

AHCA USE ONLY:	
File #: Application #: Check #: Check Amt: Batch #:	

Health Care Licensing Application Birth Center

The Agency for Health Care Administration (AHCA) has implemented the **ONLINE LICENSING SYSTEM**, which allows the electronic submission of renewal and change during licensure period applications and fees, along with the ability to upload supporting documentation. To submit online please go to: http://ahca.myflorida.com/onlinelicensure

Applications must be received at least 60 days prior to the expiration of the current license or effective date of a change of ownership to avoid a late fee. If the renewal application is received by the Agency less than 60 days prior to the expiration date, it is subject to a late fee as set forth in statute. The applicant will receive notice of the amount of the late fee as part of the application process or by separate notice. The application will be withdrawn from review if all the required documents and fees are not included with the application or received within 21 days of an omission notice. Applications will not be considered for review until payment has been received. Renewal and Change During Licensure Period applications: Supporting documentation, responses to omissions and payments may be submitted using the online system even if the application was originally mailed to the Agency.

Please fill in all blanks or mark N/A if not applicable.

Under the authority of Chapters 408, Part II and 383, Florida Statutes (F.S.), and Chapters 59A-35 and 59A-11, Florida Administrative Code (F.A.C.), an application is hereby made to operate a birth center as indicated below:

1. Provider / Licensee Information

and telephone number will be listed on http://www.floridahea			National Provider Identifier (NPI) (if applicable)			
License number (if applicable)	Ivation	ai Fiovidei id	denumer (MFT) (п арріісаріе)		
Name of Birth Center (if operated under a	fictitious name, enter as it fil	ed with the F	lorida Division	of Corporations	5)	
Street Address						
City		County		State	Zip	
Telephone Number	Fax	Number				
E-mail Address			Note: By providing your e-mail address, you agree accept e-mail correspondence from the Agency.			
Provider Website					· · · · · · · · · · · · · · · · · · ·	
Mailing Address or Same as above						
City		County		State	Zip	
Telephone Number	elephone Number E-mail Address					
B. PROPERTY OWNER INFORMATI	ON – Complete the follow	ving for the	owner of the	e property if dif	ferent from the licensee.	
Does an individual or entity other than th		erty where t	he principal	office is located	d?	
If NO, skip to section Section 1.C. C	ontact Person					
If \(\sum YES, please provide the following in the provide of the following in the provide of the provid	information:					
Full Name of Property Owner			Tele	phone Number		
Primary Address			Effective Date			

C. CONTACT PERSON - For this appli	cation				
Contact Person for this application		C	Contact Telephone Number		
Contact e-mail address or Do not have		Note: By providing your e-mail address you agree to accept e-mail correspondence from the Agency.			
D. LICENSEE INFORMATION - Pleas	e complete the following for	r the entity s	seeking to op	erate the birth center.	
Licensee Name (This is the owner of the t				ployer Identification Number (EIN)	
Mailing Address or Same as above			1		
City	Sta	ite	Zip		
	Number	E-mail	Address		
Description of Licensee (check one): For Profit Corporation Limited Liability Company Partnership Individual Sole Proprietor Other	Not for Profit ☐ Corporation ☐ Religious A ☐ Other			Public ☐ State ☐ City/County ☐ Hospital District	
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2. Application Type and					
Indicate the type of application with an "X." section 408.805(4), F.S., fees are nonrefuthe expiration of the license or the proposed Agency less than 60 days prior to the expirathe amount of the late fee as part of the app	Applications will not be p indable. Renewal and Cha d effective date of the chang ation date, it is subject to a	inge of Own ge to avoid late fee as s	ership applic a late fee. If set forth in st	ations must be received 60 days prior to the renewal application is received by the	
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B. LICENSURE FEES

ACTION	FEE	TOTAL FEES
License Fee (Initial, Renewal and Change of Ownership)	\$392.80	\$
Licensure & Life Safety Survey Fees (Initial only- \$250.00 each survey)	\$500.00	\$
Biennial Assessment	\$300.00	\$
Change During Licensure Period	\$25.00	\$
TOTAL FEES INCLUDED WITH APPLICATION		\$
Please make check or money order payable to the Agency for Health Care A	dministration (AHCA)	L

