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Application:
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= Entered
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  - Details
  - Property Ownership
  - Contact Person
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Provider/Facility Information

Under the authority of Chapters 408, Part II and 395, Part I, Florida Statutes (F.S.), and Chapters 59A-35 and 59A-5, Florida Administrative Code (F.A.C.), an application is hereby made to operate an ambulatory surgical 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.

Provider/Facility Information

License #

National Provider Identifier ☐ None ☐ Pending

Medicaid #

Medicare # (CMS CCN)

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

Provider/Facility Location Address

Edit Address

Provider 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 Home Page ☐ None

Provider/Facility Transparency Page in accordance with s.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

Telephone | Ext | Email Address ☐ None

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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

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			

Removed: (-) Added: (+)

Undo | Save | << Back | Next >>

Edit Entity

Property Owner

Full Name of Entity

Effective Date

Personal Mailing Address

Edit Address

Mailing Address

Telephone # *Ext*

Email Address

None

Done Cancel

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Provider/Facility Information

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

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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 # | Email Address

☐ None | ☐ None

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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

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						
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:

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Edit 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

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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: (+)

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Edit Management Company

Edit 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

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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:

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Edit 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

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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/Rpnd_Screening.shtml

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

- Administrator / Managing Employee
- 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: (+)

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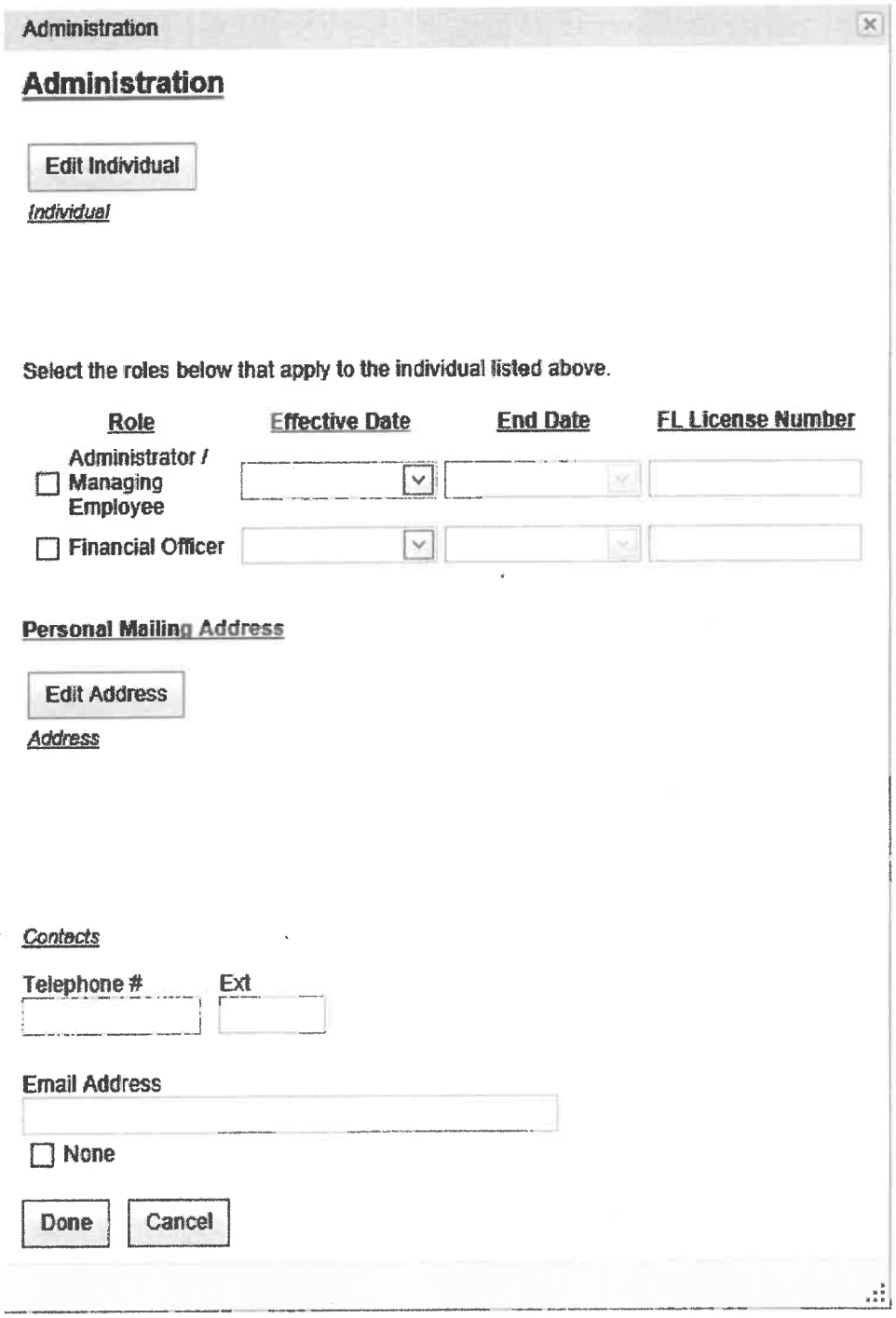
Administration
Administration
Edit Individual
Individual
Select the roles below that apply to the individual listed above.
Role
Effective Date
End Date
FL License Number
Administrator / Managing Employee
Financial Officer
Personal Mailing Address
Edit Address
Address
Contacts
Telephone #
Ext
Email Address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

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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 pusuant 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: (+)

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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

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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 occured at least 20 years before the date of the application.

