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AHCA USE ONLY:	
File #:	13960108
Application #:	1341
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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 by http://www.floridahealthfinder.gov			
License # (for renewal & change of ownership applications) 901	National Provider Identifier (NPI) (if applicable) 1259873248	CMS CCN (Medicare #)	Medicaid # 256972800
Name of <i>Abortion Clinic</i> (if operated under a fictitious name, list that here)			
Street Address 726 South Tampa Avenue			
City Orlando	County Orange	State FL	Zip 32805
Telephone Number 407.246.1788	Fax Number 407.246.8466	E-mail Address	Provider Website www.pppo.org
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 Nicole Virtue		Contact Telephone Number 407.246.1788 ext. 108	
Contact e-mail address or <input type="checkbox"/> Do not have e-mail nicole.virtue@ppgo.org		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) Planned Parenthood of Greater Orlando, Inc.		Federal Employer Identification Number (EIN) 593092996	
Mailing Address or <input checked="" type="checkbox"/> Same as above			
City		State	Zip
Telephone Number	Fax Number	E-mail Address	
Description of Licensee (check one):			
<input type="checkbox"/> For Profit <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Partnership <input type="checkbox"/> Individual <input type="checkbox"/> Other	<input checked="" type="checkbox"/> Not for Profit <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Religious Affiliation <input type="checkbox"/> Other	<input type="checkbox"/> Public <input type="checkbox"/> State <input type="checkbox"/> City/County <input type="checkbox"/> Hospital District	RECEIVED SEP 23 2013 Central Systems Management Unit

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. All 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:
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Renewal licensure

Change of ownership, proposed effective date: _____

Change during licensure period (name/address change of the provider), proposed effective date: _____

Action:	Fee	TOTAL FEES
LICENSE FEE (Initial, Renewal and Change of Ownership):	\$545.05	\$ 545.05
<input checked="" type="checkbox"/> License Fee Exemption (County or Municipal Government pursuant to 390.014(4), F.S.) = \$ 0.00		
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>		

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.**

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; 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.

Voluntary Board Member, as defined in subsection 408.803(13), Florida Statutes, means a board member or officer of a not-for-profit corporation or organization who serves solely in a voluntary capacity, does not receive any remuneration for his or her services, is not on the board of directors, and has no financial interest in the corporation or organization.

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.

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A. Individual and/or Entity Ownership of Licensee

FULL NAME OF INDIVIDUAL or ENTITY	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER	EIN (No SSN#)	OWNERSHIP INTEREST
Planned Parenthood of Greater Orlando, Inc.	726 South Tampa Ave., Orlando, FL 32805	407.246.1788	593092996	100

B. Board Members and Officers of Licensee

TITLE	FULL NAME	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER	OWNERSHIP INTEREST
Director/CEO	Jenna Tosh	726 S. Tampa Ave., Orlando, FL 32805	407.246.1788	0
President	Jenna Tosh	726 S. Tampa Ave., Orlando, FL 32805	407.246.1788	0
Vice President				
Secretary				
Treasurer				
Other:				

C. Voluntary Board Members and Officers of Licensee

If the licensee is a not-for-profit corporation/organization, provide the requested information for each individual that serves as a voluntary board member. Attach additional sheets if necessary.

FULL NAME	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER
James Fisher	515 Daniels Ave. Orlando, FL 32801	(407) 953-9267
Nancy Wolf	149 Harston Court Heathrow, FL 32746	(407) 620-5207
Leslie Line Anderson	1100 South Delaney Avenue, #F300 Orlando, FL 32806	(407) 595-3162
Sharon Jones	254 S. Ortman Drive Orlando, FL 32811	(901) 292-7483
Karen Persis	1500 East Robinson Street Orlando, FL 32801	(407) 575-8189
Karen Leetzow	5213 Shoreline Circle Sanford, Florida 32771	(407) 302-6030
Justin O'Neill	905 Ellwood Ave Orlando, FL 32804	(407) 342-0103
Boyd Lindsley	6051 Twin Lakes Drive Oviedo, FL 32765	(407) 489-0536
Dr. Luci Belnik	5474 Lake Howell Rd. Winter Park, FL 32792	(321) 439-1691
Dr. Lori Boardman	6850 Lake Nona Boulevard Orlando, FL 32827	(401) 952-5502
Jo Staffin	974 Innswood Court Longwood, Florida 32779	(407) 869-0175
Marty Haynie	201 S. Rosalind Ave. 4th Floor Orlando, FL 32801	(407) 836-5690
Susannah Randolph	1400 Mount Vernon St Orlando, FL 32803	(407) 259-1872
Dr. Janan Al-Awar Smither	4000 Central Florida Boulevard Orlando, FL 32816	(407) 823-5859

D. Administration

TITLE	NAME	TELEPHONE NUMBER	E-MAIL
President of Governing Body			RECEIVED SEP 23 2013
Facility Manager / Supervisor			
Chief Financial Officer			

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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	

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

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

C. Voluntary Board Members and Officers of Management Company

If the management company is a not-for-profit corporation/organization, provide the requested information for each individual that serves as a voluntary board member. Attach additional sheets if necessary.

