B18949 MAR 30 ≥ #300

Health Care Facility Renewal Application

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

3/31/18

Facility ID # 0596A5

Please print legibly in ink or type

1. Facility Name (DBA) Founders Women's Health Center		
2. Address 1243 East Broad Street		Suite
3. City Columbus	4. Zip 43205	5. County Franklin
6. Phone Number (614) 251-1800	7. Fax Number	
8. E-mail Address terriehubbard@gmail.com		

Mailing address, if different from above

9. Name		
10. Address		Suite
11. City	12. State	13. Zip

14. **Renewal application type**

☑ Ambulatory surgical facility

Is ASF a provider-based entity of hospital? ☐ No ☐ Yes

If yes, hospital name:

☐ Freestanding dialysis center

☐ Freestanding inpatient rehabilitation facility

☐ Freestanding birthing center

BRO REGULATORY OPS
2018 APR -2 AM 10:59

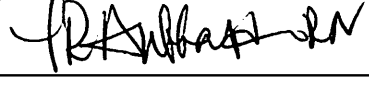
15. Has there been a change in this facility's capacity?	☑ No ☐ Yes
If yes, has an amended license been requested?	☐ No ☐ Yes
16. a) Is your facility accredited by an national accrediting body approved by CMS?	☑ No ☐ Yes
If yes, and there has been a change or update to this facility's most recent accreditation 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?	☑ No ☐ Yes

17. Has there been a change in ownership? If yes, has a change of ownership application been submitted?	☑ No ☐ Yes ☐ No ☐ 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?	☑ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ 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?	☑ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ 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.	☑ 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
Terrie Hubbard, RN	CEO
Signature 	Date CEO 3-27-18

Current Mode: Edit **Revenue Receipt Entry**

Select a page: First Previous Next Last — Current record: 124 of 124

*Batch Number: 18 - 5298 *Receipt Option: REV Other

*Receipt Number: 00818949 *Date Payment Received: 03/30/18

Customer Number: - Tracking Number:

Customer Name: FOUNDER WOMENT'S HEALTH CENTER

*Payment Option: Check

Check Name: T & S MANAGEMENT LLC Date of Check: 03/17/18

Check Number: 4104 *Check Amount: 300.00

☐ Check if NSF

Comment: Total Funding Amount: $300.00

Comment Length:

Funding Description	*Revenue Code	*Funding Amount	Invoice Number	Balance
HEALTH CARE FACILITY LICENSE FEE	8-3500	300.00		-
	-			

NSF?: N (Y/N) Liability?: N (Y/N)

DOC Number: Date Liability Clear:

Date of Deposit: Method Used To Clear:

Date Applied To A/R:

Update Cancel

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Entered by Reth Ven on 3/30/2018 3:01:41 PM
Updated by Reth Ven on 3/30/2018 3:49:09 PM

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Tracking Number: EE153852524US

Scheduled Delivery by

FRIDAY
30 MARCH 2018
by 10:30am

Status

Delivered
March 30, 2018 at 10:05 am
Delivered, To Agent
COLUMBUS, OH 43215

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- Proof of Delivery
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- Product Information