

Accessible Home Health Care
3111 North University Drive / Suite 625
Coral Springs, FL 33065
Phone: 954-341-5600 / Fax: 954-757-3009
E-mail: jrowsell@ahcglobal.com

*Accessible
Home Health Care*



"We Guarantee Compassionate Care"

CONFIDENTIAL AFFILIATE APPLICATION FORM

Name _____

Gender M F - Social Security Number _____ Date of Birth _____

Home address _____

Cell Phone _____ Home Phone _____ Business Phone _____

Best phone to contact you? Cell Home Business - Best time to call you? _____

Fax _____ E-mail Address _____

Employer and Job Title (Position) _____

Marital Status Single Married Other _____ Number of dependents _____

Spouse's Name _____

Spouse's Social Security Number _____ Spouse's Date of Birth _____

Spouse's Employer and Job Title (Position) _____

Cell Phone _____ Business Phone _____

Will someone else, other than your spouse, be involved in the ownership and operation of the business with you? Y N

If 'YES,' please, list name(s) and have the other party(ies) fill and submit separate Application(s) _____

When are you looking to open your business? _____

When are you available to attend our one week training session? _____

Where would you like to locate your business? _____

If your first choice is not available, what would your next two choices be? _____

Have you ever had any criminal or civil actions filed against you? Y N - Have you ever filed for bankruptcy? Y N

Please, list names and phone numbers of three sources of reference

1. _____

2. _____

3. _____

This is a non-binding application and it can be withdrawn at any time. No fees required. This is not a contract.

Please, fill out this application and fax it to 954-757-3009 or email to jrowsell@ahcglobal.com

To purchase a Business Affiliate License you will need between \$22,500.00 and \$31,000.00 (Depending on the level of assistance you initially require). Do you have the liquidity to invest this? Y N -

Do you have sufficient funds to support yourself and your dependents for at least 6 months as your business is in the development phase as well as initial operating capital ? Y N

Cash on hand and unrestricted in banks \$ _____

Other stocks and bonds \$ _____

Other Liquid assets (401k etc.) \$ _____

Home (Real estate) \$ _____

Accounts and loans receivable \$ _____

How much are your monthly living expenses? \$ _____

How much net income (minimum) do you need the business to generate for you? \$ _____

WHAT IS YOUR CURRENT CREDIT SCORE _____ WHEN CHECKED _____

Describe your education, professional experience (as entrepreneur or employee), companies you owned or that you have worked for, job titles, brief description of responsibilities, dates of employment. Use additional pages or attach your resume, if available.

What attracted you to the home health care business? _____

How much time per week will you dedicate to this business? _____

Will you be operating the business on a full time basis? If 'NO' then who will? _____

What are your strongest skills in business? _____

In submitting this application and statement, I certify that all information provided herein is, to the best of my knowledge, true and correct and guarantee that I have not knowingly withheld any information. I also, herein, authorize Accessible Home Health Care to verify the veracity of what I have provided and obtain additional information regarding my character, credit, and criminal history in order to help evaluate if I am suitable to become an Accessible Home Health Care Affiliate. I hereby authorize others to provide information about me, and, at the same time, I release them from any and all liability for damages resulting from furnishing such information.

Signature _____ Date _____

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