AHCA USE ONLY:

File #: _____
Application #: _____
Check #: _____
Check Amt: _____
Batch #: _____

Health Care Licensing Application
Hospital

The Agency for Health Care Administration (AHCA) has implemented the **ONLINE LICENSING SYSTEM,** which allows the electronic submission of renewal and change during licensure period applications and fees, along with the ability to upload supporting documentation. To submit online please go to: https://ahca.myflorida.com/health-care-policy-and-oversight/online-licensure-information/online-licensing-system

Applications must be received **at least 60 days prior to** the expiration of the current license or effective date of a change of ownership to avoid a late fee. If the renewal application is received by the Agency less than 60 days prior to the expiration date, it is subject to a late fee as set forth in statute. The applicant will receive notice of the amount of the late fee as part of the application process or by separate notice. The application will be withdrawn from review if all the required documents and fees are not included with your application or received within 21 days of an omission notice. **Applications will not be considered for review until payment has been received. Renewal and Change During Licensure Period applications: Supporting documentation, responses to omissions and payments may be submitted using the online system even if the application was originally mailed to the Agency.**

Under the authority of Chapters 408 Part II, and 395 Florida Statutes (F.S.), and Chapters 59A-35, and 59A-3, Florida Administrative Code (F.A.C.), an application is hereby made to operate a hospital as indicated below:

1. Provider / Licensee Information

A. PROVIDER INFORMATION – Please complete the following for the hospital name and location. Provider name, address and telephone number will be listed on https://quality.healthfinder.fl.gov/index.html.

License Number (if applicable)	National Provider Identifier (NPI)	Florida Medicaid Number (if applicable)
Name of Hospital (if operated under a fictitious name, enter as it is filed with the Florida Division of Corporations)		
Street Address		
City	State	Zip
Telephone Number	County	
E-mail Address	**Note**: By providing your e-mail address you agree to accept e-mail correspondence from the Agency	
Provider Home Website		
Provider Transparency Website in accordance with section 395.301, F.S.		
Mailing Address or ☐ Same as above		
City	County	State / Zip
Telephone Number	Email Address	

B. PROPERTY OWNER INFORMATION – Complete the following for the owner of the property if different from the licensee.

Does an individual or entity other than the licensee own the property where the principal office is located?

If ☐ NO, skip to **Section 1.C. – Contact Person**

If ☐ YES, please provide the following information:

Full Name of Property Owner	
☐ Owned ☐ Leased	Telephone Number
Primary Address	Effective Date

C. **CONTACT PERSON -** Please complete the following for the contact person for this application.	
Contact Person for this application	Contact Telephone Number
Contact e-mail address or ☐ Do not have e-mail	**Note**: By providing your e-mail address you agree to accept e-mail correspondence from the Agency.

D. **LICENSEE INFORMATION** –Please complete the following for the entity seeking to operate the hospital.		
Licensee Name (This is the owner of the hosptial)		Federal Employer Identification Number (EIN)
Mailing Address or ☐ Same as above		
City	State	Zip
Telephone Number	E-mail Address	

Description of Licensee (check one):

For Profit	Not for Profit	Public
☐ Corporation	☐ Corporation	☐ State
☐ Limited Liability Company	☐ Religious Affiliation	☐ City/County
☐ Partnership	☐ Other	☐ Hospital District
☐ Individual		
☐ Sole Proprietor		
☐ Other		

2. Application Type and Fees

Indicate the type of application with an "X." **Applications will not be processed if not all applicable fees are included. Pursuant to section 408.805(4), F.S., fees are nonrefundable.** Renewal and Change of Ownership applications must be received 60 days prior to the expiration of the license or the proposed effective date of the change to avoid a late fee. If the renewal application is received by the Agency less than 60 days prior to the expiration date, it is subject to a late fee as set forth in statute. The applicant will receive notice of the amount of the late fee as part of the application process or by separate notice.

A. TYPE OF APPLICATION

☐ Initial licensure **Proposed Effective Date**: _____

Was this entity previously licensed as a hospital? YES ☐ NO ☐

If YES, please provide the name of the agency (if different), the EIN # and the date the prior license expired or closed:

NAME:	EIN #	Date Expired/Closed:

☐ Renewal licensure

☐ Change of Ownership **Proposed Effective Date**: _____

- ☐ Licensee sale or transfer of ownership to a different individual/entity
- ☐ Transfer or assignment of 51% or more ownership, shares, membership, or controlling interest of the licensee

The hospital will ☐ keep the existing license number or ☐ use license number _____ pursuant to section 395.003(2), F.S.