3. Controlling Interest

AUTHORITY:

Pursuant to sections 408.806(1)(a) and (b), F.S., an application for licensure must include: the name, address and social security number of the applicant and each controlling interest, if the applicant or controlling interest is an individual; and the name, address, and federal employer identification number (EIN) of the applicant and each controlling interest, if the applicant or controlling interest is not an individual. Disclosure of social security number(s) is mandatory. The Agency for Health Care Administration shall use such information for purposes of securing the proper identification of persons listed on this application for licensure. However, in an effort to protect all personal information, do not include social security numbers on this form. All social security numbers must be entered on the Health Care Licensing Application Addendum, AHCA Form 3110-1024.

DEFINITIONS:

Controlling interests, as defined in section 408.803(7), F.S., are the applicant or licensee; a person or entity that serves as an officer of, is on the board of directors of, or has a 5% or greater ownership interest in the applicant or licensee; or a person or entity that serves as an officer of, is on the board of directors of, or has a 5% or greater ownership interest in the management company or other entity, related or unrelated, with which the applicant or licensee contracts to manage the provider. The term does not include a voluntary board member.

Note: For each controlling interest an AHCA screening through the Care Provider Background Screening Clearinghouse is needed or the Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008 if background screening was conducted by the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S. To verify who is to be screened, visit http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/.

A. Individual and/or Entity Ownership of Licensee as listed in section 1D above – Provide the information for each individual or entity (corporation, partnership, association) with 5% or greater ownership interest in the licensee. Attach additional sheets, if necessary. This excludes Not-for-Profit and publicly held licensees. Note: A written explanation will be required if the percentage of ownership interest indicated below does not equal 100%.

INSTRUCTIONS: Attach additional application pages if needed.

For new individual - complete all fields except the End Date.

For existing individuals - complete all fields except the Effective and End Date.

To remove an individual - complete all fields including the End Date.

FULL NAME OF INDIVIDUAL OR ENTITY	PERSONAL/PRIMARY ADDRESS	TELEPHONE NUMBER	EIN (NO SSN)	% OWNERSHIP	EFFECTIVE DATE	END DATE

