AHCA USE ONLY:

File #: _____
Application #: _____
Check #: _____
Check Amt: _____
Batch #: _____

Health Care Licensing Application
Health Care Clinic

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: https://ahca.myflorida.com/health-care-policy-and-oversight/online-licensure-information/online-licensing-system

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 The application will be withdrawn from review if all the required documents and fees are not included with your application or received within 21 days of an omission notice.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.** Please fill in all blanks or mark N/A if not applicable.

Under the authority of Chapters 408, Part II and 400, Part X, Florida Statutes (F.S.), and Chapters 59A-35 and 59A-33, Florida Administrative Code (F.A.C.), an application is hereby made to operate a health care clinic as indicated below:

1. Provider / Licensee Information

A. PROVIDER INFORMATION – Please complete the following for the health care clinic name and location.
Provider name, address and telephone number will be listed on https://quality.healthfinder.fl.gov/index.html

License # (if applicable)	National Provider Identifier (NPI) (if applicable)	Medicare # (CMS CCN) (if applicable)	Florida Medicaid # (if applicable)

Name of Health Care Clinic (if operated under a fictitious name, enter as it filed with the Florida Division of Corporations)

Street Address

City	County	State	Zip

Telephone Number	Fax Number

E-mail Address	**Note**: By providing your e-mail address, you agree to accept e-mail correspondence from the Agency

Provider Website

Mailing Address or ☐ Same as above

City	County	State	Zip

Telephone Number	E-mail Address

B. CONTACT PERSON – Please complete the following for the contact person for this application.

Contact Person for this application	Contact Telephone Number

Contact e-mail address or ☐ Do not have e-mail	**Note**: By providing your e-mail address, you agree to accept e-mail correspondence from the Agency.

C. **LICENSEE INFORMATION** – Pease complete the following for the **entity** seeking to operate the health care clinic. Enter the entity name as it is filed with the Florida Division of Corporations.		
Licensee Name (this is the entity that owns the health care clinic)		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 Type and Fees

Indicate the type of application with an "X." **Applications will not be processed if all applicable fees are not included. Pursuant to section 408.805(4), F.S., 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 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.

A. TYPE OF APPLICATION

☐ Initial licensure **Proposed Effective Date**: _____

Was this entity previously licensed as a Health Care Clinic? YES ☐ NO ☐

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

NAME:	EIN #	Date 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 ownership, shares, membership, or controlling interest of the licensee

☐ Change During Licensure Period - check all that apply: **Proposed Effective Date of each**: _____

Fee Required

- ☐ Provider Name
- ☐ Provider Address

Qualifications/Services

- ☐ Clinic type (fixed, mobile or portable; MRI only)

No Fee Required

- ☐ Personnel
- ☐ Medical/Clinic Director
- ☐ Hours of Operation
- ☐ Management Company
- ☐ Management Company Controlling Interest
- ☐ Clinic designations/services (refer to Section 9 below)
- ☐ Transfer or assignment of less than 51% ownership, shares, membership, or controlling interest of the licensee

B. LICENSURE FEES

ACTION	FEE	TOTAL FEES
License Fee (Initial, Renewal and Change of Ownership):	$2,000.00	$
Biennial Assessment Fee	$300.00	$
Change During Licensure Period only	$25.00	$
Other: _____		$
TOTAL FEES INCLUDED WITH APPLICATION		**$**

Make check or money order payable to the Agency for Health Care Administration (AHCA)

3. Controlling Interests of Licensee

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: Pursuant to section 408.809, F.S., any controlling interest are required to have an Agency screening through the Care Provider Background Screening Clearinghouse. If background screening has been 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., the Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008 may be submitted in lieu of Agency screening. To verify who is to be screened, visit Background Screening (myflorida.com).

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.

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.

If any controlling interest qualifies as a nonimmigrant alien according to 8 U.S.C. §1101 the Nonimmigrant Alien box must be selected next to their name.

