(13) KSE-NA

AHCA USE ONLY:

File #: 13910032
Application #: 1749
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Health Care Licensing Application
Abortion Clinic

The Agency for Health Care Administration (AHCA) has implemented the **ONLINE LICENSING SYSTEM,** which allows 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 The application will be withdrawn from review if all the required documents and fees are not included with your application or received within 21 days of an omission notice.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) 777		National Provider Identifier (NPI) (if applicable) 1831347293	
Name of Abortion Clinic (if operated under a fictitious name, enter as it appears in Florida Division of Corporations) All Women's Health center of Gainesville, Inc.			
Street Address 1135 N W. 23rd Ave Suite N			
City Gainesville	County Alachua	State Fl	Zip 32609
Telephone Number 352-378-9191		Fax Number 352-372-4823	
Mailing Address or ☒ Same as above 2106 Drew Street #103			
City Clearwater	County Pinellas	State fl	Zip 33765
Telephone Number 727-442-0445 ext 28		E-mail Address smyrs33@yahoo.com	
Provider Website floridaabortion.com		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)	
Mailing Address or ☐ Same as above			
City		State	Zip
Telephone Number	Fax Number	E-mail Address	

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 Sandy Myers	Contact Telephone Number 727-442-0445 ext 28
Contact e-mail address or ☒ Do not have e-mail Smyrs33@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 Licensure Period - select all that apply: — Proposed Effective Date:

Fee Required	No Fee Required
☐ Provider Name	☒ Personnel
☐ Provider Address	☐ Management Company
Services/Qualifications:	☐ Change of Controlling Interest less than 51%
☐ Change in type of procedure performed	

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AUG 26 2021
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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	Sarah Muzzey	Melinda Miller
Date of Birth	03/22/1979	05/23/1956
Effective Date	11/05/2020	03/01/1992
End Date		
Telephone Number	352-378-9191	727-442-0445 ext 25
E-mail Address	allwomenshealthc@bellsouth.net	ammmrm@hotmail.com
Personal/Primary Address	1135 N.W. 23rd Ave Suite N Gainesville, Fl.32609	2106 Drew Street # 103 CLW,Fl. 33765

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	Kirk Brody
Florida License Number (Dept. of Health)	ME 147686
Effective Date	11/01/2021
End Date	
Telephone Number	352-378-9191
E-mail Address	allwomenshealthc@bellsouth.net
Personal/Primary Address	1135 N.W. 23rd ave Suite N Gainesville,Fl 32609

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

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.

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AUG 26 2021
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11. Attestation

I, Sandy Myers, 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	President	8/23/2021
	Title	Date

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

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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AUG 26 2021
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AMERICAN MEDICAL MANAGEMENT, INC.
2106 DREW STREET SUITE 103
CLEARWATER, FL 33765

7018 1130 0001 3902 0462

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HOSPITAL AND OUTPATIENT SERVICES UNIT
2727 MAHAN DR., MS 31
TALLAHASSEE, FL 32308-5407

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