☐ Change During Licensure Period (check all that apply): **Proposed Effective Date**: _____

Fee Required

- ☐ Provider Name

Provider Address:

- ☐ Hospital Address
- ☐ Additional Addresses ☐ Add ☐ Delete

- ☐ Expiration Date pursuant to section 408.806(9), F.S.

Services/Qualifications:

- ☐ Licensed Programs ☐ Add ☐ Delete
- ☐ Emergency Services ☐ Add ☐ Delete ☐ Exemption Request
- ☐ Trauma Center Designation ☐ Add ☐ Delete

No Fee Required

- ☐ Personnel
- ☐ Management Company
- ☐ Baker Act Receiving Facility Designation ☐ Add ☐ Delete
- ☐ Transfer or assignment of less than 51% ownership. shares, membership, or controlling interest of the licensee

Beds/Capacity: ☐ Increase ☐ Decrease ☐ Bed Type Conversion ☐ Bed Type Conversion and Classification Change

B. LICENSURE FEES

ACTION	FEE	TOTAL FEES
License Fee (Initial, Renewal and Change of Ownership)	$31.46 per bed x _____ number of beds = (minimum of $1,565.13)	$
Initial licensure Survey Fee (Initial applications only)	$12.00 per bed x _____ number of beds = (minimum of $400.00)	$
Increase in Total Number of Licensed Beds	$31.46 per bed x _____ number of new beds =	$
Biennial Assessment (Initial, Renewal and Change of Ownership) Pursuant to section 408.033(2)(b)3., F.S., hospitals operated by the Department of Children and Family Services, the Department of Health, the Department of Corrections or any hospital that meets the definition of a rural hospital pursuant to section 395.602, F.S., are exempted from the health care facility assessment.	$4.00 per bed x _____ number of beds = (maximum of $1,000.00)	$
Change During Licensure Period	$ 25.00	$
Other: _____		$
TOTAL FEES INCLUDED WITH APPLICATION		**$**
Please make check or money order payable to the Agency for Health Care Administration (AHCA)		

3. Controlling Interests of Licensee

AUTHORITY:
Pursuant to sections 408.806(1)(a) and (b), F.S., an application for licensure must include: the name, address and social security number (SSN) of the applicant 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. However, in an effort to protect all personal information, **do not include social security numbers on this form. All social security numbers must be entered on the Health Care Licensing Application Addendum, AHCA Form 3110-1024.**

DEFINITIONS:
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 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 Background Screening (myflorida.com).

INSTRUCTIONS: Attach additional application pages if needed.
For new individual – complete all fields except the End Date.
For existing individuals – complete all fields except the Effective and End Date.
To remove an individual – complete all fields including the End Date.

A. Individual and/or Entity Ownership of Licensee as listed in Section 1D above – Provide the information for each individual or entity (corporation, partnership, association) with 5% or greater ownership interest in the licensee. Attach additional sheets if necessary. This excludes Not-for-Profit and publicly held licensees. **Note**: A written explanation will be required if the percentage of ownership interest indicated below does not equal 100%.

FULL NAME of INDIVIDUAL or ENTITY	PERSONAL/PRIMARY ADDRESS	TELEPHONE NUMBER	EIN (No SSN)	% OWNERSHIP	EFFECTIVE DATE	END DATE

B. Board Members and Officers of Licensee as listed in Section 1D above – Provide the information for each individual or entity (corporation, partnership, association) that serves as an officer or is on the board of directors. Do not include voluntary board members.

TITLE	FULL NAME	PERSONAL/PRIMARY ADDRESS	TELEPHONE NUMBER	EFFECTIVE DATE	END DATE
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					

4. Management Company Control

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

If ☐ NO, **skip to Section 6 Personnel**

If ☐ YES, provide the following information:

Name of Management Company	EIN (No SSN)	Telephone Number	
Street Address	E-mail Address		
City	County	State	Zip
Mailing Address or ☐ Same as above			
City		State	Zip
Contact Person	Contact E-mail	Contact Telephone Number	

5. Management Company Controlling Interest

DEFINITION:

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 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 Background Screening (myflorida.com).

