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H97000019367 PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETING THIS FORM.

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

DOCUMENT # P95000000092

1. Corporation Name

HOME CARE PROVIDERS, INC.

Principal Place of Business

Mailing Address

310 N.W. 107th Ave. #204
Miami, FL 33172

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

2. New Principal Office Address, If Applicable

555 East 25th St.

Suite, Apt. #, etc.

Suite #203

City & State

Hialeah, FL 33013

Zip

Country

3. New Mailing Office Address, If Applicable

Suite, Apt. #, etc.

City & State

Zip

Country

4. Date Incorporated or Qualified
To Do Business in Florida

01/03/1995

5. FEI Number

65-0544697

Applied For

Not Applicable

6. CERTIFICATE OF STATUS DESIRED ☒

\$8.75 Additional Fee required
for a Certificate of Status

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

1 Title(s)	2 Name of Officers and/or Directors	3 Street Address of Each Officer and/or Director (Do NOT Use Post Office Box Numbers)	4 City / State / Zip
PD	Maria I Mena	555 East 25th St. Ste 203	Hialeah FL 33172

REINSTATEMENT '97

SCC 11-20-97

8. Name and Address of Current Registered Agent

Maria I Mena
310 N.W. 107th Ave.
204
Miami, FL 33172

9. Name and Address of New Registered Agent

Name

Street Address (P.O. Box Number is Not Acceptable)

555 East 25th St. Suite #203

Suite, Apt. #, Etc.

City

Hialeah

State

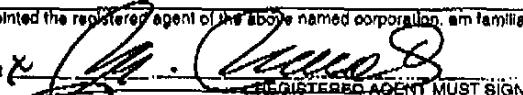
FL

Zip Code

33013

10. I, being appointed the registered agent of the above named corporation, am familiar with and accept the obligations of Section 607.0605, F.S.

Signature of
Registered Agent



Date

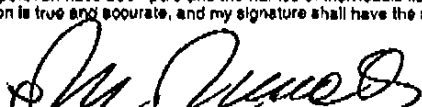
REGISTERED AGENT MUST SIGN

11. Does this corporation pay any intangible tax to the
Dept. of Revenue under S. 199.032, Florida Statutes. Yes ☒ No ☐

(See other side for information
on intangible tax.)

12. 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 satisfies the requirements of section 607.0401 or 617.0401, F.S., that all fees owed by the corporation have been paid and the names of individuals listed on this form do not qualify for an exemption under section 119.07(3)(f), F.S. 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:



11/20/97

SIGNATURE AND TYPED UP PRINTED NAME OF SIGNING OFFICER OR DIRECTOR

Date

Daytime Phone #

Prepared by: Maria I Mena 555 East 25th St. Suite 203 Hialeah, FL 33013

H97000019367

(305) 691-3307

CR25046 (1/2/95)

11/20/97

#P9500000092

FLORIDA DIVISION OF CORPORATIONS
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2:04 PM

((H97000019367 6))

TO: DIVISION OF CORPORATIONS

FAX #: (850)922-4000

FROM: FAS-T CORP. AGENTS, INC.
CONTACT: LIDIA FERNANDEZ
PHONE: (305)599-0839

ACCT#: 071001002335

FAX #: (305)716-0346

NAME: HOME CARE PROVIDERS, INC.

AUDIT NUMBER.....H97000019367

DOC TYPE.....CORPORATION REINSTATEMENT

CERT. OF STATUS..1

PAGES..... 1

CERT. COPIES.....0

DEL.METHOD.. FAX

EST.CHARGE.. \$758.75

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AUDIT NUMBER ON THE TOP AND BOTTOM OF ALL PAGES OF THE DOCUMENT

** ENTER 'M' FOR MENU. **

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DIVISION OF CORPORATIONS