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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 *The application will be withdrawn from review if all the required documents and fees are not included with your application or received within 21 days of an omission notice.* **Applications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)
902	

Name of Abortion Clinic (if operated under a fictitious name, enter as it appears in Florida Division of Corporations)
Center of Orlando For Women, LLC

Street Address
1103 Lucerne Terrace

City	County	State	Zip
Orlando	Orange	FL	32806

Telephone Number	Fax Number
407-245-7999	

Mailing Address or ☒ Same as above

City	County	State	Zip

Telephone Number	E-mail Address
	meganc@womenscenter.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)		Federal Employer Identification Number (EIN)	
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	Contact Telephone Number
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.

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

☐ 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
☒ Change during Licensure (check all that apply):
- ☐ Name/address change of the provider
- ☐ Change in type of procedure performed
- ☒ Change in Personnel (No fee required)

Proposed Effective Date:
Proposed Effective Date: 12/13/17

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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	$
Change During Licensure Period/Replacement License	$25.00	$
Biennial Assessment	$300.00	$
Other: _____		$
TOTAL FEES INCLUDED WITH APPLICATION		$
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

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					
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					

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	Megan S. Clemente	Denise Williams
Date of Birth	9.30 81	1.5.57
Effective Date		
Telephone Number	407-405-2093	407-228-2508
Email Address	meganc@womenscenter.com	N/A
Personal/Primary Address	1103 Lucerne Terrace ORL, FL 32804	609 Virginia Drive ORL, FL 32803

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	Frank Rodriguez
Florida License Number (Dept. of Health)	ME55556
Effective Date	12.13.17
Telephone Number	407-245-7999
Email Address	N/A
Personal/Primary Address	1103 Lucerne Terrace, ORL, FL 32804

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.

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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			☐
☐ Tuesday			☐
☐ Wednesday			☐
☐ Thursday			☐
☐ Friday			☐
☐ Saturday			☐

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

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APPLICATION CHECKLIST
ABORTION CLINIC

APPLICANTS CAN NOW RENEW LICENSES ONLINE

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This application checklist is for informational purposes only – to be used as a guide for applicants when completing the licensing application process. All forms listed below may be obtained from the website: http://ahca.myflorida.com/HQALicensureForms. Send completed applications to: Agency for Health Care Administration, Hospital & Outpatient Services, 2727 Mahan DR, MS 31, Tallahassee, FL 32308-5407.

Application types and definitions:

Initial (I) – application for an initial license/registration/certification

Renewal (R) – biennial renewal of existing license/registration/certification

Change of Ownership (CHOW) – licensee sells/transfers ownership to a different individual/entity or change of 51% or more of the ownership (controlling interest of licensee)

Change during licensure period (C) – request to amend /change information that displays on the license

In order to provide the Agency with a complete application and expedite the licensure process, it may be helpful to gather the following information:

Provider Information- (Application Types: All)

- ☐ Fictitious name (if applicable), street address, mailing address, telephone number, fax number, email address, website address, and National Provider Identifier (NPI)

Licensee (Owner) Information (Application Types: All)

- ☐ Organization type, complete legal name, mailing address, EIN/SSN, email address, telephone number, and fax number. Legal name and address submitted with application must be the same that is registered with Department of State, Division of Corporations

Contact Person (Application Types: All)

- ☐ Name, email address, and telephone number

Licensee Controlling Interests, Board Members, and Officers (Application Types: All)

- ☐ Name, EIN/SSN, mailing address, telephone number, % ownership interest and effective date for each controlling interest, board member and office

Management Company, (if applicable) (Application Types: All)

- ☐ Name, EIN, street address, mailing address, telephone number, fax number, email address, and contact person's name, email address, and phone number

Management Company Controlling Interests, Board Members, and Officer (Application Types: All)

- ☐ Name, EIN/SSN, mailing address, telephone number, % ownership interest and effective date for each controlling interest, board member and officer

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Form available at: http://ahca.myflorida.com/HQAlicensureforms

Personnel (Application Types: All)

- ☐ Administrator: Name, SSN, date of birth, personal/primary address, email address, telephone number, and effective date of employment
- ☐ Financial Officer: Name, SSN, date of birth, personal/primary address, email address, telephone number, and effective date of employment
- ☐ Medical Director: Name, Florida Medical License Number, personal/primary address, email address, telephone number, and effective date of employment

Disclosures (Application Types: All)

- ☐ Legal information (if any) for licensee, licensee controlling interests, management company, and management company controlling interests related to any convictions of criminal offenses and any exclusions, suspensions or terminations from the Medicare or Medicaid programs

Provider Fines and Financial Information (Application Types: All)

- ☐ Assessing entities, related case numbers, dates of assessment, final orders, next payment due dates of any monies owed to the Agency (AHCA)

Procedures/Transfer/Admitting Information (Application Types: All)

- ☐ Procedures performed, hospital information where clinic has transfer agreement and confirmation of admitting privileges for all physicians performing abortions.

