2/3 mw

RON DESANTIS
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NM-13 App#1663

January 6, 2020

Certified Mail/Read Receipt

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

CHH#6516, CHH#275.00
B — 10100041

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

Dear Administrator:

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 If the response to this letter does not satisfactorily address what is outlined below, the application will be withdrawn from consideration.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:

- **Late Renewal Application Fee of $275.25**: Pursuant section 408.806 (2)(c), Florida Statutes, applications must be received by the agency at least 60 days, but no more than 120 days, before the expiration date or a late fee will be assessed. Based on the license expiration date the application was not received in a timely manner; therefore, a $275.25 late fee has been added to your renewal application fee. Please submit the $275.25 by check or money order made payable to the Agency for Health Care Administration and include with your response a copy of this letter. To avoid delay in processing this renewal application, include the license and file number in the memo field of the check.

- **Resolve Case 2019-009495**: Case 2019-009495 in connection with deficiency sited, on or around, 2/27/2019, may stop the approval of renewal if at final order status.

- **Application Section 1.A:** Provider National Provider Identifier Number (NPI) for the facility or write "N/A" if the facility does not have one, and resubmit this section of the application.

- **Application Section 1.B**: This area is for the company that owns the license. It would be the company which holds a corporate license from the Division of Corporations, matching the EIN listed in this section: Blue Coral Women's Care, Inc.

- **Application Section 4:** Check the appropriate selection regarding Management oversight of your license, and then resubmit this section of the application.

- **Application Section 4. A & B:** If no Management Company exist then this section should be blank, correct and resubmit this section of the application.

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2727 Mahan Drive • MS#31
Tallahassee, FL 32308
AHCA.MyFlorida.com

- **Application Section 8**: This area notates that only first trimester procedures are performed, this contradicts the last renewal application received on 2/23/2018. Please document in writing (formal letter) when your facility changed the level of procedure performed at your clinic.

- **Application Addendum Section 3.B:** If no Management Company exist, then this section should be blank. Correct and resubmit this section of the application addendum, please ensure the information matches the information listed on the application.

- **Background Screening Clearinghouse Employee Roster for all Employees**: Login and complete the roster linking all employees to this facility. Dr. Richard Friefeld is not listed on the roster for Blue Coral Women's Care, Inc.

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

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,

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Mark Hajdukiewicz
Hospital and Outpatient Services Unit
Agency for Health Care Administration

1850 412 43 64 Mark

1850 - 488 58 97 fax

Employee/Contractor Roster

Last Name	First Name	Provider	Position	Provisional Hire Contract Date	Permanent Hire Contract Date	Retained Prints Expiration Date	End Date
FERNANDEZ	MARIA	BLUE CORAL WOMEN'S CARE, INC - 852	Administrator		Oct 01 1998	Feb 17 2021	
FRIEFELD	RICHARD	BLUE CORAL WOMEN'S CARE, INC - 852	Medical Director		Jan 20 2020	Sep 27 2022	

Employees/Contractors

Search Options

Last Name:

Position:

Hire/Contract Date: to:

Retained Prints Expiration Date: to:

Status: Permanent

Apply

Employee/Contractor Roster

Last Name	First Name	Position	Provisional Hire/ Contract Date	Permanent Hire/ Contract Date	Retained Prints Expiration Date	End Date	Action
FERNANDEZ	MARIA	Administrator		10/01/1998	02/17/2021		Edit
FRIEFELD	RICHARD	Medical Director		01/20/2020	09/27/2022		Edit

1 Displaying items 1 - 2 of 2

View All Print All Export To Excel

luna0116

If you have any background screening questions or issues please contact us.

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1/20/2020

WITH REGARDING TO THE APLICATION SECTION 8
WAS ONE MISTAKE OF WRITTING, YES WE PERFORM
2º TRIMESTER LEVEL, DO IT THE LEVEL CHANGE TO
12 WEEKS IS considering 2º trimester and yes
we do cases like that.
This was correct in the aplication.

