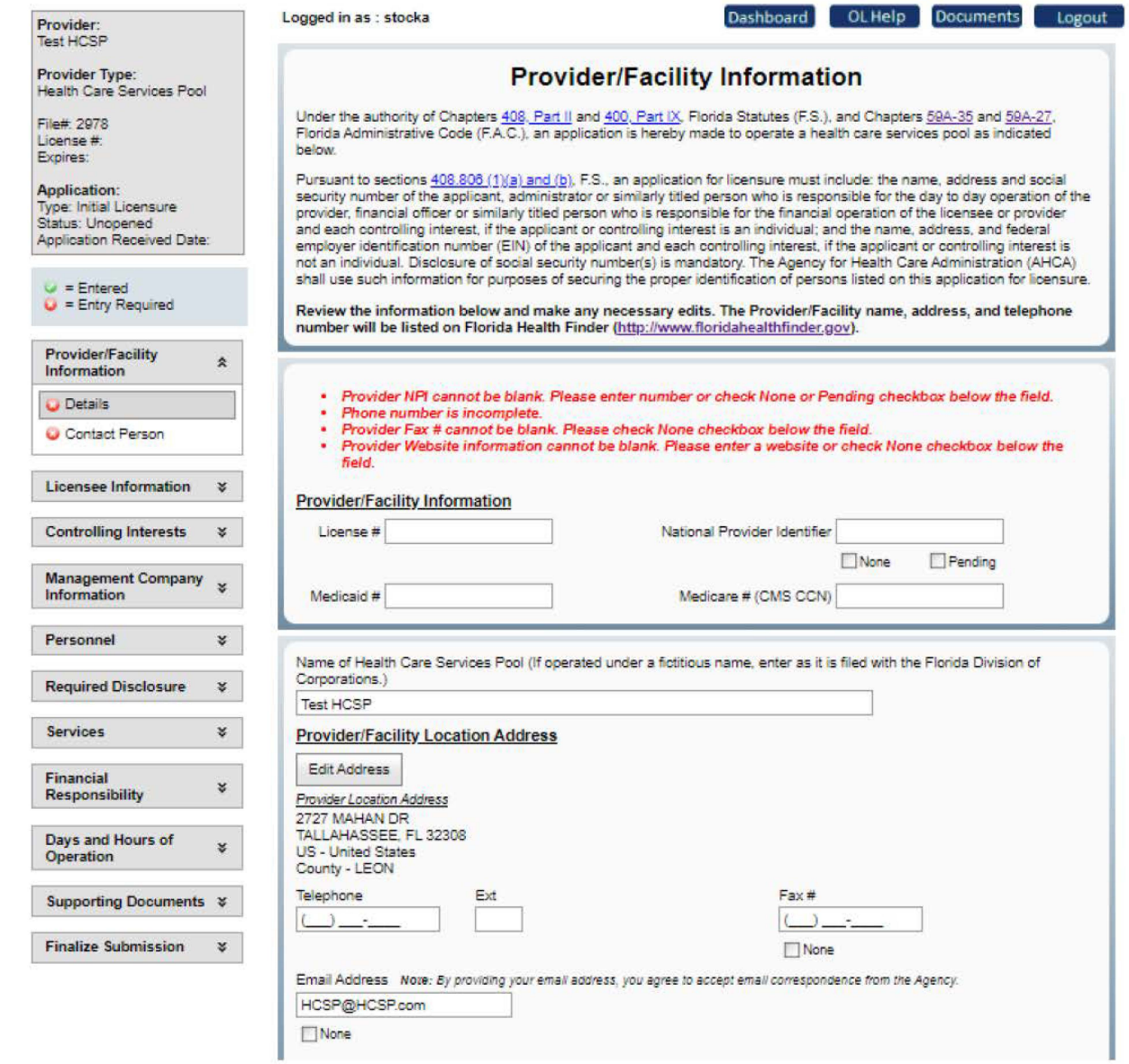


Provider:
Test HCSP

Provider Type:
Health Care Services Pool

File#: 2978
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
- Required Disclosure
- Services
- Financial Responsibility
- Days and Hours of Operation
- Supporting Documents
- Finalize Submission

Logged in as : stocka

Dashboard | OL Help | Documents | Logout

Provider/Facility Information

Under the authority of Chapters 408, Part II and 400, Part IX, Florida Statutes (F.S.), and Chapters 59A-35 and 59A-27, Florida Administrative Code (F.A.C.), an application is hereby made to operate a health care services pool 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 (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 Services Pool (If operated under a fictitious name, enter as it is filed with the Florida Division of Corporations.)

