Provider:
Test OTP

Provider Type:
Organ and Tissue Procurement

File#: 41950439
License #: 383
Expires: 10/30/2023

Logged in as : happyfeet20

Dashboard | OL Help | Documents | Logout

= Entered
= Entry Required

- Provider/Facility Information
  - Details
  - Contact Person
- Licensee Information
- Controlling Interests
- Management Company Information
- Personnel
- Required Disclosure
- Accreditation
- Donor Testing
- Equipment
- Site Location
- Facility Operation
- Days and Hours of Operation
- Supporting Documents
- Finalize Submission

Provider/Facility Information

Under the authority of Chapters 408, Part II and 765, Part V, Florida Statutes (F.S.), and Chapters 59A-35, 59A-1, Florida Administrative Code (F.A.C.), an application is hereby made to operate an organ procurement organization, tissue bank, or eye bank as indicated below.

Pursuant to section 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 (FEIN) 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.

Complete the following for the organ and tissue procurement name and location. Provider name, address, and telephone number will be listed on Florida Health Finder (http://www.floridahealthfinder.gov).

Changes have been saved.

Provider/Facility Information

License #: 383

National Provider Identifier: [ ] None [ ] Pending

Medicaid #:

Name of Organ Procurement Organization, Tissue Bank, or Eye Bank
(if operated under a fictious name, enter as it appears in Florida Division of Corporations.)

Test OTP

Provider/Facility Location Address

Edit Address

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

Telephone: (321) 654-9870 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 Mailing Address (All mail will be sent to this address.)

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

Edit Address

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

Telephone: (321) 321-3213 Ext: Email Address: [ ] None

Health Care Licensing Online Application
Organ Procurement Organization, Tissue Bank, Eye Bank, AHCA Form 3140-2001OL, August 2023
59A-35.060, Florida Administrative Code

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

Licensee Information

- *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.*

Description of Licensee (select only one option below)

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

Ownership Types

Sole Proprietorship

Entity Licensee Details

Licensee Name (may be same as provider name)

Federal Employer Identification # (EIN)

Mailing Address

Edit Address

Address
1917 MAHAN DR
TALLAHASSEE, FL 32308
US - United States
County - LEON

Telephone	Ext	Fax #	Email Address
(780) 949-8007		(___) ___-____	
		☐ None	☐ None

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

To add a controlling interest -
Utilizing the picklist below, either choose an individual/entity that is already associated with this application or select 'New Controlling Interest - Individual' or 'New Controlling Interest - Entity'.

If the percentage of ownership interest indicated above does not equal 100%, please explain why in the space below:

Management Company Information

- *Select either Yes or No option.*

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

(•) Yes ( ) No

To add a management company -
Utilizing the picklist below, either select an entity that is already associated with this application or select 'New Management Company'.

Management Company Controlling Interest

- *Add at least one Management Company Controlling Interest.*

Controlling interests, as defined in section 408.803(7), F.S., are the applicant or licensee; a person or entity that serves as an officer of, is on the board of directors of, or has a 5% or greater ownership interest in the applicant or licensee; or a person or entity that serves as an officer of, is on the board of directors of, or has a 5% or greater ownership interest in the management company or other entity, related or unrelated, with which the applicant or licensee contracts to manage the provider. The term does not include a voluntary board member.

Note: For each controlling interest, an AHCA screening through the Care Provider Background Screening Clearinghouse is needed, or the Attestation of Compliance with the Background Screening Requirements, AHCA Form 3100-0008 if background screening was conducted by the Department of Financial Services for an applicant for a certificate of authority to operate a continuing care retirement community under Chapter 651, F.S. To verify who must be screened, visit the Background Screening site.

To add a controlling interest -
Utilizing the picklist below, either choose an individual/entity that is already associated with this application or select 'New Controlling Interest - Individual' or 'New Controlling Interest - Entity' .

Personnel

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

- *One Medical Director 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
- Medical Director

To add an individual -
Utilizing the picklist below, either choose an individual that is already associated with this application or select 'New Individual'.

To edit an existing individual -
Select "Edit/View"and edit as needed.

To remove an existing individual -
Select "Remove" and enter the date the individual's relationship with the licensee ended.

