NM 13 9/23

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

December 29, 2017

Sent by email:
rafe5607@att.net
mariangie_10@yahoo.com

A 1551

Maria A Fernandez, Administrator
Blue Coral Women's Care, Inc.
7360 Coral Way Ste 16
Miami, FL 33155

File Number: 13960052
License Number: 852
Provider Type: Abortion Clinic

C# 5199
$ 275.25

*Apply C# 5198 *
$ 5.45

Re: Omission Notice for Blue Coral Women's Care, Inc., 7360 Coral Way Ste 16, Miami

Dear Administrator:

B- 10100044

This letter is to acknowledge receipt of your Renewal application for your Abortion Clinic license. After review, it was found to be incomplete. Applicants receive only **one** letter describing the errors or omissions that must be addressed to deem the application complete. If the response to this letter does not satisfactorily address what is outlined below, the application will be withdrawn from consideration. Therefore, pursuant to section 408.806, Florida Statutes, no further action can be taken until the following is received:

- **Resubmit Current Application:** The current application is required, form date of July 2016.
- **Under payment of Renewal:** Total amount due is $280.70. The renewal pay was 5.45 short as the old form was used and there is a late fee of 275.25.

Additionally, section 408.831, Florida Statutes, requires any outstanding fines, liens, or overpayments assessed by Final Order of AHCA or the Centers for Medicare and Medicaid Services by the licensee or a common controlling interest to be paid prior to license/registration issuance. Failure to comply with any repayment plan may result in the denial, suspension or revocation of a license, registration or certificate.

The required information must be submitted to the Agency no later than 21 calendar days from receipt of this letter. You may submit this information to the Agency by Email or by US Mail.

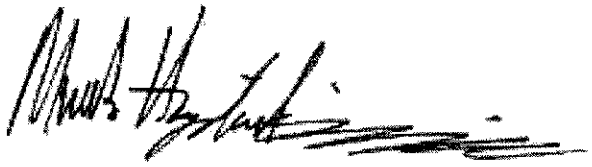
- Email: Mark.Hajdukiewicz@ahca.myflorida.com
- US Mail: Please include a copy of this letter with your response:

Agency for Health Care Administration
Hospital and Outpatient Services Unit,MS#31
2727 Mahan Drive
Tallahassee, Florida 32308

Received
FEB 23 2018
Central Services

If the applicant fails to submit all the information required in the application within 21 days of being notified by AHCA of the omissions, the application will be withdrawn from consideration and the fees will be forfeited pursuant to section 408.806(3)(b), Florida Statues.

If you have any questions or need further assistance, please call Mark Hajdukiewicz at 850-412-4364 or (850) 412-4549 or email at Mark.Hajdukiewicz@ahca.myflorida.com.
Sincerely,



Hospital and Outpatient Services Unit
Agency for Health Care Administration

Received
FEB 23 2018
Central Services

APPLICATION CHECKLIST
Health Care Licensing Application
ABORTION CLINIC

Applicants **must** include the following attachments as stated in Chapter [illegible] and Chapters 59A-35 and 59A-[illegible], Florida Administrative Code [illegible] application [illegible] prior to the expiration of the current license or effective date of a change of ownership to avoid a late fee [illegible] Agency less than 60 days prior to the expiration date [illegible] 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 this application or received within 21 days of an omission notice.***

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 and Outpatient Services Unit, 2727 Mahan Drive, Mail Stop 31, Tallahassee, FL 32308.

NOTE TO ALL APPLICANTS:The Agency will verify that all applicants, licensees and controlling interests subject to Chapters 607, 608 or 617, Florida Statutes related to Business Organizations have complied with applicable Department of State registration and filing requirements. The principal and mailing addresses submitted with any application must be the same as the addresses that appear as registered with the Department of State, Division of Corporations.

A. Initials, Renewals and Change of Ownership Applications Must Include:

☑ The biennial licensure fee (**$545.05**)- Please make check or money order payable to the *Agency for Health Care Administration (AHCA)*. All fees are nonrefundable.***Additional fees may apply. Refer to Section 2 of this application.*** *NOTE: Starter and temporary checks are not accepted.*

☐ Health Care Licensing Application, Abortion Clinic , AHCA Form 3130-1000. **NOTE:** *All Agency correspondence will be sent to the mailing address provided in Section 1A of the application. If an applicant or licensee is required to register or file with the Florida Secretary of State Division of Corporations, the principal, fictitious name and mailing address provided in Section 1 of this application must be the same as the information registered with the Division of Corporations as provided in Section 59A-35.060(4), Florida Administrative Code.*

☑ Health Care Licensing Application Addendum, AHCA Form 3110-1024 - Complete the information that is applicable, write "NA" on the items that are not applicable, sign, date and send with the application (refer to Sections 3 & 4 of the application for further details).

