(1)

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

APPROVED AND FILED

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	3. New Mailing Office Address, If Applicable
555 East 25th St.	
Suite, Apt. #, etc.: Suite #203	Suite, Apt. #, etc.
City & State: Hialeah, FL 33013	City & State
Zip / Country	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	9. Name and Address of New Registered Agent
Maria I Mena 310 N.W. 107th Ave. # 204 Miami, FL 33172	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

CR2E040 (12/96)

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: _____
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)(i), 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: [signature] 11/20/97
SIGNATURE AND TYPED OR 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

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11/20/97 FLORIDA DIVISION OF CORPORATIONS 2:04 PM

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(((H97000019367 6)))

TO: DIVISION OF CORPORATIONS FAX #: (850)922-4000

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

NAME: HOME CARE PROVIDERS, INC.
AUDIT NUMBER.....H97000019367
DOC TYPE.....CORPORATION REINSTATEMENT
CERT. OF STATUS..1 PAGES..... 1
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