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

Application for Certificate of Exemption from Licensure as a 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 exemption certificate. The application will be withdrawn from review if all the required documents and fees are not included with your application or received within 21 days of an omission notice.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 Exemption Period applications: Supporting documentation, responses to omissions and payments may be submitted using the online licensing 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 Chapter 400, Part X, Florida Statutes (F.S.), and Chapters 59A-33 and 59A-35, Florida Administrative Code (F.A.C.), an application is hereby made to obtain a certificate of exemption from the health care clinic licensure requirements, as indicated below:

1. Provider / Owner Information

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

Exemption Number (if applicable)	National Provider Identifier (NPI) (if applicable)	Medicare Number (CMS CCN) (if applicable)	Florida Medicaid Number (if applicable)

Name of the Exempt Clinic (if operated under a fictitious name, enter as it is filed with 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	Email Address		

B. OWNER INFORMATION – Pease complete the following for the **entity** seeking the exemption from clinic licensure.		
Owner Name (This is the legal name of the **owning entity** of the exempt clinic as filed with the Florida Division of Corporations)		Federal Employer Identification Number (EIN)
Mailing Address or ☐ Same as above		
City	State	Zip
Telephone Number	Fax Number	Email Address

Description of Owner (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		

C. 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.

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. Fees are nonrefundable.**

A. TYPE OF APPLICATION

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

Was this entity previously licensed as a health care clinic? YES ☐ NO ☐

Did this entity previously hold an exemption from licensure as a health care clinic certificate? YES ☐ NO ☐

If YES to either above, please provide the name of the clinic (if different), the EIN # and the date the prior license or exemption certificate expired or clinic closed:

NAME:	EIN #	Date Expired/Closed:

☐ Renewal

☐ Change During Exemption Period: (check all that apply) **Proposed Effective Date**: _____

Fee Required	No Fee Required
☐ Name change of the clinic	☐ Change to clinic type
☐ Address change of the clinic	☐ Change to service providers

B. APPLICATION FEES

ACTION	FEE	TOTAL FEES
Certificate of Exemption Fee (Initial and Renewal)	$100.00	$
Change During Exemption Period (do not include this fee with initial and renewal applications)	$25.00	$
TOTAL FEES INCLUDED WITH APPLICATION		**$**
Make check or money order payable to the Agency for Health Care Administration (AHCA)		

3. Clinic Services

A. REIMBURSEMENTS: Receives or intends to receive reimbursement from [check all that apply and attach a schedule of charges as described in section 400.9935(6), F.S.]:

- ☐ 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. for the list of entities permitted to receive reimbursement under the Florida Motor Vehicle No-Fault Law (PIP) without health care clinic licensure and mark the appropriate box below.
  - ☐ An entity wholly owned by a physician licensed under chapter 458 or chapter 459, or by the physician and the spouse, parent, child, or sibling of the physician.
  - ☐ An entity wholly owned by a dentist licensed under chapter 466, or by the dentist and the spouse, parent, child, or sibling of the dentist.
  - ☐ An entity wholly owned by a chiropractic physician licensed under chapter 460, or by the chiropractic physician and the spouse, parent, child, or sibling of the chiropractic physician.
  - ☐ A hospital or ambulatory surgical center licensed under chapter 395.
  - ☐ An entity that wholly owns or is wholly owned, directly or indirectly, by a hospital or hospitals licensed under chapter 395.
  - ☐ An entity that is a clinical facility affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows.
  - ☐ An entity that is certified under 42 C.F.R. part 485, subpart H.
  - ☐ An entity that is owned by a publicly traded corporation, either directly or indirectly through its subsidiaries, that has $250 million or more in total annual sales of health care services provided by licensed health care practitioners if one or more of the persons responsible for the operations of the entity are health care practitioners who are licensed in this state and who are responsible for supervising the business activities of the entity and the entity's compliance with state law for purposes of this section.
- ☐ Individuals pay for services by cash, check, credit card, or debit card
- ☐ Other payor source not listed above: _____
- ☐ None apply

B. DESIGNATIONS (check all that apply)**:**

- ☐ Urgent Care Center – Refer to definition in section 395.002, 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

