GROUP CARE FACILITY REQUIREMENTS

Reason for Application: new facility change of ownership change to facility (please circle)

This sheet must be completed for all new group care facilities. If this is a change of ownership, you must also complete this form but you will be held to the plumbing code at the original time of permitting until the facility is expanded or changes use.

DATE: _____ **PROPOSED # OF RESIDENTS:** _____ **PROPOSED # OF STAFF:** _____

PROJECT NAME: _____

ADDRESS: _____

PERSON TO CONTACT: **PHONE #:**

_____ **Floor plans of facility provided and drawn to scale. Scale must be shown on the floor plan.**

_____ **Utility bill showing sewer charges or letter of sewer connection provided. If facility is on septic, answer next line.**

_____ **Facility is on septic. Must fill out Existing System Verification OR modify existing annual operating permit if applicable.**

_____ **Water supply (public water or well)**

_____ **Plan Review fee & Annual Permit fee paid**

_____ **Primary Licensing Agency (e.g. AHCA, DCF, APD, etc.)**

_____ **1 toilet shown on floor plan for every 10 patrons.**

_____ **1 shower or bathtub on floor plan for every 8 patrons.**

_____ **1 hand wash sink shown on floor plan for every 10 patrons.**

_____ **1 mop sink shown on floor plan.**

_____ **Number of beds / Number of bedrooms.**

Y / N **Is this facility providing 24-hour care, limited nursing care or mental health care?**

Y / N **Does this facility prepare or serve catered meals? If yes – provide intended menu, name of caterer**

Group care facility kitchen sink requirement. Applicable kitchen sinks must be shown on floor plan.

_____ **5 or fewer residents, 1 sink required in kitchen.**

_____ **6 – 10 residents, 1 compartment sink and a mechanical dishwasher capable of sanitization and 1 hand wash sink or a 2 compartment sink with a hand wash sink in the kitchen.**

_____ **11 or more residents, 2 compartment sink and a mechanical dishwasher capable of sanitization and 1 hand wash sink or a 3 compartment sink with a hand wash sink in the kitchen.**

_____ **Owner Signature & Date**

_____ **Representative Signature & Date**

Revised 09/28/21

Florida Department of Health in Orange County

Plans Review Routing Sheet

Please note that the fee for plan review is $53.00, in addition to the permit application fee. Please sign below to acknowledge and certify that all of the information provided for permit approval is true and correct.

Facility Name: _____

Facility Address: _____

Mailing Address: _____

Type of Facility: _____ Number of Employees: _____

Number of Clients, Students, Customers or Seating Capacity: _____

Method of Sewage Disposal: _____Water Supply: _____

Person to Contact: _____ Phone #: _____

Signature: _____ **Date:** _____

For Office Use Only

Date: _____ Plan Review Routing Number: _____

Payment Type: _____ Amount Paid: $_____ Check Number: _____

Utility Reviewer: _____ **Date:** _____

Remarks: _____ **APPROVAL STAMP**

_____

_____

_____

SIGNATURE: _____

Program Reviewer: _____ **Date:** _____

Remarks: _____

_____

_____

_____ **SIGNATURE:** _____

STATE OF FLORIDA
DEPARTMENT OF HEALTH

Certificate Number

APPLICATION FOR SANITATION CERTIFICATE

AUTHORITY: Chapter 381.0072, Florida Statutes

Instructions: 1. Complete the information requested below. 2. Sign the application and return along with a completed set of plans drawn to scale and required fee (do not send cash), to the Environmental Health (EH) office of the County Health Department. A new application is not required for annual renewal unless the information below changes.