FULL NAME	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER

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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.

- 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, within the previous 15 years prior to the date of this application;

YES NO Terminated for cause from the Florida Medicaid program pursuant to s. 409.913, and not been in good standing with the Florida Medicaid program for the most recent 5 years;

YES NO Terminated for cause, pursuant to the appeals procedures established by the state or federal government, from the federal Medicare program or from any other state Medicaid program, have not been in good standing with a state Medicaid program or the federal Medicare program for the most recent 5 years and the termination was less than 20 years prior to 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

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.

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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)

DESIGNATED MEDICAL DIRECTOR: Merri Morris, MD		FLORIDA MEDICAL LICENSE NUMBER: ME96883	
MEDICAL DIRECTOR HAS: <input type="checkbox"/> Admitting privileges and/or <input checked="" type="checkbox"/> A transfer agreement With the following hospital: <i>Orlando Regional Medical Center</i>			
Hospital Street Address <i>1414 Kuhl Ave</i>		Telephone Number <i>3218415210</i>	
City <i>Orlando</i>	County <i>Orange</i>	State <i>FL</i>	Zip <i>32806</i>

8. Personnel

Provide the requested information for all licensed personnel (medical staff, nurses, technicians and consultants).
 Attach additional pages if needed.

Name	Position	Employment Type	License Number
Dr. Merri Morris	Medical Director/Physician	Employee	ME96883
Dr. Emil Felski	Physician	Contract	OS3318
Kimberly Sorensen	ARNP, Lead Clinician	Employee	ARNP9349406
Jacqueline Redlin	ARNP	Employee	ARNP3383012
Alison Hines	ARNP	Employee	ARNP2154232
Socorro Valentin	ARNP	Employee	PN5203631
Susanne McGinty	ARNP	Employee	ARNP9263776
Dr. Veenod Chulani	Physician	Contract	ME88776
Leslie Ward	ARNP	Employee	ARNP3031182
Airelys Hernandez Perez	RN	Employee	RN9314296
Angela Quiroga	LPN	Employee	PN5198375
Sondra Velozo	LPN	Employee	PN5203631

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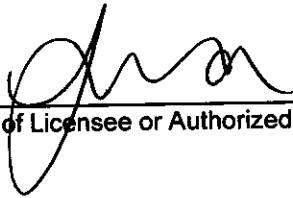
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9. Affidavit

I, Jenna Tosh, 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

President & CEO
Title

9/20/13
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 Agency at (850) 412-4549

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AFFIDAVIT OF COMPLIANCE WITH Background Screening Requirements

Authority: This form may be used by all employees to comply with:

- the attestation requirements of section 435.05(2), Florida Statutes, which state that every employee required to undergo Level 2 background screening must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer; AND
- the proof of screening within the previous 5 years in section 408.809(2), Florida Statutes which requires proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the Agency, the Department of Health, the Agency for Persons with Disabilities, the Department of Children and Family Services, or the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651 if the person has not been unemployed for more than 90 days.

This form must be maintained in the employee's personnel file. If this form is used as proof of screening for an administrator or chief financial officer to satisfy the requirements of an application for a health care provider license, please attach a copy of the screening results and submit with the licensure application.

Employee/Contractor Name:	Nicole Virtue
Health Care Provider/ Employer Name:	Planned Parenthood of Greater Orlando, Inc.
Address of Health Care Provider:	726 S. Tampa Ave, Orlando, FL 32805

I hereby attest to meeting the requirements for employment and that I have not been arrested for or been found guilty of, regardless of adjudication, or entered a plea of nolo contendere, or guilty to any offense, or have an arrest awaiting a final disposition prohibited under any of the following provisions of the Florida Statutes or under any similar statute of another jurisdiction:

Criminal offenses found in section 435.04, F.S

- a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.
- (b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.
- (c) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.
- (d) Section 782.04, relating to murder.
- (e) Section 782.07, relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child.

