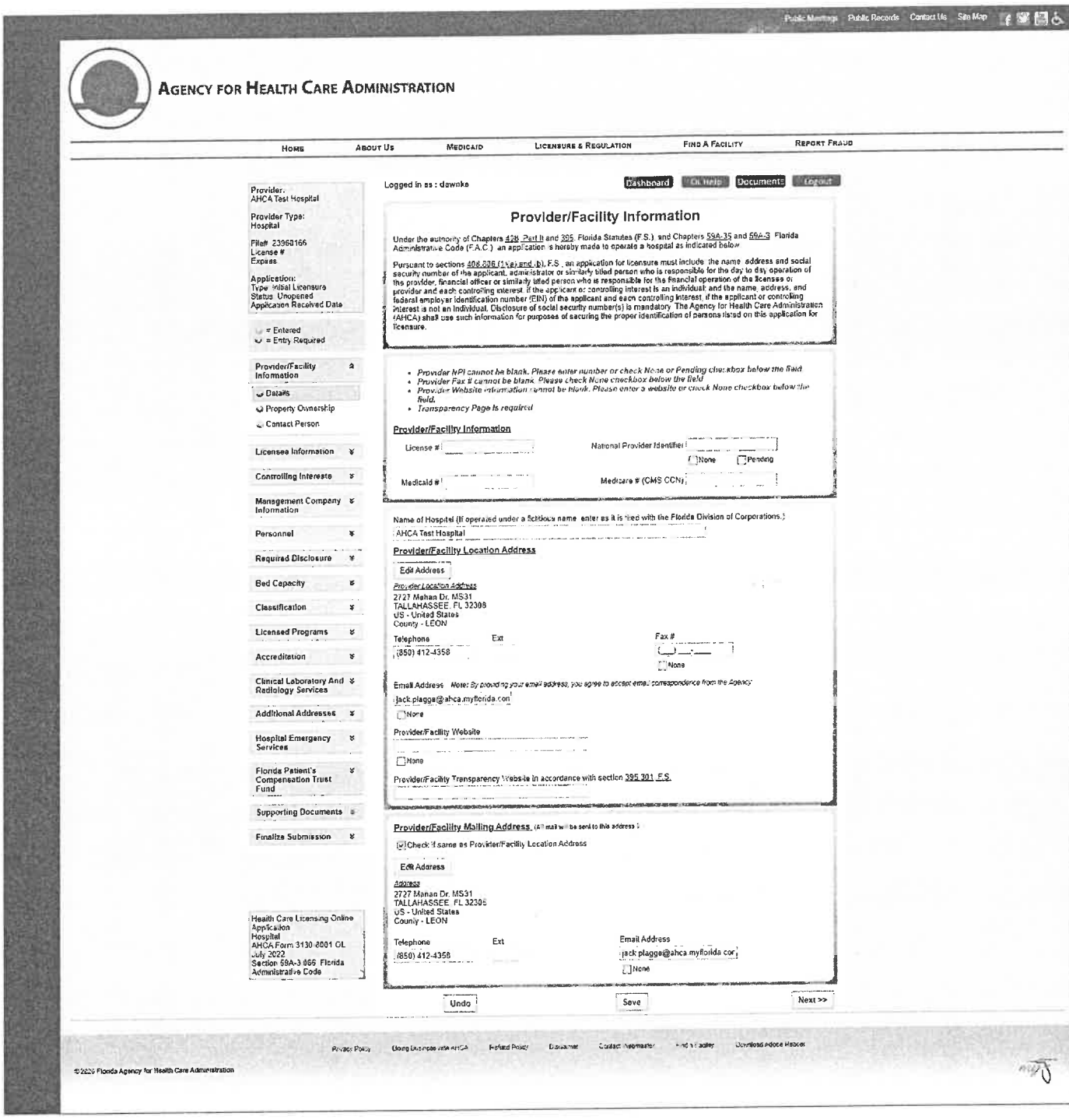
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Provider Type:
Hospital
File# 23968166
License #
Expass
Application:
Type Initial Licensure
Status Unopened
Application Received Date
= Entered
= Entry Required
Provider/Facility Information
Details
Property Ownership
Contact Person
Licensee Information
Controlling Interests
Management Company Information
Personnel
Required Disclosure
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Licensed Programs
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Provider/Facility Information
Under the authority of Chapters 408, Part II and 395, Florida Statutes (F.S.) and Chapters 59A-35 and 59A-3, Florida Administrative Code (F.A.C.), an application is hereby made to operate a hospital as indicated below.
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, administrator or similarly titled person who is responsible for the day to day operation of the provider, financial officer or similarly titled person who is responsible for the financial operation of the licensee or provider and each controlling interest. If the applicant or controlling interest is an individual and the name, address, and federal employer identification number (FEIN) 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 (AHCA) shall use such information for purposes of securing the proper identification of persons listed on this application for licensure.
Provider NPI cannot be blank. Please enter number or check None or Pending checkbox below the field.
Provider Fax # cannot be blank. Please check None checkbox below the field.
Provider Website information cannot be blank. Please enter a website or check None checkbox below the field.
Transparency Page is required.
Provider/Facility Information
License #
National Provider Identifier
None
Pending
Medicaid #
Medicare # (CMS CCN)
Name of Hospital (If operated under a fictitious name, enter as it is filed with the Florida Division of Corporations.)
AHCA Test Hospital
Provider/Facility Location Address
Edit Address
Provider Location Address
2727 Mahan Dr. MS31
TALLAHASSEE, FL 32308
US - United States
County - LEON
Telephone
Ext
Fax #
(850) 412-4358
None
Email Address Note: By providing your email address, you agree to accept email correspondence from the Agency.
jack.plagge@ahca.myflorida.com
None
Provider/Facility Website
None
Provider/Facility Transparency Website in accordance with section 395.301, F.S.
Provider/Facility Mailing Address. (All mail will be sent to this address.)
Check if same as Provider/Facility Location Address
Edit Address
Address
2727 Mahan Dr. MS31
TALLAHASSEE, FL 32308
US - United States
County - LEON
Telephone
Ext
Email Address
(850) 412-4358
jack.plagge@ahca.myflorida.com
None
Undo
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Provider:
AHCA Test Hospital

Provider Type:
Hospital

File# 23960166
License #
Expires

Application:
Type: Initial Licensure
Status: In Work
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= Entered
= Entry Required

- Provider/Facility Information
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Property Ownership

There are missing and/or invalid entries. Please correct them

- *Select a property ownership type.*

Does the licensee own or lease this facility? If leased, provide the name of the property owner by following the instructions below.

- ○ Own
- ○ Lease

Undo Save << Back Next >>

Provider:
AHCA Test Hospital

Provider Type:
Hospital

File# 23960166
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Expires

Application:
Type: Initial Licensure
Status: In Work
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= Entered
= Entry Required

- Provider/Facility Information
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Property Ownership

There are missing and/or invalid entries. Please correct them.

- *Select a property ownership type.*

Does the licensee own or lease this facility? If leased, provide the name of the property owner by following the instructions below

- ( ) Own
- (•) Lease

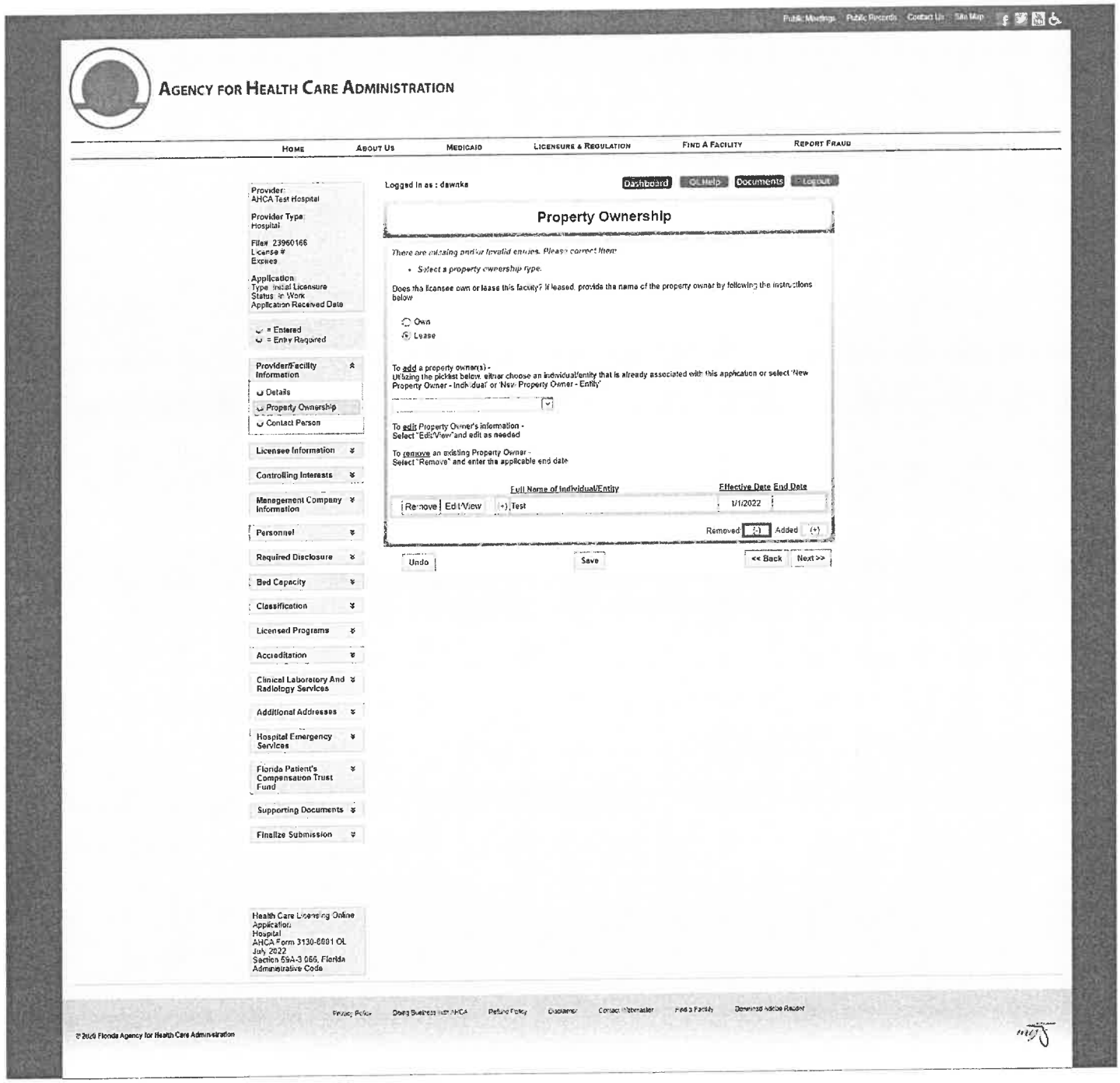
To add a property owner(s) -
Utilizing the pick list below, either choose an individual/entity that is already associated with this application or select 'New Property Owner - Individual' or 'New Property Owner - Entity'.

To edit Property Owner's information -
Select "Edit/View" and edit as needed

To remove an existing Property Owner -
Select "Remove" and enter the applicable end date

No Property Owner!

Undo | Save | << Back | Next >>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Property Ownership
There are missing and/or invalid entries. Please correct them:
Select a property ownership type.
Does the licensee own or lease this facility? If leased, provide the name of the property owner by following the instructions below
Own
Lease
To add a property owner(s) -
Utilizing the picklist below, either choose an individual/entity that is already associated with this application or select 'New Property Owner - Individual' or 'New Property Owner - Entity'
To edit Property Owner's information -
Select "Edit/View" and edit as needed
To remove an existing Property Owner -
Select "Remove" and enter the applicable end date
Full Name of Individual/Entity
Effective Date
End Date
Remove
Edit/View
(+) Test
1/1/2022
Removed (-)
Added (+)
Undo
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Provider:
AHCA Test Hospital

Provider Type:
Hospital

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License #
Expires

Application:
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- Provider/Facility Information
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Provider/Facility Information

- *Contact first name must not be blank.*
- *Contact last name must not be blank.*
- *Phone number is incomplete.*
- *If there is no Fax # please check the None check box below it.*
- *If there is no Email address please check the None check box below it.*

Provider/Facility Contact Person for this Application

First Name | Middle Name | Last Name | Suffix

Telephone | Ext | Fax #

None

Contact Email Address (By providing your email address, you agree to accept email correspondence from the Agency.)

None

Undo | Save | << Back | Next >>

Provider:
AHCA Test Hospital

Provider Type:
Hospital

Fiscal: 23960166
License #
Expires

Application:
Type: Initial Licensure
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Licensee Information

- *Ownership Type is not selected.*
- *Phone number is incomplete.*
- *Licensee Email cannot be blank. Please enter an email or check None checkbox below the field.*
- *If Licensee does not have Fax number then please select the None check box below the field.*
- *Licensee mailing address line 1 must not be blank. Licensee mailing address city must not be blank. Licensee mailing address zip must not be blank.*
- *Select description of Licensee. (Profit, Non Profit or Public)*

Description of Licensee (select only one option below)

For Profit | Not for Profit | Public

Ownership Type

Mailing Address

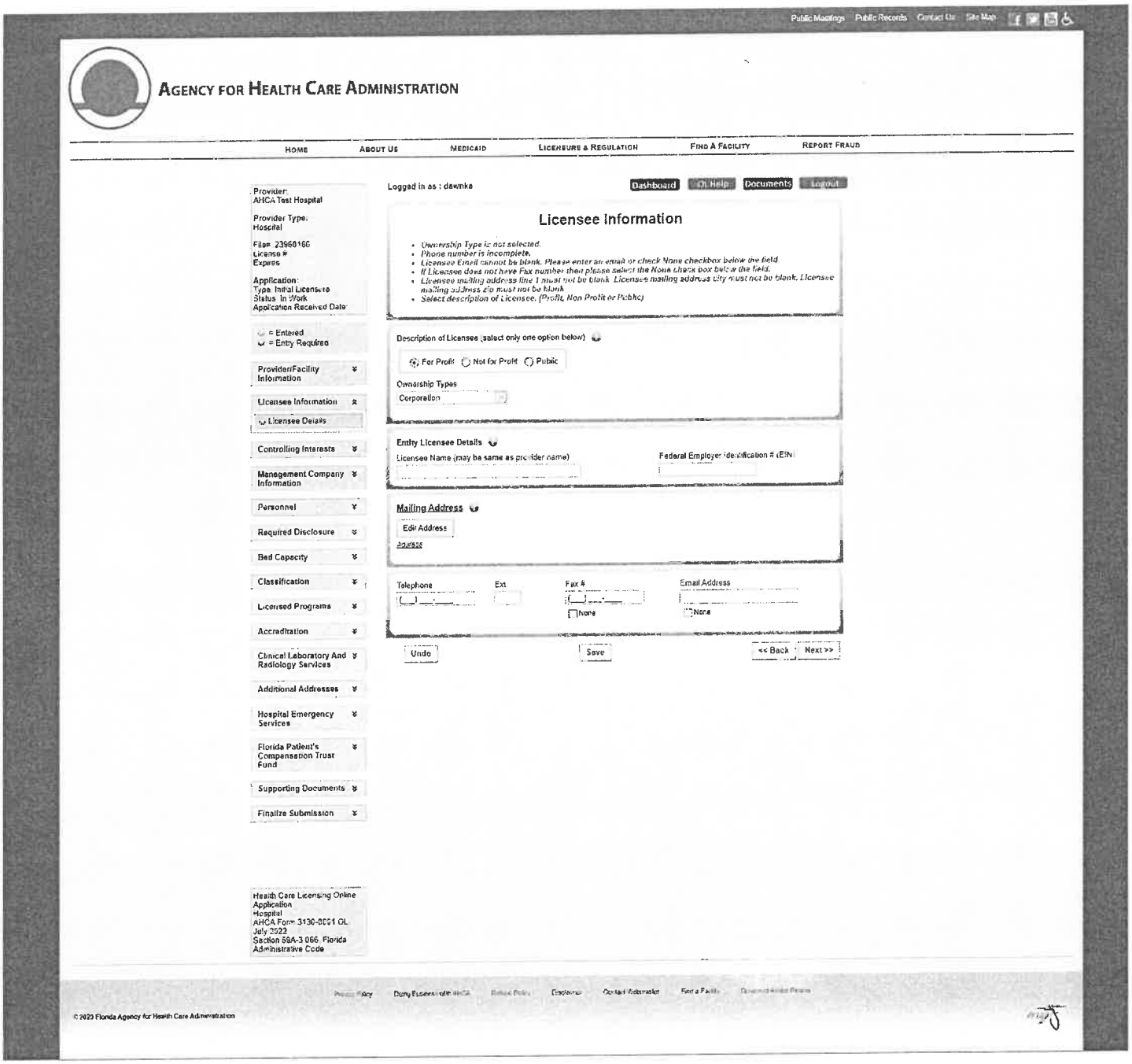
Edit Address

Address

Telephone | Ext | Fax # | Email Address

None

Undo | Save | << Back | Next >>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Licensee Information
Ownership Type is not selected.
Phone number is incomplete.
Licensee Email cannot be blank. Please enter an email or check None checkbox below the field.
If Licensee does not have Fax number then please select the None check box below the field.
Licensee mailing address line 1 must not be blank. Licensee mailing address city must not be blank. Licensee mailing address zip must not be blank.
Select description of Licensee. (Profit, Non Profit or Public)
Description of Licensee (select only one option below)
For Profit
Not for Profit
Public
Ownership Type
Corporation
Entity Licensee Details
Licensee Name (may be same as provider name)
Federal Employer Identification # (FEIN)
Mailing Address
Edit Address
Address
Telephone
Ext
Fax #
None
Email Address
None
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Provider:
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Provider Type:
Hospital

File# 23960166
License #
Expires

Application:
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Status: In Work
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= Entry Required

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Controlling Interests of Licensee

- *Select either Yes or No option.*

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 the 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 must be screened, visit the Background Screening site.