FULL NAME of INDIVIDUAL or ENTITY	PRIMARY ADDRESS	TELEPHONE NUMBER	EIN (No SSN)	% OWNERSHIP	EFFECTIVE DATE	END DATE	NON-IMMIGRANT ALIEN
							☐
							☐
							☐
							☐
							☐

B. Board Members and Officers of Licensee as listed in Section 1C above – Provide the information for each individual that serves as an officer, manager, 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					

C. Indirect Ownership of Licensee as listed in section 1C above – Pursuant to s. 400.991(4), F.S., an "applicant" for licensure as a health care clinic includes any individual owning or controlling indirectly, 5 percent or more of an interest in the clinic. These individuals are required to have an Agency screening through the Care Provider Background Screening Clearinghouse. Provide the information for each individual with 5% or greater indirect ownership in the clinic and attach an organizational chart showing each individual's relationship to the licensee. (Include EINs and percentage ownership for each listed entity.) Social security numbers for each individual must be entered on the Health Care Licensing Application Addendum, AHCA Form 3110-1024.

FULL NAME	PERSONAL/PRIMARY ADDRESS	TELEPHONE NUMBER	EFFECTIVE DATE	END DATE

4. Management Company Control

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

If ☐ NO, **skip to Section 6 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	

5. Management Company Controlling Interest

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: Pursuant to section 408.809, F.S., any controlling interest are required to have an Agency screening through the Care Provider Background Screening Clearinghouse. If background screening has been 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., the Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008 may be submitted in lieu of Agency screening. To verify who is to be screened, visit Background Screening (myflorida.com).

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.

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.

If any controlling interest qualifies as a nonimmigrant alien according to 8 U.S.C. §1101 the Nonimmigrant Alien box must be selected next to their name.

FULL NAME of INDIVIDUAL or ENTITY	PRIMARY ADDRESS	TELEPHONE NUMBER	EIN (No SSN)	% OWNERSHIP	EFFECTIVE DATE	END DATE	NON-IMMIGRANT ALIEN
							☐
							☐
							☐
							☐

B. Board Members and Officers of Management Company: Provide the information for each individual that serves as an officer, manager, 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					

6. Personnel

A. Please provide information for the individual(s) who perform the following roles. Note: the administrator and financial officer are required pursuant to section 408.809, F.S. to have an Agency screening through the Care Provider Background Screening Clearinghouse or submit 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 Background Screening (myflorida.com).

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.

INFORMATION	ADMINISTRATOR/MANAGING EMPLOYEE	FINANCIAL OFFICER / PERSON RESPONSIBLE FOR FINANCIAL OPERATIONS
Full Name		
Effective Date		
End Date		
Telephone Number		
E-mail Address		
Personal/Primary Address		

B. **Medical or Clinic Director -** Pursuant to section 400.991(2), F.S., an application for licensure must include the name, residence and business addresses, phone number, and license number of the medical or clinic director. **Note:** A licensed health care clinic may not operate or be maintained without the day-to-day supervision of a single medical/clinic director as defined in section 400.9905(5), F.S.

INFORMATION	☐ **MEDICAL DIRECTOR OR** ☐ **CLINIC DIRECTOR**	
Full Name		**Florida Dept of Health License Number**
Effective Date		**End Date**
E-mail Address		**Telephone Number**
Hours & Days at Clinic:		
Personal Address		
Business Address		
Status	☐ Employee ☐ Contracted	
Provides health care services for the clinic		☐ Yes ☐ No
Serves as Medical/Clinic Director at other licensed health care clinics? If YES, provide the following information for each below:		☐ Yes ☐ No
Clinic Name:		**License Number**
Street Address:		
Number of employees:		
Hours & Days at Clinic:		
Clinic Name:		**License Number**
Street Address:		
Number of employees:		
Hours & Days at Clinic:		
Clinic Name:		**License Number**
Street Address:		
Number of employees:		
Hours & Days at Clinic:		
Clinic Name:		**License Number**
Street Address:		
Number of employees:		
Hours & Days at Clinic:		
Clinic Name:		**License Number**
Street Address:		
Number of employees:		
Hours & Days at Clinic:		

7. 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, F.S.? YES ☐ NO ☐

If YES, enclose the following information:

- ☐ The full legal name of the individual and position held
- ☐ Description and explanation of any convictions

B. Pursuant to sections 408.810(2) and 400.991(4), 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 ☐

D. In the past five (5) years, has the applicant or any controlling interest owned any entity that provides health or residential care in Florida or any other state? YES ☐ NO ☐

If YES, has any entity the applicant or controlling interest owned been closed due to financial inability to operate; had a receiver appointed or a license denied, suspended, or revoked; was subject to a moratorium; or had an injunctive proceeding initiated against it? YES ☐ NO ☐

E. Nonimmigrant Aliens - If the applicant or any controlling interests are nonimmigrant aliens according to 8 U.S.C. §1101, then a surety bond of at least $500,000 must be filed, payable to AHCA that guarantees the health care clinic will act in full conformity with all legal requirements for operation pursuant to section 408.8065(2), F.S..

