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AHCA USE ONLY:
File #: 13960045
Application #: 1503
Check #: 44721
Check Amt: $845.05
Batch # 10 IMMQ2734

Health Care Licensing Application
ABORTION CLINIC

12/6

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) 844	National Provider Identifier (NPI) (if applicable) 1528450285		
Name of Abortion Clinic (include fictitious name, if applicable) Planned Parenthood of South, East + North Florida			
Street Address 5978 Powers Ave			
City Jacksonville	County Duval	State FL.	Zip 32217
Telephone Number 904-399-2800	Fax Number 904-399-2525	E-mail Address NA	Provider Website PPSENFL.org
Mailing Address or ☐ Same as above (All mail will be sent to this address) 2300 N FL Mango Rd			
City West Palm Beach		State Fl	Zip 33409
Contact Person for this application Penny Alterizio		Contact Telephone Number 561-472-9952	
Contact e-mail address or ☐ Do not have e-mail Penny.Alterizio@ppsenfl.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 South, Florida + the Treasure Coast Inc			Federal Employer Identification Number (EIN) 59-139-1115
Mailing Address or ☒ Same as above			
City		State	Zip
Telephone Number 561-848-6402	Fax Number 561-472-9979	E-mail Address NA	

Description of Licensee (check one):

For Profit
- ☐ Corporation
- ☐ Limited Liability Company
- ☐ Partnership
- ☐ Individual
- ☐ Sole Proprietor
- ☐ Other

Not for Profit
- ☒ Corporation
- ☐ Religious Affiliation
- ☐ Other

Public
- ☐ State
- ☐ City/County
- ☐ Hospital District

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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): ☐ 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
Other: _____		$
	TOTAL FEES INCLUDED WITH APPLICATION:	$ 845.05
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), 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.

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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 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
Planned Parenthood of South Florida & the Treasure Coast Inc	2300 N FL Mango Rd West Palm Beach FL 33409	561-848-6402	59-139-1115	100%

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

TITLE	FULL NAME	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER
Director/CEO	Lillian Tamayo	2300 N FL Mango Rd West Palm Beach, FL 33409	561-848-6402
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 N/A	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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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
N/A				

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

TITLE	FULL NAME	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER
Director/CEO	N/A		
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, 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.
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 ☐

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: Robert Pearl DO		**FLORIDA MEDICAL LICENSE NUMBER:** OS 100079	
MEDICAL DIRECTOR HAS: ☐ Admitting privileges and/or ☒ A transfer agreement With the following hospital: Shands Jacksonville medical center (UF-Jacksonville)			
Hospital Street Address 655 W 8th St.		**Telephone Number**	
City Jacksonville	**County** Duval	**State** FL	**Zip** 32209

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8. Personnel

Administrative Personnel:

TITLE	NAME	TELEHPONE NUMBER	E-MAIL
Administrator/Facility Manager	Lillian Tamayo	561-848	Lillian.Tamayo
Financial Officer	David Gartner	6402	David.Gartner @PPSENFL.org

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
☐ Sunday		
☐ Monday		
☒ Tuesday	8:am	5:pm
☒ Wednesday	8:30 am	4:pm
☒ Thursday	1:00 pm	7:pm
☒ Friday	9:00 am	5:pm
☒ Saturday	10:am	3:pm

10. Attestation

I, Lillian Tamayo, under penalty of perjury, 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, 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.

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Signature of Licensee or Authorized Representative

Pres/CEO
Title

11/16/16
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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Extremely Urgent

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FedEx Express Package US Airbill — FedEx Tracking Number 8104 2061 6365

Form ID No. 0215 — Recipient's Copy

1 From
Date 12/8/16 [redacted]
Sender's Name Penny Alterizio — Phone 561 296-4856
Company PLANNED PARENTHOOD
Address 2300 N FLORIDA MANGO RD — Dept./Floor/Suite/Room
City WEST PALM BEACH — State FL — ZIP 33409-6416

2 Your Internal Billing Reference

32

3 To
Recipient's Name AHCA — Phone
Company
Address 2727 Mahan DR — Dept./Floor/Suite/Room
We cannot deliver to P.O. boxes or P.O. ZIP codes.
Address MS #32
Use this line for the HOLD location address or for continuation of your shipping address.
City Tallahassee — State F — ZIP 32308

☐ Hold Weekday — FedEx location address REQUIRED. NOT available for FedEx First Overnight.
☐ Hold Saturday — FedEx location address REQUIRED. Available ONLY for FedEx Priority Overnight and FedEx 2Day to select locations.

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Next Business Day
- ☐ FedEx First Overnight — Earliest next business morning delivery to select locations. Friday shipments will be delivered on Monday unless Saturday Delivery is selected.
- ☐ FedEx Priority Overnight — Next business morning.* Friday shipments will be delivered on Monday unless Saturday Delivery is selected.
- ☒ FedEx Standard Overnight — Next business afternoon.* Saturday Delivery NOT available.

2 or 3 Business Days
- ☐ FedEx 2Day A.M. — Second business morning.* Saturday Delivery NOT available.
- ☐ FedEx 2Day — Second business afternoon.* Thursday shipments will be delivered on Monday unless Saturday Delivery is selected.
- ☐ FedEx Express Saver — Third business day.* Saturday Delivery NOT available.

5 Packaging *Declared value limit $500.
☐ FedEx Envelope* ☐ FedEx Pak* ☐ FedEx Box ☐ FedEx Tube ☐ Other

6 Special Handling and Delivery Signature Options Fees may apply. See the FedEx Service Guide.
☐ Saturday Delivery — NOT available for FedEx Standard Overnight, FedEx 2Day A.M., or FedEx Express Saver.
☐ No Signature Required — Package may be left without obtaining a signature for delivery.
☐ Direct Signature — Someone at recipient's address may sign for delivery.
☐ Indirect Signature — If no one is available at recipient's address, someone at a neighboring address may sign for delivery. For residential deliveries only.

Does this shipment contain dangerous goods?
One box must be checked.
☒ No ☐ Yes As per attached Shipper's Declaration. ☐ Yes Shipper's Declaration not required. ☐ Dry Ice Dry Ice, 9, UN 1845 ___ x ___ kg
Restrictions apply for dangerous goods — see the current FedEx Service Guide. ☐ Cargo Aircraft Only

7 Payment *Bill to:*
Enter FedEx Acct. No. or Credit Card No. below.
☒ Sender Acct. No. in Section 1 will be billed. ☐ Recipient ☐ Third Party ☐ Credit Card ☐ Cash/Check
[redacted]
Total Packages 1 — Total Weight — [redacted] — Credit Card Auth.

†Our liability is limited to US$100 unless you declare a higher value. See the current FedEx Service Guide for details.

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