( ) Yes ( ) No

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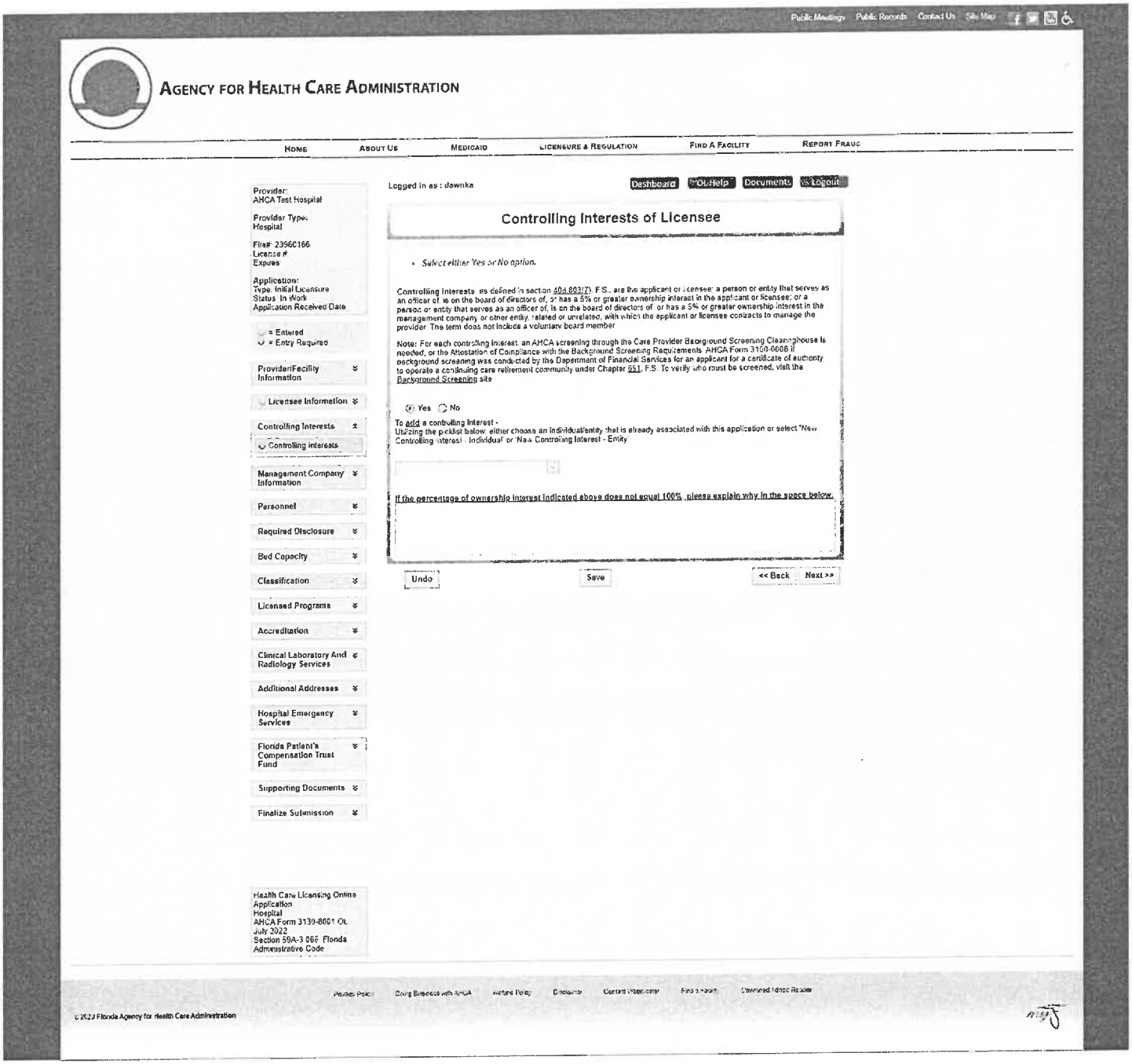
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Controlling Interests of Licensee
Select either Yes or No option.
Controlling Interests, as defined in section 408.803(7), F.S., are the applicant or licensee; a person or entity that serves as an officer of, is on the board of directors of, or has 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 the 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 must be screened, visit the Background Screening site
Yes
No
To add a controlling interest -
Utilizing the picklist below, either choose an individual/entity that is already associated with this application or select "New Controlling Interest - Individual" or New Controlling Interest - Entity
If the percentage of ownership interest indicated above does not equal 100%, please explain why in the space below.
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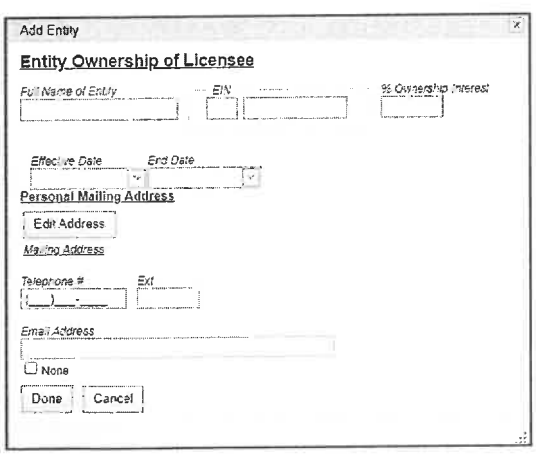
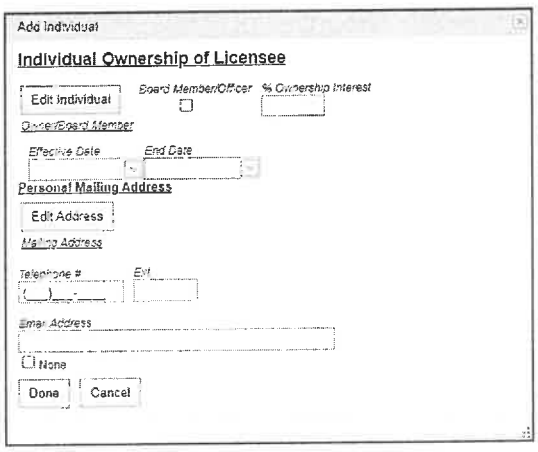
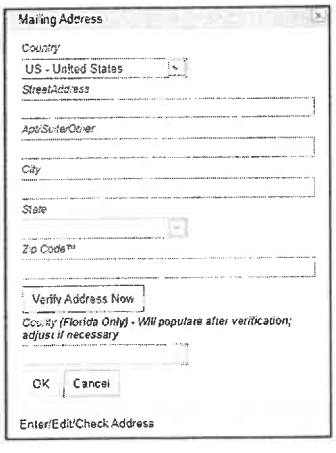
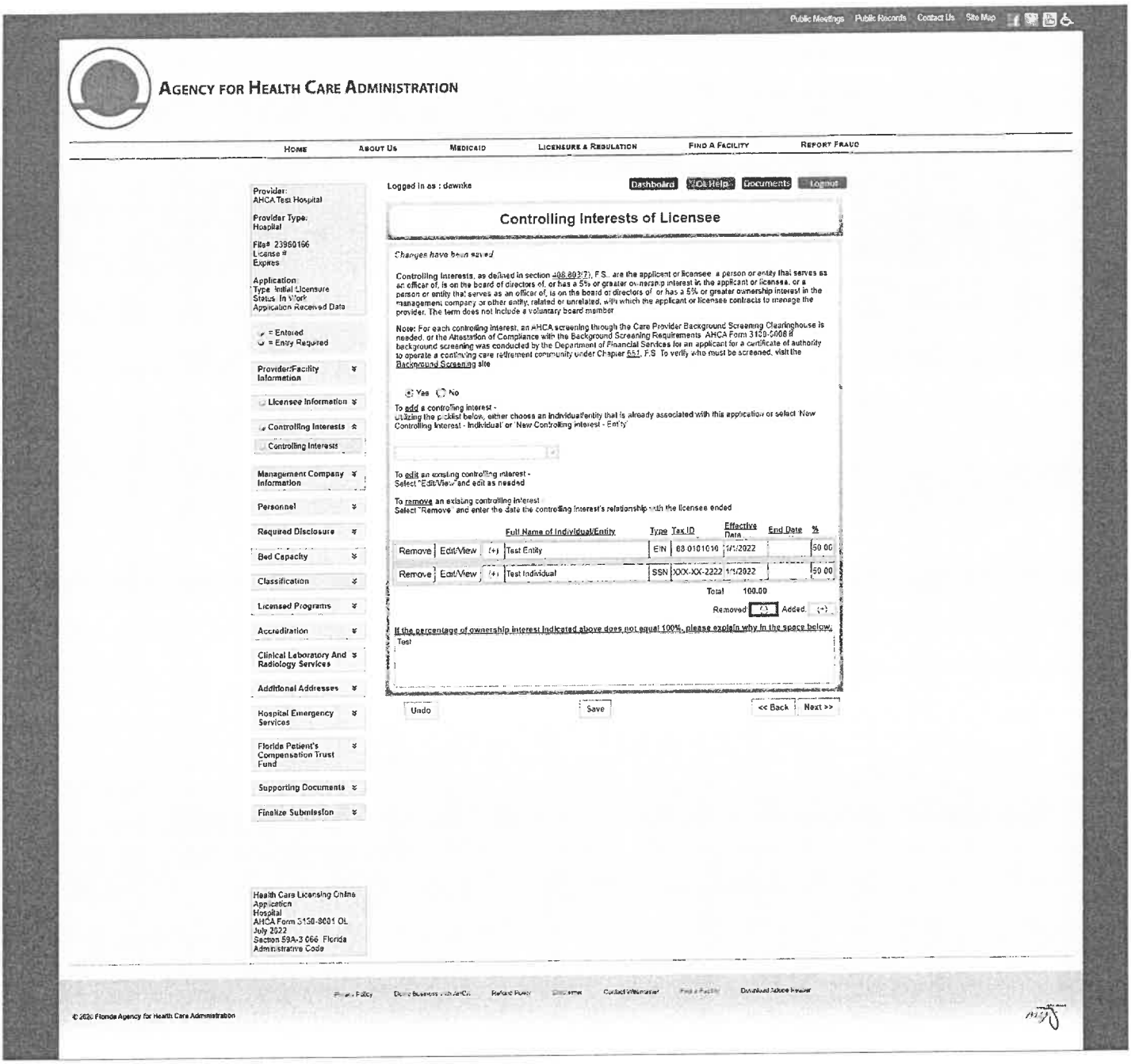

Add Entity
Entity Ownership of Licensee
Full Name of Entity
EIN
% Ownership Interest
Effective Date
End Date
Personal Mailing Address
Edit Address
Mailing Address
Telephone #
Ext
Email Address
None
Done
Cancel


Add Individual
Individual Ownership of Licensee
Edit Individual
Board Member/Officer
% Ownership Interest
Owner/Board Member
Effective Date
End Date
Personal Mailing Address
Edit Address
Mailing Address
Telephone #
Ext
Email Address
None
Done
Cancel


Mailing Address
Country
US - United States
StreetAddress
Apt/Suite/Other
City
State
Zip Code™
Verify Address Now
County (Florida Only) - Will populate after verification; adjust if necessary
OK
Cancel
Enter/Edit/Check Address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Controlling Interests of Licensee
Changes have been saved
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 the Background Screening Requirements, AHCA Form 3150-5008, 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 must be screened, visit the Background Screening site.
Yes
No
To add a controlling interest -
Utilizing the picklist below, either choose an individual/entity that is already associated with this application or select 'New Controlling Interest - Individual' or 'New Controlling Interest - Entity'
To edit an existing controlling interest -
Select "Edit/View" and edit as needed
To remove an existing controlling interest -
Select "Remove" and enter the date the controlling interest's relationship with the licensee ended
Full Name of Individual/Entity
Type
Tax ID
Effective Date
End Date
%
Remove
Edit/View
Test Entity
EIN
88 0101010
1/1/2022
50.00
Remove
Edit/View
Test Individual
SSN
XXX-XX-2222
1/1/2022
50.00
Total 100.00
Removed
Added
If the percentage of ownership interest indicated above does not equal 100%, please explain why in the space below:
Test
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= Entered
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- Provider/Facility Information
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Management Company Information

- *Select either Yes or No option.*

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

( ) Yes ( ) No

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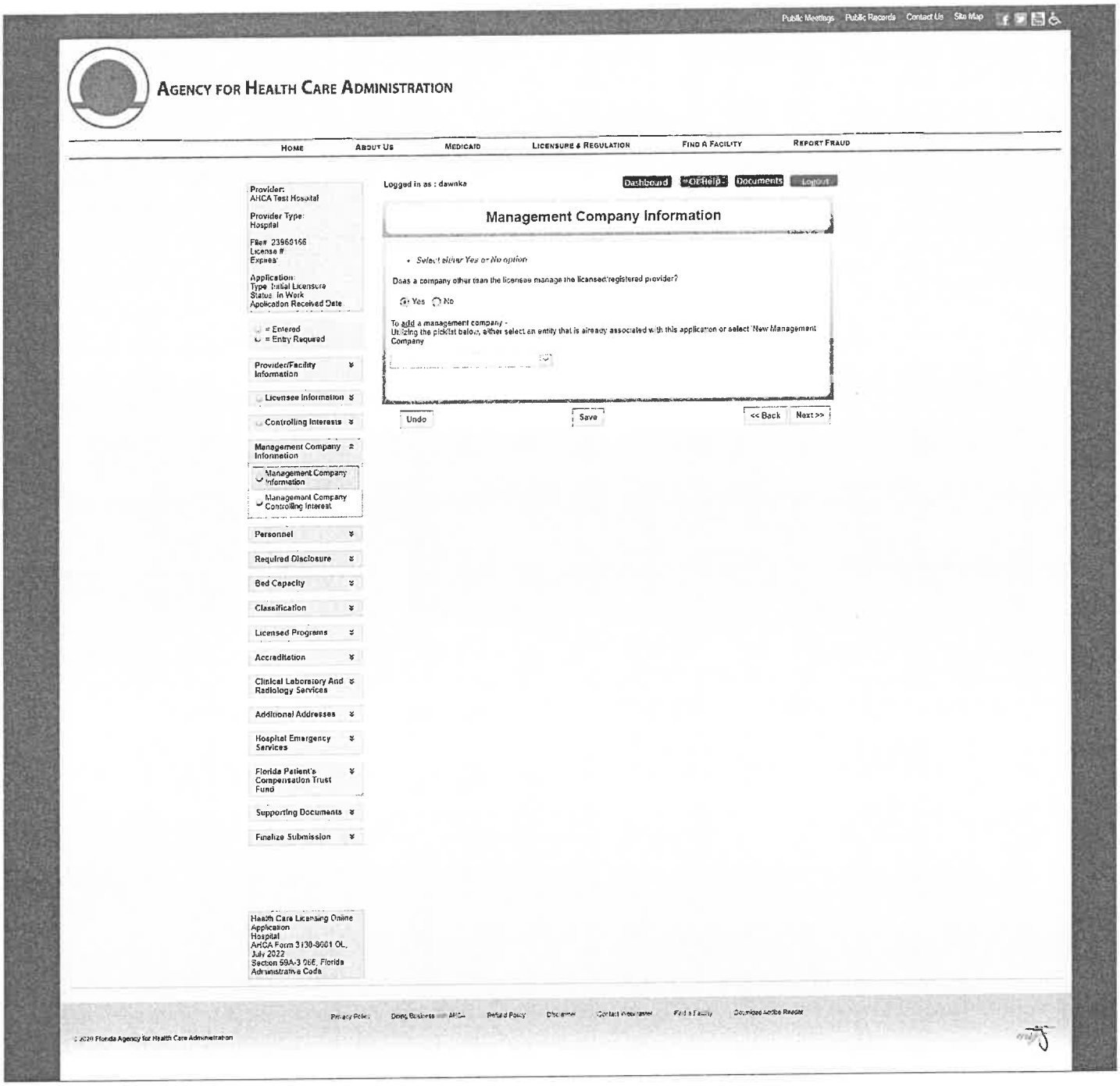
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Management Company Information
Select either Yes or No option
Does a company other than the licensee manage the licensed/registered provider?
Yes
No
To add a management company -
Utilizing the picklist below, either select an entity that is already associated with this application or select 'New Management Company'
Undo
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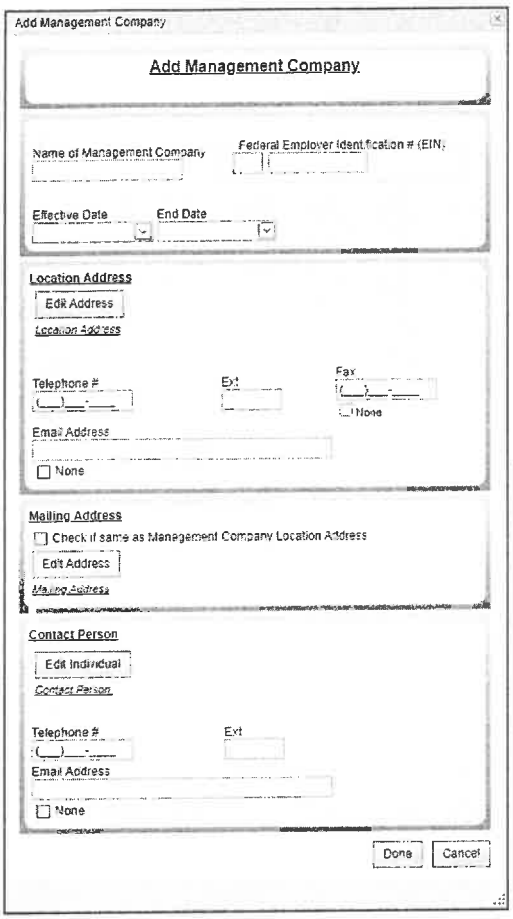
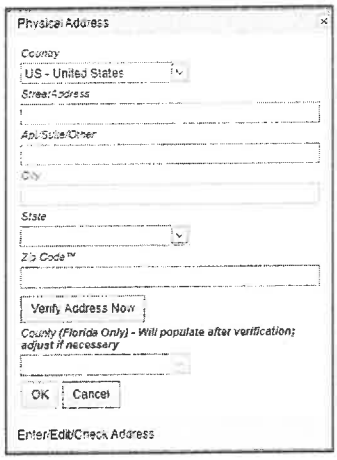
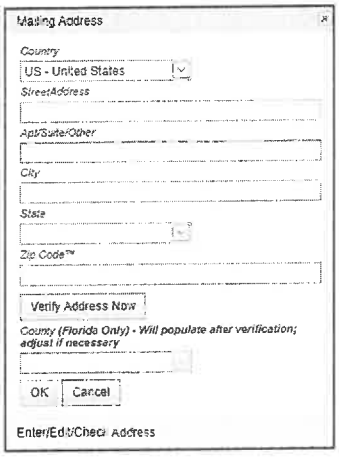
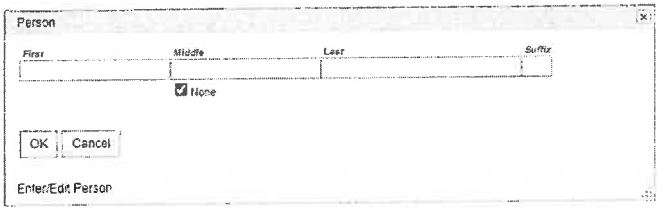
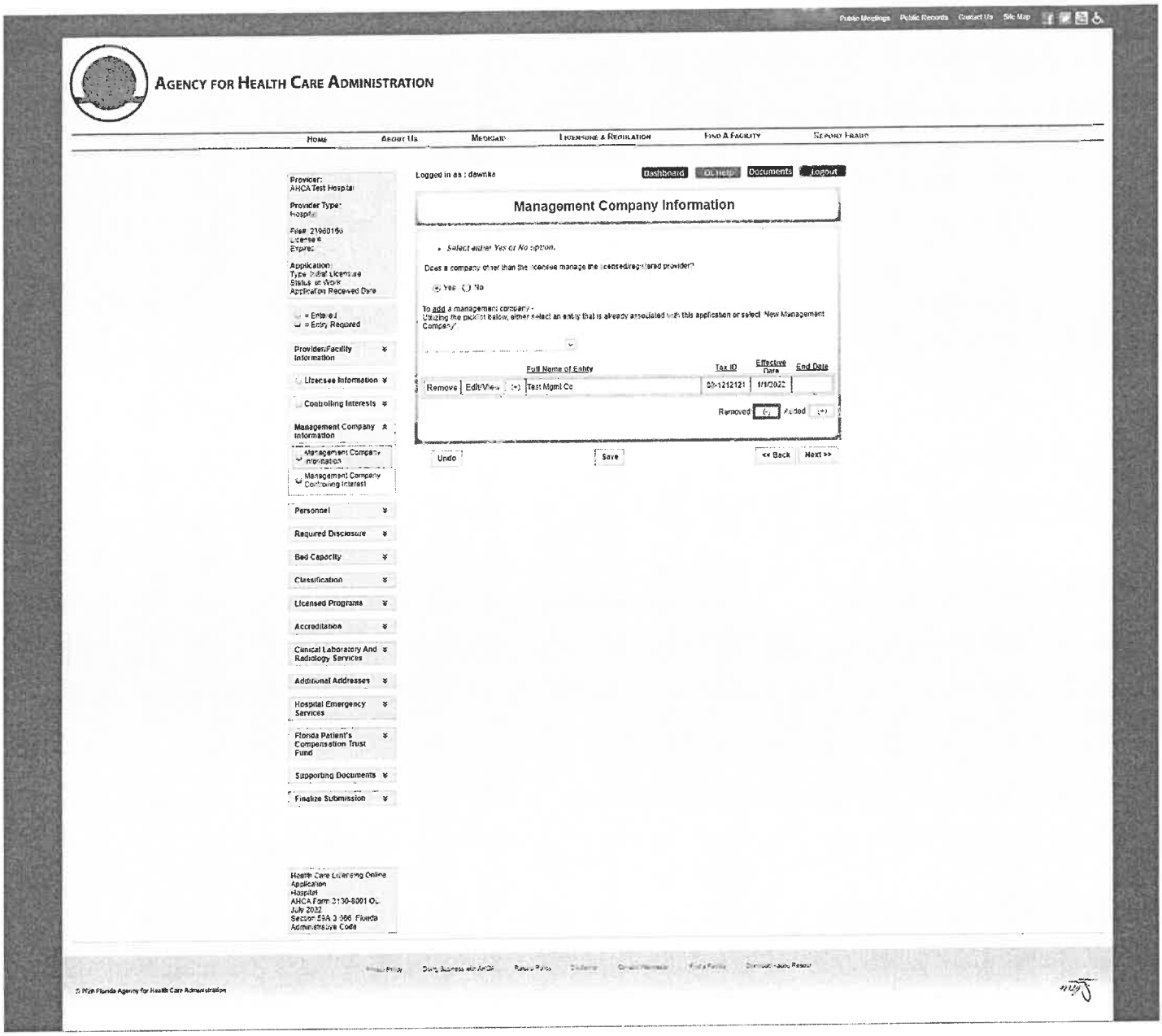

Add Management Company
Add Management Company
Name of Management Company
Federal Employer Identification # (EIN)
Effective Date
End Date
Location Address
Edit Address
Location Address
Telephone #
Ext
Fax
None
Email Address
None
Mailing Address
Check if same as Management Company Location Address
Edit Address
Mailing Address
Contact Person
Edit Individual
Contact Person
Telephone #
Ext
Email Address
None
Done
Cancel


Physical Address
Country
US - United States
Street Address
Apt/Suite/Other
City
State
Zip Code™
Verify Address Now
County (Florida Only) - Will populate after verification; adjust if necessary
OK
Cancel
Enter/Edit/Check Address


Mailing Address
Country
US - United States
Street Address
Apt/Suite/Other
City
State
Zip Code™
Verify Address Now
County (Florida Only) - Will populate after verification; adjust if necessary
OK
Cancel
Enter/Edit/Check Address


