11/05/96 14:39 NO.

PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM

APPLICATION FOR REINSTATEMENT

FLORIDA DEPARTMENT OF STATE
Sandra B. Mortham
Secretary of State
DIVISION OF CORPORATIONS

H96000015595

APPROVED AND FILED
1996 NOV -5 PM 3:03
SECRETARY OF STATE
TALLAHASSEE, FLORIDA

DO NOT WRITE IN THIS SPACE

DOCUMENT # P94000054421

1. Corporation Name

SENIOR HOME HEALTH CARE, INC.

Principal Place of Business / Mailing Address

1699 Coral Way, Suite 504
Miami, Fl 33145

If above addresses are incorrect in any way, line through incorrect information and enter correction below.

2. New Principal Office Address, if Applicable
Suite, Apt. #, etc.
City & State
Zip / Country

3. New Mailing Address, if Applicable
Suite, Apt. #, etc.
City & State
Zip / Country

4. Date Incorporated or Qualified To Do Business in Florida: 07/22/1994

5. FEI Number: 65-0520099 — Applied For / Not Applicable

6. CERTIFICATE OF STATUS DESIRED: YES

7. Names and Street Addresses of Each Officer and/or Director (Florida nonprofit corporations must list at least 3 directors)

Title(s) 1	Name of Officers and/or Directors 2	Street Address of Each Officer and/or Director (Do NOT Use Post Office Box Numbers) 3	City / State / Zip 4
D	William Chavez Jr.	1699 Coral Way Ste 504	Miami, FL 33145
D	William Chavez Sr.	1699 Coral Way Ste 504	Miami, FL 33145

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SCC 11-5-96

8. Name and Address of Current Registered Agent

William Chavez Jr
1699 Coral Way, Suite 504
Miami, FL 33145

9. Name and Address of New Registered Agent
Name
Street Address (P.O. Box Number is Not Acceptable)
Suite, Apt. #, Etc.
City / State: FL / Zip Code

10. I, being appointed the registered agent of the above-named corporation, am familiar with and accept the obligations of Section 607.0505, F.S.

Signature of Registered Agent: [signature] Date: 11/4/96
REGISTERED AGENT MUST SIGN

11. Does this corporation pay any intangible tax to the Dept. of Revenue under S. 199.032, Florida Statutes. Yes ☑ No ☐ (See cover sheet for information on intangible tax.)

12. I do hereby certify that the information supplied with this filing is voluntarily furnished and does not qualify for the exemption stated in Section 119.07(3)(i), Florida Statutes. I release the Division of Corporations from any liability of non-compliance with Section 119.07(3)(i) in the event that the information supplied is deemed exempt from public access. I certify that I am an officer or director or the receiver or trustee empowered to execute this application as provided for in chapter 607 or 617, F.S. I further certify that when filing this reinstatement application the reason for dissolution has been eliminated, the corporate name satisfied the requirements of section 607.0401 or 617.0401, F.S., and that all fees owed by the corporation have been paid. The information indicated on this application is true and accurate, and my signature shall have the same legal effect as if made under oath.

SIGNATURE: [signature] (305) 857-9881
SIGNATURE AND TYPED OR PRINTED NAME OF SIGNING OFFICER OR DIRECTOR — Date — Daytime Phone #

Prepared by: William Chavez Jr. 1699 Coral Way, Suite 504 Miami, FL 33145 H96000015595

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CHARGED, PLEASE ENTER YOUR PASSWORD. TO ABANDON THIS PROCESS, ENTER 'N'.

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(((H96000015595 7)))

TO: DIVISION OF CORPORATIONS FAX #: (904)922-4000

FROM: FAS-T CORP. AGENTS, INC. ACCT#: 071001002335
CONTACT: LIDIA FERNANDEZ
PHONE: (305)599-0839 FAX #: (305)716-0346

NAME: SENIOR HOME HEALTH CARE, INC.
AUDIT NUMBER.....H96000015595
DOC TYPE.....CORPORATION REINSTATEMENT
CERT. OF STATUS..0 PAGES..... 1
CERT. COPIES.....0 DEL.METHOD.. FAX
EST.CHARGE.. $575.00

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** ENTER 'M' FOR MENU. **

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