- (f) Section 782.071, relating to vehicular homicide.
- (g) Section 782.09, relating to killing of an unborn quick child by injury to the mother.
- (h) Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.
- (i) Section 784.011, relating to assault, if the victim of the offense was a minor.
- (j) Section 784.03, relating to battery, if the victim of the offense was a minor.
- (k) Section 787.01, relating to kidnapping.
- (l) Section 787.02, relating to false imprisonment.
- (m) Section 787.025, relating to luring or enticing a child.

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(n) Section 787.04(2), relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings.

(o) Section 787.04(3), relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.

(p) Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.

(q) Section 790.115(2)(b), relating to possessing an electric weapon or device, destructive device, or other weapon on school property.

(r) Section 794.011, relating to sexual battery.

(s) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.

(t) Section 794.05, relating to unlawful sexual activity with certain minors.

(u) Chapter 796, relating to prostitution.

(v) Section 798.02, relating to lewd and lascivious behavior.

(w) Chapter 800, relating to lewdness and indecent exposure.

(x) Section 806.01, relating to arson.

(y) Section 810.02, relating to burglary.

(z) Section 810.14, relating to voyeurism, if the offense is a felony.

(aa) Section 810.145, relating to video voyeurism, if the offense is a felony.

(bb) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.

(cc) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.

(dd) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.

(ee) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.

(ff) Section 825.103, relating to exploitation of an elderly person or disabled adult, if the offense was a felony.

(gg) Section 826.04, relating to incest.

(hh) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child.

(ii) Section 827.04, relating to contributing to the delinquency or dependency of a child.

(jj) Former s. 827.05, relating to negligent treatment of children.

(kk) Section 827.071, relating to sexual performance by a child.

(ll) Section 843.01, relating to resisting arrest with violence.

(mm) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.

(nn) Section 843.12, relating to aiding in an escape.

(oo) Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institutions.

(pp) Chapter 847, relating to obscene literature.

(qq) Section 874.05(1), relating to encouraging or recruiting another to join a criminal gang.

(rr) Chapter 893, relating to drug abuse prevention and control, only if the offense was a felony or if any other person involved in the offense was a minor.

(ss) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.

(tt) Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.

(uu) Section 944.40, relating to escape.

(vv) Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.

(ww) Section 944.47, relating to introduction of contraband into a correctional facility.

(xx) Section 985.701, relating to sexual misconduct in juvenile justice programs.

(yy) Section 985.711, relating to contraband introduced into detention facilities.

(3) The security background investigations under this section must ensure that no person subject to this section has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense that constitutes domestic violence as defined in s. 741.28, whether such act was committed in this state or in another jurisdiction.

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Criminal offenses found in section 408.809(4), F.S. Central Systems Management Unit

(a) Any authorizing statutes, if the offense was a felony.

- (b) This chapter, if the offense was a felony.
- (c) Section 409.920, relating to Medicaid provider fraud.
- (d) Section 409.9201, relating to Medicaid fraud.
- (e) Section 741.28, relating to domestic violence.
- (f) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.
- (g) Section 817.234, relating to false and fraudulent insurance claims.
- (h) Section 817.505, relating to patient brokering.
- (i) Section 817.568, relating to criminal use of personal identification information.
- (j) Section 817.60, relating to obtaining a credit card through fraudulent means.
- (k) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.
- (l) Section 831.01, relating to forgery.
- (m) Section 831.02, relating to uttering forged instruments.
- (n) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.
- (o) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.
- (p) Section 831.30, relating to fraud in obtaining medicinal drugs.
- (q) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony.

If you are also using this form to provide evidence of prior Level 2 screening (fingerprinting) in the last 5 years and have not been unemployed for more than 90 days, please provide the following information. **A copy of the prior screening results must be attached.**

Purpose of Prior Screening: ITOP Reporting
 Screened conducted by: _____ Date of Prior Screening: 1/23/13

- Agency for Health Care Administration
- Department of Health
- Agency for Persons with Disabilities
- Department of Children and Family Services
- Department of Financial Services

Affidavit

Under penalty of perjury, I, Nicole Virtue, hereby swear or affirm that I meet the requirements for qualifying for employment in regards to the background screening standards set forth in Chapter 435 and section 408.809, F.S. In addition, I agree to immediately inform my employer if arrested or convicted of any of the disqualifying offenses while employed by any health care provider licensed pursuant to Chapter 408, Part II F.S.


 Employee/Contractor Signature

Director of Patient Services 9/21/13
 Title Date

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APPLICATION CHECKLIST



All forms listed below may be obtained from the website: <http://ahca.myflorida.com/MCHQ/Corebill/index.shtml> Send completed applications to: Agency for Health Care Administration, Hospital and Outpatient Services Unit, 2727 Mahan Drive, Mail Stop 31, Tallahassee, FL 32308.