Person
First
Middle
Last
Suffix
None
OK
Cancel
Enter/Edit Person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AGENCY FOR HEALTH CARE ADMINISTRATION
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FIND A FACILITY
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Provider:
AHCA Test Hospital
Provider Type:
Hospital
Fee#: 21980150
License #:
Expires:
Application:
Type: Initial Licensure
Status: In Work
Application Received Date:
= Entered
= Entry Required
Provider/Facility Information
Licensee Information
Controlling Interests
Management Company Information
Management Company Information
Management Company Controlling Interest
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Florida Patient's Compensation Trust Fund
Supporting Documents
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July 2022
Section 59A-3.066, Florida Administrative Code
Logged in as : dawnke
Dashboard
OL Help
Documents
Logout
Management Company Information
Select either Yes or No option.
Does a company other than the licensee manage the licensed/registered provider?
Yes
No
To add a management company -
Utilizing the picklist below, either select an entity that is already associated with this application or select 'New Management Company'
Full Name of Entity
Tax ID
Effective Date
End Date
Remove
Edit/View
Test Mgmt Co
59-1212121
1/1/2022
Removed
Added
Undo
Save
<< Back
Next >>
Privacy Policy
Data Access and Audit
Refund Policy
Disclaimer
Contact Number
Find a Facility
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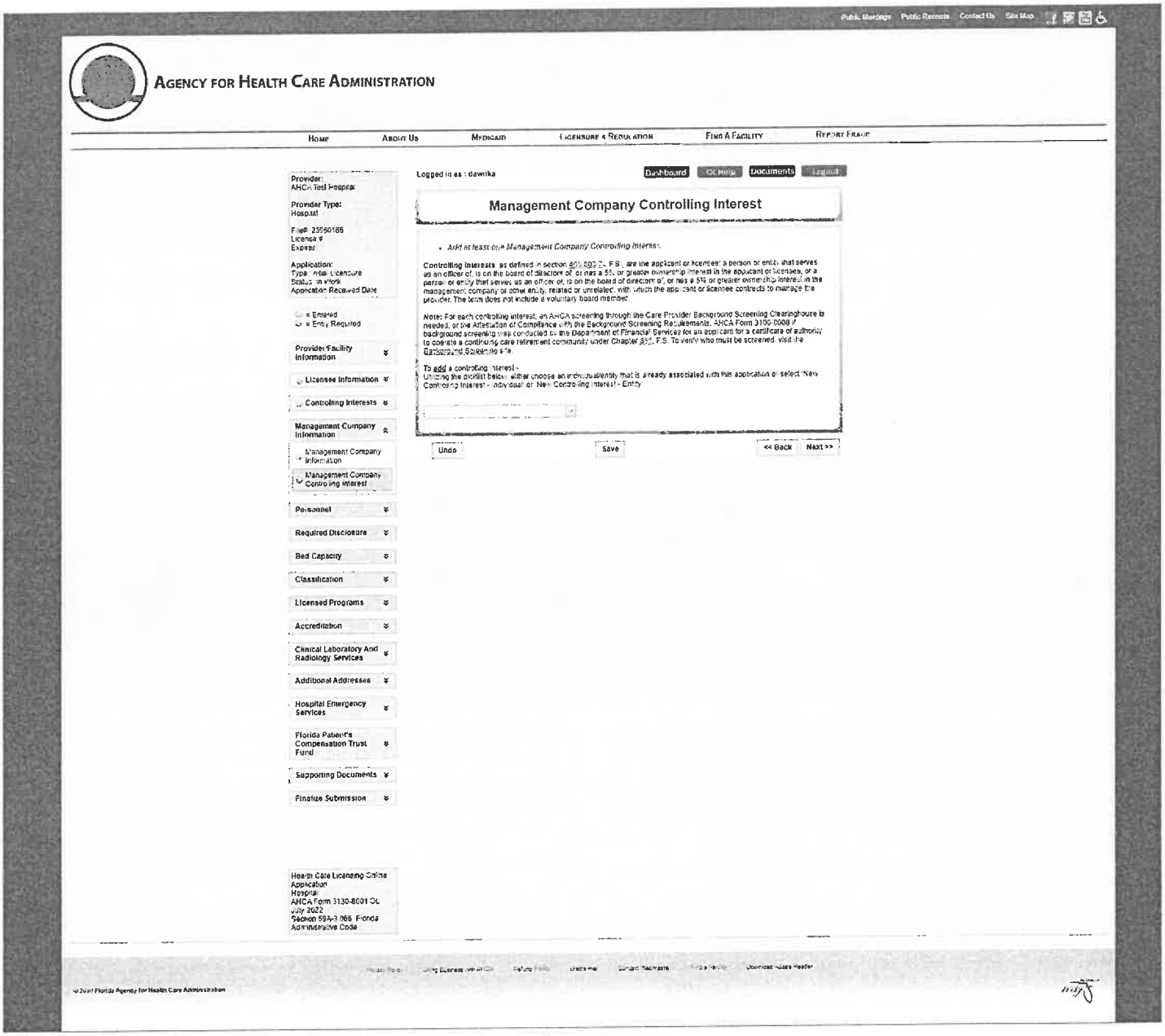
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Provider:
AHCA Test Hospital
Provider Type:
Hospital
Fin#: 23560186
License #
Expires:
Application:
Type: Initial Licensure
Status: In Work
Application Received Date:
= Entered
= Entry Required
Provider/Facility Information
Licensee Information
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Logged in as : dawnka
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Management Company Controlling Interest
Add at least one Management Company Controlling Interest.
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 the Background Screening Requirements, AHCA Form 3190-0008 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 must be screened, visit the Background Screening FAQ.
To add a controlling interest -
Utilizing the picklist below, either choose an individual/entity that is already associated with this application or select 'New Controlling Interest - Individual' or 'New Controlling Interest - Entity'
Undo
Save
<< Back
Next >>
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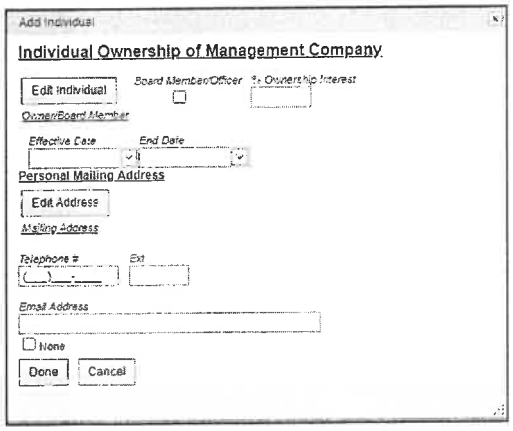
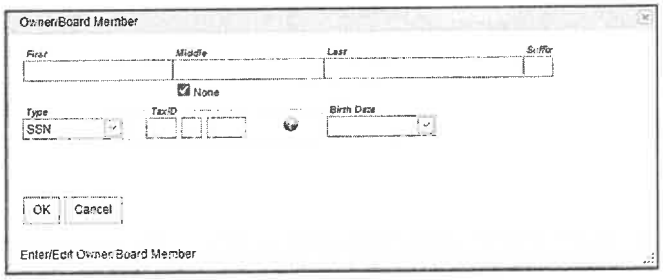
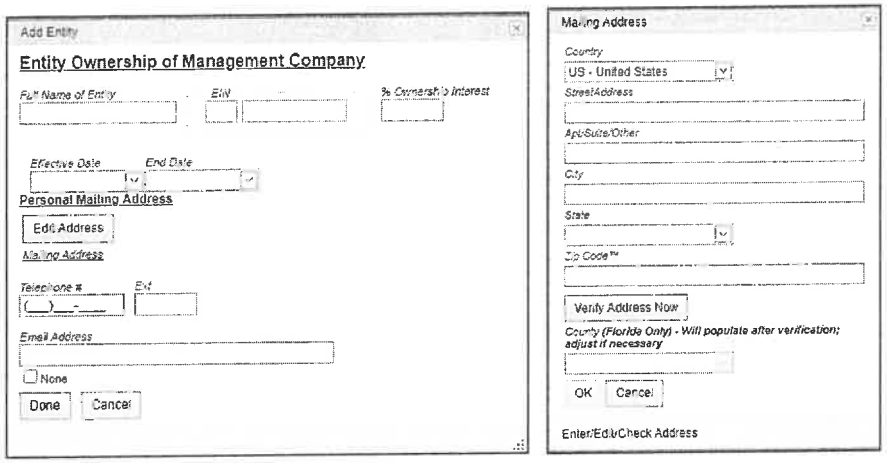
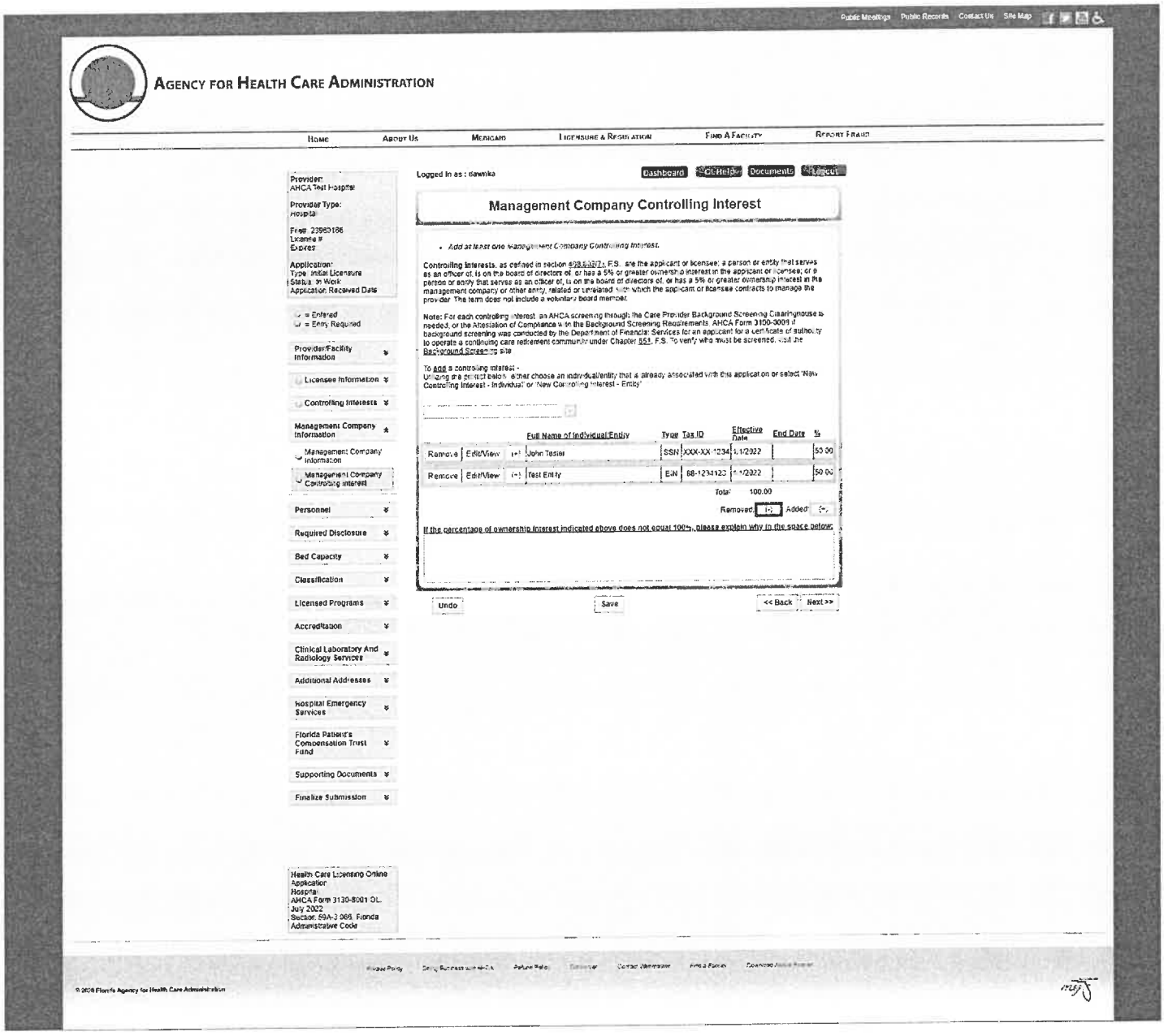

Add Individual
Individual Ownership of Management Company
Edit Individual
Board Member/Officer
% Ownership Interest
Owner/Board Member
Effective Date
End Date
Personal Mailing Address
Edit Address
Mailing Address
Telephone #
Ext
Email Address
None
Done
Cancel


Owner/Board Member
First
Middle
Last
Suffix
None
Type
SSN
Tax ID
Birth Date
OK
Cancel
Enter/Edit Owner/Board Member


Add Entity
Entity Ownership of Management Company
Full Name of Entity
EIN
% Ownership Interest
Effective Date
End Date
Personal Mailing Address
Edit Address
Mailing Address
Telephone #
Ext
Email Address
None
Done
Cancel
Mailing Address
Country
US - United States
Street Address
Apt/Suite/Other
City
State
Zip Code™
Verify Address Now
County (Florida Only) - Will populate after verification; adjust if necessary
OK
Cancel
Enter/Edit/Check Address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AHCA Test Hospital
Provider Type:
Hospital
Fresh 23959186
License #
Expires
Application:
Type: Initial Licensure
Status: In Work
Application Received Date
= Entered
= Entry Required
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Management Company Controlling Interest
Add at least one Management Company Controlling Interest.
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 the Background Screening Requirements, AHCA Form 3100-3009 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 must be screened, visit the Background Screening site.
To add a controlling interest -
Utilizing the pick list below, either choose an individual/entity that is already associated with this application or select 'New Controlling Interest - Individual' or 'New Controlling Interest - Entity'
Full Name of Individual/Entity
Type
Tax ID
Effective Date
End Date
%
Remove
Edit/View
John Tester
SSN
XXX-XX-1234
1/1/2022
50.00
Remove
Edit/View
Test Entity
EIN
68-1234123
1/1/2022
50.00
Total: 100.00
Removed:
Added:
If the percentage of ownership interest indicated above does not equal 100%, please explain why in the space below:
Undo
Save
<< Back
Next >>
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Provider:
AHCA Test Hospital

Provider Type:
Hospital

Fein: 229604156
License #
Expires:

Application:
Type: Initial Licensure
Status: In Work
Application Received Date

= Entered
= Entry Required

- Provider/Facility Information
- Licensee Information
- Controlling Interests
- Management Company Information
- Personnel
  - Administrator
  - Safety Liaison
- Required Disclosure
- Bed Capacity
- Classification
- Licensed Programs
- Accreditation
- Clinical Laboratory And Radiology Services
- Additional Addresses
- Hospital Emergency Services
- Florida Patient's Compensation Trust Fund
- Supporting Documents
- Finalize Submission

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Logged in as : dawnka

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Personnel

- *One Chief Executive Officer should be entered for this application.*
- *One Financial Officer should be entered for this application.*

A. Provider/Facility Administration

Personnel

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 must be screened, visit the Background Screening site.

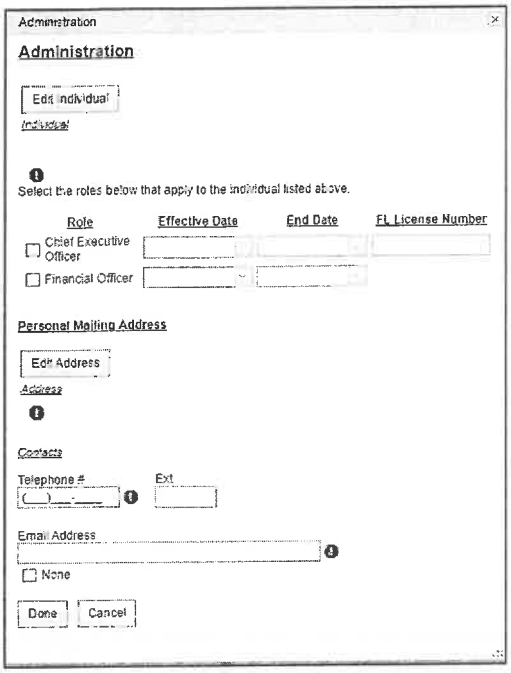
Provide the information for the individuals who perform the following roles

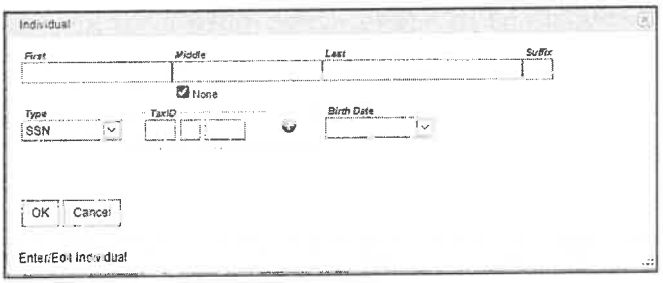
- Chief Executive Officer
- Financial Officer

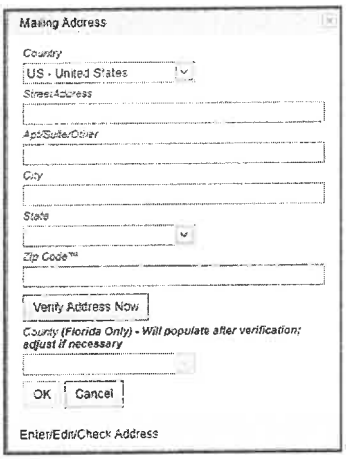
To add an individual –
Using the picklist below, either choose an individual that is already associated with this application or select 'New Individual'

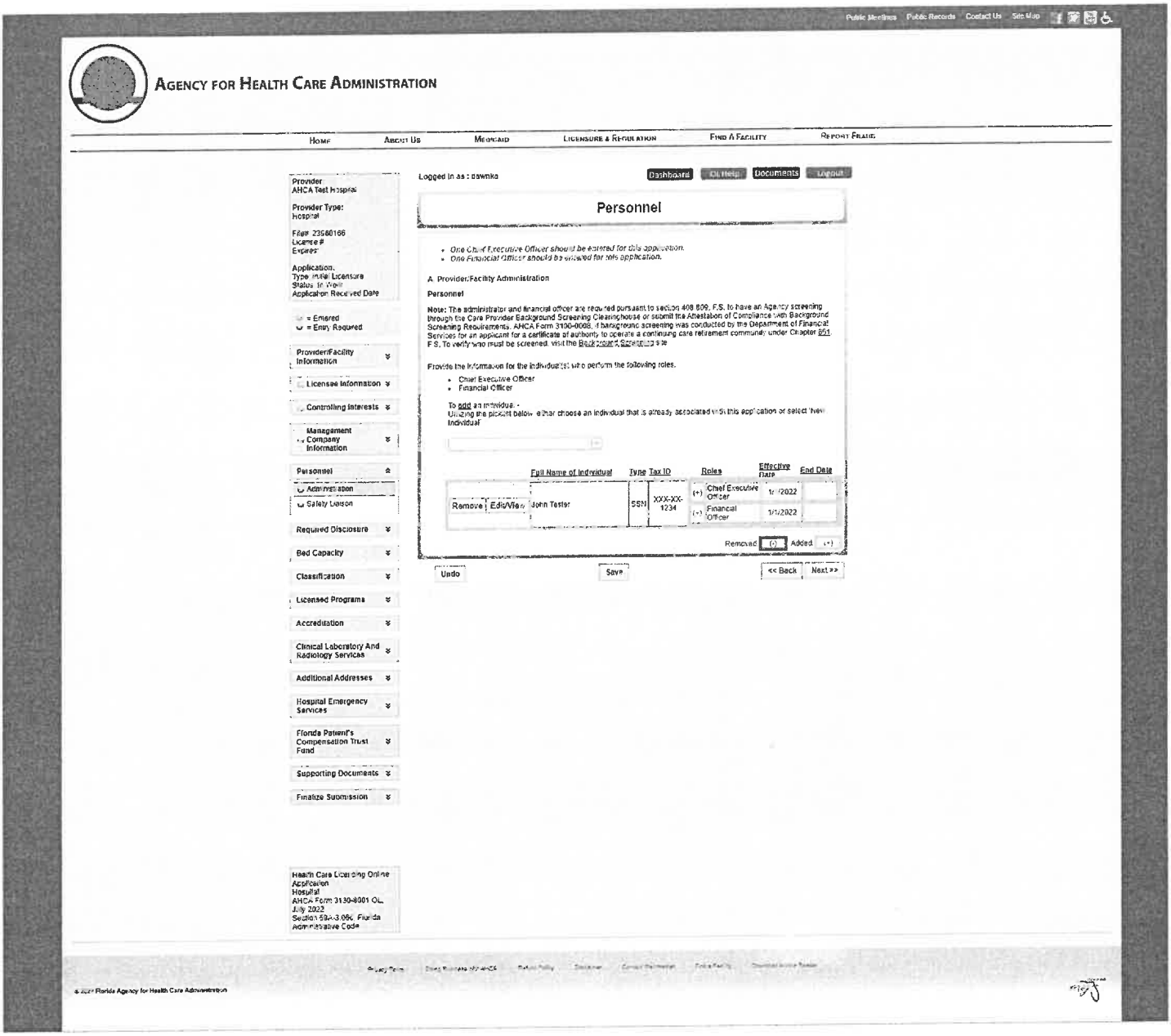
No individuals exist

Undo Save << Back Next >>


Administration
Administration
Edit Individual
Individual
Select the roles below that apply to the individual listed above.
Role
Effective Date
End Date
FL License Number
Chief Executive Officer
Financial Officer
Personal Mailing Address
Edit Address
Address
Contacts
Telephone #
Ext
Email Address
None
Done
Cancel


Individual
First
Middle
Last
Suffix
None
Type
SSN
TaxID
Birth Date
OK
Cancel
Enter/Edit Individual