INSTRUCTIONS: Attach additional application pages if needed.
For new individual – complete all fields except the End Date.
For existing individuals – complete all fields except the Effective and End Date.
To remove an individual – complete all fields including the End Date.

A. Individual and/or Entity Ownership of Management Company: Provide the information for each individual or entity (corporation, partnership, association) with 5% or greater ownership interest in the management company. Attach additional sheets if necessary.

FULL NAME of INDIVIDUAL or ENTITY	PRIMARY ADDRESS	TELEPHONE NUMBER	EIN (No SSN)	% OWNERSHIP	EFFECTIVE DATE	END DATE

B. Board Members and Officers of Management Company: Provide the information for each individual or entity (corporation, partnership, association) that serves as an officer or is on the board of directors. Do not include voluntary board members.

TITLE	FULL NAME	PERSONAL/PRIMARY ADDRESS	TELEPHONE NUMBER	EFFECTIVE DATE	END DATE
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					

6. Personnel

A. Please provide information for the individual(s) who perform the following roles. Note: For the administrator and financial officer, an AHCA screening through the Care Provider Background Screening 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 Background Screening (myflorida.com).

INSTRUCTIONS: Attach additional application pages if needed.
For new individual – complete all fields except the End Date.
For existing individuals – complete all fields except the Effective and End Date.
To remove an individual – complete all fields including the End Date.

INFORMATION	ADMINISTRATOR/MANAGING EMPLOYEE	FINANCIAL OFFICER / PERSON RESPONSIBLE FOR FINANCIAL OPERATIONS
Full Name		
Effective Date		
End Date		
Telephone Number		
Email Address		
Personal/Primary Address		

B. Safety Liaison – Provide the requested information for the individual who will serve as primary contact during emergency operations pursuant to section 408.821, F.S.

INFORMATION	SAFETY LIAISON
Full Name	
Effective Date	
End Date	
Telephone Number	
Email Address	
Personal/Primary Address	

7. Required Disclosure

The following disclosures are required:

A. Pursuant to section 408.809, F.S., the applicant shall submit to the agency a description and explanation of any convictions of offenses prohibited by sections 435.04 and 408.809, F.S., for each controlling interest.

Has the applicant or any individual listed in Sections 3 and 4 of this application been convicted of any level 2 offense pursuant to section 408.809, F.S.? YES ☐ NO ☐

If YES, provide the following information:

☐ The full legal name of the individual and the position held

☐ A description/explanation of any convictions

B. 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 sections 3 and 4 of this application been excluded, suspended, terminated or involuntarily withdrawn from participation in Medicare or Medicaid in any state? YES ☐ NO ☐

If YES, enclose the following information:

☐ The full legal name of the individual (and the position held) or the entity

☐ A description/explanation of the exclusion, suspension, termination or involuntary withdrawal.

C. 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:

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 ☐

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 ☐

8. Provider Fines and Financial Information

Pursuant to section 408.831(1)(a), F.S., the Agency may take action against the applicant, licensee, or a licensee which shares a common controlling interest with the applicant if they have failed to pay all outstanding fines, liens, or overpayments assessed by final order of the agency or final order of the Centers for Medicare and Medicaid Services (CMS), not subject to further appeal, unless a repayment plan is approved by the agency.

Are there any incidences of outstanding fines, liens or overpayments as described above? YES ☐ NO ☐

If YES, please complete the following for each incidence (attach additional sheets if necessary):

AHCA CASE NUMBER	CMS	ASSESSED AMOUNT	DATE OF RELATED INSPECTION, APPLICATION, OR OVERPAYMENT	PAYMENT DUE DATE	PENDING APPEAL OF FINAL ORDER	
					YES	NO
	☐				☐	☐
	☐				☐	☐
	☐				☐	☐

Please attach a copy of the approved repayment plan if applicable.

9. Federal Certification

Does the provider participate in or intend to participate in the

Medicaid program? YES ☐ NO ☐

Medicare program? YES ☐ NO ☐

If you plan to participate in Medicaid:

Visit the Agency's website at: https://ahca.myflorida.com/medicaid to obtain information and an application for enrollment in Medicaid.

If you plan to participate in Medicare:

The Medicare Provider Application (CMS Form 855) is available from the Medicare Administrative Contractor or on the Centers for Medicare and Medicaid Services (CMS) website at: https://www.cms.gov/medicare/cms-forms/cms-forms?redirect=/cmsforms/. The form must be sent directly to the chosen Medicare Administrative Contractor for review.

