Provider:
Test Hospital

Provider Type:
Hospital

File#: 23960245
License #:
Expires:

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

= Entered
= Entry Required

- Provider/Facility Information
  - Details
  - Property Ownership
  - Contact Person
- Licensee Information
- Controlling Interests
- Management Company Information
- Personnel
- Required Disclosure
- Bed Capacity
- Classification
- Licensed Programs
- Accreditation
- Clinical Laboratory And Radiology Services
- Additional Addresses
- Hospital Emergency Services
- Professional Liability Coverage
- Supporting Documents
- Finalize Submission

Health Care Licensing Online Application
Hospital
AHCA Form 3130-8001 OL, August 2023
59A-35.060, Florida Administrative Code

Logged in as : stocka

Dashboard | OL Help | Documents | Logout

Provider/Facility Information

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.

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.

- *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 Email cannot be blank. Please enter an email or check None checkbox below the field.*
- *Provider Website information cannot be blank. Please enter a website or check None checkbox below the field.*
- *Transparency Page is required*
- *Provider Mailing Email cannot be blank. Please check None checkbox below the field.*

Provider/Facility Information

License #

National Provider Identifier ☐ None ☐ Pending

Medicaid #

Medicare # (CMS CCN)

Name of Hospital (If operated under a fictitious name, enter as it is filed with the Florida Division of Corporations.)
Test Hospital

Provider/Facility Location Address

Edit Address

Provider Location Address
2726 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.* ☐ None

Provider/Facility Website ☐ None

Provider/Facility Transparency Website in accordance with section 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

[☑] Check if same as Provider/Facility Location Address

Edit Address

Address
2726 Mahan Dr
TALLAHASSEE, FL 32308
US - United States
County - LEON

Telephone (___) ___-____ Ext Email Address ☐ None

Undo | Save | Next >>

Property Ownership

There are missing and/or invalid entries. Please correct them.

- *Select a property ownership type.*

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

- ◯ Own
- ◯ Lease

Undo | Save | << Back | 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

- *Ownership Type is not selected.*
- *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.*
- *Select description of Licensee. (Profit, Non Profit or Public)*

Description of Licensee (select only one option below)

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

Ownership Types

Mailing Address

Edit Address

Address

Telephone	Ext	Fax #	Email Address
(___) ___-____		(___) ___-____	
		☐ None	☐ None

Undo | Save | << Back | Next >>

Controlling Interests of Licensee

- *Select either Yes or No option.*

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.

◯ Yes ◯ No

Undo | Save | << Back | Next >>

Management Company Information

- *Select either Yes or No option.*

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

◯ Yes ◯ No

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 Chief Executive Officer should be entered for this application.*
- *One Financial Officer should be entered for this application.*

A. Provider/Facility Administration

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:

- Chief Executive Officer
- 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 >>

Personnel

B. Safety Liaison

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

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.

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

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 >>

Bed Capacity

- *At least one field in the Hospital Bed Utilization section must be filled.*

- *Provide the number of beds for each type in the appropriate space below:*
- *Initial applications - Enter your bed count in the 'Increase' column.*

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				
Intensive Residential Treatment Facility				
Long Term Care				
Total Bed Capacity				

Undo | Save | << Back | Next >>

Classification

- *Applicant must select one and only one option on this screen.*

Make the appropriate selection below.

Class I Hospital

- ◯ General Acute Hospital
- ◯ Long Term Care Hospital
- ◯ Rural Hospital
  - ☐ mark if this is a 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

Undo | Save | << Back | Next >>

Licensed Programs

- *Please select a 'Burn Unit'*
- *Please select a 'Stroke Centers'*
- *Please select a 'Adult Cardiovascular Services'*
- *Please select a 'Transplant Services'*
- *Please select a 'NICU Services'*

Section 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 meets the criteria specified in Rule 59A-3.246(5), F.A.C., for a burn unit and has been verified by the American Burn Association (ABA) for adherence to the ABA Verification Criteria. A copy of the current verification certificate from the American Burn Association will be required in the Supporting Document section of this application.
- ◯ Provisional Burn Unit: The hospital meets the criteria specified in Rule 59A-3.246(5), F.A.C., for a burn unit and 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:

Section 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.