AHCA USE ONLY:
File #:
Application #:
Check #:
Check Amt:
Batch #:

Health Care Licensing Application
Abortion Clinic

The Agency for Health Care Administration (AHCA) has implemented the **ONLINE LICENSING SYSTEM,** whichallows the electronic submission of renewal and change during licensure period applications and fees, along with the ability to upload supporting documentation. To submit 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 and Change During Licensure 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 # (if applicable)	National Provider Identifier (NPI) (if applicable)
852	N/A

Name of Abortion Clinic (if operated under a fictitious name, enter as it appears in Florida Division of Corporations)
BLUE CORAL WOMEN'S CARE INC.

Street Address
7360 CORAL WAY SUITE 16

City	County	State	Zip
MIAMI	DADE	FL	33155

Telephone Number	Fax Number
305-264 4940	305 264 0099

Mailing Address or ☒ Same as above

City	County	State	Zip

Telephone Number	E-mail Address

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)
BLUE CORAL WOMEN'S CARE INC	65-0859621

Mailing Address or ☐ Same as above
7360 Coral Way # 16

City	State	Zip
Miami	FL	33143

Telephone Number	Fax Number	E-mail Address
305-264 4940	305) 264 0099	mariangie_10@yahoo.com

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 –Please complete the following for the contact person for this application.

Contact Person for this application	Contact Telephone Number
Maria. A. Fernandez	
Contact e-mail address or ☐ Do not have e-mail mariangie_10@yahoo.com	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), F.S., 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 — Proposed Effective Date:

Was this entity previously licensed as an abortion clinic? YES ☒ NO ☐

If YES, please provide the name of the provider (if different), the EIN # and the year the prior license expired or closed:

NAME:	EIN #	Year Expired/Closed:

☒ Renewal licensure

☐ Change of Ownership — Proposed Effective Date:

☐ Change During LicensurePeriod - select all that apply: — Proposed Effective Date:

Fee Required

☐ Provider Name
☐ Provider Address
Services/Qualifications:
☐ Change in type of procedure performed

No Fee Required

☐ Personnel
☐ Management Company
☐ Change of Controlling Interest less than 51%

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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 tosection 390.014(4), F.S.) = $ 0.00	$550.50	$ 550.50
Biennial Assessment	$300.00	$ 300
Other: fee (Late admission of application)	250	$ 250
TOTAL FEES INCLUDED WITH APPLICATION		$ 1,100.50
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.

Special note: Pursuant to section 408.809, F.S., any controlling interest are required to have an Agency screening through the Care Provider Background Screening Clearinghouse. If background screening has been 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., the Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008 may be submitted in lieu of Agency screening.To verify who is to be screened, visit http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/.

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
[redacted]	7360 Coral Way #16	3052644940	65-0855621		1998	UP DATE
Blue Coral Women's Care Inc	Miami FL 33155					

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	Maria A Fernandez	7360 Coral Way #16	305-2644940	1998	UP DATE
Board Member/Officer		Miami FL 33155	786-2299629		
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					

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4. Management Company

Does a company other than the licensee manage the licensed provider?

If ☒ NO, skip to section 5 Personnel

If ☐ YES, provide the following information:

Name of Management Company		EIN (No SSNs)	Telephone Number / Fax	
Street Address		E-mail Address		
City		County	State	Zip
Mailing Address or ☐ Same as above				
City			State	Zip
Contact Person	Contact E-mail		Contact Telephone Number	

N/A

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.

Special note: Pursuant to section 408.809, F.S., any controlling interest are required to have an Agency screening through the Care Provider Background Screening Clearinghouse. If background screening has been 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., the Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008 may be submitted in lieu of Agency screening.To verify who is to be screened, visit http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/.

A. **Individual and/or Entity Ownership of Management Company:** Provide the information for each individual or entity (corporation, partnership, association) with 5% or greater ownership interest in the management company. Attach additional sheets if necessary.