C. SERVICE PROVIDERS EMPLOYED BY/CONTRACTING WITH THE CLINIC (check all that apply):

☐	Acupuncturist (Ch. 457)		☐	Midwife (Ch. 467)
☐	Advanced Practice Registered Nurse (section 464.012)		☐	Naturopathic Physician (Ch. 462)
☐	Athletic Trainer (Ch. 468, Part XIII)		☐	Occupational Therapist (Ch. 468, Part III)
☐	Audiologist (Ch. 468, Part I)		☐	Optician (Ch. 484, Part I)
☐	Autonomous APRN (section 464.0123)		☐	Optometrist (Ch. 463)
☐	Behavior Analyst (BACB certified)		☐	Orthotist/Prosthetist/Pedorthist (Ch. 468, Part XIV)
☐	Certified Nursing Assistant (Ch. 464, Part II)		☐	Pharmacist (Ch. 465)
☐	Chiropractic Physician (Ch. 460)		☐	Physical Therapist (Ch. 486)
☐	Clinical Laboratory Personnel (Ch. 483, Part II)		☐	Physician (M.D. - Ch. 458, D.O. – Ch. 459)
☐	Clinical Social Worker (Ch. 491)		☐	Physician Assistant (s. 458.347, Ch. 459.022)
☐	Dentist (Ch. 466)		☐	Podiatric Physician (Ch. 461)
☐	Dietitian/Nutritionist/Nutrition Counselor (Ch. 468, Part X)		☐	Psychologist/School Psychologist (Ch. 490)
☐	Electrologist (Ch. 478)		☐	Radiological Personnel (Ch. 468, Part IV)
☐	Hearing Aid Specialist (Ch. 484, Part II)		☐	Registered Nurse (Ch. 464, Part I)
☐	Licensed Practical Nurse (Ch. 464, Part I)		☐	Respiratory Therapist (Ch. 468. Part V)
☐	Marriage & Family Therapist (Ch. 491)		☐	Speech-language Pathologist (Ch. 468, Part I)
☐	Massage Therapist (Ch. 480)		☐	Other:
☐	Mental Health Counselor (Ch. 491)		☐	Other:

4. Qualifications for Exemption from Clinic Licensure

Select the exemption type the applicant entity is seeking for this exempt clinic. Mark and complete only **one** section. **NOTE: Supporting documentation, as specified in Section 6, is required and must be submitted with the application**. Lack of documentation will deem your application incomplete.

A. ☐ Entities licensed or registered by the state as defined in section 400.9905(4)(a), F.S.

☐ License or Registration Type**:** _____

B. ☐ Entities that own, directly or indirectly, entities that are licensed or registered by the state as defined in section 400.9905(4)(b), F.S.

☐ License or Registration Type: _____

C. ☐ Entities that are owned, directly or indirectly, by an entity licensed or registered by the state as defined in section 400.9905(4)(c), F.S.

☐ License or Registration Type: _____

D. ☐ Entities that are under common ownership, directly or indirectly, with an entity licensed or registered by the state as defined in section 400.9905(4)(d), F.S.

☐ License or Registration Type: _____

E. ☐ An entity that is exempt from federal taxation under 26 U.S.C. sections 501(c)(3) or (4), an employee stock ownership plan under 26 U.S.C. section 409 that has a board of trustees at least two-thirds of which are Florida-licensed health care practitioners and provides only physical therapy services under physician orders, any community college or university clinic, and any entity owned or operated by the federal or state government, including agencies, subdivisions, or municipalities thereof. (health departments, clinics and federal health care facilities). [section 400.9905(4)(e), F.S.]

☐ Indicate the specific exemption claimed as described above: _____

F. ☐ A sole proprietorship, group practice, partnership, or corporation that provides health care services by physicians covered by section 627.419, F.S., that is directly supervised by one or more of such physicians, and that is wholly owned by one or more of those physicians or by a physician and the spouse, parent, child, or sibling of that physician [section 400.9905(4)(f), F.S.]

☐ Name of supervising licensed health care practitioner (covered by section 627.419, F.S): _____

☐ Complete Section 5 - Licensed Florida Health Care Practitioner(s) Ownership

G. ☐ A sole proprietorship, group practice, partnership, or corporation that provides health care services by licensed health care practitioners under chapter 457, chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 466, chapter 467, chapter 480, chapter 484, chapter 486, chapter 490, chapter 491, or part I, part III, part X, part XIII, or part XIV of chapter 468, or s. 464.012, and that is wholly owned by one or more licensed health care practitioners, or the licensed health care practitioners set forth in this paragraph and the spouse, parent, child, or sibling of a licensed health care practitioner if one of the owners who is a licensed health care practitioner is supervising the business activities and is legally responsible for the entity's compliance with all federal and state laws. However, a health care practitioner may not supervise services beyond the scope of the practitioner's license, except that, for the purposes of this part, a clinic owned by a licensee in section 456.053(3)(b) which provides only services authorized pursuant to section 456.053(3)(b) may be supervised by a licensee specified in section 456.053(3)(b). [section 400.9905(4)(g), F.S.]

