AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

AHCA USE ONLY:	
File #:	139600081
Application #:	1401
Check #:	59019
Check Amt:	845.05
Batch #:	

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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) **874**	**National Provider Identifier** (NPI) (if applicable) **1023221546**	

Name of ***Abortion Clinic*** (include fictitious name, if applicable)
Planned Parenthood of Southwest and Central Florida, Inc.

Street Address
8595 College Parkway Suite 259

City	County	State	Zip
Fort Myers	**Lee**	**FL**	**33919**

Telephone Number	Fax Number	E-mail Address	Provider Website
239-481-9999			**www.plannedparenthood.org**

Mailing Address or ☐ Same as above (All mail will be sent to this address)
736 Central Avenue

City	State	Zip
Sarasota	**FL**	**34236**

Contact Person for this application	Contact Telephone Number
MaryBeth McGeehan	**941-365-3913 x 1006**

Contact e-mail address or ☐ Do not have e-mail
marybeth.mcgeehan@myplannedparenthood.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)	Federal Employer Identification Number (EIN)
Planned Parenthood of Southwest and Central Florida, Inc.	**59-1274328**

Mailing Address or ☒ Same as above

City	State	Zip

Telephone Number	Fax Number	E-mail Address
941-365-3913	**941-957-1050**	

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		

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Section 59A-9.020(1), Florida Administrative Code
Form available at: http://ahca.myflorida.com/MCHQ/Corebill/index.shtml

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: 05/07/2015
☐ 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): ☒ 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	$ **300.00**
Late fee, if applicable	Contact licensure unit for details.	$
Other: _____		$
	TOTAL FEES INCLUDED WITH APPLICATION:	**$ 845.05**

Please make check or money order payable to the Agency for Health Care Administration (AHCA)
Note: Starter checks and temporary checks are not accepted.

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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; 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
Panned Parenthood of Southwest and Central Florida, Inc	736 Central Avenue Sarasota, FL 34236	941-365-3913	59-1274328	100%

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

TITLE	FULL NAME	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER
Director/CEO	Barbara Zdravecky	736 Central Avenue, Sarasota, FL 34236	941-365-3913
President			
Vice President	Pauline Parrish	736 Central Avenue, Sarasota, FL 34236	941-365-3913
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 ☐ Same as above			
City		State	Zip
Contact Person	Contact E-mail	Contact Telephone Number	

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President			
Vice President	Pauline Parrish	736 Central Avenue, Sarasota, FL 34236	941-365-3913
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 ☐ 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 (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.

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:
☐ Admitting privileges and/or
☐ A transfer agreement
With the following hospital:

Hospital Street Address		Telephone Number	
City	County	State	Zip

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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.

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

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MEDICAL DIRECTOR HAS:

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☐ 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	TELEHPONE NUMBER	E-MAIL
Administrator/Facility Manager	**Barbara Zdravecky**	**941-365-3913**	**barbara.zdravecky@myplannedparenthood.org**
Financial Officer	**Pauline Parrish**	**941-365-3913**	**pauline.parrish@myplannedparenthood.org**

9. Affidavit

I, Barbara Zdravecky, 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	Title	Date
	Pres/CEO	Feb 17 2015

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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