Test HCSP

Provider/Facility Location Address

Edit Address

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

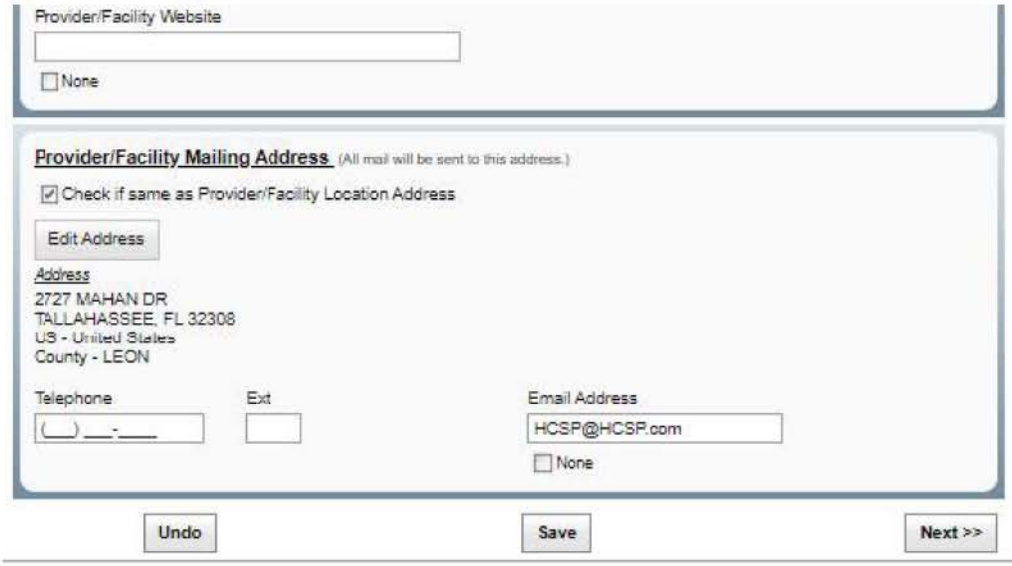
Telephone (___) ___-____ Ext

Fax # (___) ___-____ ☐ None

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

HCSP@HCSP.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
HCSP@HCSP.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

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.*

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 >>

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 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

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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. 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 >>

Services

- *Add at least one service.*

A. Health Care Personnel

Identify the health care personnel provided by the health care services pool (check all that apply).

- [ ] Audiologist
- [ ] Audiologist Aide
- [ ] Certified Nursing Assistant
- [ ] Clinical Social Worker
- [ ] Dental Hygienist
- [ ] Emergency Medical Technicians
- [ ] Medical Director
- [ ] Medical Technician
- [ ] Nurses - LPN
- [ ] Nurses - RN
- [ ] Nurse Aide
- [ ] Occupational Therapist
- [ ] Paramedic
- [ ] Pharmacist
- [ ] Pharmacy Technician
- [ ] Physical Therapist
- [ ] Radiology Technician
- [ ] Respiratory Therapist
- [ ] Speech Therapist

- [ ] Other
- [ ] Other

Undo | Save | << Back | Next >>

Services

- *Applicant must make at least one selection.*

B. Types of Providers Served

Identify the types of providers served by the health care services pool (check all that apply).

- [ ] Assisted Living Facility
- [ ] Ambulatory Surgical Center
- [ ] Clinic
- [ ] Correctional Facility
- [ ] Dialysis Center
- [ ] Doctor's Office
- [ ] Health Maintenance Organization
- [ ] Home Health Agency
- [ ] Hospice
- [ ] Hospital
- [ ] Nursing Home
- [ ] School

- [ ] Other

Undo | Save | << Back | Next >>

Financial Responsibility

- *Select at least one option below.*

As required in section 400.980, F.S. and 59A-27.009,F.A.C. each Health Care Services Pool must demonstrate financial responsibility to pay claims and costs ancillary thereto, arising out of the rendering of services or failure to render services by the Pool or its employees.

Check which of the following methods the Health Care Services Pool uses. You will be prompted to submit proof in the Supporting Documents section of this application.

☐ Professional liability insurance coverage in an amount of not less than $1,000,000 per claim, with a minimum aggregate of not less than $3,000,000 from one of the following (*submit proof of insurance in the Supporting Documents section of this application)*

- ○ An authorized insurer as defined under section 624.09,F.S.;
- ○ An eligible surplus lines as defined under subsection 626.918(2),F.S.;
- ○ A risk retention group or purchasing group as defined under section 627.942,F.S.,or
- ○ A plan of self-insurance as provided in section 627.357,F.S.

☐ Escrow account consisting of cash or assets eligible for deposit in accordance with section 625.52 , F.S. The cash or assets deposited shall be in an amount not less than $1,000,000 per claim, with a minimum aggregate deposit of not less than $3,000,000 *(provide statement from bank or savings association in the Supporting Documents section of this application).*

☐ Unexpired irrevocable letter of credit issued by any bank or savings association in this state in an amount not less than $1,000,000 per claim, with a minimum aggregate amount of credit not less than $3,000,000 *(provide statement from bank or financial institution in the Supporting Documents section of this application).*

Undo | Save | << Back | Next >>

Days and Hours of Operation

- *Either select the Opening and Closing time or select the By Appointment option*

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 or denial of an application.

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

Undo | Save | << Back | Next >>

Supporting Documents

Applicants **MUST** include the following attachments as stated in Chapters 408, Part II and 400, Part IX, F.S. and Chapters 59A-35 and 59A-27, 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.

- ***Submit at least 1 of the 3 document types that satisfy the provider's proof of financial responsibility requirement (Proof of Professional Liability Insurance Coverage, Escrow Insurance, and Letter of Credit).***

Proof of Professional Liability Insurance Coverage

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...

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...

Letter of Credit

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...

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...

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...

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. Required Disclosure
  - a. *Convictions*
  - b. *Exclusions*
  - c. *Felonies/Terminations*
- 7. Services
  - a. *Health Care Personnel*
  - b. *Types of Providers Served*
- 8. Financial Responsibility
  - a. *Financial Responsibility*
- 9. Days and Hours of Operation
  - a. *Days and Hours of Operation*
- 10. 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	09/21/2023
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 $616
- 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