☐ Name of supervising licensed health care practitioner-owner: _____

☐ Complete Section 5 - Licensed Florida Health Care Practitioner(s) Ownership

H. ☐ Clinical facilities affiliated with an accredited medical school as defined in section 400.9905(4)(h), F.S.

I. ☐ Entities that provide only oncology or radiation therapy services by physicians licensed under chapter 458 or chapter 459 or entities that provide oncology or radiation therapy services by physicians licensed under chapter 458 or chapter 459 which are owned by a corporation whose shares are publicly traded on a recognized stock exchange. [section 400.9905(4)(i), F.S.]

J. ☐ Clinical facilities affiliated with a college of chiropractic accredited by the Council on Chiropractic Education as defined in section 400.9905(4)(j), F.S.

K. ☐ Entities that provide licensed practitioners to staff emergency departments or to deliver anesthesia services as defined in section 400.9905(4)(k), F.S.

L. ☐ Orthotic, prosthetic, pediatric cardiology, or perinatology clinical facilities or anesthesia clinical facilities that are not otherwise exempt under paragraph (a) or paragraph (k) and that are a publicly traded corporation or are wholly owned, directly or indirectly, by a publicly traded corporation. As used in this paragraph, a publicly traded corporation is a corporation that issues securities traded on an exchange registered with the United States Securities and Exchange Commission as a national securities exchange. [section 400.9905(4)(l), F.S.]

☐ Indicate the clinical facility type as described above: _____

M. ☐ Entities that are owned by a corporation that has $250 million or more in total annual sales of health care services provided by licensed health care practitioners and supervised by Florida health care practitioner as defined in section 400.9905(4)(m), F.S.

☐ Name of supervising licensed health care practitioner: _____

☐ Supervising health care practitioner Florida License Number: _____

N. ☐ Entities that employ 50 or more licensed health care practitioners licensed under chapter 458 or chapter 459 where the billing for medical services is under a single tax identification number as defined in section 400.9905(4)(n), F.S. The entity and the health care clinics owned or operated by the entity has not received payment for health care services under personal injury protection insurance coverage for the preceding year.

O. ☐ Entities that are, directly or indirectly, under the common ownership of or that are subject to common control by a mutual insurance holding company, as defined in section. 628.703, F.S., with an entity issued a certificate of authority under chapter 624 or chapter 641 which has $1 billion or more in total annual sales in this state. [section 400.9905(4)(o), F.S.]

P. ☐ Entities that are owned by an entity that is a behavioral health care service provider in at least five other states; that, together with its affiliates, have $90 million or more in total annual revenues associated with the provision of behavioral health care services; and wherein one or more of the persons responsible for the operations of the entity is a health care practitioner who is licensed in this state, who is responsible for supervising the business activities of the entity, and who is responsible for the entity's compliance with state law for purposes of this part. [section 400.9905(4)(p), F.S.]

☐ Name of supervising licensed health care practitioner: _____

☐ Supervising health care practitioner Florida License Number: _____

Q. ☐ Entities that are Medicaid providers. [section 400.9905(4)(q), F.S.]

5. Licensed Florida Health Care Practitioner(s) Ownership

To be completed by entities seeking an exemption under sections 400.9905(4)(f) or (g), F.S**. only.** Attach additional sheets if needed.

A. Practitioner Ownership

FULL NAME	PERSONAL/PRIMARY ADDRESS	LICENSE NUMBER	% OWNERSHIP INTEREST

B. Family Member Ownership (If applicable)

FULL NAME	PERSONAL/PRIMARY ADDRESS	RELATIONSHIP TO PRACTITIONER	% OWNERSHIP INTEREST

6. Supporting Documentation

Note: Required documents listed below are dependent upon the type of exemption the applicant is seeking.