☑ Proof of Background Screening:

A Level 2 background screening for the Administrator and Financial Officer is required every 5 years.

All screening results must be sent to the Agency for Health Care Administration for review and employment determinations. If you choose to use a LiveScan source other than the Agency's contracted vendor you must identify the Agency for Health Care Administration as the recipient of the screening results to ensure the results are reviewed by the Agency. If the Agency does not receive the results, additional screening and fees may be required. For additional information, including finding a LiveScan vendor and screening a person who is out of state, please visit the Agency's background screening website at: http://ahca.myflorida.com/backgroundscreening.

The ☐ Administrator and/or ☐ Financial Officer submitted a new Level 2 screening through a LiveScan vendor.

The ☐Administrator and/or ☐Financial Officer submitted a Level 2 screening within the previous 5 years and results are on file with the Agency for Health Care Administration, Department of Children and Families, Department of Health, Department of Elder Affairs, Agency for Persons with Disabilities or Department of Financial Services (if the applicant has a certificate of authority or provisional certificate of authority to operate a continuing care retirement community). An Affidavit of Compliance with Background Screening Requirements, AHCA Form 3100-0008, is also enclosed.

Received

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Central Services

B. Additional Information Needed for INITIAL Applications:

☐ Proof of the licensee's right to occupy the building such as a copy of a lease, sublease agreement, or deed.

☐ A report or letter from the local government zoning office that the location is zoned appropriately for use as an abortion clinic.

C. Additional Information Needed for RENEWAL Applications:

☐ $300 Health Care Facility Fee Assessment ($150 annual assessment x 2).

Pursuant to Rule 59C-1.022(4), Florida Administrative Code, the annual assessment from all facilities shall be collected prospectively for a two year (biennial) period. For renewal applications, the biennial assessment shall be calculated at the time of the licensure renewal and shall be due at the time of filing of the renewal application.

D. Additional Information Needed for CHANGE OF OWNERSHIP Applications:

☐ Proof of the licensee's right to occupy the building such as a copy of the lease, sublease agreement, or deed.

☐ Closing documents signed and dated by all parties.

☐ A signed agreement to correct all outstanding licensure and certification deficiencies incurred by the previous owner

☐ A signed agreement to pay any outstanding payments owed to the Agency. The agreement must include who will pay and when payment will be made.

E. Change During Licensure Period:

Request to change the name or address of provider:

☐ Complete and submit sections 1, 2 and 10 of the Health Care Licensing Application, Abortion Clinic, AHCA Form 3130-1000.

☐ Proof of the licensee's right to occupy the building such as a copy of the lease, sublease agreement, or deed.

☐ For address changes, a report or letter from the local government zoning office that the location is zoned appropriately for use as an abortion clinic.

☐ $25.00 fee for replacement license/issue of license due to change during licensure period. Please make check or money order payable to the *Agency for Health Care Administration*. All fees are nonrefundable.

Request to change Administrator or Financial Officer:

☐ Complete and submit sections 1A, 2, 8 and 10 of the Health Care Licensing Application, Abortion Clinic, AHCA Form 3130-1000.

☐ Complete and submit Section 1A of the Health Care Licensing Application Addendum, AHCA Form 3110-1024, sign, date and send with application.

☐ No fee required.

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.

Received

FEB 23 2018

Central Services

000436

Local Business Tax Receipt

Miami–Dade County, State of Florida

–THIS IS NOT A BILL – DO NOT PAY

LBT

3987816

BUSINESS NAME/LOCATION
BLUE CORAL WOMENS CARE INC
7360 CORAL WAY 16
MIAMI FL 33155

RECEIPT NO.
RENEWAL
4162020

EXPIRES
SEPTEMBER 30, 2018
Must be displayed at place of business
Pursuant to County Code
Chapter 8A – Art. 9 & 10

OWNER
BLUE CORAL WOMENS CARE INC

SEC. TYPE OF BUSINESS
212 P.A./CORP/PARTNERSHIP/FIRM

PAYMENT RECEIVED BY TAX COLLECTOR
$82.50 10/16/2017
FPPU10–18–000955

Employee(s) 2

This Local Business Tax Receipt only confirms payment of the Local Business Tax. The Receipt is not a license, permit, or a certification of the holder's qualifications, to do business. Holder must comply with any governmental or nongovernmental regulatory laws and requirements which apply to the business.