Mailing Address
Country
US - United States
Street Address
Apt/Suite/Other
City
State
Zip Code™
Verify Address Now
County (Florida Only) - Will populate after verification; adjust if necessary
OK
Cancel
Enter/Edit/Check Address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Provider
AHCA Test Hospital
Provider Type:
Hospital
Fiile# 23580166
License #
Expires:
Application:
Type: Initial Licensure
Status: In Work
Application Received Date
= Entered
= Entry Required
Provider/Facility Information
License Information
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Administration
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Logged in as : dswnko
Dashboard
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Personnel
One Chief Executive Officer should be entered for this application.
One Financial Officer should be entered for this application.
A. Provider/Facility Administration
Personnel
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 3190-0008. 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 must be screened, visit the Background Screening site.
Provide the information for the individual(s) who perform the following roles.
Chief Executive Officer
Financial Officer
To add an individual: -
Utilizing the picklist below, either choose an individual that is already associated with this application or select 'new' Individual
Full Name of Individual
Type
Tax ID
Roles
Effective Date
End Date
Remove
Edit/View
John Tester
SSN
XXX-XX-1234
(+) Chief Executive Officer
1/1/2022
(-) Financial Officer
1/1/2022
Removed (-)
Added (+)
Undo
Save
<< Back
Next >>
Privacy Policy
Terms & Conditions
Refund Policy
Disclaimer
Contact Technician
Policy Facility
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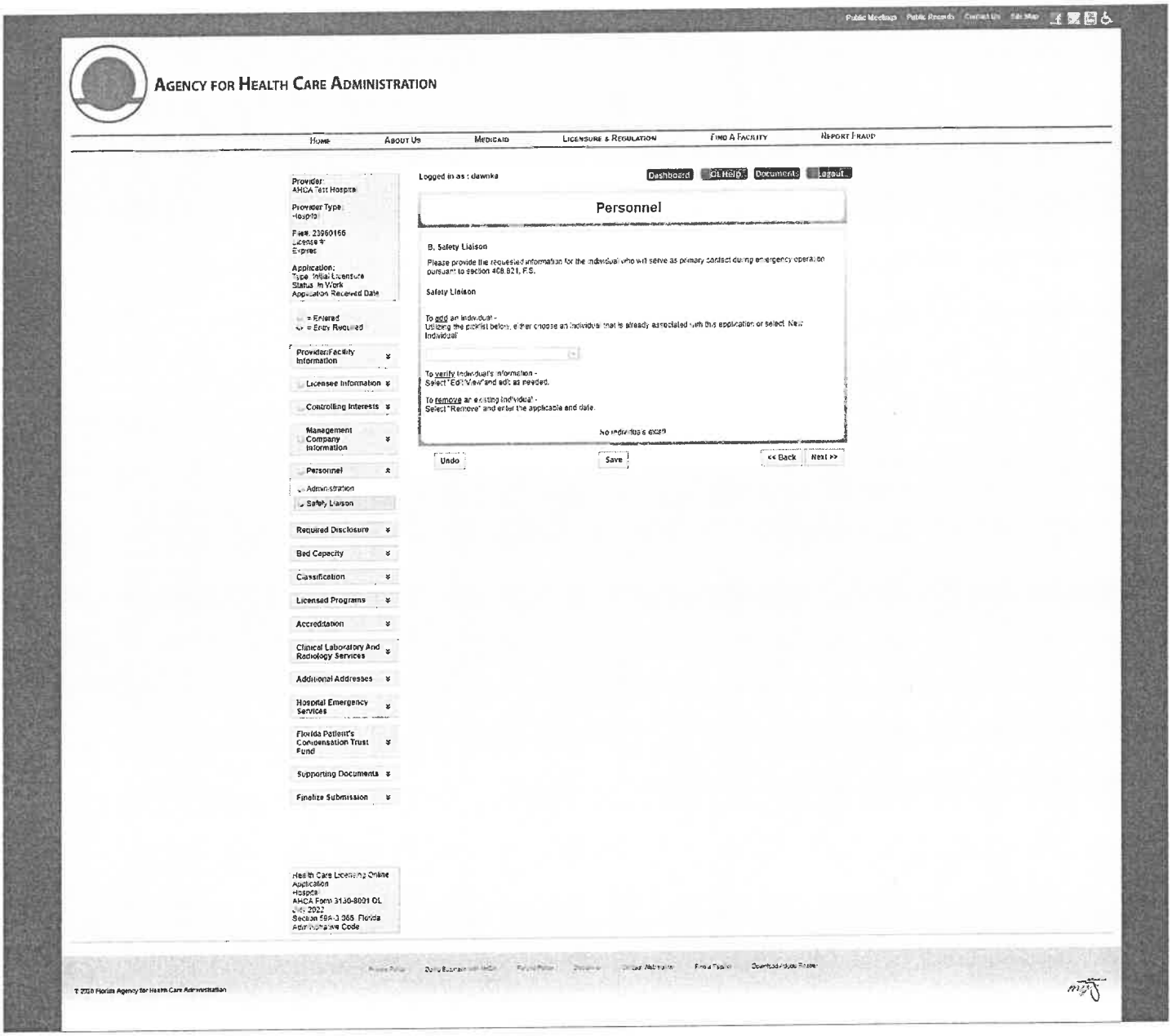
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HOME ABOUT US MEDICAID LICENSURE & REGULATION FIND A FACILITY REPORT FRAUD
Provider:
AHCA Test Hospital
Provider Type:
Hospital
Fee#: 23960166
License #:
Expires:
Application:
Type: Initial Licensure
Status: In Work
Application Received Date:
= Entered
= Entry Required
Provider/Facility Information
Licensee Information
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Administration
Safety Liaison
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Logged in as : dawnka
Dashboard
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Personnel
B. Safety Liaison
Please provide the requested information for the individual who will serve as primary contact during emergency operation pursuant to section 408.821, F.S.
Safety Liaison
To add an individual -
Utilizing the picklist below, either choose an individual that is already associated with this application or select 'New Individual'
To verify individual's information -
Select "Edit/View" and edit as needed.
To remove an existing individual -
Select "Remove" and enter the applicable end date.
No individuals exist
Undo
Save
<< Back
Next >>
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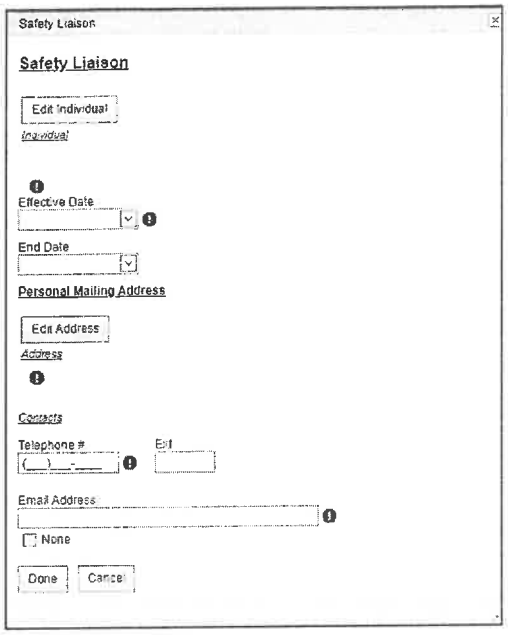
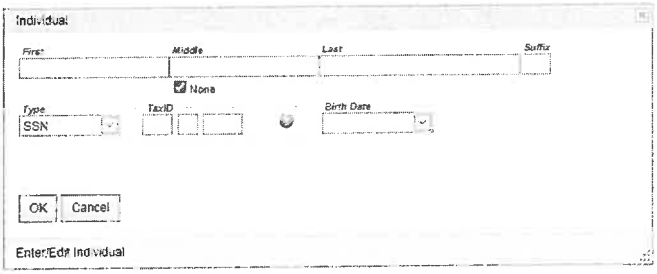
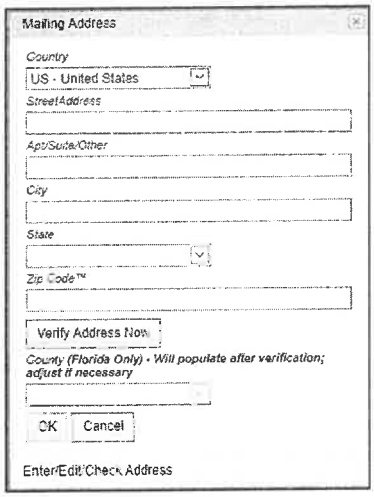
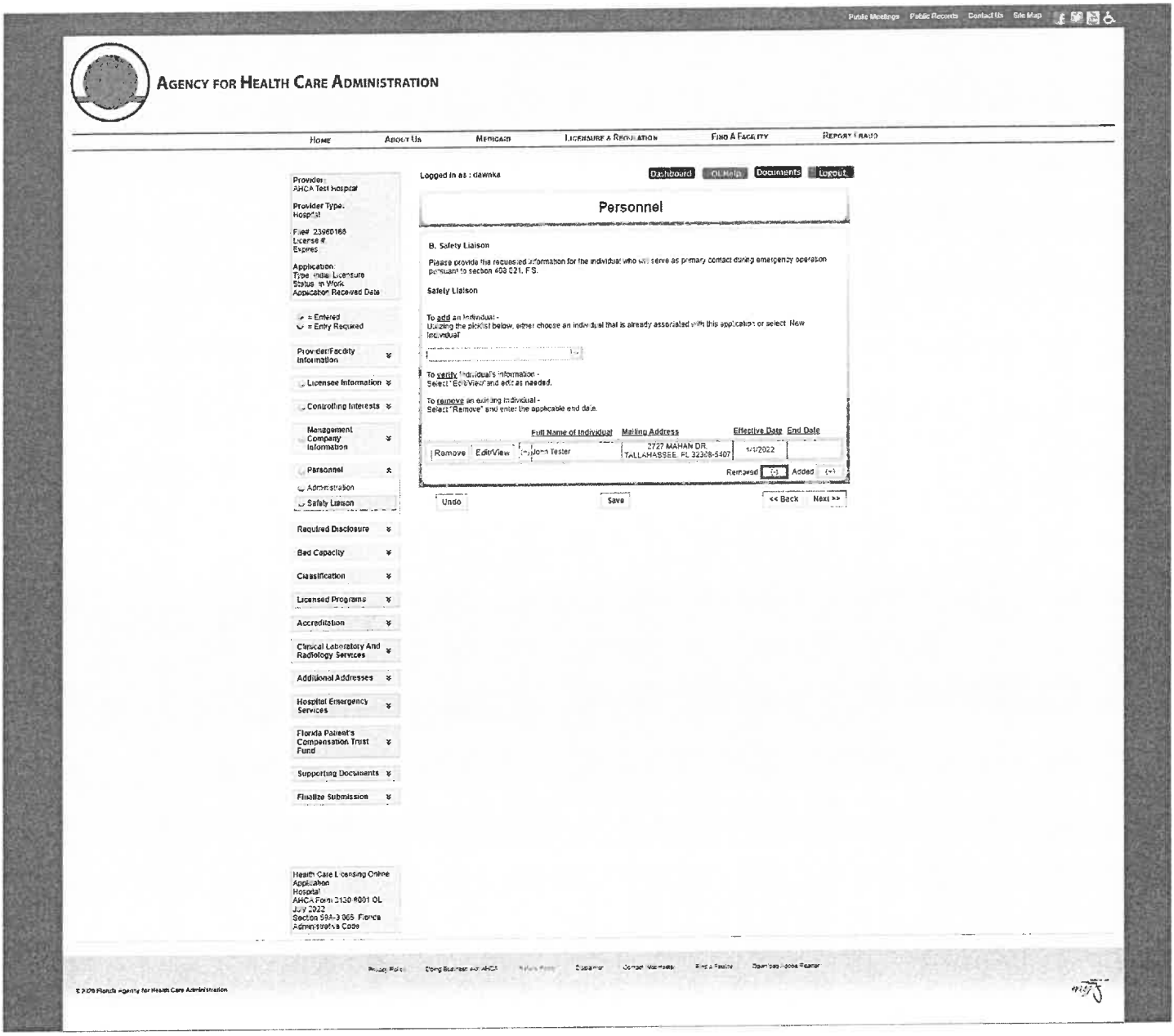

Safety Liaison
Safety Liaison
Edit Individual
Individual
Effective Date
End Date
Personal Mailing Address
Edit Address
Address
Contacts
Telephone #
Ext
Email Address
None
Done
Cancel


Individual
First
Middle
Last
Suffix
None
Type
SSN
TaxID
Birth Date
OK
Cancel
Enter/Edit Individual


Mailing Address
Country
US - United States
Street Address
Apt/Suite/Other
City
State
Zip Code™
Verify Address Now
County (Florida Only) - Will populate after verification; adjust if necessary
OK
Cancel
Enter/Edit/Check Address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AHCA Test Hospital
Provider Type:
Hospital
Fed# 23960168
License #:
Expires:
Application:
Type: Initial Licensure
Status: In Work
Application Received Date:
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= Entry Required
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Administrator
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Logged in as : dawnka
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Personnel
B. Safety Liaison
Please provide the requested information for the individual who will serve as primary contact during emergency operation pursuant to section 408.821, F.S.
Safety Liaison
To add an individual -
Utilizing the picklist below, either choose an individual that is already associated with this application or select 'New Individual'
To verify individual's information -
Select "Edit/View" and edit as needed.
To remove an existing individual -
Select "Remove" and enter the applicable end date.
Full Name of Individual
Mailing Address
Effective Date
End Date
Remove
Edit/View
John Tester
2727 MAHAN DR.
TALLAHASSEE, FL 32308-5407
1/1/2022
Removed (0)
Added (+)
Undo
Save
<< Back
Next >>
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Doing Business with AHCA
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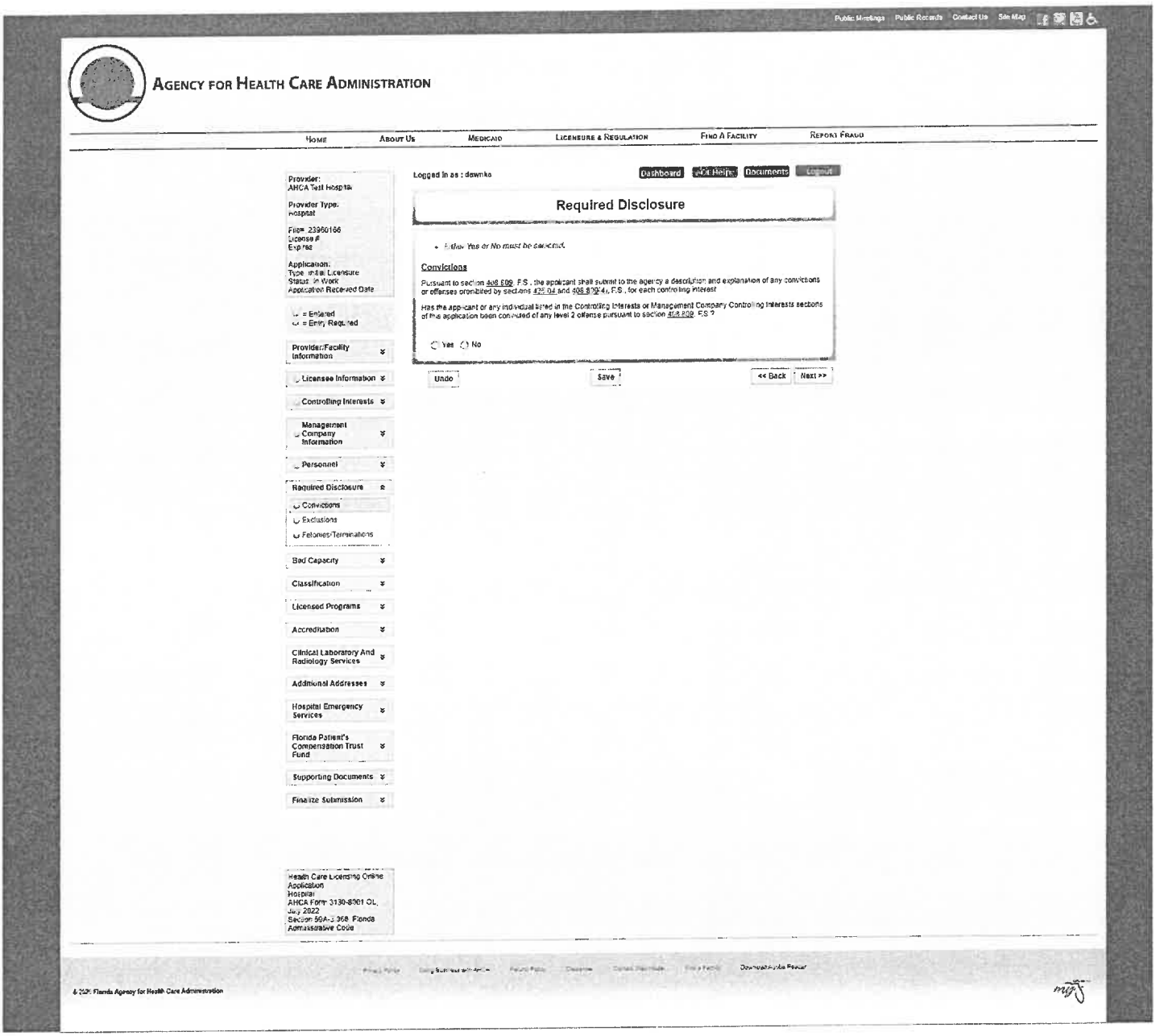
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AHCA Test Hospital
Provider Type:
Hospital
Fin# 23960166
License #
Expires
Application:
Type: Initial Licensure
Status: In Work
Application Received Date
* = Entered
* = Entry Required
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Logged in as : dawnko
Dashboard
eDit Help
Documents
Logout
Required Disclosure
* Either Yes or No must be selected.
Convictions
Pursuant to section 408.809, F.S., the applicant shall submit to the agency a description and explanation of any convictions or offenses prohibited by sections 435.04 and 408.809(4), F.S., for each controlling interest
Has the applicant or any individual listed in the Controlling Interests or Management Company Controlling Interests sections of this application been convicted of any level 2 offense pursuant to section 408.809, F.S.?
Yes
No
Undo
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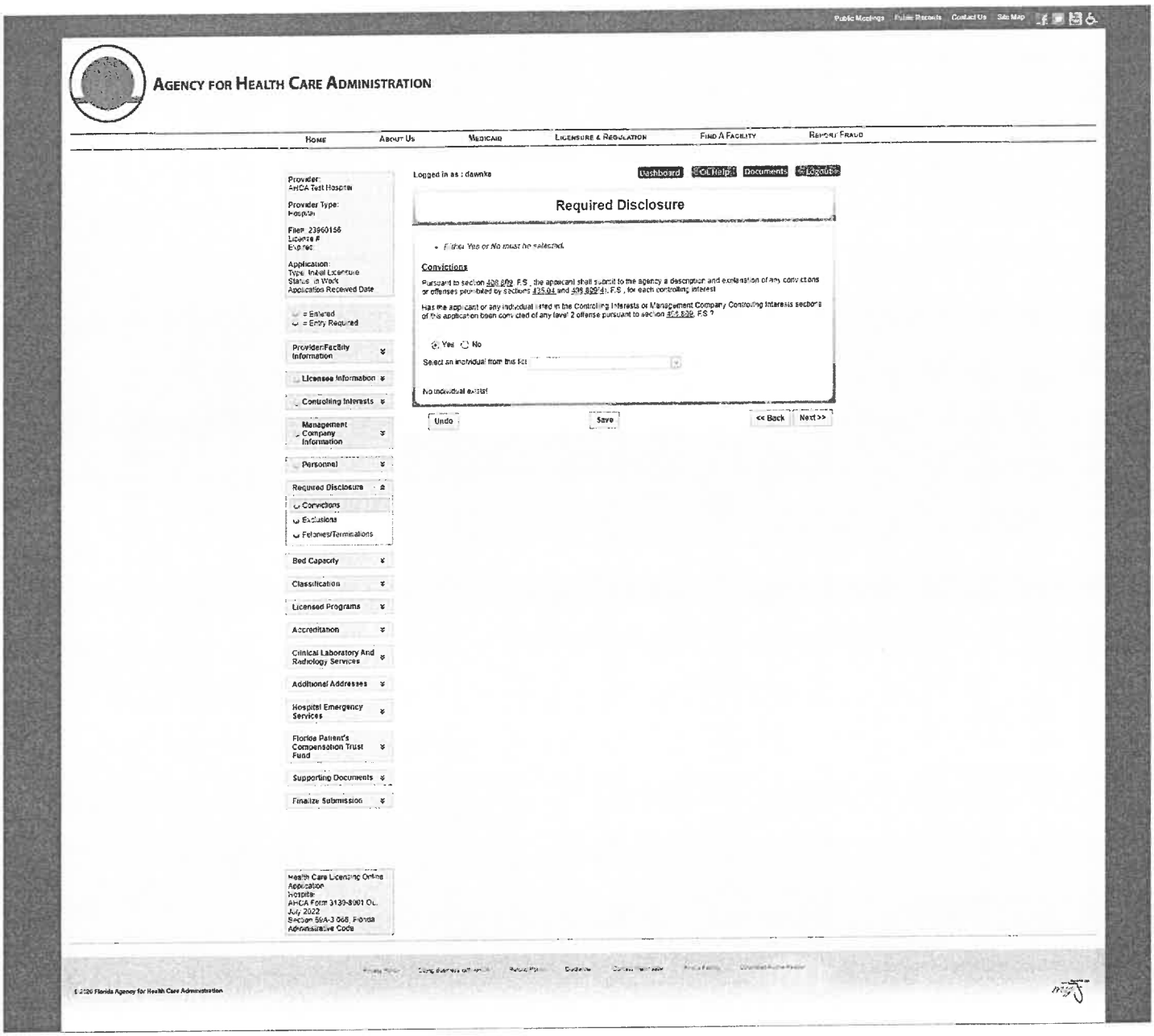
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Hospital
Filer: 23960156
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Status: In Work
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Florida Patient's Compensation Trust Fund
Supporting Documents
Finalize Submission
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July 2022
Section 59A-3.068, Florida Administrative Code
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Required Disclosure
Fields Yes or No must be selected.
Convictions
Pursuant to section 408.809, F.S., the applicant shall submit to the agency a description and explanation of any convictions or offenses prohibited by sections 435.04 and 408.809(4), F.S., for each controlling interest
Has the applicant or any individual listed in the Controlling Interests or Management Company Controlling Interests sections of this application been convicted of any level 2 offense pursuant to section 408.809, F.S.?
Yes
No
Select an individual from this list
No individual exists
Undo
Save
<< Back
Next >>
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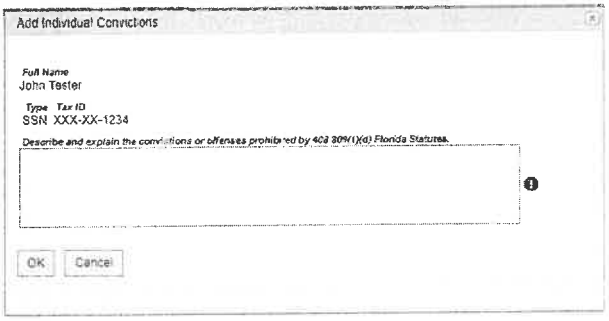
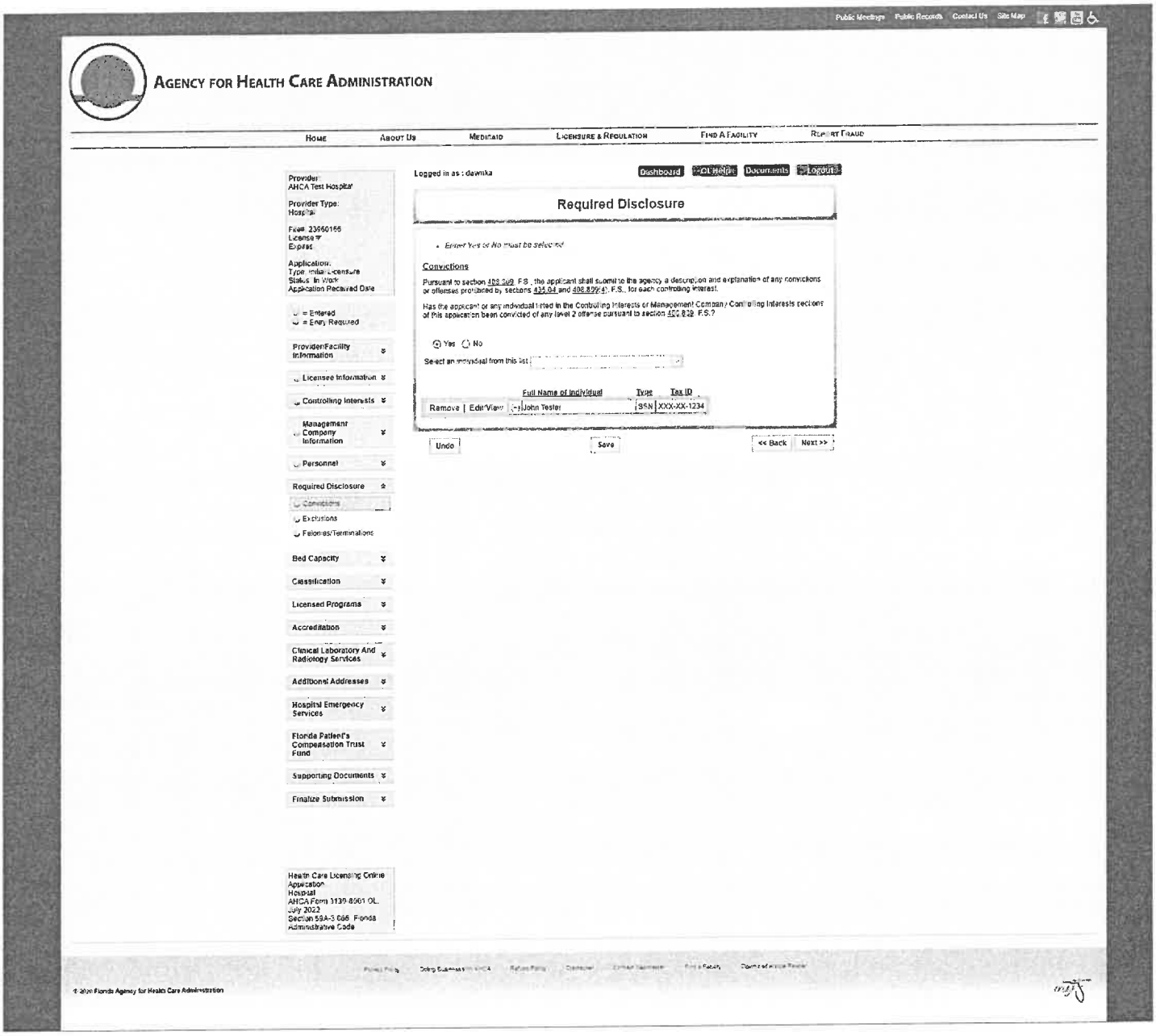