For **initial** Medicare enrollment, the following forms must be attached to the Application:

- ☐ CMS 1561
- ☐ Medicare Administrative Contractor Choice Form
- ☐ Confirmation of submission of the Assurance of Compliance to the Office of Civil Rights

10. Bed Capacity

Note for bed change applications: A letter of approval or other documents as appropriate from the Agency for Health Care Administration's Office of Plans and Construction will be required **before** a bed change can be approved. In addition, successful completion of a life safety survey may be required.

HOSPITAL BED UTILIZATION	CURRENT BED COUNT	INCREASE	DECREASE	FINAL BED COUNT
Acute Care				
Skilled Nursing Unit				
Comprehensive Medical Rehabilitation				
Adult Psychiatric				
Child Psychiatric				
Adult Substance Abuse				
Child Substance Abuse				
Neonatal Intensive Care Unit				
Intensive Residential Treatment Facility				
Long Term Care				
TOTAL BED CAPACITY:				

11. Classification

Please provide the following information:

A. Classification: Is this a change from the current classification? ☐ Yes ☐ No

Class I Hospital

- ☐ General Acute Care Hospital
- ☐ Long Term Care Hospital
- ☐ Rural Hospital (☐ Critical Access Hospital)

Class II Specialty Hospital

- ☐ Specialty Hospital for Children
- ☐ Specialty Hospital for Women

Class III Specialty Hospital

- ☐ Specialty Medical Hospital
- ☐ Specialty Rehabilitation Hospital
- ☐ Specialty Psychiatric Hospital
- ☐ Specialty Substance Abuse Hospital

Class IV Specialty Hospital

- ☐ Intensive Residential Treatment Facility

12. Licensed Programs

A. Burn Unit. Each hospital operating a burn unit must maintain compliance with the rules adopted by the Agency that establish licensure standards governing burn units.

Please select one option below:

☐ The Hospital does not operate a Burn Unit.

☐ Verified Burn Unit. The hospital has been verified by the American Burn Association (ABA) for adherence to the ABA Verification Criteria. Attach a copy of the current verification certificate from the American Burn Association.

☐ Provisional Burn Unit. The hospital is in partial compliance with the ABA Verification Criteria but has not received verification from the American Burn Association. Burn unit services will begin/began on _____.

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

Please select only one option below:

☐ The Hospital is not a Stroke Center

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

☐ The hospital is certified as an acute stroke ready center by a nationally recognized accrediting organization.

☐ The hospital is certified as a primary stroke center by a nationally recognized accrediting organization.

☐ The hospital is certified as a thrombectomy-capable stroke center by a nationally recognized accrediting organization.

☐ The hospital is certified as a comprehensive stroke center by a nationally recognized accrediting organization.

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

Please select only one option below:

☐ The Hospital does not provide Adult Cardiovascular Services

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

☐ **Adult Inpatient Diagnostic Cardiac Catheterization Services as specified in Rule 59A-3.246(1), F.A.C.**

☐ **Level I Adult Cardiovascular Services as specified in Rule 59A-3.246(2), F.A.C.**

For initial designation, complete one of the following for the most recent 12-month period begin date _____ and end date _____:

1. _____ Number of adult inpatient diagnostic cardiac catheterizations and _____ number of adult outpatient diagnostic cardiac catheterization sessions, or

2. _____ Number of patient discharges and transfers of patients with the principal diagnosis of ischemic heart disease.

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

☐ **Level II Adult Cardiovascular Services as specified in Rule 59A-3.246(3), F.A.C**

For initial designation, complete one of the following for the most recent 12-month period begin date _____ and end date _____:

1. _____ Total number of adult inpatient and outpatient cardiac catheterizations and _____ Number of therapeutic cardiac catheterizations, or

2. _____ Number of patient discharges with the principal diagnosis of ischemic heart disease.

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

D. Transplant Services.

Please select only one option below:

☐ The Hospital does not provide Transplant Services.

