

**Assisted Living Facility Application**

Date: \_\_\_\_\_

New Application: \_\_\_\_\_ Change of Application: \_\_\_\_\_ Permit #: \_\_\_\_\_

Facility Name: \_\_\_\_\_

Facility Address: \_\_\_\_\_

Owner Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Person in Charge: \_\_\_\_\_ Title: \_\_\_\_\_

Email Address: \_\_\_\_\_

Days of Operation: \_\_\_\_\_, Hours of Operation: \_\_\_\_\_

Food Service: \_\_\_\_\_ Yes \_\_\_\_\_ No. If capacity is 11 or more must obtain plan review, Contact Ani Chakraborti at 307-8015 Ext 5954 or 5960

Maximum Capacity (From Fire Inspection) \_\_\_\_\_ Projected Capacity: \_\_\_\_\_  
**If Projected Capacity is more than 10 a Food Sanitation Application Must Be Submitted.**

Potable Water Source: Well Municipal Sewage Disposal: Septic Municipal  
**Well or Septic Service Must Be Approved before Group Care Inspection Complete**

Kitchen: # of sink compartments \_\_\_\_\_ Dishwasher \_\_\_\_\_ Yes \_\_\_\_\_ No Type of Sanitizer \_\_\_\_\_

Number of Toilets \_\_\_\_\_ Urinals \_\_\_\_\_ Sinks \_\_\_\_\_ Showers \_\_\_\_\_

Water Fountain Provided: \_\_\_\_\_ Yes \_\_\_\_\_ No Number of Fountains: \_\_\_\_\_

Application Fee: Less than 50 residents is \$150 50 or more residents \$250  
**Site Plan Must Be Attached**

Mail Applications to:

Florida Department of Health – Hillsborough  
Environmental health – 59  
P.O. Box 5135  
Tampa, FL 33675-5135

**FDOH-Hillsborough Use Only**

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Plan Review Date: \_\_\_\_\_ Reviewer: \_\_\_\_\_

Approved: \_\_\_\_\_ Yes \_\_\_\_\_ No Inspection Frequency \_\_\_\_\_

Health Official: \_\_\_\_\_