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Accreditation

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

If this ambulatory surgical center is not accredited, select the "Not Accredited" option.

☐ Not Accredited

Accrediting Organization	Accrediting Org ID	Accreditation Effective Date	Accreditation Expiration Date	Deemed Status
☐ Joint Commission (JC)				
☐ Accreditation Association for Ambulatory Health Care (AAAHC)				
☐ American Association for Accreditation of Ambulatory Surg Fac (AAAASF)				
☐ Institute for Medical Quality (IMQ)				

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Days and Hours of Operation

List the regular operating hours.

Note - Site inspections by Agency surveyors will occur during the business hours submitted. Failure to be open during the listed hours may result in a fine or the denial of an application

Day	Opening Time	Closing Time	By Appointment
MONDAY			☐
TUESDAY			☐
WEDNESDAY			☐
THURSDAY			☐
FRIDAY			☐
SATURDAY			☐
SUNDAY			☐

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Bed Count

Provide/Verify the information below. The number of Operating Rooms and Recovery Beds must match the existing license. Changes to counts must be verified by evidence of an approved renovation project submitted to the Agency.

1. Number of licensed Operating Rooms
2. Number of Procedure Rooms

Note - Include any rooms staffed and equipped for patient procedures that are not currently licensed as operating rooms.

3. Number of Recovery Beds

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Services

A. Emergency Services

Is this ambulatory surgical center associated with one or more hospitals that provide emergency inpatient care?

◯ Yes ◯ No

List the hospitals that provide emergency inpatient care for this ambulatory surgical center.

To add a hospital, select 'Add Hospital'.

To remove a hospital, select Remove next to the applicable record.

Add Hospital

	Provider Name	Provider Type	License Number	EIN	Street Address
Remove					

Removed: (-) Added: (+)

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Add Hospital

Emergency Inpatient Care

Instructions:

1) Select your 'Search By' option (Provider Name, License #, or EIN).
2) Enter your search criteria in the 'Search Text' field and select 'Find'.
3) Make your choice from the 'Search Result' list. Provider specifics will appear in the 'Details' section.
4) When satisfied with your choice select 'Done'.

Search:

Provider Type

Search By

◯ Provider Name ◯ License # (no prefixes) ◯ EIN (no SSNs)

Search Text

Find

Search Result

Details:

Provider Name

License Number

EIN

Address

Done Cancel

AGENCY FOR HEALTH CARE ADMINISTRATION

HOME | ABOUT US | MEDICAID | LICENSURE & REGULATION | FIND A FACILITY | REPORT FRAUD

Provider:

Provider Type:
Ambulatory Surgical Center

Filed:
License #:
Expires:

Application:
Type:
Status:
Date Received:

= Entered
= Entry Required

- Provider/Facility Information
- Licensee Information
- Controlling Interests
- Management Company Information
- Personnel
- Required Disclosure
- Accreditation
- Days and Hours of Operation
- Bed Count
- Services
  - Emergency Services
  - X-Ray Services
- Supporting Documents
- Finalize Submission

Health Care Licensing Online Application
Ambulatory Surgical Center
AHCA Form 3130-2001 OL, September 2018
59A-5.003, Florida Administrative Code

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Services

B. X-Ray Services

Indicate whether or not x-ray services are provided by the ambulatory surgical center.

- ○ Not provided
- ○ X-ray provided on the premises or by contract in accordance with Chapter 404, F.S.

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Supporting Documents

Applicants **MUST** include the following attachments as stated in Chapters 408 Part II and 395 Part I, Florida Statutes (F.S.) and Chapters 59A-35 and 59A-5, 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.

Browse...

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.

Browse...

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.

Browse...

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.

Browse...

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

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Browse...

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Ambulatory Surgical Center

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○ = Entry Required

- Provider/Facility Information
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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. 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. Accreditation
- a. Accreditation

✓8. Days and Hours of Operation
- a. Days and Hours of Operation

✓9. Bed Count
- a. Bed Count

✓10. Services
- a. Emergency Services
- b. X-Ray Services

✓11. 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 Statues, 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 Statues, 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

☐ 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