



AHCA USE ONLY:
 File #: 13910054
 Application #: 1382
 Check #: 1704
 Check Amt: 845.05
 Batch #: 101000039

(13)
 NA
 R

Health Care Licensing Application ABORTION CLINIC

Under the authority of Chapters 408 Part II, and 390 Florida Statutes (F.S.), and Chapters 59A-35 and 59A-9, Florida Administrative Code (F.A.C.), an application is hereby made to operate an abortion clinic as indicated below:

1. Provider / Licensee Information

A. Provider Information – please complete the following for the abortion clinic name and location. Provider name, address and telephone number will be listed on <http://www.floridahealthfinder.gov/>

License # (for renewal & change of ownership applications) <u>820</u>	National Provider Identifier (NPI) (if applicable)		
Name of Abortion Clinic (include fictitious name, if applicable) <u>A Woman's World Medical Center Inc</u>			
Street Address <u>503 South 12th Street</u>			
City <u>Fort Pierce</u>	County <u>St. Lucie</u>	State <u>Florida</u>	Zip <u>34950</u>
Telephone Number <u>772-460-6506</u>	Fax Number <u>772-466-7267</u>	E-mail Address <u>awomanswr1@aol.com</u>	Provider Website <u>www.awwmc.com</u>
Mailing Address or <input checked="" type="checkbox"/> Same as above (All mail will be sent to this address)			
City		State	Zip
Contact Person for this application <u>Candace M. Dye</u>		Contact Telephone Number <u>772-460-6506</u>	
Contact e-mail address or <input type="checkbox"/> Do not have e-mail <u>awomanswr1@aol.com</u>		NOTE: By providing your e-mail address you agree to accept e-mail correspondence from the Agency.	

B. Licensee Information – please complete the following for the entity seeking to operate the abortion clinic.

Licensee Name (may be same name as listed in above) <u>Candace M. Dye</u>	Federal Employer Identification Number (EIN) <u>65-0255235</u>	
Mailing Address or <input checked="" type="checkbox"/> Same as above		
City	State	Zip
Telephone Number	Fax Number	E-mail Address
RECEIVED JUL 18 2014		
Description of Licensee (check one):		
For Profit <input checked="" type="checkbox"/> Corporation (S) <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Partnership <input type="checkbox"/> Individual <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Other	Not for Profit <input type="checkbox"/> Corporation <input type="checkbox"/> Religious Affiliation <input type="checkbox"/> Other	Public <input type="checkbox"/> State <input type="checkbox"/> City/County <input type="checkbox"/> Hospital District

2. Application Type and Fees

Indicate the type of application with an "X." **Applications will not be processed if all applicable fees are not included. Pursuant to subsection 408.805(4), Florida Statutes, 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 fine. 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.

Initial licensure

Is this application to reactivate an expired license? YES NO

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

NAME:	EIN #	Year Expired/Closed:
-------	-------	----------------------

Renewal licensure

Change of ownership, proposed effective date: _____

Change during licensure period proposed effective date: _____

Name/address change of the provider

Change in Administrator or Financial Officer (No fee required)

RECEIVED

JUL 18 2014

**Central Systems
Management Unit**

Action	Fee	TOTAL FEES
LICENSE FEE (Initial, <u>Renewal</u> and Change of Ownership):	\$545.05	\$
<input checked="" type="checkbox"/> License Fee Exemption (County or Municipal Government pursuant to 390.014(4), F.S.) = \$ 0.00		545.05
Change During Licensure Period/Replacement License	\$ 25.00	\$
Biennial Assessment (Renewal applications only)	\$300.00	\$ 300.00
Late fee, if applicable	Contact licensure unit for details.	\$
Other: _____		\$
TOTAL FEES INCLUDED WITH APPLICATION:		\$845.05
<i>Please make check or money order payable to the Agency for Health Care Administration (AHCA)</i>		
<i>Note: Starter checks and temporary checks are not accepted.</i>		

RECEIVED

JUL 18 2014

3. Controlling Interests of Licensee

AUTHORITY:

Pursuant to section 408.806(1)(a) and (b), Florida Statutes, an application for licensure must include: the name, address and Social Security number 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.**

**Central Systems
Management Unit**

DEFINITIONS:

Controlling interests, as defined in subsection 408.803(7), Florida Statutes, 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-percent 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-percent 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.

In Sections A and B below, 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.