Are there any nonimmigrant aliens listed as a licensee or controlling interest in this application? YES ☐ NO ☐

If YES, enclose documentation of the surety bond with this application.

8. 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.

9. Magnetic Resonance Imaging (MRI) Services

Does the clinic provide or intend to provide magnetic resonance imaging services? YES ☐ NO ☐

A clinic that provides magnetic resonance imaging services must provide evidence of accreditation by a nationally recognized accrediting organization that is approved by the Centers for Medicare and Medicaid Services (CMS) for magnetic resonance imaging and advanced diagnostic imaging services. Refer to section 400.9935(7)(a), F.S..

Check the accrediting organization for the health care clinic named in this application and attach proof of accreditation:

☐ American College of Radiology (ACR) ☐ InterSocietal Accreditation Commission (IAC) ☐ Joint Commission (JC) ☐ RadSite

ACCREDITATION ID	EFFECTIVE DATE	EXPIRATION DATE

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. Clinic Type, Designations and Professional Health Care Services

A. CLINIC TYPE (check only one):

- ☐ Services are provided at the street address identified in section 1 (fixed location).
- ☐ Mobile Clinic – a movable or detached self-contained health care unit, such as a vehicle or trailer, within or from which direct health care services are provided [sections 400.9905(6) & 400.991(1) F.S.]
- ☐ Portable Equipment Provider – a single administrative office from which treatment, services and/or diagnostic testing is provided to individuals in multiple locations [sections 400.9905(7) & 400.991(1) F.S.]

B. REIMBURSEMENTS - Receives or intends to receive reimbursement from (check all that apply):

- ☐ Medicare and/or Medicaid – please enter provider numbers in Section 1A, if applicable, or indicate “pending”
- ☐ Commercial insurance plans (HMO, PPO, EPO, etc.)
- ☐ Automobile Personal Injury Protection (PIP) Insurance. Refer to section 627.736(5)(h), F.S.
- ☐ Other payor source not listed above
- ☐ Individuals pay for services by cash, check, credit card or debit card
- ☐ None apply

C. DESIGNATIONS (check all that apply):

- ☐ Urgent Care Center – Refer to definition at section 395.002(29), F.S.
- ☐ Pain Management Clinic – Refer to sections 458.3265 and 459.0137, F.S.
  For renewal and change applications, list the pain management registration number issued by the Department of Health: _____
- ☐ Office Surgery Center – Refer to sections 458.328 and 459.0138, F.S.
  For renewal and change applications, list the office surgery registration number issued by the Department of Health: _____
- ☐ None apply

D. SERVICES – please indicate the total number of **licensed** staff persons employed by and/or contracted with the clinic to provide services under each of the health care professional disciplines/occupations listed below (include all that apply):

Number of Staff	Health Care Professions		Number of Staff	Health Care Professions
	Acupuncture (Ch. 457)			Naturopathy (Ch. 462)
	Advanced Nursing Practice (s. 464.012)			Nursing Practice– RN, LPN, CNA (Ch. 464)
	Athletic Training (Ch. 468, Part XIII)			Occupational Therapy (Ch. 468, Part III)