Hours of Operations (Application Types: All)

- ☐ Regular operating days and hours

Procedures/Transfer/Admitting Information (Application Types: All)

- ☐ Procedures performed, hospital information where clinic has transfer agreement and confirmation of admitting privileges for all physicians performing abortions.

Request to Change the Name or Address of Provider

- ☐ Sections 1A, 2 and 10 of the Health Care Licensing Application, AHCA Form 3130-1001

Request to Change Personnel

- ☐ Sections 1A, 2, 5 and 10 of the Health Care Licensing Application, AHCA Form 3130-1001 AB Clinic
- ☐ Section 1A of the Health Care Licensing Application Addendum, AHCA, Form 3110-1024
- ☐ No fee required

Supporting Documents (Application Types: All, unless otherwise specified)

- ☐ Health Care Licensing Application Addendum, AHCA Form 3110-1024 (Application Type: All)
- ☐ Proof of Property Occupancy, Examples: Lease, Mortgage, and Transfer Agreement. - Application Types: I, C and CHOW)
- ☐ Documentation from the appropriate local government office showing that the applicant has met local zoning requirements (Application Types: I, C and CHOW)
- ☐ Documentation of change of ownership transaction stating effective date and executed by all parties (Application Type: CHOW)
- ☐ Required disclosures related to actions taken by Medicare, Medicaid or CLIA, if applicable (Application Type: All)
- ☐ Approved repayment plan, if applicable

Biennial Licensure Fee and Other Amounts Due Upon Submission of Application

- ☐ The biennial licensure fee is $550.50.
- ☐ The biennial health care assessment fee is $300.00
- ☐ Each change during licensure period that requires issuance of a new certificate is assessed a $25.00 fee
- ☐ Other amounts due (fines, assessment, fees, etc.) will be detailed in the application

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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Form available at: http://ahca.myflorida.com/HQAlicensureforms

Pull to open.

FedEx®
Express

ORIGIN ID:ORLA (407) 245-7999
M. CELESTIN
CENTER OF ORLANDO FOR WOMEN
1103 LUCERNE TERRACE

ORLANDO, FL 32806
UNITED STATES US

SHIP DATE: 13DEC17
ACTWGT: 0.50 LB
CAD: 100231240/INET3920

BILL SENDER

TO AGENCY FOR HEALTH CARE ADMINISTRATI
HOSPITAL & OUTPATIENT SERVICES UNIT
2727 MAHAN DRIVE
MAIL STOP # 31
TALLAHASSEE FL 32308
(850) 412-4500 REF:
INV:
PO: DEPT:

549J1/674C/104C

TRK# 0201 7709 8721 4460

THU - 14 DEC 3:00P
STANDARD OVERNIGHT

XH TLHA

32308
FL-US TLH

After printing this label:
1. Use the 'Print' button on this page to print your label to your laser or inkjet printer.
2. Fold the printed page along the horizontal line.
3. Place label in shipping pouch and affix it to your shipment so that the barcode portion of the label can be read and scanned.

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Use of this system constitutes your agreement to the service conditions in the current FedEx Service Guide, available on fedex.com.FedEx will not be responsible for any claim in excess of $100 per package, whether the result of loss, damage, delay, non-delivery,misdelivery,or misinformation, unless you declare a higher value, pay an additional charge, document your actual loss and file a timely claim.Limitations found in the current FedEx Service Guide apply. Your right to recover from FedEx for any loss, including intrinsic value of the package, loss of sales, income interest, profit, attorney's fees, costs, and other forms of damage whether direct, incidental,consequential, or special is limited to the greater of $100 or the authorized declared value. Recovery cannot exceed actual documented loss.Maximum for items of extraordinary value is $1,000, e.g. jewelry, precious metals, negotiable instruments and other items listed in our ServiceGuide. Written claims must be filed within strict time limits, see current FedEx Service Guide.

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to open.

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