Health Care Licensing Application
Abortion Clinic

Provider/Facility Information

Provider Information
Provider name, address, telephone number will be listed on Florida Health Finder at: http://www.floridahealthfinder.gov/

License Number:	833	National Provider Identifier:	None		
File Number:	13910053				
Provider/Facility:	A WOMAN'S CARE				
Street Address					
Street Address:	68-A NE 167TH STREET			(Bld, Suite, Floor, Villa, Apt)	
City:	MIAMI	State:	FLORIDA	Zip:	33162
County:	MIAMI-DADE				
Telephone:	(305) 947-0885	Telephone Ext:		Fax:	(305) 919-7481
Provider Website:	awomanscare.com		Email Address:	siomaraguzman@aol.com	
Transparency Page:					
Mailing Address (All mail will be sent to this address)					
Street Address:	68-A NE 167TH STREET			(Bld, Suite, Floor, Villa, Apt)	
City:	MIAMI	State:	FLORIDA	Zip:	33162
County:	MIAMI-DADE	Telephone:	(305) 947-0885	Telephone Ext:	
Email Address	siomaraguzman@aol.com				

Contact Details

Contact Person

Contact Person:	siomara j senises		Suffix:		
Telephone:	(954) 829-2327	Telephone Ext:		Fax:	(954) 964-9530
Email:	siomaraguzman@aol.com			***Note**: By providing your email address you agree to accept email correspondence from the Agency*	

Licensee Information

Description of Licensee:	For Profit		Ownership Type:	Corporation	
Licensee Name:	A WOMAN'S CARE INC			FEIN:	650122192
Mailing Address:	68 NE 167 STREET			(Bld, Suite, Floor, Villa, Apt.)	SUITE A
City:	MIAMI	State:	FLORIDA	Zip:	33162
County:	MIAMI-DADE				
Telephone:	(305) 947-0885	Telephone Ext:		Fax:	(954) 964-9530
Email:	siomaraguzman@aol.com				

Ownership Information

[Y] Does any person or entity serve as an officer of, is on the board of directors of, or have a 5% or greater ownership interest in the applicant or licensee?

Person and/or Entity Ownership of Licensee

Full Name of Individual/Entity:	MARIA PEGUERO	SSN/EIN:	xxx-xxx-xxxx
Board Member/ Officer:	NO	Suffix:	
% Ownership:	50.00		
Effective Date:	09/18/2017	End Date:	
Mailing Address Type:	Personal		
Street Address:	68 NE 167 STREET	(Bld, Suite, Floor, Villa, Apt)	SUITE A
City:	MIAMI	State:	FL
Zip:	33162	County:	MIAMI-DADE
Telephone:	(305) 527-8044	Telephone Ext.:	
Email:	None		
Full Name of Individual/Entity:	siomara j senises	SSN/EIN:	xxx-xxx-xxxx
Board Member/ Officer:	YES	Suffix:	
% Ownership:	50.00		
Effective Date:	09/18/2017	End Date:	
Mailing Address Type:	Personal		
Street Address:	3500 FAIRFAX LN	(Bld, Suite, Floor, Villa, Apt)	
City:	DAVIE	State:	FL
Zip:	33330-4628	County:	BROWARD
Telephone:	(954) 964-9528	Telephone Ext.:	
Email:	siomaraguzman@aol.com		

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

Management Company Information

Management Company

[N] Does a company other than the licensee manage the licensed provider?

Procedures Performed

[X] First Trimester Abortions

[X] Second Trimester Abortions

Medical Director

Full Name:	DAVID S BROWN	FL Medical License #:	ME57999
Effective Date:	01/31/2017	End Date:	
Address Type:	Personal		
Mailing Address:	952 EAST 25TH ST	(Bld, Suite, Floor, Villa, Apt.):	
City:	HIALEAH	County:	MIAMI-DADE
State:	FL	Zip:	33013

Transfer Agreement / Admitting Privileges

Transfer Agreement / Admitting Privileges

☐ All the physicians performing abortions have admitting privileges at a hospital within reasonable proximity.

☐ The abortion clinic has a transfer agreement with a hospital within reasonable proximity.

Transfer Agreement Hospitals

Provider Name	License Number	Telephone	Street Address
			, , ,

Personnel Information

Personnel

First Name:	MARIA	Middle:		Last Name:	PEGUERO
Suffix:		SSN:	xxx-xxx-xxxx	DOB:	
Address Type:	Personal				
Street Name or P.O. Box:	68 NE 167 STREET		(Bld, Suite, Floor, Villa, Apt.):		SUITE A
City:	MIAMI	State:	FLORIDA		
Zip:	33162	County:	MIAMI-DADE		
Telephone:	(305) 947-0885	Telephone Ext:			
Email:	siomaraguzman@aol.com				

Title	Effective Date	End Date	FL License Number
Administrator / Facility Manager	7/13/2001		

First Name:	SIOMARA	Middle:		Last Name:	SENISES
Suffix:		SSN:	xxx-xxx-xxxx	DOB:	
Address Type:	Personal				
Street Name or P.O. Box:	68 NE 167 STREET		(Bld, Suite, Floor, Villa, Apt.):		SUITE A
City:	MIAMI	State:	FLORIDA		
Zip:	33162	County:	MIAMI-DADE		
Telephone:	(954) 829-2327	Telephone Ext:			
Email:	siomaraguzman@aol.com				

Title	Effective Date	End Date	FL License Number
Financial Officer	9/10/2015		

Required Disclosures

Convictions

Pursuant to subsection 408.809(1)(d), F.S., the applicant shall submit to the agency a description and explanation of any convictions or offences prohibited by sections 435.04 and 408.809(4), F.S., for each controlling interest.

N 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 offence pursuant to subsection 408.809(1)(d), Florida Statutes?(These offences are listed on the Affidavit of Compliance with Background Screening Requirements, AHCA Form (#3100-0008)

Full Name	SSN	Description	Exemption

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.

N 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?

Full Name	SSN	Description

Felonies / Terminations

Pursuant to section 408.815(4), F.S., does the applicant or any controlling interest in an applicant have any of the following:

N 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, within the previous 15 years prior to the date of this application?

N Terminated for cause from the Medicare program or a state Medicaid program.

Days and Hours of Operation

Day	Opening Time	Closing Time	By Appointment
MONDAY	9:00 AM	3:00 PM	
TUESDAY	9:00 AM	3:00 PM	
WEDNESDAY	9:00 AM	3:00 PM	
THURSDAY	9:00 AM	3:00 PM	
FRIDAY	9:00 AM	3:00 PM	
SATURDAY			X
SUNDAY			

Affidavit

I **SIOMARA SENISES** , under penalty of perjury, attest as follows:

(1) Pursuant to section 837.06, Florida Statutes (F.S.), 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 Statues (F.S.), 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 Statues (F.S.), the applicant is in compliance with the provisions of section 408.806 and Chapter 435, Florida Statutes (F.S.).

(4) Pursuant to section 408.809 and 435.05, Florida Statutes (F.S.), 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 (F.S.), 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 (F.S.), 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 (F.S.), 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.

SIOMARA SENISES	MANAGER	09/18/2017
Signature of Licensee or Authorized Representative	Title	Date