Add Individual Convictions
Full Name
John Tester
Type Tax ID
SSN XXX-XX-1234
Describe and explain the convictions or offenses prohibited by 408.809(1)(a) Florida Statutes.
OK
Cancel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FIND A FACILITY
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Provider:
AHCA Test Hospital
Provider Type:
Hospital
Fee#: 23660166
License #:
Expires:
Application:
Type: Initial Licensure
Status: In Work
Application Received Date:
= Entered
= Entry Required
Provider/Facility Information
Licensee Information
Controlling Interests
Management Company Information
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Required Disclosure
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Dashboard
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Documents
Logout
Required Disclosure
Enter Yes or No must be selected
Convictions
Pursuant to section 408.809, F.S., the applicant shall submit to the agency a description and explanation of any convictions or offenses prohibited by sections 435.04 and 408.809(4), F.S., for each controlling interest.
Has the applicant or any individual listed in the Controlling Interests or Management Company Controlling Interests sections of this application been convicted of any level 2 offense pursuant to section 435.03, F.S.?
Yes
No
Select an individual from this list:
Full Name of Individual
Type
Tax ID
Remove | Edit/View
(-) John Tester
SSN
XXX-XX-1234
Undo
Save
<< Back
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Provider:
AHCA Test Hospital

Provider Type:
Hospital

Fmid: 2398166
License #:
Expires:

Application:
Type: Initial Licensure
Status: In Work
Application Received Date:

= Entered
= Entry Required

- Provider/Facility Information
- Licensee Information
- Controlling Interests
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Required Disclosure

- *Either Yes or No must be selected.*

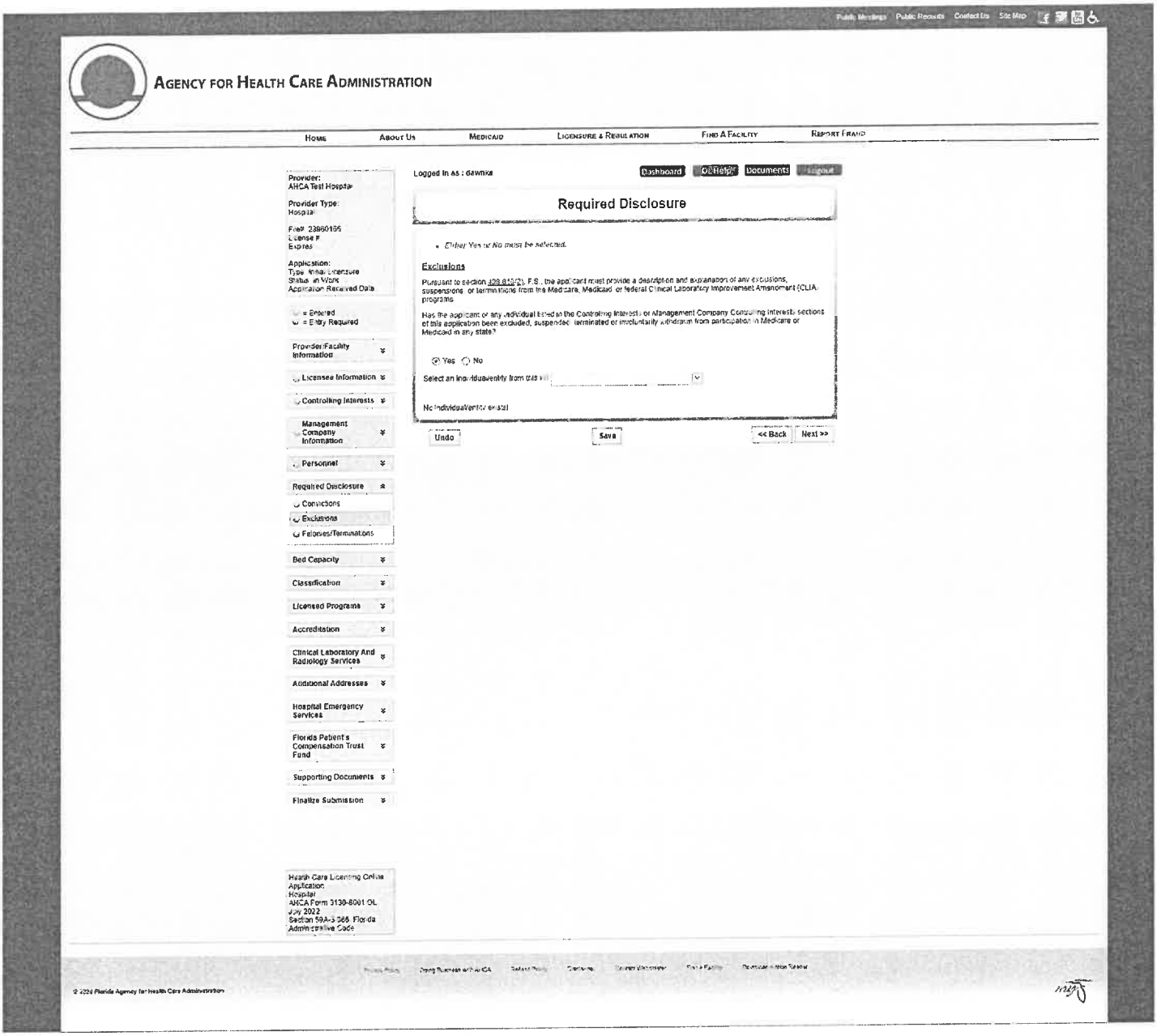
Exclusions

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 listed in the Controlling Interests or Management Company Controlling Interests sections of this application been excluded, suspended, terminated or involuntarily withdrawn from participation in Medicare or Medicaid in any state?

○ Yes ○ No

Undo | Save | << Back | Next >>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Provider:
AHCA Test Hospital
Provider Type:
Hospital
Fed# 23860186
License #
Expires
Application:
Type: Initial Licensure
Status: In Work
Application Received Date
= Entered
= Entry Required
Provider/Facility Information
Licensee Information
Controlling Interests
Management Company Information
Personnel
Required Disclosure
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Required Disclosure
Either Yes or No must be selected.
Exclusions
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 listed in the Controlling Interests or Management Company Controlling Interests sections of this application been excluded, suspended, terminated or involuntarily withdrawn from participation in Medicare or Medicaid in any state?
Yes
No
Select an individual/entity from this list:
No individual/entity exists
Undo
Save
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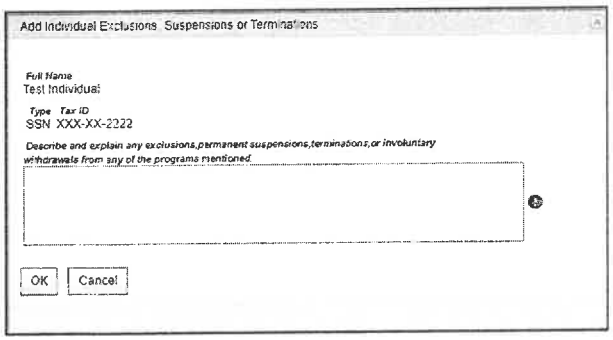
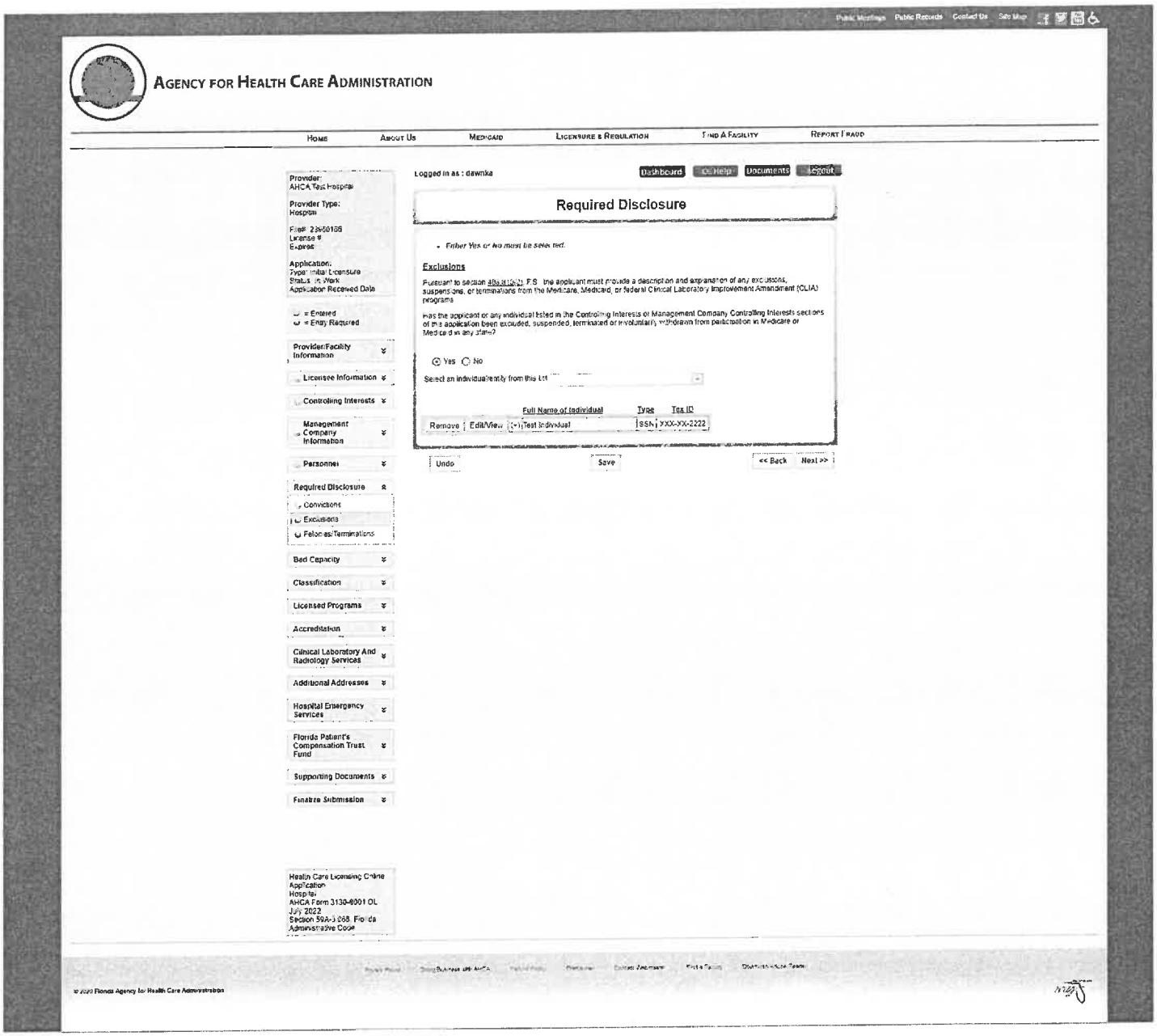

Add Individual Exclusions, Suspensions or Terminations
Full Name
Test Individual
Type Tax ID
SSN XXX-XX-2222
Describe and explain any exclusions,permanent suspensions,terminations,or involuntary withdrawals from any of the programs mentioned.
OK
Cancel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AHCA Test Hospital
Provider Type:
Hospital
Fiel# 23s50166
License #
Expires
Application:
Type: Initial Licensure
Status: In Work
Application Received Date
= Entered
= Entry Required
Provider/Facility Information
Licensee Information
Controlling Interests
Management Company Information
Personnel
Required Disclosure
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July 2022
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Required Disclosure
Either Yes or No must be selected.
Exclusions
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 listed in the Controlling Interests or Management Company Controlling Interests sections of this application been excluded, suspended, terminated or involuntarily withdrawn from participation in Medicare or Medicaid in any state?
Yes
No
Select an individual/entity from this list
Full Name of Individual
Type
Tax ID
Remove
Edit/View
(-) Test Individual
SSN
XXX-XX-2222
Undo
Save
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Provider:
AHCA Test Hospital

Provider Type:
Hospital

Field 23960168
License #
Expires

Application:
Type Initial Licensure
Status In Work
Application Received Date

= Entered
= Entry Required

- Provider/Facility Information
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  - Exclusions
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Health Care Licensing Online Application
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July 2022
Section 395.003 Florida Administrative Code

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Required Disclosure

- All questions related to Felonies/Terminations must be answered.

Felonies/ Terminations

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:

1. 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. 1305-1396, Medicaid fraud, Medicare fraud or insurance fraud, within the previous 15 years prior to the date of this application?

( ) Yes ( ) No

2. 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 5 years and the termination occurred at least 20 years before the date of the application?

( ) Yes ( ) No

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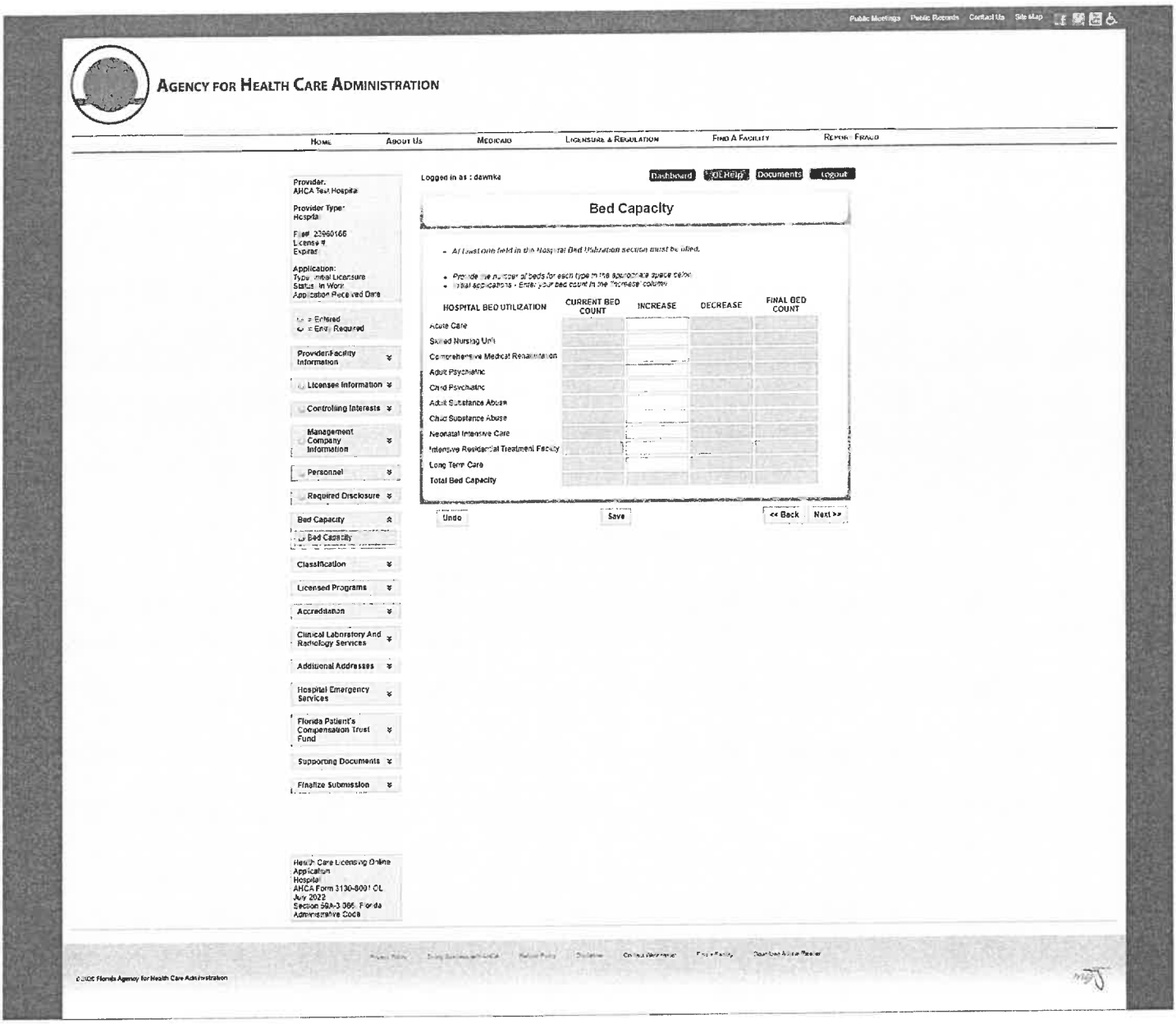
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Provider:
AHCA Test Hospital
Provider Type:
Hospital
File#: 22960166
License #:
Expires:
Application:
Type: Initial Licensure
Status: In Work
Application Received Date:
= Entered
= Entry Required
Provider/Facility Information
Licensee Information
Controlling Interests
Management Company Information
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Bed Capacity
At least one field in the Hospital Bed Utilization section must be filled.
Provide the number of beds for each type in the appropriate space(s).
Initial applications - Enter your bed count in the "Increase" column
HOSPITAL BED UTILIZATION
CURRENT BED COUNT
INCREASE
DECREASE
FINAL BED COUNT
Acute Care
Skilled Nursing Unit
Comprehensive Medical Rehabilitation
Adult Psychiatric
Child Psychiatric
Adult Substance Abuse
Child Substance Abuse
Neonatal Intensive Care
Intensive Residential Treatment Facility
Long Term Care
Total Bed Capacity
Undo
Save
<< Back
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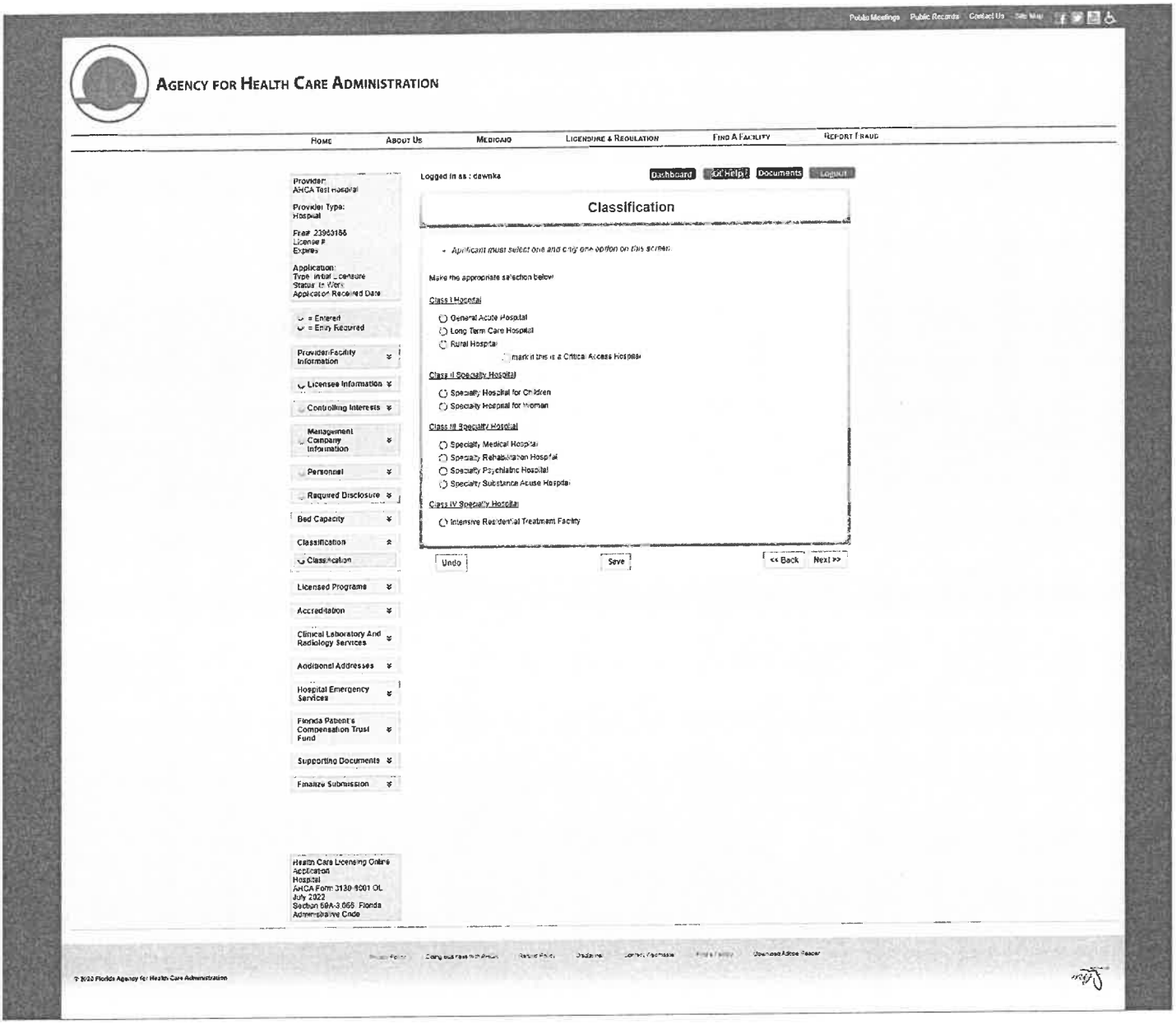
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FIND A FACILITY
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Provider:
AHCA Test Hospital
Provider Type:
Hospital
Fac# 23963186
License #
Expires
Application:
Type: Initial Licensure
Status: In Work
Application Received Date
= Entered
= Entry Required
Provider/Facility Information
Licensee Information
Controlling Interests
Management Company Information
Personnel
Required Disclosure
Bed Capacity
Classification
Classification
Licensed Programs
Accreditation
Clinical Laboratory And Radiology Services
Additional Addresses
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Florida Patient's Compensation Trust Fund
Supporting Documents
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Hospital
AHCA Form 3130-4001 OL
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Classification
Applicant must select one and only one option on this screen.
Make the appropriate selection below
Class I Hospital
General Acute Hospital
Long Term Care Hospital
Rural Hospital
Mark if this is a Critical Access Hospital
Class II Specialty Hospital
Specialty Hospital for Children
Specialty Hospital for Women
Class III Specialty Hospital
Specialty Medical Hospital
Specialty Rehabilitation Hospital
Specialty Psychiatric Hospital
Specialty Substance Abuse Hospital
Class IV Specialty Hospital
Intensive Residential Treatment Facility
Undo
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Provider:
WEST FLORIDA HOSPITAL