FULL NAME of INDIVIDUAL or ENTITY	PRIMARY ADDRESS	TELEPHONE NUMBER	EIN (No SSNs)	% OWNERSHIP	EFFECTIVE DATE	END DATE
	N/A					

B. **Board Members and Officers of Management Company:**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	N/A				
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					

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5. Personnel

A. **Please provide information for the individual(s) who perform the following roles. Special note:** Pursuant to section 408.809, F.S., the administrator and financial officer are required to have an Agency screening through the Care Provider Background Screening Clearinghouse. If background screening has been 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., the Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008 may be submitted in lieu of Agency screening. To verify who is to be screened, visit http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/.

INFORMATION	ADMINISTRATOR/MANAGING EMPLOYEE	FINANCIAL OFFICER / PERSON RESPONSIBLE FOR FINANCIAL OPERATIONS
Full Name	Maria. A. Fernandez	Maria A. Fernandez
Date of Birth	11/10/1953	
Effective Date	1998	
End Date	UP DATE	
Telephone Number	786-229-9629	
E-mail Address	mariangie_10@yahoo.com	
Personal/Primary Address	6205 SW 39 St Miami FL 33143	

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	Richard. S. Friefeld MD.
Florida License Number (Dept. of Health)	ME 36632
Effective Date	1-12-2019
End Date	1-31-2021
Telephone Number	305) 264 49 40
E-mail Address	———
Personal/Primary Address	7360 Coral Way #16 Miami FL 33155

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, F.S.? YES ☐ NO ☒

If YES, provide the following information:

☐ The full legal name of the individual and the position held

☐ A description/explanation of any convictions

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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.

N/A.

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C. Pursuant to section 408.815(4), F.S., has the applicant or a controlling interest in the applicant, or any entity in which a controlling interest of the applicant was an owner or officer when the following actions occurred ever been:

Convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, Chapter 817, Chapter 893, 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396, Medicaid fraud, Medicare fraud, or insurance fraud, within the previous 15 years prior to the date of this application? YES ☐ NO ☒

Terminated for cause from the Medicare program or a state Medicaid program? YES ☐ NO ☒

If YES, has applicant been in good standing with the Medicare program or a state Medicaid program for the most recent five (5) years and the termination occurred at least twenty (20) years before the date of the application. YES ☐ NO ☐

7. Provider Fines and Financial Information

Pursuant to subsection 408.831(1)(a), F.S., the Agency may take action against the applicant, licensee, or a licensee which shares a common controlling interest with the applicant if they have failed to pay all outstanding fines, liens, or overpayments assessed by final order of the agency or final order of the Centers for Medicare and Medicaid Services (CMS), not subject to further appeal, unless a repayment plan is approved by the agency.

Are there any incidences of outstanding fines, liens or overpayments as described above? YES ☐ NO ☒

If YES, please complete the following for each incidence (attach additional sheets, if necessary):

AHCA CASE NUMBER	CMS	ASSESSED AMOUNT	DATE OF RELATED INSPECTION, APPLICATION, OR OVERPAYMENT	PAYMENT DUE DATE	PENDING APPEAL OF FINAL ORDER	
					YES	NO
	☐		N/A.		☐	☐
	☐				☐	☐
	☐				☐	☐

Please attach a copy of the approved repayment plan, if applicable.

8. Procedure/Transfer/Admitting Information

PROCEDURES PERFORMED (check all that apply):

☐ First Trimester Only - which is the period of time from fertilization through the end of the 11th week of gestation.

☒ First and Second Trimester - which is the period of time from the beginning of the 12th week of gestation through the end of the 23rd week of gestation.

TRANSFER AGREEMENTS/ADMITTING PRIVILEGES(check all that apply):

☒ All the physicians performing abortions have admitting privileges at a hospital within reasonable proximity.

☐ The abortion clinic has a transfer agreement with a hospital within reasonable proximity.
If checked, provide the hospital information below. Attach additional sheets, if necessary.

