

#300  
918594 3-DEC '18

# Health Care Facility Renewal Application

As defined in rule 3701-83-04 of the Ohio Administrative Code

12/31/18

Facility ID # 0530AS

Please print legibly in ink or type

1. Facility Name (DBA) Planned Parenthood of Greater Ohio d/b/a Planned Parenthood East Health Center		
2. Address 3255 East Main St.		Suite
3. City Columbus	4. Zip 43213	5. County Franklin
6. Phone Number (614) 404-0219		7. Fax Number (330) 535-7145
8. E-mail Address holly.myers@ppoh.org		

Mailing address, if different from above

9. Name Holly Myers		
10. Address 444 West Exchange St.		Suite
11. City Akron	12. State OH	13. Zip 44302


<p>14. <b>Renewal application type</b></p> <p><input checked="" type="checkbox"/> Ambulatory surgical facility</p> <p>Is ASF a provider-based entity of hospital? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes, hospital name:</p> <p><input type="checkbox"/> Freestanding dialysis center</p> <p><input type="checkbox"/> Freestanding inpatient rehabilitation facility</p> <p><input type="checkbox"/> Freestanding birthing center</p>	<p>OHIO REGULATORY OPS 2018 DEC - 6 PM 12: 10</p>
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15. Has there been a change in this facility's capacity?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
If yes, has an amended license been requested?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
16. a) Is your facility accredited by an national accrediting body approved by CMS?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
If yes, and there has been a change or update to this facility's most recent accreditation status report or findings, explain and provide a copy of the most recent accreditation inspection report and findings, unless the department has been previously notified.	
Explanation:	
16. b) Is your facility deemed to meet or exceed the approved Medicare program requirements through accreditation?	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes

17. Has there been a change in ownership? If yes, has a change of ownership application been submitted?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes  <input type="checkbox"/> No <input type="checkbox"/> Yes
18. Has there been a change of onsite administrator?  A) If yes, provide name of new administrator:  B) Has the new administrator been affiliated through ownership or employment with any of the facilities listed in rule 3701-83-04 (A)(1)(c) of the OAC within five years prior to the date of this application?  C) Has the new administrator been convicted of any criminal activity or been involved in a civil judgment or administrative adjudication for an offense related to the provision of care or bearing a direct or substantial relationship to the job responsibilities?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes  <input type="checkbox"/> No <input type="checkbox"/> Yes  <input type="checkbox"/> No <input type="checkbox"/> Yes
19. Has there been a change of medical director or individual responsible for the provision of health care services?  A) If yes, provide name of new medical director/individual:  B) License/certification #  C) Has the new medical director been affiliated through ownership or employment with any of the facilities in rule 3701-83-04 (A)(1)(c) of the OAC within five years prior to the date of this application?  D) Has the new medical director/individual been convicted of any criminal activity or been involved in a civil judgment or administrative adjudication for an offense related to the provision of care or bearing a direct or substantial relationship to the job responsibilities?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes    <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes  <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
20. If you answered yes to question 18 (C) or 19 (D) provide a full explanation stating charge(s), date(s) and disposition on a separate page.	<input checked="" type="checkbox"/> NA

I affirm that to the best of my knowledge and belief, the answers provided herein and all accompanying materials are true and correct. I understand that section 3702.30 of the Ohio Revised Code and paragraph (E) of rule 3701-83-04 of the Ohio Administrative Code require the owner to inform the Director, in writing, of any changes in the information contained in the statement of ownership set forth in the initial application and any change in accreditation status, no later than 30 days after the change occurs.

I certify that I am an owner of the facility or the authorized representative of the owner.

Print/type owner's or representative's name	Title
Holly Myers	Director of RQM
Signature	Date
	11/30/18