DOCUMENTS TO BE PROVIDED:	QUALIFICATION TYPE:
• **Documentation of schedule of charges of the medical services offered to patients per section 400.9935(6), F.S.**	**All exemption types**
• Copy of the qualifying facility license, registration, or certification	Section 400.9905(4)(a), F.S.
• Copy of the qualifying facility license, registration, or certification • Ownership documents or a diagram or organizational chart showing the parent, subsidiary or common ownership which qualifies the entity for the exemption	Sections 400.9905(4)(b)-(d), F.S.
<u>As Applicable for the specific exemption claimed</u>: • Copy of the Internal Revenue Service. letter granting the tax exemption • A letter describing the ownership structure, listing the Florida practitioner names, their Florida license, and indicating if the facility provides physical therapy services under physician orders • A letter, on official letterhead and signed by an authorized representative of the university or community college • A letter on official letterhead and signed by an authorized representative of a federal or state government office confirming that the entity is applying for an exemption	Section 400.9905(4)(e), F.S.

As Applicable: • Copy of the health care practitioner license(s) from the Florida Department of Health and any other specialty certifications necessary for supervision of the services provided • Documentation demonstrating the relationship between the licensed practitioner owner and the family member(s) owner [i.e. copy of birth certificate, marriage certificate]	Sections 400.9905(4)(f)-(g), F.S.
• A letter, on official letterhead and signed by an authorized representative of the medical school, confirming that training for medical students, residents or fellows is provided at this facility	Section 400.9905(4)(h), F.S.
As Applicable for the specific exemption claimed: • A letter, on official letterhead and signed by an authorized representative of the facility attesting that the facility provides only oncology or radiation therapy services by physicians licensed under chapter 458 or chapter 459, F.S. • Documentation demonstrating that the entity is owned by a corporation whose shares are publicly traded on a recognized stock exchange	Section 400.9905(4)(i), F.S.
• A letter, on official letterhead and signed by an authorized representative of the college of chiropractic medicine attesting that the facility is affiliated with the college and confirming that training is provided for chiropractic students • Documentation demonstrating that the college is accredited by the Council on Chiropractic Education	Section 400.9905(4)(j), F.S.
• Provide a list of locations, licensed under chapter 395, F.S., where the entity provides licensed practitioners to staff emergency departments or to deliver anesthesia services • Documentation demonstrating that the entity derives at least 90 percent of their gross annual revenues from the provision of such services	Section 400.9905(4)(k), F.S.
• Documentation demonstrating that the entity is a publicly traded corporation or is wholly owned, directly or indirectly, by a publicly traded corporation	Section 400.9905(4)(l), F.S.
• Documentation showing that the corporation has $250 million or more in total annual sales of health care services provided by licensed health care practitioners • A copy of the contract or agreement between the entity and the supervising health care practitioner accepting responsibility for supervising the business activities of the entity and for the entity's compliance with state law for purposes of this part • A copy of health care practitioner supervisor's license from the Florida Department of Health	Section 400.9905(4)(m), F.S.
• A complete list of the names and contact information of all officers and directors of the corporation • The name, residence address, business address, and medical license number of each health care practitioner licensed under chapter 458 or 459, F.S. employed by the entity • A listing of health care services to be provided at the clinics owned or operated by the entity • A certified statement prepared by an independent certified public accountant, which states that the entity and the clinics owned or operated by the entity have not received payment for health care services under personal injury protection insurance coverage for the preceding year	Section 400.9905(4)(n), F.S.
• Name and FEIN of the related mutual insurance holding company • Copy of the certificate of authority issued under chapter 624 or 641, F.S. to the related entity • Documentation showing the entity, which was issued the certificate of authority, has $1 billion or more in total annual sales in this state • Ownership documents or a diagram or organizational chart demonstrating the common ownership which qualifies the applicant entity for the exemption	Section 400.9905(4)(o), F.S.
• Documentation demonstrating the parent entity provides behavioral health care services in at least five other states and, together with its affiliates, has $90 million or more in total annual revenues associated with the provision of behavioral health care services • Ownership documents or a diagram or organizational chart showing the direct or indirect ownership which qualifies the entity for the exemption	Section 400.9905(4)(p), F.S.
• Copy of the entity's original Medicaid enrollment letter (the applicant must be a currently active Medicaid provider and the name, street address and FEIN provided on the application must match the current information in the Medicaid data base, FLMMIS)	Section 400.9905(4)(q), F.S.

7. 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 400.9935(4)(e), Florida Statutes, I acknowledge that false representation of a material fact in the application or omission of any material fact from the application by a controlling interest may be used by the Agency for denying the application and revoking a certificate of exemption.

_____	_____	_____
Signature of Owner 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 E-mail: 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 certificate of exemption 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