Please select 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 comprehensive stroke center by a nationally recognized accrediting organization
- ◯ The hospital is certified as a thrombectomy-capable stroke center by a nationally recognized accrediting organization

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Section 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.

Note: 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.

Please select only one option below: If options selected is not valid, please contact the Hospital and Outpatient Services Unit at Hospitals@ahca.myflorida.com

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

Section D - Transplant Services: Please mark all that apply.

- ◯ The hospital does not provide Transplant Services
- ◯ The hospital provides the following Transplant Services

Section 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 and supplies 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
- ◯ 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

Accreditation

- *Either select an Accrediting Organization or check the Not Accredited check box.*

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

If this hospital is not accredited, select the "Not Accredited" option.

☐ Not Accredited

Accrediting Organization	Accrediting Org ID	Accreditation Effective Date	Accreditation Expiration Date	Deemed Status
☐ Accreditation Commission for Health Care (ACHC)				
☐ Commisssion on Accreditation of Rehabilitation Facilities (CARF)				
☐ Center for Improvement in Healthcare Quality (CIHQ)				
☐ DNV GL Healthcare, Inc (DNVGL)				
☐ The Joint Commission (JC)				

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)*

☐ 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 to each citation, the effective date of accreditation and verification of Medicare (CMS) deemed status, if applicable.

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

Undo | Save | << Back | Next >>

Clinical Laboratory And Radiology Services

- *Select at least one Clinical Laboratory Service.*

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 license.

Please indicate which of the following apply:

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

Undo | Save | << Back | Next >>

Additional Addresses

- *Select either Yes or No option.*

A. Offsite Outpatient Facility

Provide the following information regarding the non-emergency, non-surgical offsite outpatient facilities, excluding urgent care centers. For new locations, you will need to provide proof of ownership/right to occupy.

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.

Note: Locations currently on the license not listed below will be removed from the license.

Does the licensee of this application operate under any other facility as described above?

◯ Yes ◯ No

Undo | Save | << Back | Next >>

Additional Addresses

- *Select either Yes or No option.*

B. Urgent Care Center

Provide the following information regarding outpatient locations meeting the definition of urgent care center in section 395.002, F.S. For new locations, you will need to provide proof of ownership/right to occupy.

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.

Note: Locations currently on the license not listed below will be removed from the license.

Does the licensee of this application operate under any other facility as described above?

◯ Yes ◯ No

Undo | Save | << Back | Next >>

Additional Addresses

- *Select either Yes or No option.*

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. For new locations, you will need to provide proof of ownership/right to occupy and approval from the Agency's Bureau and Plans of Construction in the Supporting Documents section of this application.

Note: Locations currently on the license not listed below will be removed from the license.

Does the licensee of this application operate under any other facility as described above?

◯ Yes ◯ No

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Additional Addresses

D. Hospital-Based Off-Campus Emergency Department

Provide the requested information regarding hospital-based off-campus emergency department. Emergency services offered off-campus must be available 24 hours per day, 7 days per week offering the same services as the emergency department located on the hospital premises.For new locations, you will need to provide proof of ownership/right to occupy and approval from the Agency's Bureau of Plans and Construction in the Supporting Documents section of this application.

Note: Locations currently on the license not listed below will be removed from the license.

To **add** a facility, select 'Add Facility' below and provide the requested information.

Add Facility

Undo | Save | << Back | Next >>

Hospital Emergency Services

- *Please provide answer to all the questions below.*

Provide the appropriate answers below regarding the emergency services provided by this hospital.

1. Emergency Services

   ◯ There is no dedicated emergency department in this hospital.

   ◯ Emergency services are offered via an emergency department located within the hospital and/or off site as indicated in the Offsite Facilities section of this application.

2. Does this hospital have an emergency 2 Way Radio System approved by the Department of Management Services, Division of Communications and the Federal Communications Commission in accordance with section 395.1031,F.S.?.

   ◯ Yes ◯ No

3. Are you requesting an emergency service exemption per section 395.1041(3)(d)3,F.S.? If so, you will be required to attach AHCA Form3000-1 in the Supporting Documents section of this application.

