



Logged in as :

Provider:

Provider Type:
 Birth Center

File#:

License #:

Expires:

Application:
 Type:

Status:

Date Received:

- = Entered
- = Entry Required

- Provider/Facility Information
- Details
- Contact Person
- Property Ownership
- Licensee Information
- Controlling Interests
- Management Company Information
- Personnel
- Required Disclosures
- General Information
- Accreditation
- Days and Hours of Operation
- Supporting Documents
- Finalize Submission

Health Care Licensing Online
 Application
 Birth Center
 AHCA Form 3130-3001 OL,
 June 2018
 59A-11.003 Florida
 Administrative Code

Provider/Facility Information

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

Pursuant to section [408.806 \(1\)\(a\) and \(b\)](#), Florida Statutes, 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 (EIN) of the applicant and each controlling interest, if the applicant or controlling interest is not an individual. Disclosure of social security number(s) is mandatory. The Agency for Health Care Administration shall use such information for purposes of securing the proper identification of persons listed on this application for licensure.

Review the information below and make any necessary edits. The Provider/Facility name, address, and telephone number will be listed on Florida Health Finder (<http://www.floridahealthfinder.gov>).

Provider/Facility Information

License # National Provider Identifier

None Pending

Medicaid # Medicare # (CMS CCN)

Name of Birth Center (If operated under a fictitious name, enter as it appears in Florida Division of Corporations.)

Provider/Facility Location Address

Telephone Ext Fax #

None

Email Address *Note: By providing your email address, you agree to accept email correspondence from the Agency.*

None

Provider/Facility Website

None

Provider/Facility Mailing Address. (All mail will be sent to this address.)

Check if same as Provider/Facility Location Address

Address

Telephone Ext Email Address

None





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Provider/Facility Information

Provider/Facility Contact Person for this Application

First Name	Middle Name	Last Name	Suffix
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Telephone	Ext	Fax #	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input type="checkbox"/> None			

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

None

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License #:
[Blank field]

Expires:
[Blank field]

Application:
Type: [Blank field]

Status: [Blank field]

Date Received: [Blank field]

- = Entered
- = Entry Required

Provider/Facility Information ▲

- Details
- Contact Person
- Property Ownership**

Licensee Information ▼

Controlling Interests ▼

Management Company Information ▼

Personnel ▼

Required Disclosure ▼

General Information ▼

Accreditation ▼

Days and Hours of Operation ▼

Supporting Documents ▼

Finalize Submission ▼

Property Ownership

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

- Own
- Lease

Undo

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Type: Renewal Licensure
Status:
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Licensee Information

Description of licensee (select only one option below)

 For Profit Not for Profit Public

Ownership Types

Entity Licensee Details

Licensee Name (may be same as provider name)

Federal Employer Identification # (EIN)

Mailing Address

[Edit Address](#)Address

Telephone

Ext

Fax #

 None

Email Address

 None[Undo](#)[Save](#)[<< Back](#)[Next >>](#)

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Provider/Facility Information ▾

Licensee Information ▾

Controlling Interests ▲

Controlling Interests

Management Company Information ▾

Personnel ▾

Required Disclosure ▾

General Information ▾

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Controlling Interests of Licensee

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.

Do any individuals or entities possess 5% or greater ownership interest in the licensee, or, function as a board member or officer?

Yes No

Undo

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Edit 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





Provider:
[Redacted]

Provider Type:
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[Redacted]

License #:
[Redacted]

Expires:
[Redacted]

Application:
Type: [Redacted]
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Date Received: [Redacted]

= Entered
 = Entry Required

- Provider/Facility Information** ▾
- Licensee Information** ▾
- Controlling Interests** ▾
- Management Company Information** ▲
- Management Company Information**
- Management Company Controlling Interest**
- Personnel** ▾
- Required Disclosure** ▾
- General Information** ▾
- Accreditation** ▾
- Days and Hours of Operation** ▾
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- Finalize Submission** ▾

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Management Company Information

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

Yes No

To **verify** Management Company's information -
Select "Edit/View" and edit as needed.

To **remove** an existing Management Company -
Select "Remove" and enter the applicable end date.

	Full Name of Entity	Tax ID	Effective Date	End Date
Remove Edit/View				

Removed: (-) Added: (+)

Undo

Save

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Edit Management Company

Name of Management Company Federal Employer Identification # (EIN)

Effective Date End Date

Location Address

Location Address

Telephone # Ext Fax

None

Email Address

None

Mailing Address

Check if same as Management Company Location Address

Mailing Address

Contact Person

Contact Person:

Telephone # Ext

Email Address

None



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Management Company Information

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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 3100-0008 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.

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					

Total

Removed: (-) Added: (+)

If the percentage of ownership interest indicated above does not equal 100%, please explain why in the space below:

Undo

Save

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Edit 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





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Controlling Interests

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Personnel

Administration

Safety Liaison

Required Disclosure

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Personnel

Personnel

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

Provide the information for the individual(s) who perform the following roles:

- Administrator
- 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'.