TITLE	FULL NAME	PERSONAL	/PRIMARY	ADDRESS	TELEPHONE NUMBER	EFFECTIVE DATE	E END DATE
Board Member/Officer							
Soard Member/Officer							
Board							
lember/Officer							
	ent Company						
es a company other t		_	ed provider	?			
	Section 6 - Personne de the following inform						
lame of Management C			EIN (No	SSN)	Telephone	Number / Fax	-
Street Address				E-mail Add			
			County			7in	
City			County		State	Zip	134
lailing Address or Sa	ame as above						
City					State	Zip	
ontact Person	(Contact E-mail		Contact Telephone Number			er
						*	
. Wanadem	ent Combany	Controllir	na Inter	ests			
	ent Company	Controllin	ng Inter	ests			
EFINITION: ontrolling interests, a	s defined in section 40	08.803(7), F.S., a	re the appli	cant or license			
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EFINITION: controlling interests, a fficer of, is on the board nat serves as an officer ther entity, related or ur	s defined in section 40 of directors of, or has of, is on the board of c arelated, with which the	08.803(7), F.S., a a 5% or greater directors of, or ha	are the appli ownership as a 5% or g	cant or license interest in the reater owners	applicant or licenship interest in the	see; or a perso management	on or entity company or
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TITLE	FULL NAME	PERSONAL/PRIMARY ADDRESS	TELEPHONE	EFFECTIVE	END
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or existing individuals	omplete all fields except : – complete all fields ex al – complete all fields i	cept the Effective and End Date.			
INFORMATION	I	TOR/MANAGING EMPLOYEE	RESPONSIBL	OFFICER / PERS LE FOR FINANCE ERATIONS	
uit Name					
ate of Birth					
ffective Date					
Ind Date					
elephone Number					
mail Address					
Personal/Primary Address					
. Require	d Disclosure				
ne following disclos Pursuant to section		olicant shall submit to the Agency a descri	ption and explanati	on of any convict	ons of
offenses prohibited	by sections 435.04 an	d 408.809(4), F.S., for each controlling int ted in Sections 3 and 4 of this application	erest.	•	
		ES NO	been convicted of a	arry level 2 offeris	e pursua
to section 408					
to section 408	e the following informat				
to section 408 If YES, provid The	full legal name of the inc	dividual and the position held			
to section 408 If YES, provid The	_	dividual and the position held			
to section 408 If YES, provid The factor A desertion	full legal name of the inc scription/explanation of n 408.810(2), F.S., the a	dividual and the position held			nsions, o
to section 408 If YES, provid The factor A description of the section terminations from the section involuntarily with the section of the s	full legal name of the indiscription/explanation of a 408.810(2), F.S., the after Medicaid, the Medicare, Medicaid, that or any individual/entithdrawn from participal	dividual and the position held any convictions applicant must provide a description and e or federal Clinical Laboratory Improveme tity listed in Sections 3 and 4 of this applic tion in Medicare or Medicaid in any state?	nt Amendment (CL ation been exclude	IA) programs.	
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C. Pursuant to section 408.81 interest of the applicant wa Convicted of, or entere 817, Chapter 893, 21 within the previous 15	is an owne ed a plea o U.S.C. ss.	r or office of guilty or 801-970,	when the nolo cor or 42 U.	ne following action Itendere to, regains.C. ss. 1395-139	ns occurred ev dless of adjud 96, Medicaid fr	ver been: ication, a felony	under C	hapter 4	409, Chapter
Terminated for cause If YES, has applicant I (5) years and the term	peen in go	od standin	g with th	e Medicare prog	ram or a state	Medicaid progr		e most r	recent five
8. Provider Fine	s and	Finan	cial lı	nformation					
Pursuant to section 408.831(1) common controlling interest with order of the agency or final order repayment plan is approved by	h the applicer of the Co the agency	cant if the enters for y.	y have fa Medican	ailed to pay all ou e and Medicaid S	tstanding fines services (CMS)	i, liens, or overp), not subject to 	ayments further a	assess opeal, u	ed by final
Are there any incidences of out	-		•	•			NO 🗌	I	
AHCA CASE NUMBER	CMS	ASSES	SSED	DATE OF FINSPECT	RELATED TION, TON, OR	PAYMENT DUE DATE		NAL OF	PPEAL OF RDER NO
				OVERPA	YMENT			-	
					7				
	Please	attach a c	opy of th	e approved repa	yment plan, if	applicable,	1,		
9. General Inform	mation	1							
Please provide the number of B	irthing Roo	oms:							
10. Accreditation									
The applicant participates in acc	crediting or	rganizatio	n selecte	ed below or 🗌 N	ot accredited:				
					ACC	CREDITATION		SHP	VEY END
ACCREDITING ORGA	NIZATIO	۷.	ACCR	EDITATION ID	EFFECTIV DATE	END	DATE	DATE	
Accreditation Association Health Care (AAAHC)	n for Ambu	ilatory							
Commission for the Acci	editation o	f Birth							
☐ The Joint Commission (JC)								
NOTE: If accredited, provide a review Chapter 119, F.S. for a	dditional info	ormation.							
I understand that is to be accepted considered public correspondence accreditation organs and verification or acceptation or a	in lieu of a documen from the ad anization re	a complete ts subject ccrediting equires a	e licensu to disclo organiza respons	re inspection and psure per Chapte ation containing the e, the facility's re	I such reports r 119, F.S. A c ne dates of the sponse to eacl	used to meet lid omplete accred survey, any cit	ensure re litation rep ations to	equirem port incl which th	ents are ludes ne

11. Hours of Operation

List the regular operating hours. **Note:** Site inspections by surveyors will occur during the business hours submitted. Failure to be open during the listed hours may result in a fine.

