AHCA USE ONLY:
File #: ____________________
Application #: ________________
Check #: ____________________
Check Amt: __________________
Batch #: ____________________

Health Care Licensing Application
Multiphasic Health Testing 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 *The application will be withdrawn from review if all the required documents and fees are not included with your application or received within 21 days of an omission notice.* **Applications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.**

Under the authority of Chapters 408, Part II, and 483, Part II Florida Statutes (F.S.), and Chapters 59A-35 and 59A-6, Florida Administrative Code (F.A.C.), an application is hereby made to operate a multiphasic health testing center as indicated below.

1. Provider / Licensee Information

A. PROVIDER INFORMATION – Please complete the following for the multiphasic health testing center name and location. Provider name, address and telephone number will be listed on http://www.floridahealthfinder.gov/

AHCA Laboratory License #: (if applicable)	CLIA #		
National Provider Identifier (NPI) (if applicable)	Medicare # (CMS CCN)	Medicaid #	
Name of Multiphasic Health Testing Center (if operated under a fictitious name, enter as it appears in Florida Division of Corporations)			
Street Address			
City	County	State	Zip
Telephone Number	Fax Number		
Mailing Address or ☐ Same as above			
City	State	Zip	
Telephone Number	E-mail Address		
Provider Website	NOTE: By providing your e-mail address, you agree to accept e-mail correspondence from the Agency.		

B. CONTACT PERSON - For this application

Contact Person for this application	Contact Telephone Number
Contact e-mail address or ☐ Do not have e-mail	

C. **LICENSEE INFORMATION –** Please complete the following for the entity seeking to operate the multiphasic health testing center.				
Licensee Name (This is the owner of the Multiphasic Health Testing Center)			Federal Employer Identification Number (EIN)	
Mailing Address or ☐ Same as above				
City			State	Zip
Telephone Number	Fax Number	E-mail Address		

Description of Licensee (check one):

For Profit	Not for Profit	Public
☐ Corporation	☐ Corporation	☐ State
☐ Limited Liability Company	☐ Religious Affiliation	☐ City/County
☐ Partnership	☐ Other	☐ Hospital District
☐ Individual		
☐ Sole Proprietor		
☐ Other		

2. Application Fees

Indicate the type of application with an "X." **Applications will not be processed if all applicable fees are not included. All fees are nonrefundable.** Renewal and Change of Ownership applications must be received 60 days prior to the expiration of the license or the proposed effective date of the change to avoid a late fine. 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.

☐ Initial Licensure — Proposed Effective Date:

Was this entity previously licensed as a Multiphasic Health Testing Center in Florida? YES ☐ NO ☐

If YES, please provide the name of the MHTC (if different), the EIN # and the year the prior license expired or closed:

NAME:	EIN #	Year Expired/Closed:

☐ Renewal Licensure

☐ Change of Ownership — Proposed Effective Date:

- ☐ Licensee sale or transfer of ownership to a different individual/entity
- ☐ Transfer or assignment of 51% or more of the ownership, shares, membership or controlling interest of the licensee

☐ Change during Licensure Period – select all that apply: — Proposed Effective Date:

Fee Required

- ☐ Provider or Licensee Name
- ☐ Provider Address
- Services/Qualifications:
  - ☐ Category of Center
- ☐ Replacement License Certificate

No Fee Required

- ☐ Mailing Address Only
- ☐ Management Company
- ☐ Personnel Change
- Services/Qualifications:
  - ☐ Type of Test(s) Provided
- ☐ Hours of Operation
- ☐ Transfer or assignment of less than 51% of the ownership, shares, membership or controlling interest of the licensee

ACTION	FEE	TOTAL FEES
License Fee (Initial, Renewal and Change of Ownership):	$652.64	$
Biennial Assessment	$300.00	$
Change During Licensure Period/Replacement License Certificate	$25.00	$
TOTAL FEES INCLUDED WITH APPLICATION		**$**
Please make check or money order payable to the Agency for Health Care Administration (AHCA)		

3. Controlling Interests of Licensee

AUTHORITY:
Pursuant to section 408.806(1) (a) and (b), F.S., an application for licensure must include: the name, address and social security number (SSN) 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 1C 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. **Note:** This excludes Not-for-Profit and publicly held licensees. A written explanation will be required if the percentage of ownership interest indicated below does not equal 100%.