☐ The hospital provides the following Transplant Services. Initial designation requires submission of the supplemental information listed at https://ahca.myflorida.com/health-care-policy-and-oversight/bureau-of-health-facility-regulation/hospital-outpatient-services-unit/hospitals. Except for bone marrow programs, initial designation also requires evidence of application for Medicare certification as described in Title 42 CFR Part 482 Subpart E (§ 482.68 - § 482.104) for the comparable Medicare transplant program. By entering a transplant service program for initial designation, the authorized representative submitting this application attests the hospital will be eligible for an initial Medicare certification survey within one year from initial licensure of each transplant program.

Mark the services applied for and/or provided:

Instructions:

To add a new transplant program, check 'Add' for the appropriate program and age group.
For existing transplant program, check 'Continue' for the appropriate program and age group.
For closed transplant program, check 'Remove' for the appropriate program and age group to remove the program from the license.

TRANSPLANT PROGRAM	ADULT			PEDIATRIC		
	Add	Continue	Remove	Add	Continue	Remove
Heart	☐	☐	☐	☐	☐	☐
Intestines	☐	☐	☐	☐	☐	☐
Kidney	☐	☐	☐	☐	☐	☐
Liver	☐	☐	☐	☐	☐	☐
Lung	☐	☐	☐	☐	☐	☐
Pancreas and Islet Cells	☐	☐	☐	☐	☐	☐
Bone Marrow						
Autologous	☐	☐	☐	☐	☐	☐
Allogeneic	☐	☐	☐	☐	☐	☐

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

Please select only one option below.

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

Mark the highest level of service applied for or provided.

☐ The hospital does not provide Neonatal Intensive Care Services , or all current services will cease on the effective date provided in section 2 of this application.

☐ The hospital provides Level II Neonatal Intensive Care Services only.

☐ The hospital provides Level III Neonatal Intensive Care Services.

☐ The hospital provides Level IV Neonatal Intensive Care Services.

13. Accreditation

The applicant participates with one or more of the accrediting organizations below or ☐ Not accredited.

ACCREDITING ORGANIZATION		ACCREDITATION ID	FEDERALLY DEEMED	EFFECTIVE DATE	EXPIRATION DATE	SURVEY END DATE
☐	Center for Improvement in Healthcare Qualify (CIHQ)		☐			
☐	DNV GL Healthcare, Inc		☐			
☐	Accreditation Commission for Health Care (ACHC)		☐			
☐	The Joint Commission (JC)		☐			
☐	Commission on Accreditation of Rehabilitation Facilities (CARF) For Class IV hospitals only					

Note: If accredited, provide a copy of the full accreditation survey, award letter and any follow up letters to or from the accrediting organization.

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

14. Clinical Laboratory and Radiology Services

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

Mark the following boxes as appropriate.

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

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

- ☐ Alternate-site testing is performed within the hospital premises. The tests performed at each location are listed on the attached AHCA Form 3130-8013.
- ☐ Alternate-site testing is not performed within the hospital premises.

15. Additional Addresses

A. OFFSITE OUTPATIENT FACILITY. Provide the following information regarding the non-emergency, non-surgical offsite outpatient facilities, excluding urgent care centers. Attach additional sheets if necessary. For new locations, attach proof of ownership/right to occupy and proof of compliance with local zoning requirements. **Note:** Approval from the Agency's Office of Plans and Construction or verification of exemption from project review pursuant to section 395.0163(1)(b), F.S. must be received **before** a new address is added to the license.

NAME	STREET ADDRESS	CITY	ZIP	PHONE #	DATE	
					OPENED	CLOSED

B. URGENT CARE CENTER. Provide the following information regarding outpatient locations meeting the definition of urgent care center in section 395.002, F.S. Attach additional sheets if necessary. For new locations, attach proof of ownership/right to occupy and proof of compliance with local zoning requirements. **Note:** Approval from the Agency's Office of Plans and Construction or verification of exemption from project review pursuant to section 395.0163(1)(b), F.S. must be received **before** a new address is added to the license.

NAME	STREET ADDRESS	CITY	ZIP	PHONE #	DATE	
					OPENED	CLOSED

C. SURGICAL OUTPATIENT CENTER. Provide the following information regarding non-emergency outpatient facilities providing surgical treatments requiring general anesthesia or IV conscious sedation or cardiac catheterization services. Attach additional sheets if necessary. For new locations, attach proof of ownership/right to occupy and proof of compliance with local zoning requirements. **Note:** Approval must be granted from the Agency for Health Care Administration's Plans and Construction **before** a new location can be approved.