The RECEIPT NO. above must be displayed on all commercial vehicles – Miami–Dade Code Sec 8a–276.

For more information, visit www.miamidade.gov/taxcollector

Received
FEB 28 2018
Central Services

DEPARTMENT OF PLANNING, DEVELOPMENT AND REGULATION
PERMANENT CERTIFICATE OF USE AND OCCUPANCY

METRO-DADE

METROPOLITAN DADE COUNTY

CERT NO: 99002269
SEC: 14 TWP: 54 RNG: 40
PROCESS NO: U98014884
FOLIO: 3040140260010
ZONE: BU1A
FEE: $137.80

MAILING ADDRESS/CONTACT PERSON:
BLUE CORAL WOMEN
7360 SW 24 ST #12
MIAMI, FL 33155-

CORP NAME/D/B/A AND ADDRESS:
BLUE CORAL WOMEN
MAIRA A. FERNANDEZ
7360 SW 24 ST #12

BUSINESS USE: MEDICAL OFFICE
USE SPECIFICS: MEDICAL & HEALTH CARE CENTER
CONDITIONS: OUTPATIENT BASIS ONLY/NO OUTDOOR DISPLAYS
ONE DOCTOR ONLY

LEGAL DESCRIPTION: CARTAGENA PLAZA
PB 126-72
DATE OF CO ISSUANCE:10/ 8/98
THIS CERTIFICATE M U S T B E P O S T E D ON PREMISES.

METROPOLITAN DADE COUNTY

THIS CERTIFICATE OF OCCUPANCY IS VALID FOR AN UNLIMITED TIME, UNLESS REVOKED FOR CAUSE, PROVIDED THE USE COMPLIES WITH APPLICABLE CODE REQUIREMENTS OF METROPOLITAN DADE COUNTY AND PROVIDED THERE IS NO CHANGE OF USE, BUSINESS NAME OR OWNERSHIP, AND NO ENLARGEMENT, ALTERATION OR ADDITION IN THE USE, BUILDING OR STRUCTURE. SUCH CHANGES MUST BE SUBMITTED TO THE DADE COUNTY DEPARTMENT OF PLANNING, DEVELOPMENT AND REGULATION, ZONING PERMIT SECTION. 271-1242.

PLEASE CONTACT THE DADE COUNTY OCCUPATIONAL LICENSE OFFICE FOR THEIR REQUIREMENTS AT 270-4949.

%1P&%5B16m

34 4712 001 100898 000013780

010 01 04980140340 000013780

Received
FEB 23 2018
Central Services

PRESS FIRMLY TO SEAL

Received
FEB 23 2018
Central Services

PRESS FIRMLY TO SEA

U.S. POSTAGE PAID
MIAMI, FL
33155
FEB 22, 18
AMOUNT
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BLUE CORAL WOMEN'S CARE INC
7360 Coral Way #10
Miami FL 33155

PAYMENT BY ACCOUNT (if applicable)

DELIVERY OPTIONS (Customer Use Only)

☐ SIGNATURE REQUIRED Note: The mailer must check the "Signature Required" box if the mailer: 1) Requires the addressee's signature; OR 2) Purchases additional insurance; OR 3) Purchases COD service; OR 4) Purchases Return Receipt service. If the box is not checked, the Postal Service will leave the item in the addressee's mail receptacle or other secure location without attempting to obtain the addressee's signature on delivery.

Delivery Options
☐ No Saturday Delivery (delivered next business day)
☐ Sunday/Holiday Delivery Required (additional fee, where available*)
☐ 10:30 AM Delivery Required (additional fee, where available*)
*Refer to USPS.com® or local Post Office™ for availability.

TO: (PLEASE PRINT) PHONE ( )

ACHA
Hospital and Out Patient
Services Unit, MS #31
2727 Mahan Drive
Tallahassee, FL 32308

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■ For pickup or USPS Tracking™, visit USPS.com or call 800-222-1811.
■ $100.00 insurance included.