   ◯ Yes ◯ No

4. Does this hospital have a Baker Act receiving facility designation from the Department of Children and Families? If so, you will be required to attach your certificate in the Supporting Documents section of this application.

   ◯ Yes ◯ No

5. Select the appropriate Trauma Center designation(s) issued from the Department of Health, Office of Trauma.

   ☐ Provisional Level 1

   ☐ Provisional Level 2

   ☐ Provisional Pediatric

   ☐ Level 1

   ☐ Level 2

   ☐ Pediatric

   ☐ Not applicable

Undo | Save | << Back | Next >>

Hospital Emergency Services

- *Please select an answer for each service. If a services is not provided, select the 'Not Provided' option.*

Select the appropriate selection below for each of the services listed.

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/Maxillo-facial Surgery	○	○	○	○	○
Orthopedics	○	○	○	○	○
Otolaryngology	○	○	○	○	○
Plastic Surgery	○	○	○	○	○
Podiatry	○	○	○	○	○
Psychiatry	○	○	○	○	○
Pulmonary Medicine	○	○	○	○	○
Radiology	○	○	○	○	○
Thoracic Surgery	○	○	○	○	○
Urology	○	○	○	○	○
Vascular Surgery	○	○	○	○	○

Undo Save << Back Next >>

Professional Liability Coverage

- *User must select one of the options.*

AUTHORITY: Pursuant to subsection 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. Make the applicable selection below. You will need to provide the appropriate documentation in the Supporting Documents section of this application. 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 or from the Joint Underwriting Association established under section 627.351(4) F.S., not to exceed a $2,500,000 annual aggregate.
- ☐ A plan of **self-insurance** as provided in section 627.357 F.S. in an amount equivalent to $10,000 or more per claim for each hospital bed, not to exceed a $2,500,000 annual aggregate.
- ☐ **Exempt under section 395.1061(3)(b) F.S.** State Agencies, subdivisions, or instrumentalities of the state. No additional documentation is required with this application if previously documented.

Undo | Save | << Back | Next >>

Supporting Documents

Applicants **MUST** include the following attachments as stated in Chapters 408, Part II, and 395, F.S. and Chapters 59A-35 and 59A-3 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 4 document types that satisfy the provider's proof of financial responsibility requirement (Escrow Insurance, Private Insurance, Self Insurance, and Exempt Insurance).***
- ***Documentation signed by the appropriate local government official, which states that the applicant has met local zoning requirements***
  - ***Upload document is required/check the document mailed checkbox.***
- ***Copy of Visitation Policy and Procedure***
  - ***Upload document is required/check the document mailed checkbox.***

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...

Private Insurance

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...

Self 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...

Exempt Insurance

Effective Date

☐ 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...

Documentation signed by the appropriate local government official, which states that the applicant has met local zoning requirements

☐ 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 Visitation Policy and Procedure

☐ 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...

License Application Alternate-Site Testing, AHCA Form 3130-8013

☐ 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...

Emergency Services Exemption Request Form and Supporting Documents

☐ 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...

Baker Act Receiving Facility Certificate

☐ 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.

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Adult Cardiovascular Services Supporting Documents

☐ 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.

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

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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.

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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.

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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.

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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. *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. Bed Capacity
   a. *Bed Capacity*

8. Classification
   a. *Classification*

9. Licensed Programs
   a. *Licensed Programs*

10. Accreditation
    a. *Accreditation*

11. Clinical Laboratory And Radiology Services
    a. *Clinical Laboratory And Radiology Services*

12. Additional Addresses
    a. *Offsite Outpatient Facility*
    b. *Urgent Care Center*
    c. *Surgical Outpatient Center*
    d. Hospital-Based Off-Campus Emergency Department

13. Hospital Emergency Services
    a. *Section I*
    b. *Section II*

14. Professional Liability Coverage
    a. *Professional Liability Coverage*

15. 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.

- ○ 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.

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 $31.46 per bed, with minimum of $1,565.13
- The biennial assessment fee is $4.00 per bed, not to exceed $1,000
- 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