To **edit** an existing individual - Select "Edit/View" and edit as needed.

To **remove** an existing individual - Select "Remove" and enter the date the individual's relationship with the licensee ended.

	Full Name of Individual	Type	Tax ID	Roles	Effective Date	End Date
Remove						
Edit/View						

Removed: (-) Added: (+)

Undo

Save

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Administration

Edit Individual

Individual

Select the roles below that apply to the individual listed above.

<u>Role</u>	<u>Effective Date</u>	<u>End Date</u>	<u>FL License Number</u>
<input type="checkbox"/> Administrator	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Financial Officer	<input type="text"/>	<input type="text"/>	<input type="text"/>

Personal Mailing Address

Edit Address

Address

Contacts

Telephone # Ext

Email Address

None

Done Cancel





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✓ Administration

✓ Safety Liaison

✓ Required Disclosure

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✓ Days and Hours of Operation

✓ Supporting Documents

Finalize Submission

Personnel

B. Safety Liaison

Please provide the requested information for the individual who will serve as primary contact during emergency operation pursuant to 408.821, Florida Statutes.

. 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			

Removed: (-) Added: (+)

Undo

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Safety Liaison

Edit Individual

Individual

Effective Date

End Date

Personal Mailing Address

Edit Address

Address

Contacts

Telephone #

Ext

Email Address

None

Done

Cancel





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 - Exclusions
 - Felonies/Terminations
- General Information ▾
- Accreditation ▾
- Days and Hours of Operation ▾
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Required Disclosure

Convictions

Pursuant to subsection [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 subsection [408.809](#), Florida Statutes?

Yes No

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Required Disclosure

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/entity 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

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Required Disclosure

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. 1395-1396, 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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Personnel ▾

Required Disclosure ▾

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General Information

Enter number of Birthing Rooms.

1. Number of Birthing Rooms

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Accreditation

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Accreditation

Please check the appropriate accrediting organization(s) below. If accredited, provide a copy of the full accreditation survey, award letter, and any follow up letters to or from the accrediting body in the Supporting Documents section of this application. Please review Chapter 394.741, F.S. for additional information.

Not Accredited

Accrediting Organization	Accrediting Org ID	Accreditation Effective Date	Accreditation Expiration Date	Survey Date
<input type="checkbox"/> Joint Commission (JC)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Accreditation Association for Ambulatory Health Care (AAAHC)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Commission for the Accreditation of Freestanding Birth Centers (CAFBC)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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Licensee Information ▾

Controlling Interests ▾

Management Company Information ▾

Personnel ▾

Required Disclosure ▾

General Information ▾

Accreditation ▾

Days and Hours of Operation ▲

Days and Hours of Operation

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Days and Hours of Operation

List the regular operating hours.

Note - Site inspections by surveyors will occur during the business hours submitted. Failure to be open during the listed hours may result in a fine. For physician offices, AHCA surveyors need to be able to review testing, so please provide testing hours.

Day	Opening Time	Closing Time	By Appointment
MONDAY	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
TUESDAY	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
WEDNESDAY	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
THURSDAY	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
FRIDAY	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
SATURDAY	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
SUNDAY	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

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Supporting Documents

Applicants **MUST** include the following attachments as stated in Chapters [408 Part II](#) and [383](#), Florida Statutes (F.S.) and Chapter [59A-35](#) and [59A-11](#), Florida Administrative Code (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.

Accreditation Documentation

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.

Facility Ownership/Lease Documentation

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.

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

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.

Approved Repayment Plan

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.

Additional Documentation

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.





Provider:

Provider Type:
 Birth Center

Facility:
 License #: _____
 Expires: _____

Application:
 Type: _____
 Status: _____
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- = Entered
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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. Contact Person
 - c. Property Ownership
- 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. General Information
 - a. General Information
- 8. Accreditation
 - a. Accreditation
- 9. Days and Hours of Operation
 - a. Days and Hours of Operation
- 10. Supporting Documents
 - a. Supporting Documents

I _____ attest as follows:

- (1) Pursuant to section 837.06, Florida Statutes, I have not knowingly made a false statement with the intent to mislead the Agency in the performance of its official duty.
- (2) Pursuant to section 408.815, Florida Statutes, I acknowledge that false representation of a material fact in the license application or omission of any material fact from the license application by a controlling interest may be used by the Agency for denying and revoking a license or change of ownership application.
- (3) Pursuant to section 408.806, Florida Statutes, under penalty of perjury, the applicant is in compliance with the provisions of section 408.806 and Chapter 435, Florida Statutes.
- (4) Pursuant to 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.

Signature of Licensee or Authorized Representative	Title	Date
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I agree

Biennial Licensure Fee and Other Amounts Due Upon Submission of Application

- The biennial licensure fee is
- The biennial health care assessment fee is
- 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. Select 'OK' to continue, 'Cancel' to remain in the application.

Submit Application