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☐ 1-Day ☐ 2-Day ☐ Military ☐ DPO

PO ZIP Code: 33155	Scheduled Delivery Date (MM/DD/YY): 2/23/18	Postage: $ 24.70	
Date Accepted (MM/DD/YY): 2/22/18	Scheduled Delivery Time: ☐ 10:30 AM ☒ 3:00 PM ☐ 12 NOON	Insurance Fee: $	COD Fee: $
Time Accepted: 11:11 ☒ AM ☐ PM	10:30 AM Delivery Fee: $	Return Receipt Fee: $	Live Animal Transportation Fee: $
Special Handling/Fragile: $	Sunday/Holiday Premium Fee: $	Total Postage & Fees: $ 24.70	
Weight: ☒ Flat Rate lbs. ozs.	Acceptance Employee Initials: YC		

DELIVERY (POSTAL SERVICE USE ONLY)

Delivery Attempt (MM/DD/YY)	Time	Employee Signature
	☐ AM ☐ PM	
	☐ AM ☐ PM	

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APPLICATION CHECKLIST
Health Care Licensing Application
ABORTION CLINIC

Applicants **must** include the following attachments as stated in Chapters 408, Part II, and 390, Florida Statutes (F.S.), and Chapters 59A-35 and 59A-9, Florida Administrative Code (F.A.C). 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 this application or received within 21 days of an omission notice.***

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The ☐Administrator and/or ☐Financial Officer submitted a Level 2 screening within the previous 5 years and results are on file with the Agency for Health Care Administration, Department of Children and Families, Department of Health, Department of Elder Affairs, Agency for Persons with Disabilities or Department of Financial Services (if the applicant has a certificate of authority or provisional certificate of authority to operate a continuing care retirement community). An Affidavit of Compliance with Background Screening Requirements, AHCA Form 3100-0008, is also enclosed.

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DEC 21 2017
Central Intake

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C. Additional Information Needed for RENEWAL Applications:

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Pursuant to Rule 59C-1.022(4), Florida Administrative Code, the annual assessment from all facilities shall be collected prospectively for a two year (biennial) period. For renewal applications, the biennial assessment shall be calculated at the time of the licensure renewal and shall be due at the time of filing of the renewal application.

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Request to change Administrator or Financial Officer:

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- 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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DEC 21 2017

CENTRAL INTAKE

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33155
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AMOUNT
$23.75
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FROM: (PLEASE PRINT) PHONE ( )

Blue Coral Women's Care Inc
7360 Coral Way #116
Miami FL 33155

PAYMENT BY ACCOUNT (if applicable)

DELIVERY OPTIONS (Customer Use Only)

☐ SIGNATURE REQUIRED Note: The mailer must check the "Signature Required" box if the mailer: 1) Requires the addressee's signature; OR 2) Purchases additional insurance; OR 3) Purchases COD service; OR 4) Purchases Return Receipt service. If the box is not checked, the Postal Service will leave the item in the addressee's mail receptacle or other secure location without attempting to obtain the addressee's signature on delivery.

Delivery Options
☐ No Saturday Delivery (delivered next business day)
☐ Sunday/Holiday Delivery Required (additional fee, where available*)
☐ 10:30 AM Delivery Required (additional fee, where available*)
*Refer to USPS.com® or local Post Office™ for availability.

TO: (PLEASE PRINT) PHONE ( )

AGENCY FOR HEALTH CARE ADMINISTRATION
HOSPITAL AND OUT PATIENT SERVICES UNIT
2727 MAHAN DR MS 31
TALLAHASSEE FL 32308-5417

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ORIGIN (POSTAL SERVICE USE ONLY)

☐ 1-Day ☐ 2-Day ☐ Military ☐ DPO

PO ZIP Code	Scheduled Delivery Date (MM/DD/YY)	Postage
33155	12/21/17	$23.75
Date Accepted (MM/DD/YY)	**Scheduled Delivery Time**	**Insurance Fee** / **COD Fee**
12/20/17	☐ 10:30 AM ☐ 3:00 PM ☑ 12 NOON	$ / $
Time Accepted	**10:30 AM Delivery Fee**	**Return Receipt Fee** / **Live Animal Transportation Fee**
1637 ☐ AM ☐ PM	$	$ / $
Special Handling/Fragile	**Sunday/Holiday Premium Fee**	**Total Postage & Fees**
$	$	$23.75
Weight ☐ Flat Rate	**Acceptance Employee Initials**	
lbs. 6 ozs.		

DELIVERY (POSTAL SERVICE USE ONLY)

Delivery Attempt (MM/DD/YY)	Time	Employee Signature
	☐ AM ☐ PM	
Delivery Attempt (MM/DD/YY)	Time	Employee Signature
	☐ AM ☐ PM	

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