

Accessible Home Health Care
210 North University Drive / Suite 806
Coral Springs, FL 33071
Phone: 954-341-5600 / Fax: 954-757-3009
E-mail: jrowsell@ahcglobal.com



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This is a non-binding application and it can be withdrawn at any time.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

ASSETS		LIABILITIES AND NET WORTH	
	\$		\$
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	
		TOTAL LIABILITIES	
		NET WORTH	
TOTAL ASSETS		TOTAL LIABILITIES & NET WORTH	

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 _____

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

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.

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

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? _____

5. What are your strongest skills in business? _____

6. How much are your monthly living expenses? _____

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

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