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AHCA USE ONLY:
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NAR-13

**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) 894 | National Provider Identifier (NPI) (if applicable) | | |
| Name of Abortion Clinic (include fictitious name, if applicable) BREAD AND ROSES NEW WOMAN CARE | | | |
| Street Address 1233 NW 10th Ave | | | |
| City GAINESVILLE | County ALACHUA | State FL | Zip 32601 |
| Telephone Number 352-372-1664 | Fax Number 352 372 3222 | E-mail Address breadroses@hotmail.com | Provider Website |
| Mailing Address or <input checked="" type="checkbox"/> Same as above (All mail will be sent to this address) com | | | |
| City | | State | Zip |
| Contact Person for this application KRISTIN DAVY | | Contact Telephone Number 352 372 1664 | |
| Contact e-mail address or <input type="checkbox"/> Do not have e-mail breadroses@hotmail.com | | 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) GAINESVILLE WOMAN CARE, LLC | Federal Employer Identification Number (EIN) 20-1789123 | | |
| Mailing Address or <input checked="" type="checkbox"/> Same as above | | | |
| City | | State | Zip |
| Telephone Number 352 372 1664 | Fax Number 352 372 3222 | E-mail Address | |
| Description of Licensee (check one): | | | |
| <input type="checkbox"/> For Profit Corporation <input checked="" type="checkbox"/> Limited Liability Company <input type="checkbox"/> Partnership <input type="checkbox"/> Individual <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Other | <input type="checkbox"/> Not for Profit Corporation <input type="checkbox"/> Religious Affiliation <input type="checkbox"/> Other | <input type="checkbox"/> Public State <input type="checkbox"/> City/County <input type="checkbox"/> Hospital District | <p>RECEIVED MAR 04 2016 CENTRAL INTAKE</p> |

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)

| Action | Fee | TOTAL FEES |
|--|-------------------------------------|------------------|
| LICENSE FEE (Initial, Renewal and Change of Ownership): <input type="checkbox"/> License Fee Exemption (County or Municipal Government pursuant to 390.014(4), F.S.) = \$ 0.00 | \$545.05 | \$545.05 |
| Change During Licensure Period/Replacement License | \$ 25.00 | \$ |
| Biennial Assessment (Renewal applications only) | \$300.00 | \$ 300 |
| 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> | | |

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3. Controlling Interests of Licensee

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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.**

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 |
|-----------------------------------|--|------------------|---------------|----------------------|
| Gamesville Women Centre, LLC | 1233 NW 10th Ave Gamesville, FL 32601 | 352 372 1664 | | 100 |
| | | | | |
| | | | | |
| | | | | |

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

| TITLE | FULL NAME | PERSONAL OR BUSINESS ADDRESS | TELEPHONE NUMBER |
|----------------|--------------|--|------------------|
| Director/CEO | KRISTIN DAVY | 1233 NW 10th Ave Gamesville, FL 32601 | 352 372 1664 |
| 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 | | |

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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.

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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: | | FLORIDA MEDICAL LICENSE NUMBER: | |
| MEDICAL DIRECTOR HAS: <input type="checkbox"/> Admitting privileges and/or <input type="checkbox"/> A transfer agreement With the following hospital: | | | |
| Hospital Street Address | | Telephone Number | |
| City | County | State | Zip |

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8. Personnel

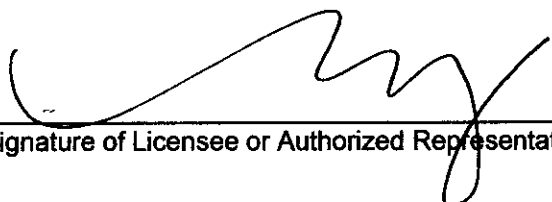
Administrative Personnel:

| TITLE | NAME | TELEPHONE NUMBER | E-MAIL |
|--------------------------------|--------------|------------------|------------------------|
| Administrator/Facility Manager | KRISTIN DAVY | 352 372 1664 | breadroses@hotmail.com |
| Financial Officer | KRISTIN DAVY | 352-372-1664 | breadroses@hotmail.com |

9. Affidavit

I, KRISTIN DAVY, 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.



Signature of Licensee or Authorized Representative

Director

Title

2/25/16

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

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