Nursing Home
PATIENT TRUST SURETY BOND

KNOWN TO ALL PERSONS BY THESE PRESENT THAT ____ (nursing home) of ____ (nursing home street address) (county) (city/state/zip) as Principal and ____ a Surety Company organized under the laws of the state of ____ and licensed to do business in the state of Florida as Surety, are held and firmly bound unto the Agency for Health Care Administration, the obligee, in the total penal sum of __________________________ dollars (_____________) lawful money of the United States of America, for which sum well and truly to be paid said Principal and Surety bind themselves, their heirs, executors, administrators, successors and assigns, jointly and severally firmly by these present.

A. WHEREAS, The above named Principal is a nursing home as defined in Chapter 400, Part II, Florida Statutes, and as such, is a licensee under Chapter 400, Part II, Florida Statutes and

B. WHEREAS, Section 400.162(5)(b), Florida Statutes, requires each nursing home to post a surety bond, in an amount equal to twice the average monthly balance in the patient trust fund during the prior year or $5,000.00, whichever is greater.

NOW, THEREFORE, the condition of this obligation is such that is the above named Principal shall: (1) well and truly hold separately and in trust all patients' funds deposited with Principal as a nursing home and (2) shall administer said funds on behalf of said patients in the manner directed by Section 400.162, Florida Statutes, and (3) shall render true and complete accounts to the patients, the depositors and the Obligee when requested, and (4) upon termination of each such deposit , shall account for all funds received thereunder, expended and held on hand, then this obligation shall be null and void, otherwise to remain in full force and effect.
This bond is executed and accepted subject to the following conditions:

(1) The Agency for Health Care Administration or, with the written consent of the Secretary of such Agency, any aggrieved patient or depositor, may maintain in his own name, an action on this bond, to recover for Principal's alleged breaches of the contract hereof, in any Court of competent jurisdiction in the state of Florida. (2) This bond shall be effective as of 12:01 a.m. of ______________, and shall continue in full force and effect until _______________ .

IN WITNESS WHEREOF, the parties hereto have affixed their hands seals this _____ day of ___________, _____.

_________________________________ Principal's Representative

_________________________________ Surety Company's Representative

Upon issuance of renewal, forward original to address shown below. Upon cancellation or non-renewal advise office indicated below no less than 30 days in advance giving reason for such action.

Agency for Health Care Administration
Long Term Care Unit, MS 33
2727 Mahan Drive
Tallahassee, FL 32308

SAMPLE

Bond forms change; this is for educational purposes only.

Surety Bond Application

AGENCY NAME: ______________________ AGENCY CONTACT: ______________________

AGENCY PHONE: ____________ AGENCY FAX: ____________ AGENCY EMAIL: ____________

AGENCY ADDRESS: ____________ City: ____________ State: ____________ Zip: ____________

CURRENT OR EXPIRING QUOTE WE ARE LOOKING TO BEAT? ______________________

NAME OF PREVIOUS SURETY COMPANY WRITING THE BOND? ______________________

SECTION I: BOND APPLIED FOR

Type of Bond: ____________ Effective Date: ____________ Expiration Date: ____________

Type of Company **CORP**☐ **LLC**☐ **DBA**☐ **PARTNERSHIP** ☐ Bond Amount: ____________

(Obligee): ______________________

Obligee Address ______________________

SECTION II: GENERAL INFORMATION

Applicant's Name: ____________ Spouse Name: ____________

SS#: ____________ Spouse SS#: ____________ Home Phone: ( ) ____________

Residence Address: ____________ City: ____________ State: ____________ Zip: ____________

Business Name: ______________________

Business Phone: ( ) ____________ Business Fax: ( ) ____________ E-mail: ____________

Business Address: ____________ City: ____________ State: ____________ Zip: ____________

Date Business BEGAN under present Individual or Firm Name: ____________ BUSINESS TAX ID: ____________

HAS ANY COMPANY REFUSED TO ISSUE BONDS FOR ANY PURPOSE? YES ☐ NO☐

DO YOU HAVE ANY LIENS, CLAIMS OR JUDGMENTS AGAINST YOU? YES ☐ NO☐

HAS APPLICANT EVER FAILED IN BUSINESS? YES ☐ NO☐

HAS APPLICANT EVER FILED BANKRUPTCY? YES ☐ NO☐

IF YES TO ANY, PLEASE EXPLAIN ON A SEPERATE SHEET OF PAPER

SECTION III: ADDITIONAL OWNERS OR PARTNERS AS REQUIRED

NAME: ____________ SPOUSE NAME: ____________

SS#: ____________ SPOUSE SS#: ____________ PHONE: ____________

HOME ADDRESS: ____________ City: ____________ State: ____________ Zip: ____________

PERSONAL FINANCIALS ***(IF MORE THAN ONE OWNER, EACH HAS TO FILL OUT THIS APPLICATION)***

STATEMENT OF ASSETS AND LIABILITIES AS OF

ASSETS		**LIABILITIES**	
CASH IN BANK		NOTES PAYABLE TO BANKS	
CASH ON HAND		NOTES TO OTHERS (excl. of equipment)	
STOCKS AND BONDS		ACCOUNTS PAYABLE	
ACCOUNTS RECEIVABLE		FEDERAL & STATE INCOME TAX DUE	
NOTES RECEIVABLE		ALL OTHER TAXES	
INVENTORY		ACCRUALS, PAYROLLS, ETC.	
CASH VALUE LIFE INSURANCE			
EQUIPMENT		DUE ON EQUIPMENT	
REAL ESTATE		DUE ON REAL ESTATE	
OTHER ASSETS		OTHER LIABILITIES	
		CAPITAL STOCK (if a corporation)	
		SURPLUS AND UNDIVIDED PROFITS	
TOTAL ASSETS		**TOTAL LIABILITIES**	
		NET WORTH	

Name of Owners	Name and Title of Officers	% OWNERSHIP IN COMPANY

COMPLETION OF THIS FORM CONSTITUTES PERMISSION FOR WORLDWIDE INSURANCE SPECIALISTS INC. TO OBTAIN CONSUMER INFORMATION WHICH WILL BE USED TO DETERMINE BONDING ELIGIBILITY. THIS INFORMATION WILL BE HELD IN THE STRICTEST CONFIDENCE
NO PREMIUM FINANCING WILL BE ACCEPTED AS PREMIUM IS EARNED IN FULL.

Worldwide Insurance Specialists, Inc
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SAMPLE WWISINC.COM