Provider Type:
Hospital

File#: 10023
License #: 4318
Expires: 9/28/2021

Application:
Type: Renewal Licensure
Status: In Review
Application Received Date: 6/23/2022

= Entered
= Entry Required

Health Care Licensing Online Application
Hospital
AHCA Form 3130-8001 OL, July 2022
Section 59A-3.066, Florida Administrative Code

Licensed Programs

Section A - Burn Unit: Each hospital operating a burn unit must maintain compliance with the rules adopted by the Agency that establish licensure standards governing burn units. Please select one option below.

- ○ The Hospital does not operate a Burn Unit
- ◉ Verified Burn Unit: The hospital meets the criteria specified in Rule 59A-3.246(5), F.A.C., for a burn unit and has been verified by the American Burn Association (ABA) for adherence to the ABA Verification Criteria. A copy of the current verification certificate from the American Burn Association will be required in the Supporting Document section of this application.
- ○ Provisional Burn Unit. The hospital meets the criteria specified in Rule 59A-3.246(5), F.A.C., for a burn unit and is in partial compliance with the ABA Verification Criteria but has not received verification from the American Burn Association.

Burn unit services will begin/began on:

Section B - Stroke Centers: Each hospital listed as a stroke center by the Agency must be certified as a stroke center by a nationally recognized accrediting organization. The following accrediting organizations are recognized by the Agency as offering stroke center certifications: Center for Improvement in Healthcare Quality; DNV GL Healthcare; Healthcare Facilities Accreditation Program; and The Joint Commission.

Please select one option below:

- ○ The Hospital is not a Stroke Center

By marking one of the following boxes, the authorized representative submitting this application attests that the hospital is certified as the selected Stroke Center by a nationally recognized accrediting organization.

- ○ The hospital is certified as an acute stroke ready center by a nationally recognized accrediting organization
- ◉ The hospital is certified as a primary stroke center by a nationally recognized accrediting organization
- ○ The hospital is certified as a comprehensive stroke center by a nationally recognized accrediting organization
- ○ The hospital is certified as a thrombectomy-capable stroke center by a nationally recognized accrediting organization

Section C - Adult Cardiovascular Services: Each hospital providing adult cardiovascular services must maintain compliance with the rules adopted by the Agency that establish licensure standards governing adult cardiovascular services.

Note: For continuation of services, provide a list of national registries in which the hospital participates and documentation of meeting or exceeding benchmarks reported by the registry as specified in section 395.1055(18)(g), F.S.

Please select only one option below. If options selected is not valid, please contact the Hospital and Outpatient Services Unit at Hospitals@ahca.myflorida.com

- ○ The Hospital does not provide Adult Cardiovascular Services

By selecting one of the following options, the authorized representative submitting this application attests the hospital meets the criteria specified in rule, including compliance with the incorporated national guidelines, minimum volume requirements, physical plant requirements, transfer agreements and transfer times, data reporting as applicable to the level of service, and the hospital has a formalized plan to provide adult cardiovascular services to Medicaid and charity care patients

- ○ Adult Inpatient Diagnostic Cardiac Catheterization Services as specified in Rule 59A-3.246(1), F.A.C.
- ○ Level I Adult Cardiovascular Services as specified in Rule 59A-3.246(2), F.A.C.
- ◉ Level II Adult Cardiovascular Services as specified in Rule 59A-3.246(3), F.A.C.

For Initial designation, complete one of the following for the most recent 12-month period.

Designate the time period:
Begin Date:
End Date:

1.Total number of adult inpatient and outpatient cardiac catheterizations and number of therapeutic cardiac catheterizations

OR

2. Number of patient discharges and transfers of patients with the principal diagnosis of ischemic heart disease (ICD-10-CM codes I20 through I25)

Section D - Transplant Services: Please mark all that apply.

- ◉ The hospital does not provide Transplant Services
- ○ The hospital provides the following Transplant Services

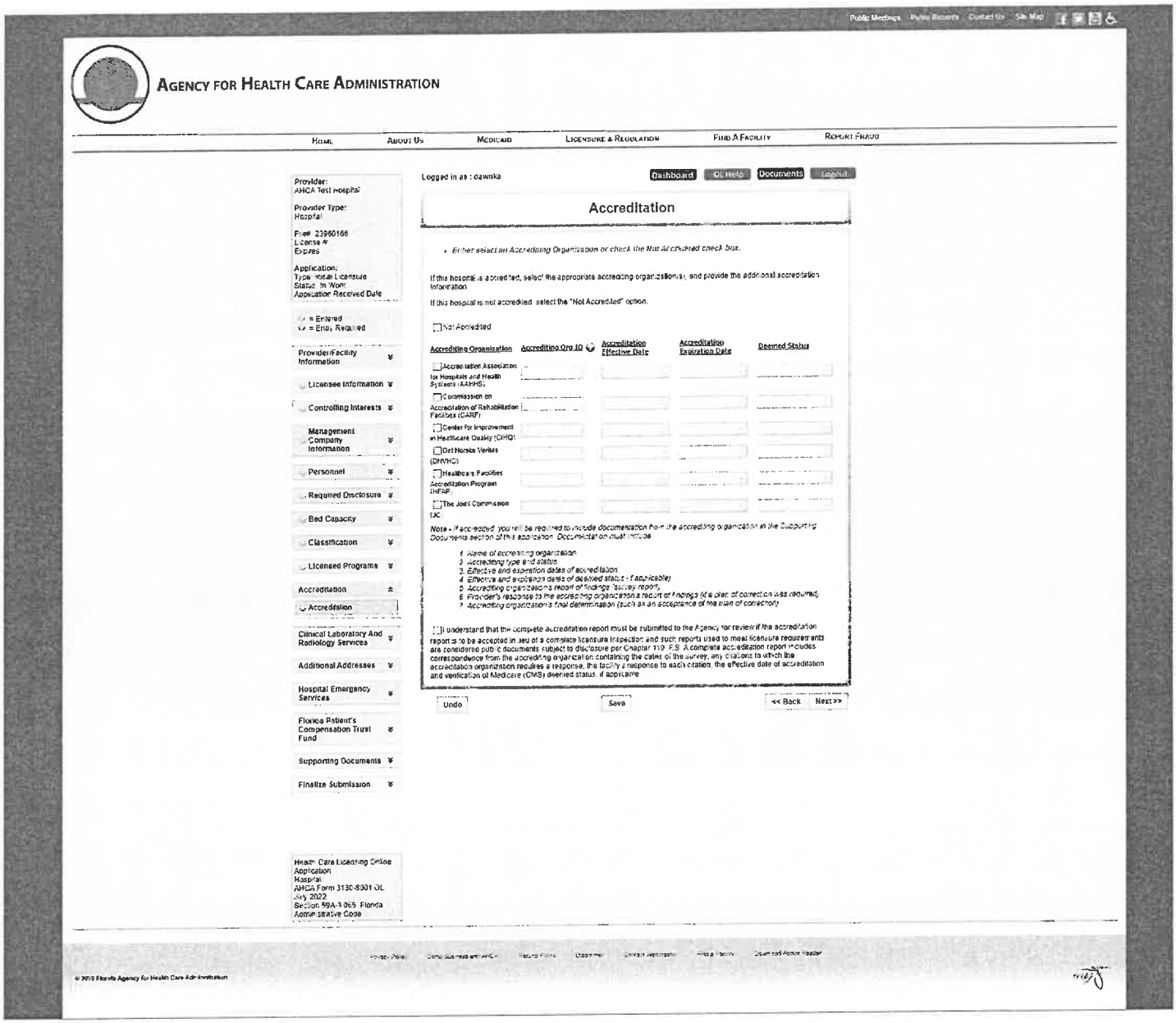
Section E - Neonatal Intensive Care Services. Each hospital providing neonatal intensive care services must maintain compliance with the rules adopted by the Agency that establish licensure standards governing neonatal intensive care services.

Please select only one option below.

By selecting Level II, Level III, or Level IV Neonatal Intensive Care Services, the authorized representative submitting this application attests the hospital meets the standards specified in Rule 59A-3.249, F.A.C. for the level of service indicated, including emergency transportation, transfer agreements, qualified medical director, qualified neonatal nursing and respiratory care personnel, pediatric medical subspecialties available onsite or via telemedicine as applicable per level of service, onsite pediatric medical and surgical services, as applicable per level of service, and neonatal beds with the specified equipment and supplies available.

Mark the highest level of service applied for or provided.

- ○ The hospital does not provide Neonatal Intensive Care Services, or all current services will cease
- ○ The hospital provides Level II Neonatal Intensive Care Services only
- ◉ The hospital provides Level III Neonatal Intensive Care Services
- ○ The hospital provides Level IV Neonatal Intensive Care Services



AGENCY FOR HEALTH CARE ADMINISTRATION

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Provider:
AHCA Test Hospital

Provider Type:
Hospital

Fac# 23960166
License #
Expires

Application:
Type: Initial Licensure
Status: In Work
Application Received Date

* = Entered
** = Entry Required

- Provider/Facility Information
- Licensee Information
- Controlling Interests
- Management Company Information
- Personnel
- Required Disclosure
- Bed Capacity
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- Accreditation
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Health Care Licensing Online Application
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AHCA Form 3130-8001 OL
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Accreditation

- *Either select an Accrediting Organization or check the Not Accredited check box.*

If this hospital is accredited, select the appropriate accrediting organization(s), and provide the additional accreditation information.

If this hospital is not accredited, select the "Not Accredited" option.

☐ Not Accredited

Accrediting Organization	Accrediting Org ID	Accreditation Effective Date	Accreditation Expiration Date	Deemed Status
☐ Accreditation Association for Hospitals and Health Systems (AAHHS)				
☐ Commission on Accreditation of Rehabilitation Facilities (CARF)				
☐ Center for Improvement in Healthcare Quality (CIHQ)				
☐ Det Norske Veritas (DNVHC)				
☐ Healthcare Facilities Accreditation Program (HFAP)				
☐ The Joint Commission (JC)				

Note - If accredited, you will be required to include documentation from the accrediting organization in the Supporting Documents section of this application. Documentation must include:

1. *Name of accrediting organization*
2. *Accrediting type and status*
3. *Effective and expiration dates of accreditation*
4. *Effective and expiration dates of deemed status, if applicable)*
5. *Accrediting organization's report of findings (survey report)*
6. *Provider's response to the accrediting organization's report of findings (if a plan of correction was required)*
7. *Accrediting organization's final determination (such as an acceptance of the plan of correction)*

☐ I understand that the complete accreditation report must be submitted to the Agency for review if the accreditation report is to be accepted in lieu of a complete licensure inspection and such reports used to meet licensure requirements are considered public documents subject to disclosure per Chapter 119, F.S. A complete accreditation report includes correspondence from the accrediting organization containing the dates of the survey, any citations to which the accreditation organization requires a response, the facility's response to each citation, the effective date of accreditation and verification of Medicare (CMS) deemed status, if applicable.

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Provider:
AHCA Test Hospital

Provider Type:
Hospital

Fee# 23950165
License #
Express

Application:
Type: Initial Licensure
Status: In Work
Application Received Date

= Entered
= Entry Required

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- Licensee Information
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Logged in as : downka

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Clinical Laboratory And Radiology Services

- *Select at least one Clinical Laboratory Service.*

Pursuant to section 395.009 and 395.0091, F.S. minimum standards are required for clinical laboratory test results and diagnostic X-ray results as a prerequisite for issuance or renewal of license.

Please indicate which of the following apply:

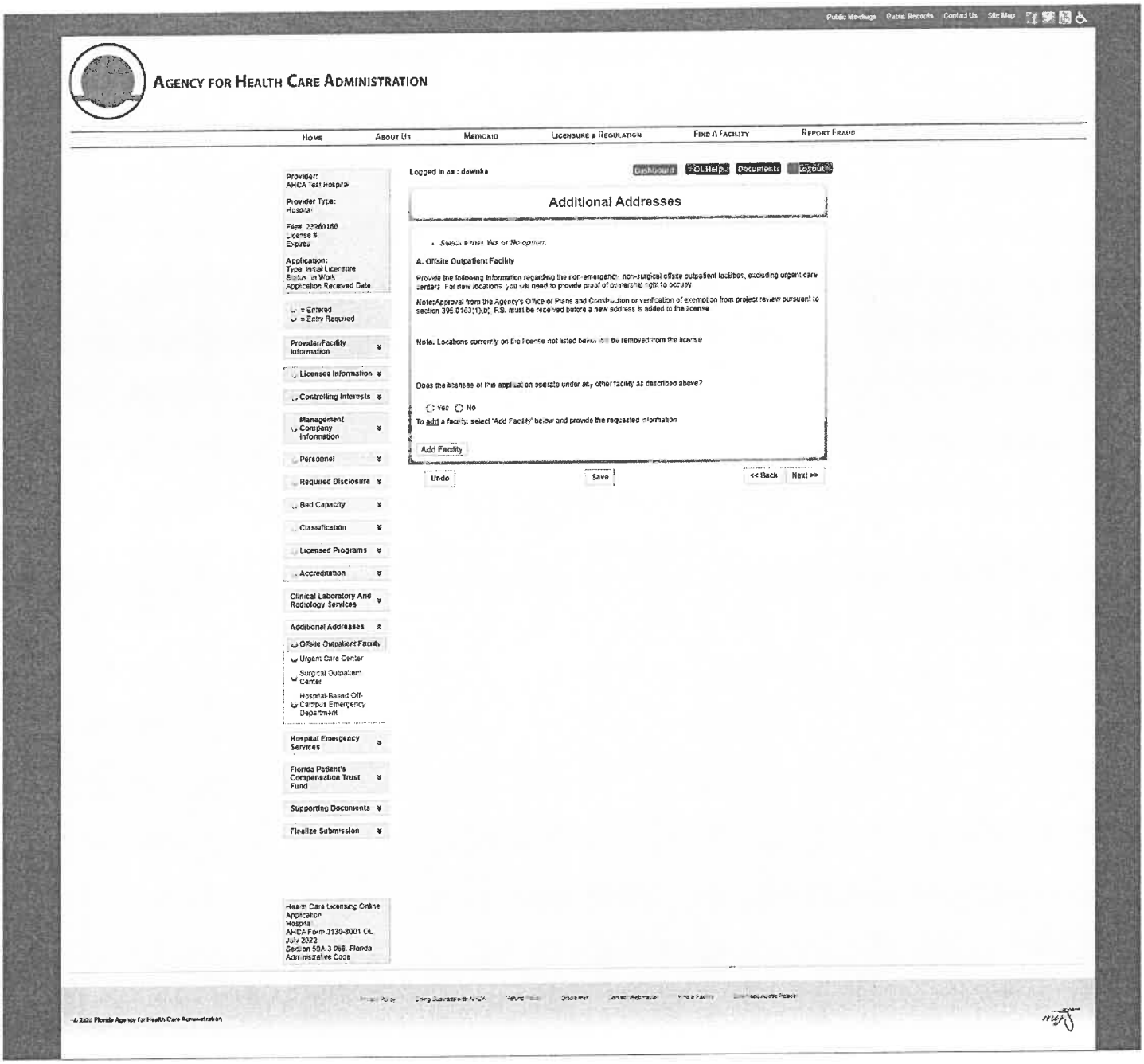
☐ Minimum standards are established for acceptance of results of diagnostic X- rays performed by or for the hospital. These standards require licensure or registration of the source of ionizing radiation under the provisions of Chapter 404, F.S.

☑ All clinical laboratory tests performed by or for the hospital are performed by a clinical laboratory appropriately certified by the Centers for Medicare and Medicaid Services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder.

○ Alternate-site testing are performed within the hospital premises. The tests performed at each location are listed on the attached AHCA Form 3130-8012.

○ Alternate-site testing are not performed within the hospital premises.