NAME	STREET ADDRESS	CITY	ZIP	PHONE #	DATE	
					OPENED	CLOSED

D. HOSPITAL-BASED OFF-CAMPUS EMERGENCY DEPARTMENT. Provide the following information regarding hospital-based off-campus emergency departments. Emergency services offered offsite must be available 24 hours per day, 7 days per week offering the same services as the emergency department located on the hospital premises. In addition, please complete section 15 **Hospital Emergency Services** of this application. Attach additional sheets if necessary. For new locations, attach proof of ownership/right to occupy and proof of compliance with local zoning requirements. **Note:** Approval must be granted from the Agency for Health Care Administration's Office of Plans and Construction **before** a new location can be approved.

NAME	STREET ADDRESS	CITY	ZIP	PHONE #	DATE	
					OPENED	CLOSED

16. Hospital Emergency Services

Please indicate the emergency services provided. Mark the appropriate box for each service.

☐ Emergency services are offered via an emergency department located within the hospital and/or off site if indicated in section 11C of this application.

☐ Hospital has an Emergency 2 Way Radio System pursuant to section 395.1031, F.S.

☐ Request for emergency service exemption per section 395.1041(3)(d)3, F.S., attach AHCA Form 3000-1, if applicable.

☐ Baker Act Receiving Facility designation from the Department of Children and Families, attach certificate, if applicable.

☐ Trauma Center designation issued from the Department of Health, Office of Trauma, if applicable. Indicate level:

☐ Provisional Level 1 ☐ Provisional Level 2 ☐ Provisional Pediatric
☐ Level 1 ☐ Level 2 ☐ Pediatric

☐ No dedicated emergency department.

☐ Dedicated emergency department. Mark the below boxes as appropriate.

SERVICE	NOT PROVIDED	PROVIDED ON SITE 24 HOURS PER DAY, 7 DAYS PER WEEK	PROVIDED THROUGH A COMBINATION OF ONSITE AND TRANSFER AGREEMENT(S) WITH ANOTHER HOSPITAL(S) 24 HOURS PER DAY, 7 DAYS PER WEEK	PROVIDED THROUGH TRANSFER AGREEMENT WITH ANOTHER HOSPITAL(S)	PROVIDED ON A LIMITED BASIS BY EXEMPTION OR PARTIAL EXEMPTION
Anesthesia	☐	☐	☐	☐	☐
Burns	☐	☐	☐	☐	☐
Cardiology	☐	☐	☐	☐	☐
Cardiovascular Surgery	☐	☐	☐	☐	☐
Colon/Rectal Surgery	☐	☐	☐	☐	☐
Emergency Medicine	☐	☐	☐	☐	☐
Endocrinology	☐	☐	☐	☐	☐
Gastroenterology	☐	☐	☐	☐	☐
General Surgery	☐	☐	☐	☐	☐
Gynecology	☐	☐	☐	☐	☐
Hematology	☐	☐	☐	☐	☐
Hyperbaric Medicine	☐	☐	☐	☐	☐
Internal Medicine	☐	☐	☐	☐	☐
Nephrology	☐	☐	☐	☐	☐
Neurology	☐	☐	☐	☐	☐
Neurosurgery	☐	☐	☐	☐	☐
Obstetrics	☐	☐	☐	☐	☐
Ophthalmology	☐	☐	☐	☐	☐
Oral/Maxillofacial Surgery	☐	☐	☐	☐	☐
Orthopedics	☐	☐	☐	☐	☐
Otolaryngology	☐	☐	☐	☐	☐
Plastic Surgery	☐	☐	☐	☐	☐
Podiatry	☐	☐	☐	☐	☐
Psychiatry	☐	☐	☐	☐	☐
Pulmonary Medicine	☐	☐	☐	☐	☐
Radiology	☐	☐	☐	☐	☐
Thoracic Surgery	☐	☐	☐	☐	☐
Urology	☐	☐	☐	☐	☐
Vascular Surgery	☐	☐	☐	☐	☐

17. Professional Liability Coverage

AUTHORITY: Pursuant to section 395.1061(2), F.S., Each hospital, unless exempted under paragraph (3)(b), must demonstrate financial responsibility for maintaining professional liability coverage to pay claims and costs ancillary thereto arising out of the rendering of or failure to render medical care or services and for bodily injury or property damage to the person or property of any patient arising out of the activities of the hospital or arising out of the activities of covered individuals, to the satisfaction of the Agency for Health Care Administration.