		Full Name of Individual	Type	Tax ID		Roles	Effective Date	End Date
Remove	Edit/View	EEYORE BLUE	SSN	XXX-XX-7931		Administrator / Managing Employee	09/01/2023	
Remove	Edit/View	PIGLET PINK	SSN	XXX-XX-0000		Financial Officer	09/01/2023	

Removed: (-) Added: (+)

Personnel

- *At least one entry is required.*

B. Advisory Board

Provide the requested information for all individuals on the advisory board.

#	First Name	Last Name	Area of Expertise
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

+ Add Rows

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

Select an individual from this list

No individual exists!

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

Select an individual/entity from this list

No individual/entity exists!

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

Accreditation

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

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

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

Note - Participation in a Proficiency Testing Program is not equivalent to accreditation.

☐ Not Accredited

Accrediting Organization	Accrediting Org ID	Accreditation Effective Date	Accreditation Expiration Date	Survey Date
☐ American Association of Tissue Banks (AATB)				
☐ Association of Organ Procurement Organizations (AOPO)				
☐ Eye Bank Association of America (EBAA)				

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.

Donor Testing

- *Select either Yes or No option.*

Does this facility perform laboratory testing on donors or donated organs and/or tissues?

(•) Yes ( ) No

If yes, list all locations and laboratory tests performed below. If tests are performed by the applicant, indicate 'On Site' for the location. For any testing laboratory outside Florida, supply evidence of current CLIA certification in the Supporting Documents section of this application.

#	Site Address	City	State	Zip Code	Laboratory Tests Performed
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					

+ Add Rows

Equipment

- *User must enter information in at least 1 row.*

List and breifly describe the equipment used.

#	Equipment	Description
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		

+ Add Rows

Site Location

- *Select either Yes or No for question 1.*
- *Select either Yes or No for question 2.*
- *Select either Yes or No for question 3.*

1. Is the space contiguous?

(•) Yes ( ) No

2. Is there more than one site?

(•) Yes ( ) No

If yes, provide the requested information below.

#	Name of Site	Site Address	City	County	State	Zip Code
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						

+ Add Rows

3. Is the agency sharing the sites(s) with another health provider?

(•) Yes ( ) No

If yes, explain the relationship in the space provided below.

Facility Operation

1. This facility operates as a/an:

- (•) Eye Bank
- ( ) Tissue Bank
- ( ) Organ Procurement Organization (OPO)

2. This facility provides the following services:

- [ ] Recovery/Retrieval
- [ ] Storage
- [ ] Distribution
- [ ] Processing

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			☐

Supporting Documents

Applicants **MUST** include the following attachments as stated in Chapters 408, Part II and 765 Part V, Florida Statutes (F.S.) and Chapters 59A-35 and 59A-1, Florida Administrative Code (F.A.C)

The following file types are suggested for uploading and submitting electronic documents to the Agency:
.DOC, .PDF, .TIFF, .TXT, .JPG, .XLS, and .PPT.

The following file types are **NOT** permitted for upload: .ZIP, .EXE, .BIN, .COM, .CMD, .SYS, .BAT, and .JS.
The upload and submission process will fail if any of these unpermitted file types are selected.

- *Detailed Explanation of Services the Facility Intends on Performing*
  - *Upload document is required/check the document mailed checkbox.*

Detailed Explanation of Services the Facility Intends on Performing

☐ An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Browse...

Accreditation Documentation

☐ An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Browse...

FDA Registration 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...

CLIA 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...

CMS Certification 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...

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

☐ An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Browse...

Approved Repayment Plan

☐ An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Browse...

Additional Documentation

☐ An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Browse...

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*
  - b. *Advisory Board*
- 6. Required Disclosure
  - a. *Convictions*
  - b. *Exclusions*
  - c. *Felonies/Terminations*
- 7. Accreditation
  - a. *Accreditation*
- 8. Donor Testing
  - a. *Donor Testing*
- 9. Equipment
  - a. *OTP Equipment*
- 10. Site Location
  - a. *Site Location*
- 11. Facility Operation
  - a. *Facility Operation*
- 12. Days and Hours of Operation
  - a. *Days and Hours of Operation*
- 13. Supporting Documents
  - a. *Supporting Documents*

I **MANDI MANZIE**, 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.

MANDI MANZIE		**09/21/2023**
Signature of Licensee or Authorized Representative	Title	Date

☐ I agree