NAME OF FACILITY_____

LOCATION_____
Street City State ZIP Code

OWNER'S NAME_____ EMAIL ADDRESS_____

OWNER'S ADDRESS_____
Street City State ZIP Code

OWNER'S PHONE_____ BUSINESS PHONE_____

Type of Food Service Subtypes Select One:

	Adult Day Care		Afterschool Meal		Assisted Living Facility
	Bar/Lounge		Civic/Fraternal Organization		Crisis Stabilization Unit
	Detention Facility		Domestic Violence Shelter		Home for Special Services
	Hospice		Intermediate Care Facility		Migrant Labor Camp
	Movie Theater		Prescribed Pediatric Extended Care Center (PPEC)		Recreational Camp
	Residential Treatment Facility (AHCA)		School		Short Term Residential Treatment (DCF)
	Transitional Living Facility		Other:		

Food Service Operations Select One:

	Afterschool Meal		Bakery		Boarding School
	Canteen		Caterer		College/University Cafeteria
	Concession Stand		Culinary Education		Deli/Sandwich Shop
	Main Operation		Mobile Food Unit		Non-Alcoholic Beverage
	Restaurant		Retail Food Store		Satellite Kitchen
	School (9 months or less)		School (greater than 9 months)		Temporary Event Sponsor
	Temporary Event Vendor		Vending Machine (TCS/PHF)		Other:

Comment/Special Instructions: _____

FOR EH USE ONLY: Annual Fee for Your Facility: $_____.

Please make check or money order payable to: Florida Department of Health in _____ County.

The undersigned owner/owner's representative hereby agrees to operate the food establishment described in this application in accordance with the requirements of Chapter 381.0072, Florida Statutes, and Chapter 64E-11, Florida Administrative Code,. The information contained in this application, which serves as the basis for licensure, is true and correct. I understand that any misrepresentation to the facts in this application, or failure to comply with sanitary standards, is grounds for denial or revocation of the sanitation certificate.

_____ _____
Signature (Facility Owner/Owner's Representative) Date Signature (EH Official) Date

STATE OF FLORIDA
DEPARTMENT OF HEALTH

FOOD SERVICE ESTABLISHMENT PLAN REVIEW APPLICATION

Instructions: 1. Complete the information requested below. 2. Sign the application and return along with a set of scaled plans, for both new and remodeled establishments, showing all kitchen equipment with specifications, plumbing fixtures, bars, storage areas, etc. Also, submit the proposed menu listing specific foods. Submit all the above to the Environmental Health (EH) office of the County Health Department. Grease traps must meet all local plumbing codes and be located so they can be easily cleaned.

Plan Review Type: ☐ **New** ☐ **Remodel** **Property Appraiser Assessed Value (if remodel): $**_____

Printed Name of Property Appraiser: _____

Signature of Property Appraiser: _____ **Date:** _____

Name of Establishment: _____

Establishment Address: _____
Street City State ZIP Code

Owner/Owner's Representative Name & Title: _____

Owner/Owner's Representative Address: _____
Street City State ZIP Code

Phone Number: _____ Email: _____

Type of Food Service Establishment:

Bar/Lounge ☐ Concession Stand ☐ Detention Facility ☐ Mobile Food Unit ☐ Fraternal/Civic ☐

Movie Theater ☐ School ☐ Residential Type Facility (List Type) _____

(Full Service Operation: ☐ Limited Prep: ☐ Packaged Products Only: ☐)

Projected Start Date of Project: _____ Projected Completion Date of Project: _____

Is property on an onsite sewage system (septic tank)? ☐ Yes ☐ No (If yes, submit a completed evaluation of capacity.)

Is property served by an onsite/private well? ☐ Yes ☐ No (If yes, submit a completed evaluation of capacity.)

Plans have been submitted to (circle all that apply): Zoning Plumbing Planning Fire Authority Building

The undersigned owner/owner's representative hereby agrees to operate in accordance with the requirements of Chapter 381.0072, Florida Statutes, and Chapter 64E-11, Florida Administrative Code. The information contained in this application, which serves as the basis for licensure, is true and correct. I understand that any misrepresentation to the facts in this application, or failure to comply with sanitary standards, is grounds for denial or revocation of the sanitation certificate.

_____
Owner/Owner's Representative Name & Title

_____
Owner/Owner's Representative & Date