

Accessible Home Health Care  
210 North University Drive / Suite 806  
Coral Springs, FL 33071  
Phone: 954-341-5600 / Fax: 954-757-3009  
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*Accessible Home Health Care*  
"We Guarantee Compassionate Care"



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**CONFIDENTIAL FRANCHISE 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**This is a non-binding application and it can be withdrawn at any time.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**

To open this franchise you need \$108,000.00 - \$125,000.00 (includes the franchise fee). Do you have \$108,000.00 available to invest? 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? Y N

| <b>ASSETS</b>                          |    | <b>LIABILITIES AND NET WORTH</b>                                 |    |
|--|----|--|----|
|  | \$ |  | \$ |
| Cash on hand and unrestricted in banks |    | Notes payable to banks. Unsecured direct borrowing only          |    |
| U.S. Government securities             |    | Notes payable to banks. Secured direct borrowings only           |    |
| Accounts and loans receivable          |    | Notes receivable, discounted with banks, finance companies, etc. |    |
| Notes receivable, not discounted       |    | Notes payable to other, unsecured                                |    |
| Life insurance, cash surrender value   |    | Loans against life insurance                                     |    |
| Other stocks and bonds                 |    | Accounts payable   |    |
| Real estate                            |    | Interest payable   |    |
| Automobiles registered in own name     |    | Taxes and assessments payable                                    |    |
| Other assets                           |    | Mortgages payable on real estate                                 |    |
|  |    | Other liabilities  |    |
|  |    |  |    |
|  |    |  |    |
|  |    | <b>TOTAL LIABILITIES</b>   |    |
|  |    | <b>NET WORTH</b>   |    |
| <b>TOTAL ASSETS</b>                    |    | <b>TOTAL LIABILITIES &amp; NET WORTH</b>                         |    |

Total Assets – Total Liabilities = Net Worth

WHAT IS YOUR CURRENT CREDIT SCORE \_\_\_\_\_ WHEN CHECKED \_\_\_\_\_

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 franchisee. 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.

If you submit a copy of your credit report from one of the three major consumer credit reporting bureaus we may not be required to run a credit check and have the inquiry listed on your report.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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The following are optional questions and it is totally up to you to provide answers or not. Please, use these questions as a general guideline, but feel free to add whatever information you believe would be relevant to help us on our decision to grant you an Accessible Home Health Care franchise. Feel free to use as many additional sheets of paper as you might find necessary.

1. 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.

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2. What attracted you to the home health care business?

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3. How much time per week will you dedicate to this business? \_\_\_\_\_

4. Will you be operating the business on a full time basis? Y N - If 'NO' then who will? \_\_\_\_\_

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5. What are your strongest skills in business? \_\_\_\_\_

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6. How much are your monthly living expenses? \_\_\_\_\_

7. How much net income (minimum) do you need the business to generate for you? \_\_\_\_\_

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