A. Initials, Renewals and Change of Ownership Applications Must Include:

NOTE TO ALL APPLICANTS: The Agency will verify that all applicants, licensees and controlling interests subject to Chapters 607, 608 or 617, Florida Statutes related to Business Organizations have complied with applicable Department of State registration and filing requirements. The principal and mailing addresses submitted with any application must be the same as the addresses that appear as registered with the Department of State, Division of Corporations.

- The Appropriate Biennial Licensure Fee (\$545.05) - Please make check or money order payable to the Agency for Health Care Administration. All fees are nonrefundable.
- Health Care Licensing Application, Abortion Clinic, AHCA Form 3130-1000. **NOTE:** All Agency correspondence will be sent to the mailing address provided in Section 1 of the application. If an applicant or licensee is required to register or file with the Florida Secretary of State Division of Corporations, the principal, fictitious name and mailing address provided in Section 2 of this application must be the same as the information registered with the Division of Corporations as provided in section 59A-35.060(4), Florida Administrative Code.
- Health Care Licensing Application Addendum, AHCA Form 3110-1024 - Complete the information that is applicable, write "NA" on the items that are not applicable, sign, date and send with the application (refer to Sections 3 & 4 of the application for further details).
- Background Screening

A Level 2 background screening for the Administrator and Chief Financial Officer is required every 5 years.

All screening results must be sent to the Agency for Health Care Administration for review and employment determinations. If you choose to use a LiveScan source other than the Agency's contracted vendor you must identify the Agency for Health Care Administration as the recipient of the screening results to ensure the results are reviewed by the Agency. If the Agency does not receive the results, additional screening and fees may be required. For additional information, including finding a LiveScan vendor and screening a person who is out of state, please visit the Agency's background screening website at http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/index.shtml.

The Administrator and/or Chief Financial Officer submitted a new Level 2 screening through a LiveScan vendor.

The Administrator and/or Chief Financial Officer submitted a Level 2 screening within the previous 5 years and results are on file with the Agency for Health Care Administration, Department of Children and Families, Department of Health, Department of Elder Affairs, Agency for Persons with Disabilities or Department of Financial Services (if the applicant has a certificate of authority to operate a continuing care retirement community). An Affidavit of Compliance with Background Screening Requirements, AHCA Form 3100-0008, is also enclosed.

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B. Additional Information Needed for INITIAL Applications:

- Proof of the licensee's right to occupy the building such as a copy of a lease, sublease agreement, or deed.
- A report or letter from the local government zoning office that the location is zoned appropriately for use as an abortion clinic.

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C. Additional Information Needed for RENEWAL Applications:

- \$300 Health Care Facility Fee Assessment (\$150 annual assessment x 2).

Pursuant to Rule 59C-1.022(4), Florida Administrative Code, the annual assessment from all facilities shall be collected prospectively for a two year (biennial) period. For renewal applications, the biennial assessment shall be calculated at the time of the licensure renewal and shall be due at the time of filing of the renewal application.

D. Additional Information Needed for CHANGE OF OWNERSHIP Applications:

- Proof of the licensee's right to occupy the building such as a copy of the lease, sublease agreement, or deed.
- Closing documents signed and dated by all parties.
- A signed agreement to correct all outstanding licensure and certification deficiencies incurred by the previous owner
- A signed agreement to pay any outstanding payments owed to the Agency. The agreement must include who will pay and when payment will be made.

E. Change During Licensure Period:

Request to change the name or address of provider:

- Complete and submit sections 1, 2 and 9 of the Health Care Licensing Application, Abortion Clinic, AHCA Form 3130-1000.
- Proof of the licensee's right to occupy the building such as a copy of the lease, sublease agreement, or deed.
- For address changes, a report or letter from the local government zoning office that the location is zoned appropriately for use as an abortion clinic.
- \$25.00 fee for replacement license/issue of license due to change during licensure period. Please make check or money order payable to the *Agency for Health Care Administration*. All fees are nonrefundable.

The Agency for Health Care Administration scans all documents for electronic storage. In an effort to facilitate this process, we ask that you please remember to:

- Please place checks or money orders on top of the application
- Include license number or case number on your check
- Do not submit carbon copies of documents
- Do not fold any of the documents being submitted
- No staples, paperclips, binder clips, folders, or notebooks
- Please ***do not bind any*** of the documents submitted to the Agency.

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PPGO
726 S. Tampa Ave.
Orlando, FL 32805



AHCA, Hospital & Outpatient Services
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