Hospital Name			
Palmetto General Hospital			
Street Address		Telephone Number	
2001 West 68 street			
City	County	State	Zip
Hialeah	Dade	FL	33016

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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	9AM	3.00 PM	First ☐ Come
☒ Monday	9AM	3.00 PM	First ☐ Serve
☒ Tuesday	9.AM	3.00 PM	Basis ☐
☒ Wednesday	9.AM	3.00 P.M	☐
☒ Thursday	9.AM	3.00 P.M	☐
☒ Friday	9.AM	3.00 PM	☐
☒ Saturday	9.AM	3.00 PM	☐

10. Supporting Documentation

Applicants must include the following attachments as stated in Chapters 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,andChange of ,Provider Name or Address application types
Documentation from the appropriate local governmentofficeshowingthat 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 Ownershipapplication 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

11. Attestation

I, Maem. A. Fernández, attest as follows:

(1) Pursuant to section 837.06, Florida Statutes, I have not knowingly made a false statement with the intent to mislead the Agency in the performance of its official duty.

(2) Pursuant to section 408.815, Florida Statutes, I acknowledge that false representation of a material fact in the license application or omission of any material fact from the license application by a controlling interest may be used by the Agency for denying and revoking a license or change of ownership application.

(3) Pursuant to section 408.806, Florida Statutes, under penalty of perjury, the applicant is in compliance with the provisions of section 408.806 and Chapter 435, Florida Statutes.

(4) Pursuant to sections 408.809 and 435.05, Florida Statutes, every employee of the applicant required to be screened has attested, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to Chapter 408, Part II, and Chapter 435, Florida Statutes, and has agreed to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer.

(5) Pursuant to section 435.05, Florida Statutes, the applicant has conducted a level 2 background screening through the Agency on every employee required to be screened under Chapter 408, Part II, or Chapter 435, Florida Statutes, as a condition of employment and continued employment and that every such employee has satisfied the level 2 background screening standards or obtained an exemption from disqualification from employment.

Signature of Licensee or Authorized Representative	Title	Date	12/4/19
[signature]	Administrator	12/4/19	

NOTICE: If you are a **Medicaid** provider, you may have a separate obligation to notify the Medicaid program of a name/address change, change of ownership or other change of information. Please refer to your Medicaid handbooks for additional information about Medicaid program policy regarding changes to provider enrollment information.

RETURN THIS COMPLETED FORM WITH FEES AND ALL REQUIRED DOCUMENTS TO:

AGENCY FOR HEALTH CARE ADMINISTRATION
HOSPITAL AND OUTPATIENT SERVICES UNIT
2727 MAHAN DR., MS 31
TALLAHASSEE FL 32308-5407

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Questions?

Review the information available at http://ahca.myflorida.com/or contact the Hospital & Outpatient Services Unit at (850) 412-4549.

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
- No staples, paperclips, binder clips, folders, or notebooks
- Please ***do not bind any*** of the documents submitted to the Agency

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MARY C. MAYHEW
SECRETARY

01/27/2020

BLUE CORAL WOMEN'S CARE, INC
7360 CORAL WAY
STE 16
MIAMI FL 33155

13960052

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We recently received documents and/or fees that cannot be processed.

Item(s) enclosed for return:

- [x] Check/ Money Order# 6498 in the amounts of $ 250.00
- [x] Application for [ ] Change of Ownership [ ] Initial Application [x] Renewal Application
- [ ] Other:

Reason returned:

- [ ] No payment was enclosed. An application for licensure must be accompanied by the appropriate fee.
- [ ] No licensure application enclosed. Payment will only be accepted when accompanied by the licensure application.
- [ ] Licensure application received more than 120 days before the requested effective date.
- [ ] Licensure application received after the license expiration date. An initial application must be submitted after the license has expired.
- [ ] Check or Money Order must be made payable to the Agency for Health Care Administration (AHCA).
- [ ] If this payment is intended for the CLIA program please mail to: CLIA Laboratory Program, P. O. Box 3056, Portland, OR 97208-3056.
- [ ] The Agency does not accept Starter Checks. Payment may be in the form of a permanent check, cashier's check or money order.
- [ ] Health Care Trust Fund – Deceased Residents. Please furnish the resident name, name of the facility, date of death **and full social security number for each resident. Date of discharge is not an acceptable alternative for date of** death and the last four digits of the social security is not an acceptable alternative for the social security number.
- [ ] 101 CMS-116 Applications Version (05/15) are no longer accepted. Please resubmit these on the updated version of the form dated (09/17).
- [x] Other: LEGAL LINE AND NUMERIC BOX DO NOT MATCH

If you have questions regarding this letter, please contact the: Hospital and Outpatient Services Unit (850)412-4549

2727 Mahan Drive • Mail Stop # 31
Tallahassee, FL 32308
AHCA.MyFlorida.com

Facebook.com/AHCAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL

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PENALTY FOR PRIVATE USE $300
FP ★ ★ ★
$ 28.30
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01/21/2020
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EE 300 650 168 US

CUSTOMER USE ONLY

FROM: (PLEASE PRINT) PHONE ( )
Blue Coral Women's Care Inc
7360 Coral Way #16
Miami FL 33155

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 adm.
Hospital and Out Patient
Service Unit MS #31
2727 Mahan Drive
ZIP + 4® (U.S. ADDRESSES ONLY) Talahassee FL
32308

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

PEEL FROM THIS CORNER

PAYMENT BY ACCOUNT (if applicable)

USPS® Corporate Acct. No.	Federal Agency Acct. No. or Postal Service™ Acct. No.

ORIGIN (POSTAL SERVICE USE ONLY)

☑ 1-Day ☐ 2-Day ☐ Military ☐ DPO

PO ZIP Code: 33155	Scheduled Delivery Date (MM/DD/YY)	Postage: $ 28.30	
Date Accepted (MM/DD/YY): 01/21/20	Scheduled Delivery Time: ☐ 10:30 AM ☐ 3:00 PM ☐ 12 NOON	Insurance Fee: $	COD Fee: $
Time Accepted: 4.15 ☑ AM ☐ PM	10:30 AM Delivery Fee: $	Return Receipt Fee: $ 2.80	Live Animal Transportation Fee: $
Special Handling/Fragile: $	Sunday/Holiday Premium Fee: $	Total Postage & Fees: $ 28.30	
Weight: ☑ Flat Rate lbs. 12 ozs.	Acceptance Employee Initials: DM		

DELIVERY (POSTAL SERVICE USE ONLY)

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

LABEL 11-B, JULY 2018 PSN 7690-02-000-9996

This envelope is made from post-consumer waste. Please recycle - again.

* Money Back Guarantee to U.S., select APO/FPO/DPO, and select International destinations. See DMM...

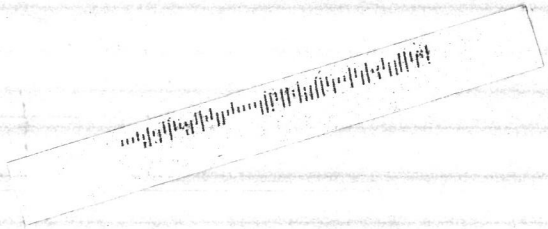
BLUE CORAL WOMEN'S CARE INC.
7171 Coral Way #215
Miami FL 33155

PLACE STICKER AT TOP OF ENVELOPE TO THE RIGHT OF THE RETURN ADDRESS. FOLD AT DOTTED LINE
CERTIFIED MAIL®

7019 0160 0000 6809 2304

U.S. OFFICIAL MAIL US POSTAGE
PENALTY FOR PRIVATE USE $300
$ 08.20
FP
Mailed From 33155
01/31/2020
031A 0004189307

2727 MAHAN DRIVE
MAIL STOP # 31
TALLAHASSEE, FL 32308
AHCA. MyFlorida.com.



RECEIVED
FEB 03 2020
CENTRAL INTAKE