Provider:
Beta HCC

Provider Type:
Health Care Clinics

File#: 15011
License #:
Expires:

Application:
Type: Initial Licensure
Status: Unopened
Application Received Date:

= Entered
= Entry Required

- Provider/Facility Information
  - Details
  - Contact Person
- Licensee Information
- Controlling Interests
- Management Company Information
- Personnel
- Medical Director
- Required Disclosure
- Magnetic Resonance Imaging (MRI) Services
- Days and Hours of Operation
- Clinic Type, Services and Professional Staff
- Supporting Documents
- Finalize Submission

Health Care Licensing Online Application
Health Care Clinic
AHCA Form 3110-0013OL, August 2023
59A-35.060, Florida Administrative Code

Provider/Facility Information

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

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 (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 (AHCA) 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 NPI cannot be blank. Please enter number or check None or Pending checkbox below the field.*
- *Phone number is incomplete.*
- *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.*

Provider/Facility Information

License #

National Provider Identifier ☐ None ☐ Pending

Medicaid #

Medicare # (CMS CCN)

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

Beta HCC

Provider/Facility Location Address

Edit Address

Provider Location Address

2727 MAHAN DR
TALLAHASSEE, FL 32308
US - United States
County - LEON

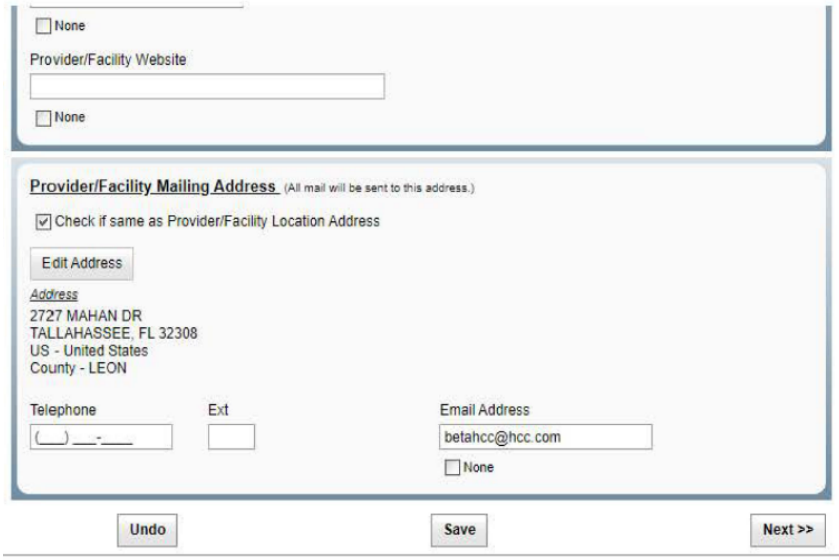
Telephone (___) ___-____

Ext

Fax # (___) ___-____ ☐ None

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

betahcc@hcc.com


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
Edit Address
Address
2727 MAHAN DR
TALLAHASSEE, FL 32308
US - United States
County - LEON
Telephone
(___) ___-____
Ext
Email Address
betahcc@hcc.com
None
Undo
Save
Next >>

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 >>

Licensee Information

- *Individual information is incomplete*
- *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.*

Description of Licensee (select only one option below)

(•) For Profit ( ) Not for Profit ( ) Public

Ownership Types

Individual

Individual Licensee Details

Licensee Name

First Name | Middle Name | Last Name | Suffix

Tax ID | Type

Mailing Address

Edit Address

Address

Mailing Address

Edit Address

Address

Telephone (___) ___-____ | Ext | Fax # (___) ___-____ | Email Address

[ ] None [ ] None

Undo | Save | << Back | Next >>

Controlling Interests of Licensee

- *You have selected 'Individual' as the licensee's ownership type. Therefore, you are unable to add Controlling Interests. Select 'Next' to proceed.*

Undo | Save | << Back | Next >>

Management Company Information

- *You have selected 'Individual' as the licensee's ownership type. Therefore, you are unable to add a Management Company. Select 'Next' to proceed.*

Undo | Save | << Back | Next >>

Management Company Controlling Interest

- *There is no Management Company associated with this application. Therefore, you are unable to add Management Company Controlling Interests. Select "Next" to proceed.*

Undo | Save | << Back | Next >>

Personnel

- *One Administrator / Managing Employee should be entered for this application.*
- *One Financial Officer should be entered for this application.*

A. Provider/Facility Personnel

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 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'.

