3/16/18 MW

AHCA USE ONLY:
File #: 13960064
Application #: 1573
Check #: 4258
Check Amt: $850.50
Batch #: 10100478

NA-R-13

Health Care Licensing Application
Abortion Clinic

APPLICANTS CAN NOW RENEW LICENSES ONLINE
The Agency for Health Care Administration (AHCA) has implemented the **ONLINE LICENSING SYSTEM** which allows the electronic submission of renewal applications and fees, along with the ability to upload supporting documentation.
To renew online please go to: http://ahca.myflorida.com/onlinelicensure

Applications must be received **at least 60 days prior to** the expiration of the current license or effective date of a change of ownership to avoid a late fee. 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. *The application will be withdrawn from review if all the required documents and fees are not included with your application or received within 21 days of an omission notice.* **Applications will not be considered for review until payment has been received. Renewal applications: Supporting documentation, responses to omissions and payments may be submitted using the online system even if the application was originally mailed to the Agency.**

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)	National Provider Identifier (NPI) (if applicable)
862	1881714137

Name of Abortion Clinic (if operated under a fictitious name, enter as it appears in Florida Division of Corporations)
BSS International Inc

Street Address
7777 N. University Drive Ste 102

City	County	State	Zip
Tamarac	Broward	FL	33321

Telephone Number	Fax Number
954-726-7773	954-726-2896

Mailing Address or [X] Same as above

City	County	State	Zip

Telephone Number	E-mail Address
954-726-7330	drbnurse@gmail.com

Provider Website	NOTE: By providing your e-mail address you agree to accept e-mail correspondence from the Agency.

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B. LICENSEE INFORMATION – Please complete the following for the entity seeking to operate the abortion clinic.		
Licensee Name (This is the owner of the abortion clinic) BSS International, Inc		Federal Employer Identification Number (EIN) 650082821
Mailing Address or ☒ Same as above		
City	State	Zip
Telephone Number	Fax Number	E-mail Address

Description of Licensee (check one):

For Profit	Not for Profit	Public
☒ Corporation	☐ Corporation	☐ State
☐ Limited Liability Company	☐ Religious Affiliation	☐ City/County
☐ Partnership	☐ Other	☐ Hospital District
☐ Individual		
☐ Sole Proprietor		
☐ Other		

C. CONTACT PERSON - For this application	
Contact Person for this application Robin	Contact Telephone Number 954-726-7330
Contact e-mail address or ☐ Do not have e-mail drbnurse@gmail.com	NOTE: By providing your e-mail address you agree to accept e-mail correspondence from the Agency.

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 fee. 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.

A. TYPE OF APPLICATION Renewal

☐ Initial licensure
Was this entity previously licensed as an abortion clinic? 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 (check all that apply): — Proposed Effective Date:
- ☐ Name/address change of the provider
- ☐ Change in type of procedure performed
- ☐ Change in Personnel (No fee required)

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B. LICENSURE FEES

ACTION	FEE	TOTAL FEES
License Fee (Initial, Renewal and Change of Ownership): ☐ License Fee Exemption (County or Municipal Government pursuant to 390.014(4), F.S.) = $ 0.00	$550.50	$550.50
Change During Licensure Period/Replacement License	$25.00	$
Biennial Assessment	$300.00	$300.00
Other: _____		$
TOTAL FEES INCLUDED WITH APPLICATION		$850.50
Please make check or money order payable to the Agency for Health Care Administration (AHCA)		

3. Controlling Interests of Licensee

AUTHORITY:
Pursuant to Section 408.806(1)(a) and (b), F.S., an application for licensure must include: the name, address and social security number (SSN) 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.**

DEFINITION:
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.

A. **Individual and/or Entity Ownership of Licensee (as listed in section 1B above)** – 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. *Note: This excludes Not-for-Profit and Publicly held licensees.*

FULL NAME of INDIVIDUAL or ENTITY	PERSONAL/PRIMARY ADDRESS	TELEPHONE NUMBER	EIN (No SSNs)	% OWNERSHIP	EFFECTIVE DATE	END DATE
Lynda L. Benjamin	7777 N. University Dr.	954-726-7773	650082821	100%	1988	
	Ste. 102 Tamarac, FL					
	33321					

B. **Board Members and Officers of Licensee** – Provide the information for each individual or entity (corporation, partnership, association) that serves as an officer or is on the board of directors. Do not include voluntary board members.

TITLE	FULL NAME	PERSONAL/PRIMARY ADDRESS	TELEPHONE NUMBER	EFFECTIVE DATE	END DATE
Board Member/Officer	Lynda L. Benjamin	7777 N University Drive Ste 102 Tamarac, FL 33321	954-726-7773	1988	
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					

4. Management Company

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

If ☒ NO, skip to section 5 Personnel

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 ☐ Same as above				
City			State	Zip
Contact Person	Contact E-mail		Contact Telephone Number	

DEFINITION:
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.

A. **Individual and/or Entity Ownership of Management Company:** 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.

FULL NAME of INDIVIDUAL or ENTITY	PRIMARY ADDRESS	TELEPHONE NUMBER	EIN (No SSNs)	% OWNERSHIP	EFFECTIVE DATE	END DATE

B. **Board Members and Officers of Management Company:** Provide the information for each individual or entity (corporation, partnership, association) that serves as an officer or is on the board of directors. Do not include voluntary board members.

