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AHCA USE ONLY:
File #: 13960053
Application #: 1489
Check #: 2547
Check Amt: $845.05
Batch #: 10100008U

Health Care Licensing Application 8/11
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) 853	National Provider Identifier (NPI) (if applicable) 1861621195		
Name of ***Abortion Clinic*** (include fictitious name, if applicable) Women's Center of Hyde Park, LLC			
Street Address 502 South Magnolia Avenue			
City Tampa	County Hillsborough	State FL	Zip 33606
Telephone Number 813-258-5995	Fax Number 813-253-3330	E-mail Address N/A	Provider Website N/A
Mailing Address or ☒ Same as above (All mail will be sent to this address)			
City		State	Zip
Contact Person for this application Heidi Mullis		Contact Telephone Number 813-258-5995	
Contact e-mail address or ☒ Do not have e-mail	***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) Women's Center of Hyde Park		Federal Employer Identification Number (EIN) 59-3528808
Mailing Address or ☒ Same as above		
City	State	Zip
Telephone Number 813-258-5995	Fax Number 813-253-3330	E-mail Address N/A

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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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
Denise Williams	609 Virginia Drive Orlando, FL 32803	407-228-2808		100%

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

TITLE	FULL NAME	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER
Director/CEO			
President			
Vice President			
Secretary			
Treasurer			
Other Managing member	Denise Williams	609 Virginia Drive Orlando, FL 32803	407-228-2808

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 N/A		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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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			
President	N/A		
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.

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:	FLORIDA MEDICAL LICENSE NUMBER:
Harvey C. Roth, MD	ME64837

MEDICAL DIRECTOR HAS:

☐ Admitting privileges and/or

☒ A transfer agreement

With the following hospital: Tampa General Hospital

Hospital Street Address	Telephone Number
1 Tampa General Circle	813-251-7000

City	County	State	Zip
Tampa	Hillsborough	FL	33606

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8. Personnel

Administrative Personnel:

TITLE	NAME	TELEHPONE NUMBER	E-MAIL
Administrator/Facility Manager	Denise Williams	407-228-2808	Denise1557@aol.com
Financial Officer	Denise Williams	407-228-2808	Denise1557@aol.com

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	9:00 Am	5:00pm
☒ Tuesday	9:00 Am	5:00 pm
☒ Wednesday	9:00 Am	5:00pm
☒ Thursday	9:00 Am	5:00pm
☒ Friday	9:00 Am	5:00pm
☒ Saturday	9:00 Am	1:00pm

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10. Attestation

I, Denise Williams, 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.

Signature of Licensee or Authorized Representative	Title	Date
Denise Williams	Facility Manager Financial Officer	8-5-16

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

Attestation

Under penalty of perjury, I, Denise Williams, 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.

Denise Williams	Member Manager	8-5-16
Employee/Contractor Signature	Title	Date

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