No Individuals exist!

Undo | Save | << Back | Next >>

Medical/Clinic Director

- *At least one Medical/Clinic Director must be listed in this application.*

A. Medical/Clinic Director

Pursuant to section 400.991(2), F.S., an application for licensure must include the name, residence and business addresses, phone number, and license number of the medical or clinic director.

NOTE: A licensed health care clinic may not operate or be maintained without the day-to-day supervision of a single medical/clinic director as defined in section 400.9905(5), F.S.

Please Note: A Medical/Clinic Director may only represent up to five (5) Health Care Clinics.

To **add** a Director -
Utilizing the picklist below, either choose an director that is already associated with this application or select 'New Director'.

Undo | Save | << Back | Next >>

Medical/Clinic Director

- *A director must be listed in the previous section before adding a clinic.*

Does the medical/clinic director currently supervise any other licensed health care clinics? If so, identify them below.

Yes No

To **add** a clinic, select "Add Clinic" below.

Add Clinic

Undo Save << Back Next >>

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 | Save | << Back | Next >>

Required Disclosure

- *Either Yes or No must be selected.*

Exclusions

Pursuant to sections 408.810(2) and 400.991(4), F.S., the applicant must provide a description and explanation of any exclusions, suspensions, or terminations from the Medicare, Medicaid, or federal Clinical Laboratory Improvement Amendment (CLIA) programs.

Has the applicant or any individual 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 >>

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. 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?

◯ Yes ◯ No

Undo | Save | << Back | Next >>

Required Disclosure

- *Either Yes or No must be selected.*

Health and Residential Care

In the past 5 years, has the applicant or any controlling interest owned any entity that provided health or residential care in Florida or any other state?

◯ Yes ◯ No

If yes, has any entity the applicant or controlling interest owned been closed due to financial inability to operate; had a receiver appointed or a license denied, suspended, or revoked; was subject to a moratorium; or had an injunctive proceeding initiated against it?

◯ Yes ◯ No

Undo | Save | << Back | Next >>

Required Disclosure

- *Either Yes or No must be selected.*

Nonimmigrant Aliens

If the applicant or any controlling interests are nonimmigrant aliens according to 8 U.S.C. ss1101, then a surety bond of at least $500,000 must be filed, payable to AHCA, that guarantees the health care clinic will act in full conformity with all legal requirements for operation (section 408.8065(2), F.S.). Include the surety bond in the Supporting Documents section of this application.

Are there any nonimmigrant aliens listed as a licensee or controlling interest in this application?

◯ Yes ◯ No

Undo | Save | << Back | Next >>

Magnetic Resonance Imaging (MRI) Services

- *Select either Yes or No option for the MRI question*
- *Either select an Accrediting Organization or check the Accreditation pending check box.*

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

Does the clinic provide magnetic resonance imaging services (MRI)? ◯ Yes ◯ No

If yes, select the appropriate accrediting organization(s), and provide the requested information.
If MRI services are not provided, select "Next" to proceed.

☐ Accreditation pending

Accrediting Organization	Accrediting Org ID	Accreditation Effective Date	Accreditation Expiration Date	Survey Date
☐ American College of Radiology (ACR)				
☐ InterSocietal Accreditation Commission (ISAC)				
☐ Joint Commission (JC)				
☐ RadSite (RADSITE)				

(Note - If you indicated that accreditation is pending, you will need to provide a copy of the application for accreditation and proof of payment or a letter of intent to achieve accreditation in the Supporting Documents section of this application.)

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)*

Undo | Save | << Back | Next >>

Days and Hours of Operation

- *Either select 24 hour checkbox or enter opening and closing times or select By Appointment option.*

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.

☐ Check this box if the clinic is open 24 hours a day, 7 days a week.

