



# Health Care Licensing Application Addendum

**THIS FORM IS RECOMMENDED FOR USE TO COMPLY WITH THE REPORTING REQUIREMENTS PURSUANT TO CHAPTER 408, PART II, FLORIDA STATUTES. PLEASE FILL OUT THE INFORMATION AS APPLICABLE TO THE ENTITY REQUESTING LICENSURE:**

**Provider/Facility Type:** \_\_\_\_\_

**National Provider ID#:** \_\_\_\_\_  
(if applicable)

**Provider/Facility Name**

**AUTHORITY:**

Pursuant to subsections 408.806(1)(a) and (b), Florida Statutes, an application for licensure must include: the name, address and social security number of the applicant and each controlling interest if the applicant or controlling interest is an individual; and the name, address, and federal employer identification number (EIN) of the applicant and each controlling interest if the applicant or controlling interest is not an individual. Disclosure of your social security number is mandatory. The Agency for Health Care Administration shall use such information for purposes of securing the proper identification of persons listed on the application for licensure.

## **2. Controlling Interests of Licensee**

### **A. Individual and/or Entity Ownership of Licensee**

Provide the following information for **each person with 5% or greater ownership interest** in the licensee/provider. This information must match the information contained in Section 2A of the Health Care Licensing Application. Attach additional sheets if necessary.

FULL NAME	SOCIAL SECURITY NUMBER

**B. Board Members and Officers of Licensee**

Provide the following information for **each person that serves as an officer or is on the board of directors** (excludes voluntary board members) for the licensee/provider. This information must match the information contained in Section 2B of the Health Care Licensing Application. Attach additional sheets if necessary.

TITLE	FULLNAME	SOCIAL SECURITY NUMBER
Director/CEO		
President		
Vice President		
Secretary		
Treasurer		
Other:		

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**3. Management Company Controlling Interests**

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If a company other than the licensee manages the licensee/provider, complete the following information:

**A. Individual and/or Entity Ownership of Management Company**

Provide the following information for **each person or entity (corporation, partnership, association) with 5% or greater ownership interest** in the management company. This information must match the information contained in Section 3A of the Health Care Licensing Application. Attach additional sheets if necessary.

FULL NAME of INDIVIDUAL	SOCIAL SECURITY NUMBER

**B. Board Members and Officers of Management Company**

Provide the following information for **each person that serves as an officer or is on the board of directors** (excludes voluntary board members). This information must match the information contained in Section 3B of the Health Care Licensing Application. Attach additional sheets if necessary.

TITLE	FULL NAME	SOCIAL SECURITY NUMBER
Director/CEO		
President		
Vice President		
Secretary		
Treasurer		
Other:		

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**4. Affidavit**

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I, \_\_\_\_\_, hereby swear or affirm that the statements in this application are true and correct.

\_\_\_\_\_  
Signature of Licensee or Authorized Representative

\_\_\_\_\_  
Title

STATE OF FLORIDA  
COUNTY OF \_\_\_\_\_

Sworn to and subscribed before me this . day of \_\_\_\_\_, \_\_\_\_\_ by \_\_\_\_\_.

This individual is personally known to me or produced the following identification: \_\_\_\_\_

\_\_\_\_\_  
Notary Public

NOTARY SEAL: