



MARY C. MAYHEW SECRETARY

## Certified Article Number 9414 7266 9904 2148 0591 67 SENDER'S RECORD

**CERTIFIED** 

February 4, 2020

Crystal Valentine, Administrator A Woman's Choice of Jacksonville 4131 University Blvd S Bldg 2 Jacksonville, FL 32216-4346 File Number: 13960038 Application Number: 1664 Provider Type: Abortion Clinic

RE: Complaint Number 2020001524, 4131 University Blvd S, Bldg 2, Jacksonville

### **Notice of Intent to Deny**

Pending the outcome of the legal process, it is the intent of the Agency that the renewal application submitted by the above-named provider be denied.

The specific basis to deny this application is:

The provider is not in compliance with background screening licensing requirements due to failure to provide evidence of satisfactory level 2 background screening for an individual, who is the 100% controlling interest of the licensee, in accordance with s. 435.04, 408.809, 408.810 and 390.014(1), Florida Statutes (F.S.) and s. 59A-35.090, Florida Administrative Code (F.A.C.).

#### **EXPLANATION OF RIGHTS**

Pursuant to Section 120.569, F.S., you have the right to request an administrative hearing. In order to obtain a formal proceeding before the Division of Administrative Hearings under Section 120.57(1), F.S., your request for an administrative hearing must conform to the requirements in Section 28-106.201, Florida Administrative Code (F.A.C), and must state the material facts you dispute.

#### SEE ATTACHED ELECTION AND EXPLANATION OF RIGHTS FORMS.

If you need further assistance, please contact the General Counsel's Office at (850) 412-3630.

Noël Cronin Lawrence, Program Administrator

Jack Plagge, Manager

Hospital and Outpatient Services Unit Agency for Health Care Administration

cc: Legal Intake Unit, MS 3



# STATE OF FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RE: A Woman's Choice of Jacksonville

Case Number: 2020001524

#### **ELECTION OF RIGHTS**

This Election of Rights form is attached to a proposed Notice of Intent to Deem Incomplete and Withdraw from Further Review of the Agency for Health Care Administration (AHCA). The title may be **Notice of Intent to Deem Incomplete and Withdraw from Further Review or some other notice of intended action by AHCA.** 

An Election of Rights must be returned by mail or by fax within 21 days of the day you receive the attached Notice of Intent to Deem Incomplete and Withdraw from Further Review or any other proposed action by AHCA.

If an <u>Election of Rights</u> with your selected option is not received by AHCA within twenty-one (21) days from the date you received this notice of proposed action, you will have given up your right to contest the Agency's proposed action and a final order will be issued.

(Please reply using this <u>Election of Rights</u> form unless you, your attorney or your representative prefer to reply according to Chapter 120, Florida Statutes (2006) and Rule 28, Florida Administrative Code.)

Please return your ELECTION OF RIGHTS to:

Agency for Health Care Administration Attention: Agency Clerk 2727 Mahan Drive, Mail Stop #3 Tallahassee, Florida 32308

Phone: (850) 412-3630

PLEASE SELECT ONLY 1 OF THESE 3 OPTIONS:

Fax: (850) 921-0158

OPTION ONE (1)	I admit to the allegations of facts and law contained in the Notice of Intent to
waive my right to object	ithdraw from Further Review, or other notice of intended action by AHCA and land have a hearing. I understand that by giving up my right to a hearing, a final order the proposed agency action and imposes the proposed penalty, fine or action.
OPTION TWO (2)	I admit to the allegations of facts contained in the Notice of Intent to Deem
at an informal proceedin	w from Further Review, or other proposed action by AHCA, but I wish to be heard g (pursuant to Section 120.57(2), Florida Statutes) where I may submit testimony and ency to show that the proposed administrative action is too severe or that the fine should
Incomplete and Withdray	I dispute the allegations of fact contained in the Notice of Intent to Deem we from Further Review or other proposed action by AHCA, and I request a formal ion 120.57(1), Florida Statutes) before an Administrative Law Judge appointed by the Hearings.

A Woman's Choice of Jacksonville February 4, 2020 Page 2

<u>PLEASE NOTE</u>: Choosing OPTION THREE (3), by itself, is <u>NOT</u> sufficient to obtain a formal hearing. You also must file a written petition in order to obtain a formal hearing before the Division of Administrative Hearings under Subsection 120.57(1), Florida Statutes. It must be received by the Agency Clerk at the address above within 21 days of receipt of this proposed administrative action. The request for formal hearing must conform to the requirements of Rule 28-106.201, Florida Administrative Code, which requires that it contain:

- 1. The name and address of each agency affected and each agency's file or identification number, if known;
- 2. Your name, address, and telephone number, and the name, address, and telephone number of your representative or lawyer, if any;
- 3. An explanation of how your substantial interests will be affected by the Agency's proposed action;
- 4. A statement of when and how you received notice of the Agency's proposed action;
- 5. A statement of all disputed issues of material fact. If there are none, you must state that there are none;
- 6. A concise statement of the ultimate facts alleged, including the specific facts you contend warrant reversal or modification of the Agency's proposed action;
- 7. A statement of the specific rules or statutes you claim require reversal or modification of the Agency's proposed action; and
- 8. A statement of the relief you are seeking, stating exactly what action you wish the Agency to take with respect to its proposed action.

(Mediation under Section 120.573, Florida Statutes, may be available in this matter if the Agency agrees.)

License Type: Abortion Clinic	License Number:	License Number: 795	
Licensee Name: A Woman's Choic	ee of Jacksonville		
Contact Person:			
Name	Title		
Address: Street and number	City	Zip Code	
Telephone Nbr.:	Fax Nbr.:		
Email (optional ):			
I hereby certify that I am duly author Care Administration on behalf of th		tice of Election of Rights to the Agency for Health ove.	
Signed:		Date:	
Print Name		Title:	