPENSES

UP TO 20 Participants	**PPEC PFA + Notes & Assumptions**	**$850.00**
21 TO 45 Participants	**PPEC PFA + Notes & Assumptions**	**$1,250.00**
OVER 45 Participants	**PPEC PFA + Notes & Assumptions**	**$1,750.00**

OPTIONAL SERVICES: AHCA usually require the following documents with the application. If you wish, we can provide them according to what AHCA expects. Check any that you want us to provide for you.

Letters of Commitment & Administrator Certification	$0.00	
Bifurcated Sale Agreement (if Change of Ownership)	$50.00	☐
Bill of Sale (if Change of Ownership)	$50.00	☐
Furniture Affidavit	$25.00	☐

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

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 digits)	
Name on Card			[Card billing address ☜☜]	
Bill Address				
City		State/Zip Code		
Signature			Date Signed	

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THIS IS YOUR ACTUAL OR EXPECTED MONTHLY REVENUE

State number of participants 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 Patients	Monthly Charge	Amount of the monthly charge paid by					
			Patient	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 (required liability)		AHCA requirement for licensing
Accountant/Bookkeeper		
Supplies (office + medical)		
Menu preparation		If applicable
Dietary/Meals/Food		If applicable
Repair/Maintenance		
Security Monitoring		
Equipment lease payment		
Contracted service		
Other:		
Other:		
Other:		

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STATE THE $ AMOUNTS YOU PAID OR EXPECT TO PAY FOR THE ITEMS INDICATED.

COPY THE RECEIPTS TO SEND TO AHCA FOR ITEMS LISTED AS "ALREADY PAID"
PUT THE AMOUNTS BELOW EXACTLY AS THEY APPEAR ON THE RECEIPTS

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		
Other:		
Other:		
Other:		

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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		
Other Items:		

AS PROOF OF FUNDS FOR WORKING CAPITAL AND CONTINGENCY FUNDS, AHCA REQUIRES YOU TO SEND IN WITH THE APPLICATION AND FINANCIALS BANK STATEMENTS IN ENGLISH, DATED LESS THAN 10 DAYS BEFORE THEY RECEIVE YOUR APPLICATION.

Send datasheets to us by:

Fax: 1-866-209-0444 (This is a secured, confidential fax)

Or email it to **caregiverconsulting@hotmail.com**

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