DAY	OF THE WEEK	OPENING TIME	CLOSING TIME	BY APPOINTMENT
	Monday			
	Tuesday			
	Wednesday			
	Thursday			
	Friday			
	Saturday			
	Sunday			

12. Supporting Documentation

Applicants <u>must</u> include the following attachments as stated in Chapters 408, Part II and 383, F.S. and Chapters 59A-35 and 59A-11, F.A.C. Note: Required documents listed below are dependent on the type of application submitted. (Initial, Renewal, Change of Ownership, Change During Licensure Period)

DOCUMENTS TO BE PROVIDED	REQUIRED FOR
Accreditation report, if applicable	Initial, Renewal and Change of Ownership applications
Health Care Licensing Application Addendum, AHCA Form 3110-1024	Initial, Renewal, Change of Ownership, and Change of Personnel or of Controlling Interest applications
Right to Occupy (examples: Deed, current Lease, Mortgage, Transfer Agreement)	Initial, Change of Ownership, and Request to Change Name or Address of Provider application
Documentation from the appropriate local government office showing the applicant has met local zoning requirements	Initial, Renewal, Change of Ownership, Change of Provider Name or Address applications
Documentation of change of ownership transaction stating effective date and executed by all parties	Change of Ownership and Change of Controlling Interest applications
A signed agreement to pay any outstanding payments owed to the Agency. The agreement must include who will pay and when payment will be made	Change of Ownership applications
Required disclosures related to actions taken by Medicare, Medicaid or CLIA, if applicable	All application types, if documentation is required due to responses provided in application
Approved repayment plan, if applicable	All applications

13. **Attestation** ្ធ attest as follows: (1) Pursuant to section 837.06, Florida Statutes, I have not knowingly made a false statement with the intent to mislead the Agency in the performance of its official duty. (2) Pursuant to section 408.815, Florida Statutes, I acknowledge that false representation of a material fact in the license application or omission of any material fact from the license application by a controlling interest may be used by the Agency for denying and revoking a license or change of ownership application. (3) Pursuant to section 408.806, Florida Statutes, under penalty of perjury, the applicant is in compliance with the provisions of section 408.806 and Chapter 435, Florida Statutes. (4) Pursuant to sections 408.809 and 435.05, Florida Statutes, every employee of the applicant required to be screened has attested, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to Chapter 408, Part II, and Chapter 435, Florida Statutes, and has agreed to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer. (5) Pursuant to section 435.05, Florida Statutes, the applicant has conducted a level 2 background screening through the Agency on every employee required to be screened under Chapter 408, Part II, or Chapter 435, Florida Statutes, as a condition of employment and continued employment and that every such employee has satisfied the level 2 background screening standards or obtained an exemption from disqualification from employment. (6) Pursuant to section 408.810(12), Florida Statutes, the licensee ensures that no person holds any ownership interests, either directly or indirectly, regardless of ownership structure; who has a disqualifying offense pursuant to section 408.809, Florida Statutes or in a provider that had a license revoked or application denied pursuant to section 408.815, Florida Statutes. Title Signature of Licensee or Authorized Representative Date NOTICE: If you are a Medicaid provider, you may have a separate obligation to notify the Medicaid program of a name/address change, change of ownership or other change of information. Please refer to your Medicaid handbooks for additional information. about Medicaid program policy regarding changes to provider enrollment information.

RETURN THIS COMPLETED FORM WITH FEES TO:

AGENCY FOR HEALTH CARE ADMINISTRATION HOSPITAL AND OUTPATIENT SERVICES UNIT 2727 MAHAN DR., MS 31 TALLAHASSEE FL 32308-5407

Questions? Visit the Agency's website: http://ahca.myflorida.com or contact the Hospital and Outpatient Services Unit at (850) 412-4549 or Email: hospitals@ahca.myflorida.com

The Agency for Health Care Administration scans all documents for electronic storage. In an effort to facilitate this process, we ask that you please remember to:

- · Please place checks or money orders on top of the application
- Include license number or case number on your check
- · Do not submit carbon copies of documents
- · Do not fold any of the documents being submitted
- · No staples, paperclips, binder clips, folders, or notebooks
- Please do not bind any of the documents submitted to the Agency.