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

B. Board Members and Officers of Licensee as listed in section 1C above – Provide the information for each individual or entity (corporation, partnership, association) that serves as an officer or is on the board of directors. Do not include voluntary board members.

TITLE	FULL NAME	PERSONAL/PRIMARY ADDRESS	TELEPHONE NUMBER	EFFECTIVE DATE	END DATE
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					

4. Management Company Controlling Interests

Does a company other than the licensee manage the licensed provider?

If ☐ NO, skip to section 5 - Personnel
If ☐ YES, provide the following information:

Name of Management Company		EIN (No SSN)	Telephone Number / Fax	
Street Address		E-mail Address		
City	County		State	Zip
Mailing Address or ☐Same as above				
City			State	Zip
Contact Person	Contact E-mail		Contact Telephone Number	

DEFINITION:
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 Management Company: Provide the information for each individual or entity (corporation, partnership, association) with 5% or greater ownership interest in the management company. Attach additional sheets if necessary. **Note:** A written explanation will be required if the percentage of ownership interest indicated below does not equal 100%.

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

B. Board Members and Officers of Management Company: Provide the information for each individual or entity (corporation, partnership, association) that serves as an officer or is on the board of directors. Do not include voluntary board members.

TITLE	FULL NAME	PERSONAL/PRIMARY ADDRESS	TELEPHONE NUMBER	EFFECTIVE DATE	END DATE
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					

5. Personnel

A. Please provide information for the individual(s) who perform the following roles. Note: For the administrator and financial officer 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/.

INFORMATION	ADMINISTRATOR	FINANCIAL OFFICER / PERSON RESPONSIBLE FOR FINANCIAL OPERATIONS
Full Name		
Begin Date		
End Date		
Telephone Number		
Email Address		
Personal/Primary Address		

B. Medical Director – Pursuant to section 483.308(1), F.S., each center licensed under this part shall employ a medical director who is either a physician licensed under chapter 458 or an osteopathic physician licensed under chapter 459 and who, as part of her or his usual medical practice, interprets electrocardiograms. The medical director is responsible for assuring the proper clinical operation of the center.

INFORMATION	MEDICAL DIRECTOR/RESPONSIBLE FOR CLINICAL OPERATIONS
Full Name	
Effective Date	
End Date	
Telephone Number	
Email Address	
Personal/Primary Address	
Florida License Number	

C. Other Personnel - Provide the following information on **ALL** personnel employed by the center who are trained to perform and interpret dipstick urinalysis and fecal occult blood test as required in section 59A-6.002(15), F.A.C..

FULL NAME	LICENSURE/CERTIFICATION OR REGISTRATION TITLE	FLORIDA LICENSE NUMBER	JOB TITLE

6. Required Disclosure

The following disclosures are required:

A. Pursuant to section 408.809, F.S., the applicant shall submit to the Agency a description and explanation of any convictions of offenses prohibited by sections 435.04 and 408.809(4), F.S., for each controlling interest.

Has the applicant or any individual listed in Sections 3 and 4 of this application been convicted of any level 2 offense pursuant to section 408.809, Florida Statutes? YES ☐ NO ☐

If YES, provide the following information:

☐ The full legal name of the individual and the position held
☐ A description/explanation of any convictions

B. Pursuant to section 408.810(2), F.S., the applicant must provide a description and explanation of any exclusions, suspensions, or terminations from the Medicare, Medicaid, or federal Clinical Laboratory Improvement Amendment (CLIA) programs.

Has the applicant or any individual/entity listed in sections 3 and 4 of this application been excluded, suspended, terminated or involuntarily withdrawn from participation in Medicare or Medicaid in any state? YES ☐ NO ☐

If YES, enclose the following information:

☐ The full legal name of the individual (and the position held) or the entity
☐ A description/explanation of the exclusion, suspension, termination or involuntary withdrawal.

