3/18 mw

AHCA USE ONLY:

File #: 13930016
Application #: 1723
Check #: 3497
Check Amt: $850.00
Batch #: 10100531

NA-R-13

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 The application will be withdrawn from review if all the required documents and fees are not included with your application or received within 21 days of an omission notice.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) 907		National Provider Identifier (NPI) (if applicable)	
Name of Abortion Clinic (if operated under a fictitious name, enter as it appears in Florida Division of Corporations) EVE OF KENDALL, INC			
Street Address 8603 SOUTH DIXIE HIGHWAY SUITE 102			
City MIAMI	County MIAMI-DADE	State FL	Zip 33156
Telephone Number (305) 668-5629		Fax Number (305) 668-5628	
Mailing Address or ☑ Same as above			
City	County	State	Zip
Telephone Number	E-mail Address BOOK402590@AOL.COM		
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)
EVE OF KENDALL, INC	65-0274565

Mailing Address or ☑ Same as above: 8603 SOUTH DIXIE HIGHWAY SUITE 102

City	State	Zip
MIAMI-DADE	FL	33156

Telephone Number	Fax Number	E-mail Address
(305) 668-5629	305 668-5628	BOOK402590@AOL.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
KAREN BOOKBINDER	(305) 332-8299

Contact e-mail address or ☐ Do not have e-mail	NOTE: By providing your e-mail address, you agree to accept e-mail correspondence from the Agency.
BOOK402590@AOL.COM	

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

☐ 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 to section 390.014(4), F.S.) = $ 0.00	$550.50	$ 550
Biennial Assessment	$300.00	$ 300
Other: _____		$
TOTAL FEES INCLUDED WITH APPLICATION		$
Please make check or money order payable to the Agency for Health Care Administration (AHCA)		850.00

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
KAREN BOOKBINDER	5660 COLLINS AVE	(305) 332-8299		100 STOCK	CONCEPTION PRESENT.	

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 ARES. Member/Officer	KAREN BOOKBINDER	5660 COLLINS AVE	305 3328299	CONCEPTION PRESENT	
Board EX DIR. Member/Officer	"	"	"	"	
Board Member/Officer			MAR 18 2021		
Board Member/Officer			Central Services		
Board Member/Officer					

4. Management Company

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

NA 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	

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

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					
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	KAREN BOOKBINDER	//
Date of Birth	12/10/1951	//
Effective Date	CONCEPTION	//
End Date	PRESENT.	//
Telephone Number	305 332-8299	//
E-mail Address	BOOK402590@AOL.COM	//
Personal/Primary Address	5660 COLLINS AVE 12C	//

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	DR. GERALD APPLEGATE
Florida License Number (Dept. of Health)	ME82602
Effective Date	NOV 8/2019
End Date	FEB 31/2022
Telephone Number	1(412) 849-7821
E-mail Address	JERRYAPPLE@COMCAST.NET
Personal/Primary Address	7101 NE. 57th St. MIAMI FL 33137

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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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
	☐				☐	☐
	☐				☐	☐
	☐				☐	☐

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			
LARKIN HOSPITAL			
Street Address		Telephone Number	
7031 SW 62ND AVE			
City	County	State	Zip
SOUTH MIAMI	MIAMI-DADE	FL	33143

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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			☐
☑ Monday	[redacted]	[redacted]	☑
☑ Tuesday			☑
☑ Wednesday			☑
☑ Thursday			☑
☑ Friday			☑
☑ Saturday			☑

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, and Change of ,Provider Name or Address application types
Documentation from the appropriate local government office showing that 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 Ownership application 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

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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	—	—	☑
☑ Monday			☑
☑ Tuesday			☑
☑ Wednesday			☑
☑ Thursday			☑
☑ Friday			☑
☑ Saturday			☑

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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

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ORIGIN ID:RIDA (305) 332-8289
KAREN BOOKBINDER
5660 COLLINS AVE APT 12C
MIAMI BEACH, FL 33140
UNITED STATES US

SHIP DATE: 17MAR2
ACTWGT: 0.25 LB
CAD: 6991276/SSFC

TO **AGENCY FOR HEALTH CARE ADMIN**
HOSPITAL & OUTPATIENT SERVICE UIN
2727 MAHAN DRIVE MS31
MS31
TALLAHASSEE FL 32308
(000) 000-0000

DEPT:

REF:

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TRK# 7848 5965 2640

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