TITLE	FULL NAME	PERSONAL/PRIMARY ADDRESS	TELEPHONE NUMBER	EFFECTIVE DATE	END DATE
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					

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5. Personnel

A. **Please provide information for the individual(s) who perform the following roles. NOTE:** For the administrator, and financial officer an AHCA Screening through the Care Provider Background Screening Clearinghouse (Clearinghouse) is needed, or 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 is to be screened, visit ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/Rqrd_Screening.shtml.

INFORMATION	ADMINISTRATOR/MANAGING EMPLOYEE	FINANCIAL OFFICER / PERSON RESPONSIBLE FOR FINANCIAL OPERATIONS
Full Name	Eileen Diamond	Lynda L. Benjamin
Date of Birth	04/12/1957	12/30/1946
Effective Date	August 2012	1988
Telephone Number	954-726-7773	954-726-7773
Email Address	mbenjamin@gmail.com	Lyndabenjamin@gmail.com
Personal/Primary Address	7777 N University Drive Ste 102 Tamarac, FL 33321	7777 N. University Drive Ste 102 Tamarac, FL 33321

B. **Medical Director** – Pursuant to section 390.012(3), F.S., if second trimester abortions are performed, provide the following information.

INFORMATION	MEDICAL DIRECTOR
Full Name	Michael Benjamin MD
Florida License Number (Dept. of Health)	ME14909
Effective Date	med. director 1988
Telephone Number	954-726-7773
Email Address	gynoben@gmail.com
Personal/Primary Address	7777 N University Drive Ste 102 Tamarac, FL 33321

6. Required Disclosure

The following disclosures are required:

A. Pursuant to section 408.809, 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(4), 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 section 408.809, Florida Statutes? YES ☐ NO ☒

If YES, provide the following information the full legal name of the individual/entity and the position held

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/entity 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) or the entity

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

C. 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:

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? 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 occurred at least 20 years before the date of the application. YES ☐ NO ☐

7. 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):

AHCA CASE NUMBER	CMS	ASSESSED AMOUNT	DATE OF RELATED INSPECTION, APPLICATION, OR OVERPAYMENT	PAYMENT DUE DATE	PENDING APPEAL OF FINAL ORDER	
					YES	NO
	☐				☐	☐
	☐				☐	☐
	☐				☐	☐

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

8. Procedure/Transfer/Admitting Information

PROCEDURES PERFORMED (check all that apply):

☒ First Trimester - which is the period of time from fertilization through the end of the 11th week of gestation.

☒ Second Trimester - which is the period of time from the beginning of the 12th week of gestation through the end of the 23rd week of gestation.

TRANSFER AGREEMENTS/ADMITTING PRIVILEGES (check all that apply):

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☒ 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. If checked provide the hospital information below. Attach additional sheets if necessary.

Hospital Name			
Northwest Medical Center			
Street Address		Telephone Number	
2801 N. State Rd 7		954-974-0400	
City	County	State	Zip
Margate	Broward	FL	33063

9. Hours of Operation

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).

DAY OF THE WEEK	OPENING TIME	CLOSING TIME	BY APPOINTMENT
☐ Sunday			☐
☒ Monday	9 am	5 pm	☒
☒ Tuesday	9 am	5 pm	☒
☒ Wednesday	9 am	5 pm	☒
☒ Thursday	9 am	5 pm	☒
☒ Friday	9 am	5 pm	☒
☒ Saturday	7 am	12 noon	☒

10. Supporting Documentation

Applicants must include the following attachments as stated in Chapter 408, Part II and 390 F.S. and Chapters 59A-35 and 59A-9, F.A.C. **Note: Required documents listed below are dependent on the type of application submitted. (Initial, Renewal, Change of Ownership, Change during licensure period)**

DOCUMENTS TO BE PROVIDED:	REQUIRED FOR:
Health Care Licensing Application Addendum, AHCA Form 3110-1024	Initial, Renewal, Change in Personnel, and Change of Ownership application types
Proof of Property Occupancy, Examples: Lease, Mortgage, and Transfer Agreement	Initial, Change of Ownership, and Request to Change Name or Address of Provider application types
Documentation from the appropriate local government office showing that the applicant has met local zoning requirements	Initial, Change of Address, and Change of Ownership application types
Documentation of change of ownership transaction stating effective date and executed by all parties	Change of Ownership application type
Required disclosures related to actions taken by Medicare, Medicaid or CLIA, if applicable	All application types, if documentation is required due to responses provided in application
Approved repayment plan, if applicable	All application types

11. Attestation

I, Lynda L. Benjamin 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 sections 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.

Signature of Licensee or Authorized Representative	Title	Date
Lynda L. Benjamin	owner/president	3/15/18

NOTICE: If you are a **Medicaid** provider, you may have a separate obligation to notify the Medicaid program of a name/address change, change of ownership or other change of information. Please refer to your Medicaid handbooks for additional information about Medicaid program policy regarding changes to provider enrollment information.

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

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
- No staples, paperclips, binder clips, folders, or notebooks
- Please ***do not bind any*** of the documents submitted to the Agency