Undo Save << Back Next >>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Hospital
Fac# 22969186
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Expires
Application:
Type: Initial Licensure
Status: In Work
Application Received Date
= Entered
= Entry Required
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Required Disclosure
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Additional Addresses
Offsite Outpatient Facility
Urgent Care Center
Surgical Outpatient Center
Hospital-Based Off-Campus Emergency Department
Hospital Emergency Services
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Additional Addresses
Select a new Yes or No option.
A. Offsite Outpatient Facility
Provide the following information regarding the non-emergency, non-surgical offsite outpatient facilities, excluding urgent care centers. For new locations, you will need to provide proof of ownership right to occupy.
Note: Approval from the Agency's Office of Plans and Construction or verification of exemption from project review pursuant to section 395.0103(1)(b), F.S. must be received before a new address is added to the license.
Note: Locations currently on the license not listed below will be removed from the license.
Does the licensee of this application operate under any other facility as described above?
Yes
No
To add a facility, select 'Add Facility' below and provide the requested information.
Add Facility
Undo
Save
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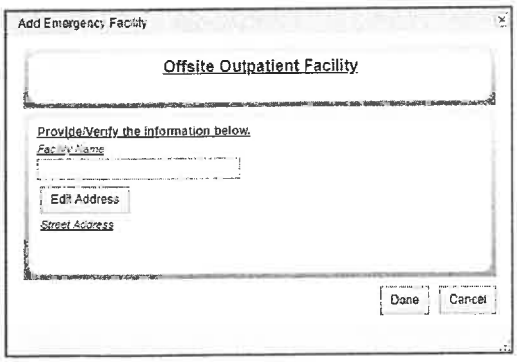
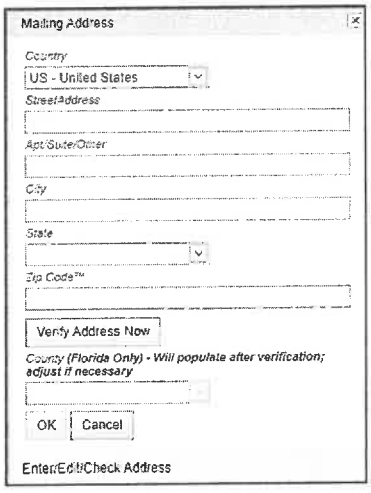
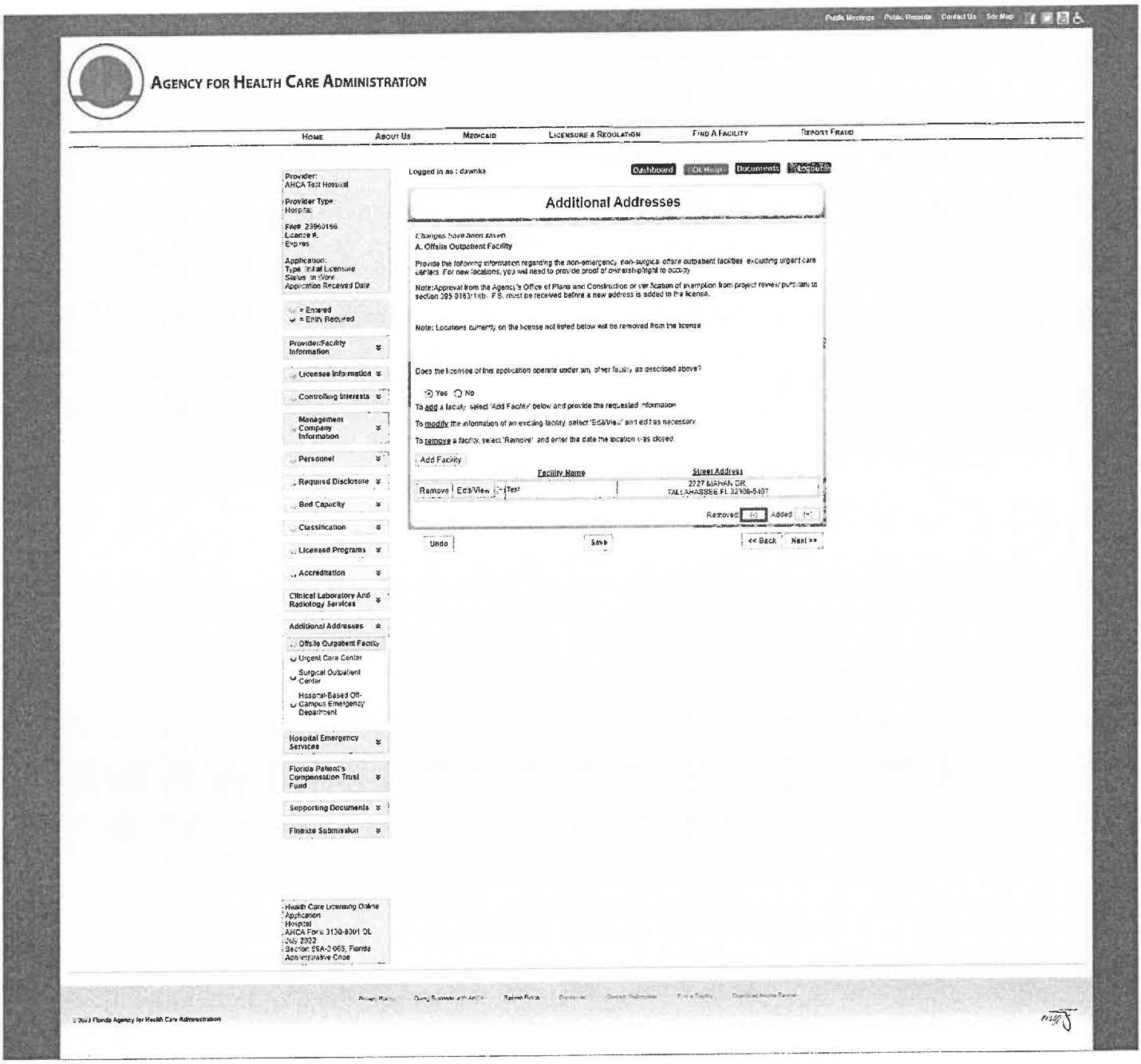

Add Emergency Facility
Offsite Outpatient Facility
Provide/Verify the information below.
Facility Name
Edit Address
Street Address
Done
Cancel


Mailing Address
Country
US - United States
Street Address
Apt/Suite/Other
City
State
Zip Code™
Verify Address Now
County (Florida Only) - Will populate after verification; adjust if necessary
OK
Cancel
Enter/Edit/Check Address


Public Meetings
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Contact Us
Site Map
AGENCY FOR HEALTH CARE ADMINISTRATION
HOME
ABOUT US
MEDICAID
LICENSURE & REGULATION
FIND A FACILITY
REPORT FRAUD
Provider:
AHCA Test Hospital
Provider Type:
Hospital
File# 23960166
License #:
Expires
Application:
Type: Initial Licensure
Status: In Work
Application Received Date
= Entered
= Entry Required
Provider/Facility Information
Licensee Information
Controlling Interests
Management Company Information
Personnel
Required Disclosure
Bed Capacity
Classification
Licensed Programs
Accreditation
Clinical Laboratory And Radiology Services
Additional Addresses
Offsite Outpatient Facility
Urgent Care Center
Surgical Outpatient Center
Hospital-Based Off-Campus Emergency Department
Hospital Emergency Services
Florida Patient's Compensation Trust Fund
Supporting Documents
Finalize Submission
Health Care Licensing Online Application
Hospital
AHCA Form 3130-8001 OL
July 2022
Section 59A-3.065, Florida Administrative Code
Logged in as : dawnka
Dashboard
OL Help
Documents
Logout
Additional Addresses
Changes have been saved.
A. Offsite Outpatient Facility
Provide the following information regarding the non-emergency, non-surgical offsite outpatient facilities, excluding urgent care centers. For new locations, you will need to provide proof of ownership/right to occupy.
Note: Approval from the Agency's Office of Plans and Construction or verification of exemption from project review pursuant to section 395.0163(1)(b), F.S. must be received before a new address is added to the license.
Note: Locations currently on the license not listed below will be removed from the license.
Does the licensee of this application operate under any other facility as described above?
Yes
No
To add a facility, select 'Add Facility' below and provide the requested information.
To modify the information of an existing facility, select 'Edit/View' and edit as necessary.
To remove a facility, select 'Remove' and enter the date the location was closed.
Add Facility
Facility Name
Street Address
Remove
Edit/View
iTest
2727 MAHAN DR
TALLAHASSEE FL 32308-5407
Removed: (-)
Added: (+)
Undo
Save
<< Back
Next >>
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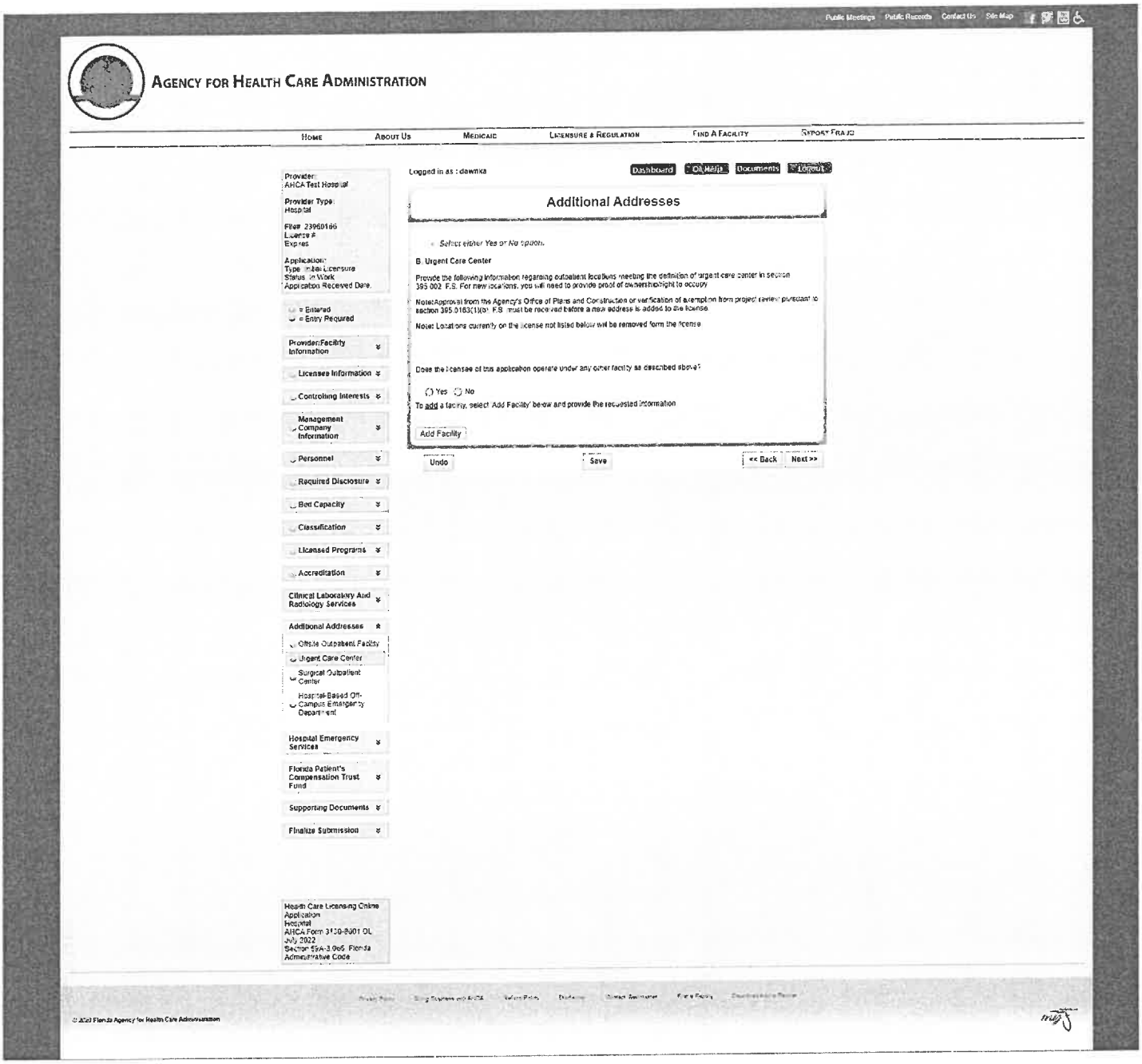
Public Meetings
Public Records
Contact Us
Site Map
AGENCY FOR HEALTH CARE ADMINISTRATION
HOME
ABOUT US
MEDICAID
LICENSURE & REGULATION
FIND A FACILITY
REPORT FRAUD
Provider:
AHCA Test Hospital
Provider Type:
Hospital
FEI#: 239601186
License #:
Expires:
Application:
Type: Initial Licensure
Status: In Work
Application Received Date:
= Entered
= Entry Required
Provider/Facility Information
Licenses Information
Controlling Interests
Management Company Information
Personnel
Required Disclosure
Bed Capacity
Classification
Licensed Programs
Accreditation
Clinical Laboratory And Radiology Services
Additional Addresses
Offsite Outpatient Facility
Urgent Care Center
Surgical Outpatient Center
Hospital-Based Off-Campus Emergency Department
Hospital Emergency Services
Florida Patient's Compensation Trust Fund
Supporting Documents
Finalize Submission
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Hospital
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July 2022
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Logged in as : dawnka
Dashboard
Help
Documents
Logout
Additional Addresses
* Select either Yes or No option.
B. Urgent Care Center
Provide the following information regarding outpatient locations meeting the definition of urgent care center in section 395.002, F.S. For new locations, you will need to provide proof of ownership/right to occupy.
Note: Approval from the Agency's Office of Plans and Construction or verification of exemption from project review pursuant to section 395.0163(1)(b), F.S. must be received before a new address is added to the license.
Note: Locations currently on the license not listed below will be removed form the license.
Does the licensee of this application operate under any other facility as described above?
Yes
No
To add a facility, select 'Add Facility' below and provide the requested information.
Add Facility
Undo
Save
<< Back
Next >>
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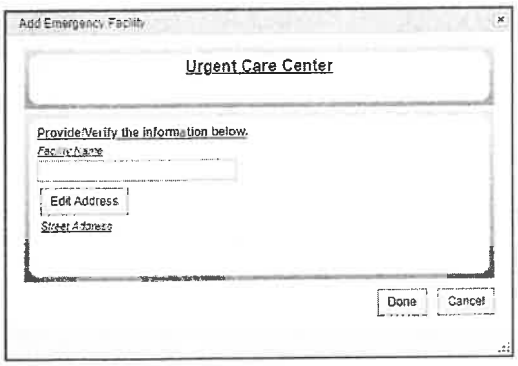
Add Emergency Facility
Urgent Care Center
Provide/Verify the information below.
Facility Name
Edit Address
Street Address
Done
Cancel

Provider:
AHCA Test Hospital

Provider Type:
Hospital

File#: 23960166
License #
Expired

Application:
Type: Initial Licensure
Status: In Work
Application Received Date

= Entered
= Entry Required

- Provider/Facility Information
- Licensee Information
- Controlling Interests
- Management Company Information
- Personnel
- Required Disclosure
- Bed Capacity
- Classification
- Licensed Programs
- Accreditation
- Clinical Laboratory And Radiology Services
- Additional Addresses
  - Offsite Outpatient Facility
  - Urgent Care Center
  - Surgical Outpatient Center
  - Hospital-Based Off-Campus Emergency Department
- Hospital Emergency Services
- Florida Patient's Compensation Trust Fund
- Supporting Documents
- Finalize Submission

Health Care Licensing Online Application
Hospital
AHCA Form 3130-8001 OL
July 2022
Section 59A-3.066, Florida Administrative Code

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Dashboard OL Help Documents Logout

Additional Addresses

Changes have been saved.

B. Urgent Care Center

Provide the following information regarding outpatient locations meeting the definition of urgent care center in section 395.002, F.S. For new locations, you will need to provide proof of ownership/right to occupy.

Note: Approval from the Agency's Office of Plans and Construction or verification of exemption from project review pursuant to section 395.0163(1)(b), F.S. must be received before a new address is added to the license.

Note: Locations currently on the license not listed below will be removed form the license.

Does the licensee of this application operate under any other facility as described above?

(•) Yes ( ) No

To add a facility, select 'Add Facility' below and provide the requested information.

To modify the information of an existing facility, select 'Edit/View' and edit as necessary.

To remove a facility, select 'Remove', and enter the date the location was closed.

Add Facility

	Facility Name	Street Address
Remove Edit/View	Test Urgent Care Center	2727 MAHAN DR. TALLAHASSEE FL 32308-5407

Removed ( ) Added (+)

Undo Save << Back Next >>

Provider:
AHCA Test Hospital

Provider Type:
Hospital

Filer# 23960186
License #:
Expires

Application:
Type: Initial Licensure
Status: In Work
Application Received Date:

= Entered
= Entry Required

- Provider/Facility Information
- Licensee Information
- Controlling Interests
- Management Company Information
- Personnel
- Required Disclosure
- Bed Capacity
- Classification
- Licensed Programs
- Accreditation
- Clinical Laboratory And Radiology Services
- Additional Addresses
  - Offsite Outpatient Facility
  - Urgent Care Center
  - Surgical Outpatient Center
  - Hospital-Based Off-Campus Emergency Department
- Hospital Emergency Services
- Florida Patient's Compensation Trust Fund
- Supporting Documents
- Finalize Submission

Health Care Licensing Online Application
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Additional Addresses

- *Select either Yes or No below.*

C. Surgical Outpatient Center

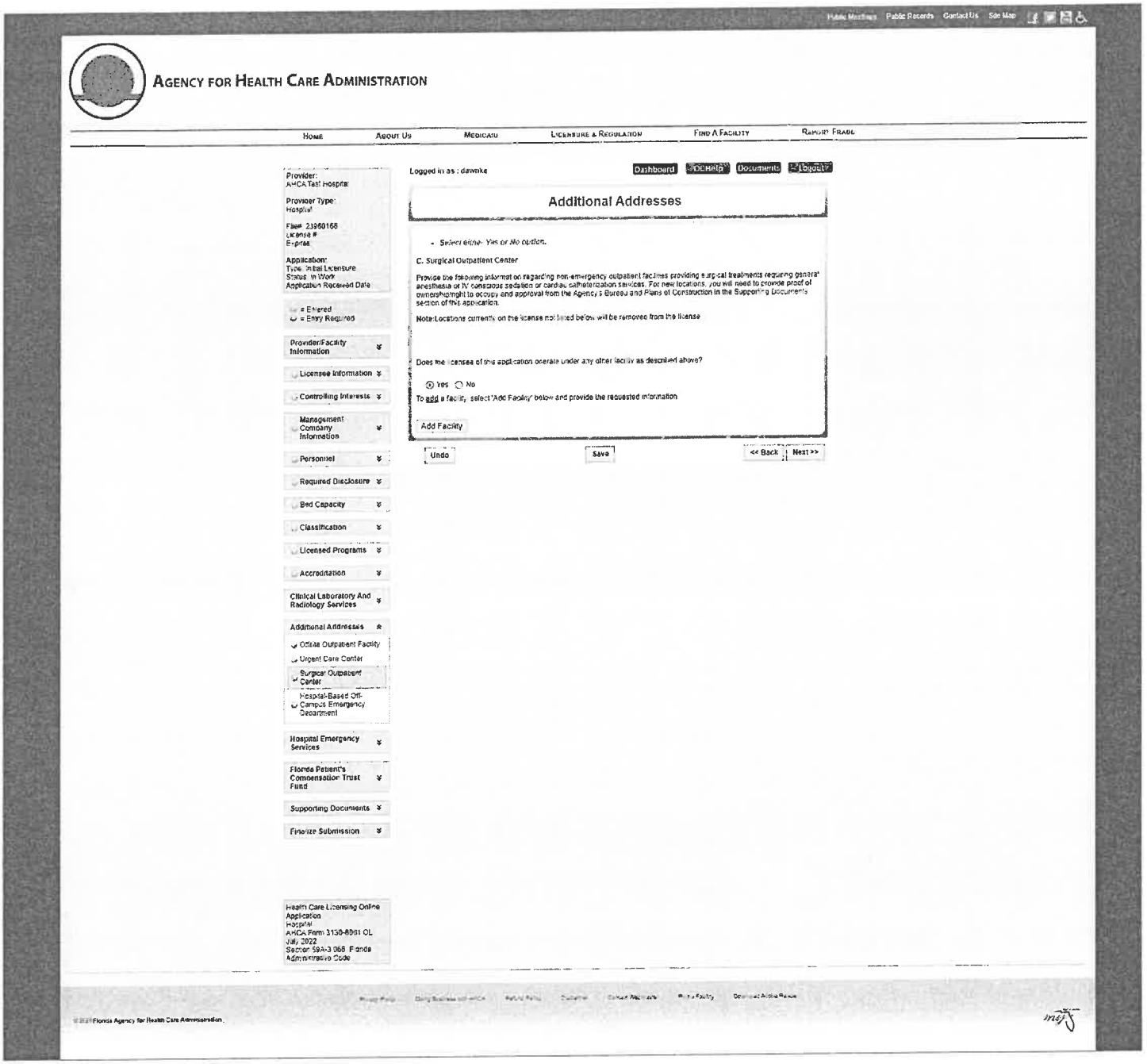
Provide the following information regarding non-emergency outpatient facilities providing surgical treatments requiring general anesthesia or IV conscious sedation or cardiac catheterization services. For new locations, you will need to provide proof of ownership/right to occupy and approval from the Agency's Bureau and Plans of Construction in the Supporting Documents section of this application.

Note: Locations currently on the license not listed below will be removed from the license.

Does the licensee of this application operate under any other facility as described above?

( ) Yes ( ) No

Undo | Save | << Back | Next >>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FIND A FACILITY
REPORT FRAUD
Provider:
AHCA Test Hospital
Provider Type:
Hospital
Fiad# 23960168
License #
Expires
Application:
Type: Initial Licensure
Status: In Work
Application Received Date
= Entered
= Entry Required
Provider/Facility Information
Licensee Information
Controlling Interests
Management Company Information
Personnel
Required Disclosure
Bed Capacity
Classification
Licensed Programs
Accreditation
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Finalize Submission
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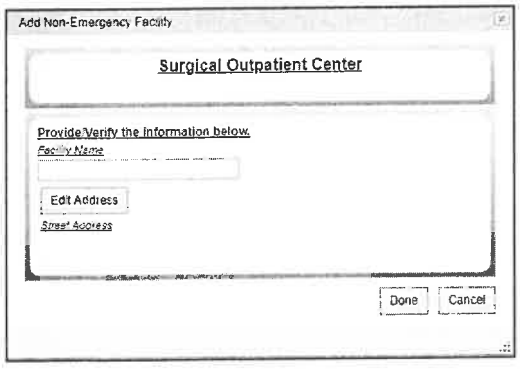
AHCA Form 3130-8001 OL
July, 2022
Section 59A-3.066, Florida Administrative Code
Logged in as : dawnke
Dashboard
OLHelp
Documents
Logout
Additional Addresses
Select either Yes or No option.
C. Surgical Outpatient Center
Provide the following information regarding non-emergency outpatient facilities providing surgical treatments requiring general anesthesia or IV conscious sedation or cardiac catheterization services. For new locations, you will need to provide proof of ownership/right to occupy and approval from the Agency's Bureau and Plans of Construction in the Supporting Documents section of this application.
Note: Locations currently on the license not listed below will be removed from the license
Does the licensee of the application operate under any other facility as described above?
Yes
No
To add a facility, select 'Add Facility' below and provide the requested information.
Add Facility
Undo
Save
<< Back
Next >>
Florida Agency for Health Care Administration


Add Non-Emergency Facility
Surgical Outpatient Center
Provide/Verify the information below.
Facility Name
Edit Address
Street Address
Done
Cancel

Provider:
AHCA Test Hospital

Provider Type:
Hospital

FI#: 23960166
License #:
Expires:

Application:
Type: Initial Licensure
Status: In Work
Application Received Date:

= Entered
= Entry Required

- Provider/Facility Information
- Licensee Information
- Controlling Interests
- Management Company Information
- Personnel
- Required Disclosure
- Bed Capacity
- Classification
- Licensed Programs
- Accreditation
- Clinical Laboratory And Radiology Services
- Additional Addresses
  - Offsite Outpatient Facility
  - Urgent Care Center
  - Surgical Outpatient Center
  - Hospital-Based Off-Campus Emergency Department
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Health Care Licensing Online Application
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Additional Addresses

Changes have been saved.

C. Surgical Outpatient Center

Provide the following information regarding non-emergency outpatient facilities providing surgical treatments requiring general anesthesia or IV conscious sedation or cardiac catheterization services. For new locations, you will need to provide proof of ownership/right to occupy and approval from the Agency's Bureau and Plans of Construction in the Supporting Documents section of this application.

Note: Locations currently on the license not listed below will be removed from the license.

Does the licensee of this application operate under any other facility as described above?