Please complete the applicable section of this form and return it with the appropriate documentation. ***Please be advised – a policy binder is not sufficient proof of coverage.***

☐ An escrow account in an amount equivalent to $10,000 per claim for each hospital bed, not to exceed a $2,500,000 annual aggregate.

☐ Professional liability coverage in an amount equivalent to $10,000 or more per claim for each hospital bed, from a private insurer, the Joint Underwriting Association established under section 627.351(4); or through a plan of self-insurance as provided in section 627.357, F.S., not to exceed a $2,500,000 annual aggregate. Include proof of funding any self-insurance retention.

☐ Exempt under section 395.1061(3)(b), F.S. State Agencies, subdivisions or instrumentalities of the state. No additional documentation necessary if previously documented.

18. Supporting Documents

Applicants must include the following attachments as stated in Chapter 408, Part II and Chapter 395, F.S. and Chapters 59A-35 and 59A-3 F.A.C. **Note: Required documents listed below are dependent on the type of application submitted. (Initial, Renewal, Change of Ownership, Change During Licensure Period)**

DOCUMENTS TO BE PROVIDED:	REQUIRED FOR:
Proof of accreditation documentation and survey report, if applicable. For change of ownership, proof of continued accreditation under new ownership.	Renewal and Change of Ownership application types
Health Care Licensing Application Addendum, AHCA Form 3110-1024	Initial, Renewal, Change of Ownership, Change of Personnel and Controlling Interest application types
Documentation signed by the appropriate local government official, which states that the applicant has met local zoning requirements	Initial, Addition of Offsite Location, and Address Change application types
Proof of legal right to occupy property may include but not limited to, copies of warranty deeds, lease or rental agreements, contracts for deeds, quitclaim deeds, or other such documentation	Initial, Change of Ownership, Address Change, and Addition of Offsite Location application types
Baker Act Receiving Facility certificate, if applicable.	Initial and Change During Licensure application types
List of the cardiovascular registries in which the hospital participates and documentation of meeting or exceeding benchmarks reported by the registry, if applicable	Renewal, Change of Adult Cardiovascular Services
Emergency Service Exemption Application, AHCA Form 3000-1, if applicable	Request for Emergency Service Exemption application type
Documentation of compliance with professional liability coverage as provided under section 395.1061, F.S. (Escrow, Professional Liability or self-insurance)	Initial, Renewal, Change of Ownership and Bed Addition application types
License Application Alternate-Site Testing, AHCA Form 3130-8013, if applicable	All application types
Current Stroke Center Certificate	Renewal, Change of Ownership and Change of Licensed Programs application types
Copy of Comprehensive Emergency Management Plan (CEMP) Approval Letter or Documentation of the CEMP submission for review within the last 365 days	Renewal application type
Documentation of change of ownership transaction stating effective date and executed by all parties.	Change of Ownership application type
Required disclosures related to actions taken by Medicare, Medicaid or CLIA, if applicable	All application types
Approved repayment plan, if applicable	All application types

19. Attestation

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 sections 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), FS, 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), FS, 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, FS.

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

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

Signature of Licensee or Authorized Representative	Title	Date

NOTICE: If you are a **Medicaid** provider, you may have a separate obligation to notify the Medicaid program of a name/address change, change of ownership or other change of information. Please refer to your Medicaid handbooks for additional information about Medicaid program policy regarding changes to provider enrollment information.

RETURN THIS COMPLETED FORM WITH FEES TO:

AGENCY FOR HEALTH CARE ADMINISTRATION
HOSPITAL AND OUTPATIENT SERVICES UNIT
2727 MAHAN DR., MS 31
TALLAHASSEE FL 32308-5407

Questions? Visit the Agency's website : https://ahca.myflorida.com/ or contact the Hospital and Outpatient Services Unit at (850) 412-4549 or Email: hospitals@ahca.myflorida.com

The Agency for Health Care Administration scans all documents for electronic storage. In an effort to facilitate this process, we ask that you please remember to:

- Please place checks or money orders on top of the application
- Include license number or case number on your check
- Do not submit carbon copies of documents
- Do not fold any of the documents being submitted
- No staples, paperclips, binder clips, folders, or notebooks
- Please **do not bind any** of the documents submitted to the Agency.