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

Undo | Save | << Back | Next >>

Clinic Types

- *Select a Clinic Type.*
- *Select at least one Reimbursement.*
- *Select at least one Designation.*

A. CLINIC TYPE

- ○ Services are provided at the street address on record for the provider (fixed location)
- ○ Mobile Clinic
- ○ Portable Equipment Provider

B. REIMBURSEMENTS

Check all that apply:

- ☐ Medicare and/or Medicaid
- ☐ Commercial Insurance Plans (HMO, PPO, EPO, etc.)
- ☐ Automobile Personal Injury Protection (PIP) Insurance
- ☐ Individuals pay for services by cash, check, credit card, or debit card
- ☐ Other payer source not listed above
- ☐ None apply

C. DESIGNATIONS

Check all that apply:

- ☐ Urgent Care Center
- ☐ Pain Management Clinic
- ☐ Office Surgery Center
- ☐ None apply

Undo | Save | << Back | Next >>

Services and Professional Staff

- *At least one 'Services and Professional Staff' must be selected.*

D. SERVICES

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

Select	Health Care Professions	Number of Staff	Select	Health Care Professions	Number of Staff
☐	Acupuncture		☐	Naturopathy	
☐	Advanced Nursing Practice		☐	Nursing Practice - RN, LPN, CNA	
☐	Athletic Training		☐	Occupational Therapy	
☐	Audiology		☐	Optical Dispensing	
☐	Autonomous Practice – APRN		☐	Optometry	
☐	Behavior Analysis (BACB Certification)		☐	Orthotics, Prosthetics, Pedorthics	
☐	Chiropractic Medicine		☐	Osteopathic Medicine - DO & PA	
☐	Clinical, Counseling, Psychotherapy Services		☐	Pharmacy	
☐	Dentistry		☐	Physical Therapy	
☐	Diagnostic Imaging		☐	Podiatric Medicine	
☐	Dietetics & Nutrition Practice		☐	Psychological Services	
☐	Electrolysis		☐	Radiology	
☐	Health Testing/Laboratory Services		☐	Renal Dialysis	
☐	Hearing Aid Dispensing		☐	Respiratory Therapy	
☐	Massage Practice		☐	Sleep Study	
☐	Medical Practice - MD & PA		☐	Speech-Language Pathology	
☐	Midwifery		☐	Other 1	

Undo Save << Back Next >>

Supporting Documents

Applicants **MUST** include the following attachments as stated in Chapters 408, Part II and 400, Part X, F.S. and Chapters 59A-35 and 59A-33, F.A.C.

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.

- *Medical/Clinic Director Attestation*
  - *Upload document is required/check the document mailed checkbox.*
- *Proof of Financial Ability to Operate*
  - *Upload document is required/check the document mailed checkbox.*
- *Medical/Clinic Director's contract or agreement with the clinic including the effective date of service*
  - *Upload document is required/check the document mailed checkbox.*
- *Copy of the Medical/Clinic Director's Florida Health Care Practitioner's License and Any Other Specialty Certifications Necessary for Supervision of Services Provided*
  - *Upload document is required/check the document mailed checkbox.*

Medical/Clinic Director Attestation

☐ 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...

Evidence of a Surety Bond

☐ 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...

Organizational Chart showing any individual's indirect ownership of the clinic, if an individual is identified as having an indirect ownership under the Controlling Interests section

☐ 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...

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...

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.

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...

Proof of Financial Ability to Operate

☐ 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...

Medical/Clinic Director's contract or agreement with the clinic including the effective date of service

☐ 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...

Copy of the Medical/Clinic Director's Florida Health Care Practitioner's License and Any Other Specialty Certifications Necessary for Supervision of Services Provided

☐ 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...

Undo | Save | << Back | Next >>

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*
- 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*
- 6. Medical Director
  - a. *Medical Director*
  - b. *Director's Clinics*
- 7. Required Disclosure
  - a. *Convictions*
  - b. *Exclusions*
  - c. *Felonies/Terminations*
  - d. *Health and Residential Care*
  - e. *Nonimmigrant Aliens*
- 8. Magnetic Resonance Imaging (MRI) Services
  - a. *Magnetic Resonance Imaging (MRI) Services*
- 9. Days and Hours of Operation
  - a. *Days and Hours of Operation*
- 10. Clinic Type, Services and Professional Staff
  - a. *Clinic Types*
  - b. *Services and Professional Staff*
- 11. Supporting Documents
  - a. *Supporting Documents*

I **ANGEL STOCK**, 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(12), Florida Statutes, the licensee ensures that no person holds any ownership interests, either directly or indirectly, regardless of ownership structure, who has a disqualifying offense pursuant to section 408.809, Florida Statutes or in a provider that had a license revoked or application denied pursuant to section 408.815, Florida Statutes.

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

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

ANGEL STOCK	ANALYST	09/22/2023
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 $2,000
- The biennial health care assessment fee is $300
- 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