	Audiology (Ch. 468, Part I)			Optical Dispensing (Ch. 484, Part I)
	Autonomous Practice – APRN (s. 464.0123)			Optometry (Ch. 463)
	Behavior Analysis (BACB certification)			Orthotics, Prosthetics, Pedorthics (Ch. 468, Part XIV)
	Chiropractic Medicine (Ch. 460)			Osteopathic Medicine – DO & PA (Ch. 459
	Clinical, Counseling, Psychotherapy Services (Ch. 491)			Pharmacy (Ch. 465)
	Dentistry (Ch. 466)			Physical Therapy (Ch. 486)
	Diagnostic Imaging			Podiatric Medicine (Ch. 461)
	Dietetics & Nutrition Practice (Ch. 468, Part X)			Psychological Services (Ch. 490)
	Electrolysis (Ch. 478)			Radiology (Ch. 468, Part IV)
	Health Testing/Laboratory Services (Ch. 483)			Renal Dialysis
	Hearing Aid Dispensing (Ch. 484, Part II)			Respiratory Therapy (Ch. 468, Part V)
	Massage Practice (Ch. 480)			Sleep Study
	Medical Practice – MD & PA (Ch. 458)			Speech-Language Pathology (Ch. 468, Part I)
	Midwifery (Ch. 467)			Other:

12. Supporting Documents

Applicants must include the following attachments as stated in Chapters 408, Part II and 400, Part X, F.S. and Chapters 59A-35 and 59A-33, 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
Health Care Licensing Application Addendum, AHCA Form 3110-1024	Initial, Renewal, Change of Ownership, and Personnel Changes application types
Organizational chart showing any individual's indirect ownership of the clinic, if applicable (see Section 3C of the application)	Initial, Renewal, Change of Ownership, and Change of Controlling Interest application types
Proof of Financial Ability to Operate (AHCA Form 3100-0009)	Initial and Change of Ownership application types
Surety Bond, if required per section 408.8065, F.S.	Initial, Renewal, Change of Ownership, and Change of Controlling Interest application types
Medical/Clinic Director Attestation, AHCA Form 3110-1028	Initial, Renewal, Change of Ownership, and Change of Medical/Clinic Director application types
Medical/Clinic Director's contract or agreement with the clinic including the effective date of service	Initial, Change of Ownership, and Change of Medical/Clinic Director application types
Copy of the Medical/Clinic Director's Florida health care practitioner's license and any other specialty certifications necessary for supervision of services provided	Initial, Change of Ownership, and Change of Medical/Clinic Director application types
Documentation of change of ownership transaction stating effective date and executed by all parties	Change of Ownership and Change of Controlling Interest application types
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
Proof of new or continued MRI accreditation, or letter of intent to achieve MRI accreditation within 12 months (MRI providers only)	Initial, Renewal, Change of Ownership, adding Clinic Services application types
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

13. Attestation

I, _____, 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.

(7) Pursuant to sections 408.810(14) and 408.051(3), FS, the licensee ensures that all patient information stored in an offsite physical or virtual environment, including through a third-party or subcontracted computing facility or an entity providing cloud computing services, is physically maintained in the continental United States or its territories or Canada.

(8) Pursuant to section 408.810(15), FS, the licensee ensures that controlling interests of the licensee do not hold, either directly or indirectly, regardless of ownership structure, an interest in an entity that has a business relationship with a foreign country of concern or that is subject to section 287.135, FS.

Signature of Licensee or Authorized Representative	Title	Date

INSURANCE FRAUD NOTICE.—A person who knowingly submits a false, misleading, or fraudulent application or other document when applying for licensure as a health care clinic, seeking an exemption from licensure as a health care clinic, or demonstrating compliance with Part X of Chapter 400, Florida Statutes, with the intent to use the license, exemption from licensure, or demonstration of compliance to provide services or seek reimbursement under the Florida Motor Vehicle No-Fault Law, commits a fraudulent insurance act, as defined in section 626.989, Florida Statutes. A person who presents a claim for personal injury protection benefits knowing that the payee knowingly submitted such health care clinic application or document, commits insurance fraud, as defined in section 817.234, Florida Statutes.

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 AND ALL REQUIRED DOCUMENTS TO:

AGENCY FOR HEALTH CARE ADMINISTRATION
HOSPITAL AND OUTPATIENT SERVICES UNIT
2727 MAHAN DR., MS 53
TALLAHASSEE FL 32308-5407

Questions? Visit the Agency's website at https://ahca.myflorida.com/ or contact the Hospital & 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
- No staples, paperclips, binder clips, folders, or notebooks
- Please ***do not bind any*** of the documents submitted to the Agency