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: ________________________________________________________________

___________________________________________________________

SIGNATURE: ___________________________

___________________________________________________________

FACILITY REVIEWER: ___________________________    DATE: ___________________________

REMARKS: ________________________________________________________________

___________________________________________________________

SIGNATURE: ___________________________

Revised: 08/11/16
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:

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

Food Service Operations
Select One:

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

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 ______________

DH 4086, 02/18
Rule 64E-11.013(2)(a), F.A.C.