C. Pursuant to section 408.815(4), F.S., has the applicant or a controlling interest in the applicant, or any entity in which a controlling interest of the applicant was an owner or officer when the following actions occurred ever been:

Convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, chapter 893, 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396, Medicaid fraud, Medicare fraud, or insurance fraud, within the previous 15 years prior to the date of this application? YES ☐ NO ☐

Terminated for cause from the Medicare program or a state Medicaid program? YES ☐ NO ☐

If YES, has applicant been in good standing with the Medicare program or a state Medicaid program for the most recent five (5) years and the termination occurred at least twenty (20) years before the date of the application. YES ☐ NO ☐

7. Provider Fines and Financial Information

Pursuant to section 408.831(1)(a), F.S., the Agency may take action against the applicant, licensee, or a licensee which shares a common controlling interest with the applicant if they have failed to pay all outstanding fines, liens, or overpayments assessed by final order of the agency or final order of the Centers for Medicare and Medicaid Services (CMS), not subject to further appeal, unless a repayment plan is approved by the agency.

Are there any incidences of outstanding fines, liens or overpayments as described above? YES ☐ NO ☐

If YES, please complete the following for each incidence (attach additional sheets if necessary):

AHCA CASE NUMBER	CMS	ASSESSED AMOUNT	DATE OF RELATED INSPECTION, APPLICATION, OR OVERPAYMENT	PAYMENT DUE DATE	PENDING APPEAL OF FINAL ORDER	
					YES	NO
	☐				☐	☐
	☐				☐	☐
	☐				☐	☐

Please attach a copy of the approved repayment plan if applicable.

8. Category of Center

☐ Fixed ☐ Mobile

☐ Consumer ☐ Contract

9. Services

LIST ALL SERVICES OFFERED BY THE CENTER. (ATTACH ADDITIONAL SHEETS AS NEEDED.)	

LABORATORY SERVICES PROVIDED BY:		
Name	Street Address	CLIA ID
Name	Street Address	CLIA ID
EKG INTERPRETATION PROVIDED BY:		
Name	Personal/Primary Address	License #
Name	Personal/Primary Address	License #
OTHER FACILITIES OR INDIVIDUALS PROVIDING SERVICES FOR THE CENTER		
Name	Street Address	License #
Name	Street Address	License #

10. 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			☐

11. Supporting Documents

Applicants must include the following attachments as stated in Chapter 408, Part II and Chapter 483, Part II, F.S. and Chapters 59A-35, 59A-6, 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:
Proof of General Liability Insurance Coverage	Initial, Renewal and Change of Ownership application types
Health Care Licensing Application Addendum, AHCA Form 3110-1024	Initial, Renewal and Change of Ownership application types
Current biomedical waste permit or exemption from such permitting pursuant to section 381.0098, Florida Statutes	Initial, Renewals, and Change of Ownership application types
Medical Director Curriculum Vitae	Initial, Renewals, and Change of Ownership application types
Attestation of Compliance, AHCA Form 3170-4005	Initial, Renewals and Change of Ownership application types
A copy of CLIA Certificate of Waiver if performing clinical laboratory waived testing on site.	All application types
Evidence of certification by the American Board of Internal Medicine in Cardiology or the American Board of Radiology for the individual designated by the medical director of a contract multiphasic health testing center to read and interpret electrocardiograms and x-rays, if applicable.	Initial, Renewals,and Change of Ownership application types
Current registration under Chapter 404, Florida Statutes, for all x-ray equipment if applicable	Initial, Renewals, and Change of Ownership application types
Documentation of change of ownership transaction stating effective date and executed by all parties	Change of Owner application type
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 application types

12. Attestation

I, ________________________________, under penalty of perjury, 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.

______________________________________ ______________________ ___________

Signature of Licensee or Authorized Representative Title Date

NOTE: If you are a Medicaid provider, you may have 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
LABORATORY AND IN-HOME SERVICES UNIT
2727 MAHAN DR MS 32
TALLAHASSEE FL 32308-5407

Questions? Review the information available at:
http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Laboratory_Licensure/clinical.shtml.
If the director or administrator has questions after review, contact the Laboratory and In-Home Services Unit at 850-412-4500 or E-mail: labstaff@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
- No staples, paperclips, binder clips, folders, or notebooks
- Please **do not bind any** of the documents submitted to the Agency