(•) Yes ( ) No

To add a facility, select 'Add Facility' below and provide the requested information.

To modify the information of an existing facility, select 'Edit/View' and edit as necessary.

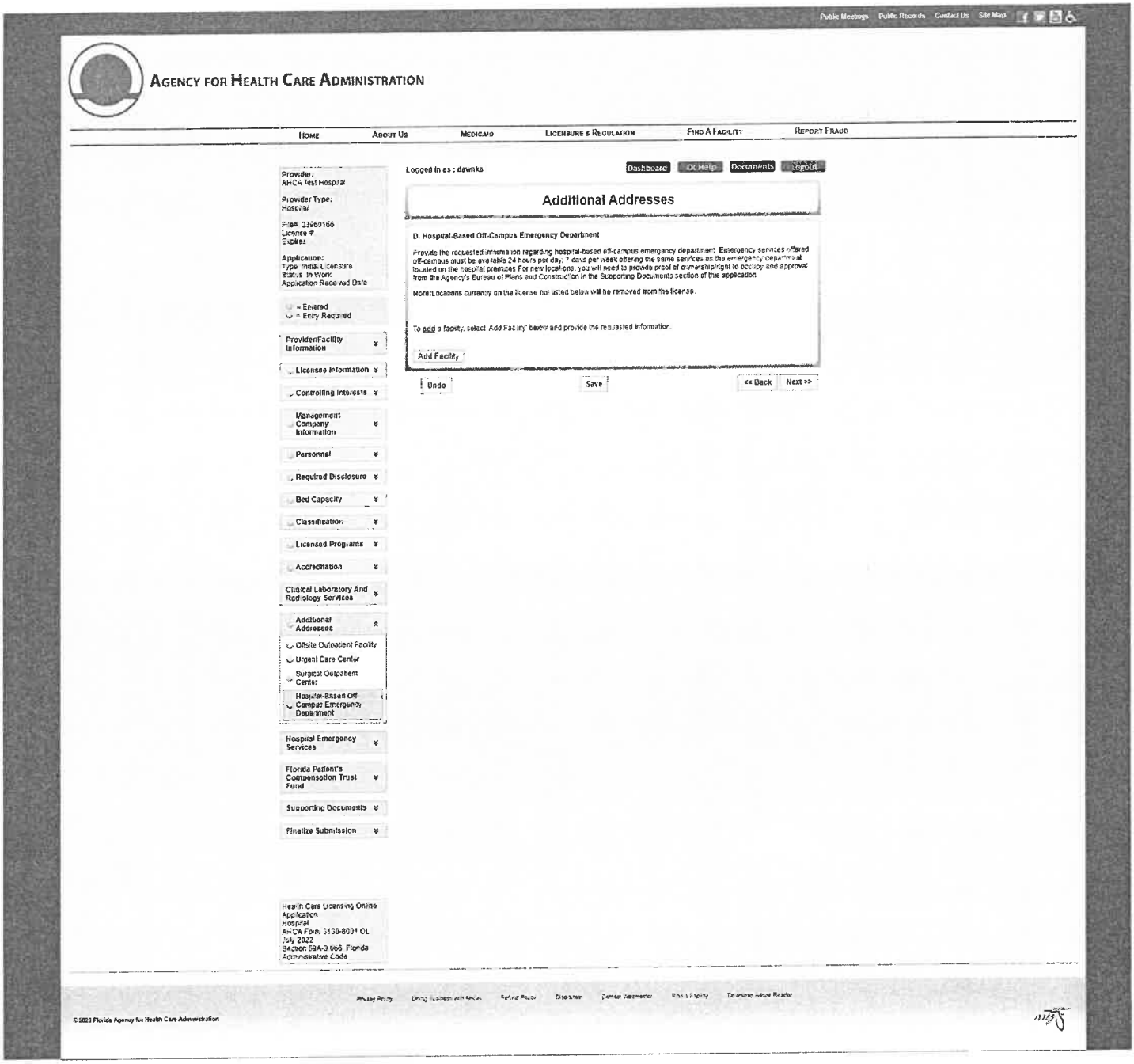
To remove a facility, select 'Remove', and enter the date the location was closed.

[Add Facility]

	Facility Name	Street Address
Remove | Edit/View	Test Surgical Out Patient Center	2727 MAHAN DR TALLAHASSEE FL 32308-5407

Removed: [ ] Added: [ ]

Undo | Save | << Back | Next >>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LICENSURE & REGULATION
FIND A FACILITY
REPORT FRAUD
Provider:
AHCA Test Hospital
Provider Type:
Hospital
Fiad: 23960166
License #:
Expires:
Application:
Type: Initial-Licensure
Status: In Work
Application Received Date:
= Entered
= Entry Required
Provider/Facility Information
License Information
Controlling Interests
Management Company Information
Personnel
Required Disclosure
Bed Capacity
Classification
Licensed Programs
Accreditation
Clinical Laboratory And Radiology Services
Additional Addresses
Offsite Outpatient Facility
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Surgical Outpatient Center
Hospital-Based Off-Campus Emergency Department
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July 2022
Section 59A-3.066, Florida Administrative Code
Logged in as : dawnka
Dashboard
OK Help
Documents
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Additional Addresses
D. Hospital-Based Off-Campus Emergency Department
Provide the requested information regarding hospital-based off-campus emergency department. Emergency services offered off-campus must be available 24 hours per day, 7 days per week offering the same services as the emergency department located on the hospital premises. For new locations, you will need to provide proof of ownership/right to occupy and approval from the Agency's Bureau of Plans and Construction in the Supporting Documents section of this application.
Note: Locations currently on the license not listed below will be removed from the license.
To add a facility, select 'Add Facility' below and provide the requested information.
Add Facility
Undo
Save
<< Back
Next >>
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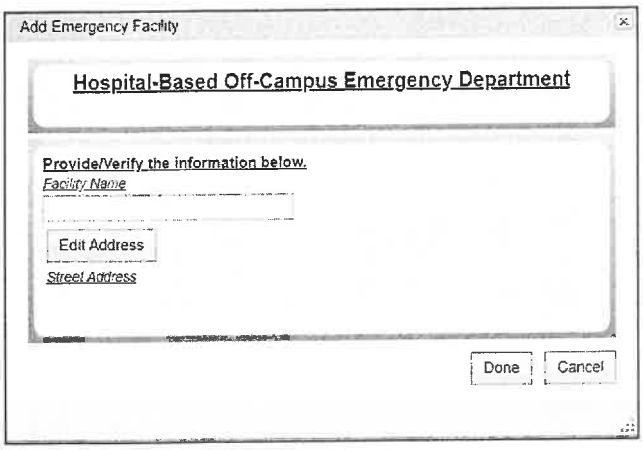
Add Emergency Facility
Hospital-Based Off-Campus Emergency Department
Provide/Verify the information below.
Facility Name
Edit Address
Street Address
Done
Cancel

Provider:
AHCA Test Hospital

Provider Type:
Hospital

Fac# 23980163
License #
Expires

Application:
Type Initial Licensure
Status In Work
Application Received Date

= Entered
= Entry Required

- Provider/Facility Information
- License Information
- Controlling Interests
- Management Company Information
- Personnel
- Required Disclosure
- Bed Capacity
- Classification
- Licensed Programs
- Accreditation
- Clinical Laboratory And Radiology Services
- Additional Addresses
  - Offsite Outpatient Facility
  - Urgent Care Center
  - Surgical Outpatient Center
  - Hospital Based Off-Campus Emergency Department
- Hospital Emergency Services
- Florida Patient's Compensation Trust Fund
- Supporting Documents
- Finalize Submission

Health Care Licensing Online Application
Hospital
AHCA Form 3130-8001 OL
July 2022
Section 59A-3.056, Florida Administrative Code

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Additional Addresses

D. Hospital-Based Off-Campus Emergency Department

Provide the requested information regarding hospital-based off-campus emergency department. Emergency services offered off-campus must be available 24 hours per day, 7 days per week offering the same services as the emergency department located on the hospital premises. For new locations, you will need to provide proof of ownership/right to occupy and approval from the Agency's Bureau of Plans and Construction in the Supporting Documents section of this application.

Note: Locations currently on the license not listed below will be removed from the license.

To add a facility, select 'Add Facility' below and provide the requested information.

Add Facility

	Facility Name	Street Address
Remove | Edit/View	Test Hospital Based Off Campus ED	2727 MAHAN DR TALLAHASSEE FL 32308-5407

Removed: 0 | Added: 0

Undo | Save | << Back | Next >>

Provider:
AHCA Test Hospital

Provider Type:
Hospital

Fed#: 23960165
License #:
Expires

Application
Type: Initial Licensure
Status: In Work
Application Received Date

= Entered
= Entry Required

- Provider/Facility Information
- Licensee Information
- Controlling Interests
- Management Company Information
- Personnel
- Required Disclosure
- Bed Capacity
- Classification
- Licensed Programs
- Accreditation
- Clinical Laboratory And Radiology Services
- Additional Addresses
- Hospital Emergency Services
  - Section I
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- Florida Patient's Compensation Trust Fund
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- Finalize Submission

Health Care Licensing Online Application
Hospital
AHCA Form 3130-6001 OL
July 2020
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Hospital Emergency Services

- *Please provide answer to all the questions below*

Provide the appropriate answers below regarding the emergency services provided by this hospital

1. Emergency Services
   - ( ) There is no dedicated emergency department in this hospital
   - ( ) Emergency services are offered via an emergency department located within the hospital and/or off site as indicated in the Offsite Facilities section of this application.
2. Does this hospital have an emergency 2 Way Radio System approved by the Department of Management Services Division of Communications and the Federal Communications Commission in accordance with section 395.1041, F.S.?
   ( ) Yes ( ) No
3. Are you requesting an emergency service exemption per section 395.1041(3)(c), F.S.? If so, you will be required to attach AHCA Form 3000-1 in the Supporting Documents section of this application
   ( ) Yes ( ) No
4. Does this hospital have a Baker Act receiving facility designation from the Department of Children and Families? If so you will be required to attach your certificate in the Supporting Documents section of this application
   ( ) Yes ( ) No
5. Select the appropriate Trauma Center designation(s) issued from the Department of Health, Office of Trauma
   - [ ] Provisional Level 1
   - [ ] Provisional Level 2
   - [ ] Provisional Pediatric
   - [ ] Level 1
   - [ ] Level 2
   - [ ] Pediatric
   - [ ] Not applicable

Undo | Save | << Back | Next >>

Provider:
AHCA Test Hospital

Provider Type:
Hospital

Fac#: 23960166
License #
Expires

Application
Type: Initial Licensure
Status: In Work
Application Received Date

= Entered
= Entry Required

- Provider/Facility Information
- Licensee Information
- Controlling Interests
- Management Company Information
- Personnel
- Required Disclosure
- Bed Capacity
- Classification
- Licensed Programs
- Accreditation
- Clinical Laboratory And Radiology Services
- Additional Addresses
- Hospital Emergency Services
  - Section I
  - Section II
- Florida Patient's Compensation Trust Fund
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Health Care Licensing Online Application
Hospital
AHCA Form 3130-8001 OL
July 2022
Section 59A-3.065 Florida Administrative Code

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Hospital Emergency Services

- *Please select an answer for each service. If a service is not provided, select the "Not Provided" option.*

Select the appropriate selection below for each of the services listed.

Service	Not Provided	Provided on site 24 hours per day, 7 days per week	Provided through a combination of onsite and transfer agreement(s) with another hospital(s) 24 hours per day, 7 days per week	Provided through transfer agreement with another hospital(s)	Provided on a limited basis by exemption or partial exemption
Anesthesia	○	○	○	○	○
Burns	○	○	○	○	○
Cardiology	○	○	○	○	○
Cardiovascular Surgery	○	○	○	○	○
Colon & Rectal Surgery	○	○	○	○	○
Emergency Medicine	○	○	○	○	○
Endocrinology	○	○	○	○	○
Gastroenterology	○	○	○	○	○
General Surgery	○	○	○	○	○
Gynecology	○	○	○	○	○
Hematology	○	○	○	○	○
Hyperbaric Medicine	○	○	○	○	○
Internal Medicine	○	○	○	○	○
Nephrology	○	○	○	○	○
Neurology	○	○	○	○	○
Neurosurgery	○	○	○	○	○
Obstetrics	○	○	○	○	○
Ophthalmology	○	○	○	○	○
Oral/Maxillo-facial Surgery	○	○	○	○	○
Orthopedics	○	○	○	○	○
Otolaryngology	○	○	○	○	○
Plastic Surgery	○	○	○	○	○
Podiatry	○	○	○	○	○
Psychiatry	○	○	○	○	○
Pulmonary Medicine	○	○	○	○	○
Radiology	○	○	○	○	○
Thoracic Surgery	○	○	○	○	○
Urology	○	○	○	○	○
Vascular Surgery	○	○	○	○	○

Undo | Save | << Back | Next >>

Provider:
AHCA Test Hospital

Provider Type:
Hospital

FI###: 23960166
License #:
Expires:

Application:
Type: Initial Licensure
Status: In Work
Application Received Date:

= Entered
= Entry Required

- Provider/Facility Information
- Licensee Information
- Controlling Interests
- Management Company Information
- Personnel
- Required Disclosure
- Bed Capacity
- Classification
- Licensed Programs
- Accreditation
- Clinical Laboratory And Radiology Services
- Additional Addresses
- Hospital Emergency Services
- Florida Patient's Compensation Trust Fund
  - Florida Patient's Compensation Trust Fund
- Supporting Documents
- Finalize Submission

Health Care Licensing Online Application
Hospital
AHCA Form 3130-8001 OL
July 2020
Section 59A-3.065, Florida Administrative Code

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Florida Patient's Compensation Trust Fund

- *User must enter Calendar year in the space provided*
- *User must select one of the options.*

AUTHORITY: Pursuant to subsection 766.106(2)(a)2, F.S. "Annually, the Agency for Health Care Administration shall require documentation by each hospital that such hospital is in compliance, and will remain in compliance, with the provisions of this section. The agency may not issue or renew the license of any hospital which has not been certified by the board of governors. The license of any hospital that fails to remain in compliance or fails to provide such documentation shall be revoked or suspended by the Agency."

The hospital named in this application is exempt from participation in the FPCF for calendar year [ ]

because it has demonstrated its current financial responsibility and certifies it will maintain such financial injury or property damage to the person or property of any patient arising out of their activities for this period by:

- A bond posted in the amount equivalent to $10,000 per claim for each hospital bed, not to exceed a $2,500,000 annual aggregate. You will be asked to provide proof in the Supporting Documents section of this application.
- An escrow account in an amount equivalent to $10,000 per claim for each hospital bed, not to exceed a $2,500,000 annual aggregate to the satisfaction of the Agency for Health Care Administration. You will be asked to provide proof in the Supporting Documents section of this application.
- Professional liability coverage in an amount equivalent to $10,000 or more per claim for each hospital bed from a private insurer or from the Joint Underwriting Association established under s. 627.351(4), Florida Statutes, not to exceed a $2,500,000 annual aggregate.
- A plan of self-insurance as provided in s. 627.357, Florida Statutes in an amount equivalent to $10,000 or more per claim for each hospital bed, not to exceed a $2,500,000 annual aggregate.
- Sovereign immunity. State Agencies, subdivisions or instrumentalities of the state. No additional documentation is required with this application if previously documented.

Make the applicable selection below. You will need to provide the appropriate documentation in the Supporting Documents section of this application. Please be advised – a policy binder is not sufficient proof of coverage.

- [ ] Bond
- [ ] Escrow account
- [ ] Professional liability coverage from a private insurer
- [ ] Self-insurance plan
- [ ] Sovereign immunity

Undo | Save | << Back | Next >>

Provider:
AHCA Test Hospital

Provider Type
Hospital

Fiel: 2396016
License #
Expires:

Application:
Type: Initial Licensure
Status: In Work
Application Received Date:

* = Required
= Entry Required

- Provider/Facility Information
- Licensee Information
- Controlling Interests
- Management Company Information
- Personnel
- Required Disclosure
- Bed Capacity
- Classification
- Licensed Programs
- Accreditation
- Clinical Laboratory And Radiology Services
- Additional Addresses
- Hospital Emergency Services
- Florida Patient's Compensation Trust Fund
- Supporting Documents
  - Supporting Documents
- Finalize Submission

Health Care Licensing Online Application
Hospital
AHCA Form 3130 8001 OL, July 2022
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Supporting Documents

Applicants **MUST** include the following attachments as stated in: Chapters 395, Part II, and 408, F.S. and Chapters 59A-35 and 59A-3, F.A.C.

The following file types are suggested for uploading and submitting electronic documents to the Agency:
.DOC, .PDF, .TIFF, .TXT, .JPG, .XLS, and .PPT.

The following file types are **NOT** permitted for upload: .ZIP, .EXE, .BIN, .COM, .CMD, .SYS, .BAT, and .JS
The upload and submission process will fail if any of these unpermitted file types are selected.

- *Copy of Visitation Policy and Procedure*
  - *Upload documents required check the document marked checkbox.*
- *Documentation signed by the appropriate local government official, which states that the applicant has met local zoning requirements*
  - *Upload documents required check the document marked checkbox.*

Escrow Insurance

Policy #:
Effective Date:
Expiry Date:
Aggregate Policy Amount: $0.00
Occurrence Policy Amount: $0.00

☐ An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Browse...

Private Insurance

Carrier:
Policy #:
Effective Date:
Expiry Date:
Aggregate Policy Amount: $0.00
Occurrence Policy Amount: $0.00

☐ An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Browse...

Self Insurance

Policy #:
Effective Date:
Expiry Date:
Aggregate Policy Amount: $0.00
Occurrence Policy Amount: $0.00

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Browse...

Exempt Insurance

Effective Date:

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Browse...

Documentation signed by the appropriate local government official, which states that the applicant has met local zoning requirements

☐ An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Browse...

Provider:
AHCA Test Hospital

Provider Type
Hospital

File# [illegible]
License #
Expires

Application:
Type: Initial Licensure
Status: In Work
Application Received Date

✓ = Entered
○ = Entry Required

- Provider/Facility Information
- Licensee Information
- Controlling Interests
- Management Company Information
- Personnel
- Required Disclosure
- Bed Capacity
- Classification
- Licensed Programs
- Accreditation
- Clinical Laboratory And Radiology Services
- Additional Addresses
- Hospital Emergency Services
- Florida Patient's Compensation Trust Fund
- Supporting Documents
- Finalize Submission
  - Finalize Application

Health Care Licensing Online Application
Hospital
AHCA Form 3130-8001 [illegible]
Section 59A-3.066, Florida Administrative Code

Logged in as : dawnka

Dashboard | Get Help | Documents | Logout

Finalize Application

Any areas marked in red are incomplete and must be completed before the application can be submitted. To submit the application, select the appropriate subsection below or from the Applications Components list to the left, and provide the missing information.

1. Provider/Facility Information
   a. Details
   b. Property Ownership
   c. Contact Person
2. Licensee Information
   a. Licensee Details
3. Controlling Interests
   a. Controlling Interests
4. Management Company Information
   a. Management Company Information
   b. Management Company Controlling Interest
5. Personnel
   a. Administration
   b. Safety Liaison
6. Required Disclosure
   a. Convictions
   b. Exclusions
   c. Felonies/Terminations
7. Bed Capacity
   a. Bed Capacity
8. Classification
   a. Classification
9. Licensed Programs
   a. Licensed Programs
10. Accreditation
    a. Accreditation
11. Clinical Laboratory And Radiology Services
    a. Clinical Laboratory And Radiology Services
12. Additional Addresses
    a. Offsite Outpatient Facility
    b. Urgent Care Center
    c. Surgical Outpatient Center
    d. Hospital-Based Off-Campus Emergency Department
13. Hospital Emergency Services
    a. Section I
    b. Section II
14. Florida Patients Compensation Trust Fund
    a. Florida Patients Compensation Trust Fund
15. Supporting Documents
    a. Supporting Documents

Select the Document Mailer link below, print the mailer, and include it with the documents you mail.

Document Mailer

Item	Document
1	[illegible]
2	Documentation signed by the appropriate local government official, which states that the applicant has met local zoning requirements
3	Copy of Visitation Policy and Procedure

I, DAWN ASHWORTH, 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 section 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(1)(c), 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 is a provider that has a license revoked or application denied pursuant to section 408.815, Florida Statutes.

( ) This hospital offers birthing services and is in compliance with section 382.013(2)(c), Florida Statutes, regarding assistance to unmarried parents who wish to execute a voluntary acknowledgement of paternity.

( ) This hospital does not offer birthing services and section 395.003(5)(a), Florida Statutes is not applicable to this application.

DAWN ASHWORTH
Signature of Licensee or Authorized Representative

Title

05/18/2022
Date

☑ I agree

REMINDER

You have indicated that you will be mailing documents to the Agency.

☑ I agree

Download and print your document mailer if you have not yet done so.

Document Mailer

Biennial Licensure Fee and Other Amounts Due Upon Submission of Application

- The biennial licensure fee is $31.46 per bed, with minimum of $1,565.13
- The biennial assessment fee is $4.00 per bed, not to exceed $1,500
- Other amounts due (fines, assessment fees, etc.) will be detailed in the application

Selecting the 'Submit Application' you will no longer be able to make changes to your application.

Submit Application

Copy of Mediation Policy and Procedure

An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer is available for printing upon completing your application; will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Browse...

License Application Alternate-Site Testing, AHCA Form 3130-6013

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Browse...

Emergency Services Exemption Request Form and Supporting Documents

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Browse...

Baker Act Receiving Facility Certificate

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Browse...

Accreditation Documentation

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Browse...

Adult Cardiovascular Services Supporting Documents

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Browse...

Required Disclosures Related to Actions Taken by Medicare, Medicaid, or CLIA

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Browse...

Facility Ownership/Lease Documentation

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Browse...

Approved Repayment Plan

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Browse...

Additional Documentation

An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer is available for printing upon completing your application; will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Browse...

Undo | Save | << Back | Next >>