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 08/11/16

ORANGE COUNTY HEALTH DEPARTMENT PLANS REVIEW ROUTING SHEET

DATE: _____ **PLANS ROUTING NUMBER:** _____
PAYMENT TYPE: _____ **AMOUNT:** _____ **CHECK NUMBER:** _____

Please note, the fee for plan review is $53 per hour. If your plan review requires additional time or requires revisions, you will be charged an additional $53 per hour before approval. Please sign below to acknowledge your understanding and acceptance of these conditions. By signing below, you are also certifying that the information provided is true and correct.

SIGNATURE: _____ **DATE:**_____

FACILITY NAME: _____

FACILITY ADDRESS: _____

BILLING 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 #:** _____

FOR OFFICE USE ONLY

UTILITY REVIEWER: _____ **DATE:** _____

REMARKS: _____ **APPROVAL STAMP**

_____

_____

_____

SIGNATURE:_____

FACILITY REVIEWER: _____ **DATE:** _____

REMARKS: _____

_____

SIGNATURE: _____

Revised: 08/11/16

APPLICATION FOR A SANITATION CERTIFICATE / PERMIT

Specific Authority: Chapter 381, FS

NAME OF FACILITY: _____

ADDRESS OF FACILITY: _____

BILLING ADDRESS: _____ **ZIP CODE:** _____

OWNERS NAME: _____

OWNER ADDRESS: _____

OWNER'S PHONE NUMBER: _____ **BUSINESS PHONE NUMBER:** _____

TYPE OF FACILITY: _____ **IS FOOD SERVED? YES** ☐ **NO** ☐

PLEASE FILL OUT A FACILITY DETAIL SHEET FOR ALL REQUIRED PERMITS AND CERTIFICATES

COMMENTS / SPECIAL INSTRUCTIONS: _____

The undersigned owner/owner's representative, hereby agrees to operate the permitted facility described in this application in accordance with the requirements of Chapter 381 FS and all applicable Florida Administrative Codes. 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 the sanitary standards of all applicable Florida Administrative Codes is grounds for denial or revocation of all permits and sanitation certificates.

_____ _____
SIGNATURE, OWNER / OWNER'S REPRESENTATIVE **DATE**

FOR OFFICE USE ONLY

INTIAL INSPECTION OF FACILITY: _____ **APPROVED or DISAPPROVED:** _____
DATE **(circle one)** **DATE**

_____ _____
SIGNATURE, INSPECTOR **PRINT NAME, INSPECTOR**

Revised 08-11-16

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