A. Individual and/or Entity Ownership of Licensee

FULL NAME of INDIVIDUAL or ENTITY	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER	EIN (No SSNs)	% OWNERSHIP INTEREST
Candace M. Dye	503 S. 12 th Street. 7P.	772-460-1504	605-0255235	100%

B. Board Members and Officers of Licensee (Excludes Voluntary Board Members)

TITLE	FULL NAME	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER
Director/CEO	N/A	A	
President			
Vice President			
Secretary			
Treasurer			
Other:			

4. Management Company Control

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

If NO, skip to section 5 – Required Disclosure

If YES, provide the following information:

Name of Management Company		EIN (No SSNs)		Telephone Number / Fax	
Street Address			E-mail Address		
City		County		State	Zip
Mailing Address or <input type="checkbox"/> Same as above					
City				State	Zip
Contact Person		Contact E-mail		Contact Telephone Number	

RECEIVED
JUL 18 2014
Central Systems
Management Unit

In Sections A and B below, 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.

A. Individual and/or Entity Ownership of Management Company

FULL NAME of INDIVIDUAL or ENTITY	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER	EIN (No SSNs)	% OWNERSHIP INTEREST

B. Board Members and Officers of Management Company (Excludes Voluntary Board Members)

TITLE	FULL NAME	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER
Director/CEO			
President			
Vice President			
Secretary			
Treasurer			
Other:			

5. Required Disclosure

The following disclosures are required:

A. Pursuant to subsection 408.809(1)(d), 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(5), 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 subsection 408.809(1)(d), Florida Statutes? (These offenses are listed on the Affidavit of Compliance with Background Screening Requirements, AHCA Form #3100-0008.) YES NO

If yes, enclose the following information:

- The full legal name of the individual and the position held.
- A description/explanation of the conviction(s) - If the individual has received an exemption from disqualification for the offense, include a copy.

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

RECEIVED

JUL 18 2014

Central Systems Management Unit

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

YES NO 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, have not 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 this application.

6. Provider Fines and Financial Information

Pursuant to subsection 408.831(1)(a), Florida Statutes, 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):

Amount: \$ _____ assessed by: Agency for Health Care Administration CMS

Date of related inspection, application or overpayment period if applicable: _____

Due date of payment: _____

Is there an appeal pending from a Final Order? YES NO

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

7. Procedure / Director / Hospital Information

PROCEDURES PERFORMED (check all that apply):

First Trimester Abortions (the first 12 weeks of pregnancy)

Second Trimester Abortions (the portion of the pregnancy following the 12th week through the 24th week)

If second trimester abortions are performed, provide the following information:

DESIGNATED MEDICAL DIRECTOR: <i>Harvey C. Roth MD</i>		FLORIDA MEDICAL LICENSE NUMBER: <i>ME 64837</i>	
MEDICAL DIRECTOR HAS: <input type="checkbox"/> Admitting privileges and/or <input checked="" type="checkbox"/> A transfer agreement With the following hospital: <i>Lawnwood Regional Medical Center</i>			
Hospital Street Address <i>1700 S 23rd St.</i>		Telephone Number <i>772-461-4000</i>	
City <i>Fort Pierce, FL</i>	County <i>St. Lucie</i>	State <i>FL</i>	Zip <i>34950</i>

RECEIVED

JUL 18 2014

**Central Systems
Management Unit**

8. Personnel

Administrative Personnel:

TITLE	NAME	TELEPHONE NUMBER	E-MAIL
Administrator/Facility Manager	Candace M. Dye	772-460-7506	awomanswr1@aol.com
Financial Officer	" " "	"	" " "

9. Affidavit

I, Candace M. Dye, hereby swear or affirm, under penalty of perjury, that the statements in this application are true and correct. As administrator or authorized representative of the above named provider/facility, I hereby attest that all employees required by law to undergo Level 2 background screening have met the minimum standards of sections 435.04, and 408.809(5), Florida Statutes (F.S.) or are awaiting screening results.

In addition, I attest that all employees subject to Level 2 screening standards have attested to meeting the requirements for qualifying for employment and agree to inform me immediately if arrested for or convicted of any of the disqualifying offenses while employed here as specified in subsection 435.04(5), F.S.

Candace M. Dye
Signature of Licensee or Authorized Representative

Administrator/owner
Title

6/20/14
Date

RETURN THIS COMPLETED FORM WITH FEES AND ALL REQUIRED DOCUMENTS TO:

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

Questions?

Review the information available at <http://ahca.myflorida.com/> or contact the Hospital & Outpatient Services Unit at (850) 412-4549

RECEIVED

JUL 18 2014

**Central Systems
Management Unit**