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) **PRESIDENTIAL WOMEN'S CENTER, INC.**		Federal Employer Identification Number (EIN) **59-2011653**	
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 **MONA S. REIS**	Contact Telephone Number **561-686-3859**
Contact e-mail address or ☐ Do not have e-mail **pwcsuite19@aol.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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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	$550.50	**$ 550.50**
Biennial Assessment	$300.00	**$ 300.00**
Other: _____		$
TOTAL FEES INCLUDED WITH APPLICATION		**$ 850.50**
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
PRESIDENTIAL WOMEN'S CENTER, INC.	**100 NORTHPOINT PKWY, WEST PALM BEACH, FL 33407**	**561-686-3859**	**59-2011653**	**100%**	**05/09/1980**	**NONE**

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	**MONA S. REIS, DIRECTOR**	**100 NORTHPOINT PKWY, WEST PALM BEACH, FL 33407**	**561-686-3859**	**05/09/1980**	**NONE**
Board Member/Officer	**MONA S. REIS, PRESIDENT**	**100 NORTHPOINT PKWY, WEST PALM BEACH, FL 33407**	**561-686-3859**	**05/09/1980**	**NONE**
Board Member/Officer	**MONA S. REIS, VICE-PRESIDENT**	**100 NORTHPOINT PKWY, WEST PALM BEACH, FL 33407**	**561-686-3859**	**05/09/1980**	**NONE**
Board Member/Officer	**MONA S. REIS, SECRETARY**	**100 NORTHPOINT PKWY, WEST PALM BEACH, FL 33407**	**561-686-3859**	**05/09/1980**	**NONE**

Board Member/Officer	**MONA S. REIS, TREASURER**	**100 NORTHPOINT PKWY, WEST PALM BEACH, FL 33407**	**561-686-3859**	**05/09/1980**	**NONE**

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	

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					

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Board Member/Officer					

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	MONA S. REIS	MONA S. REIS
Date of Birth	09/08/1951	09/08/1951
Effective Date	05/09/1980	05/09/1980
End Date	NONE	NONE
Telephone Number	561-686-3859	561-686-3859
E-mail Address	pwcsuite19@aol.com	pwcsuite19@aol.com
Personal/Primary Address	100 NORTHPOINT PKWY, WEST PALM BEACH, FL 33407	100 NORTHPOINT PKWY, WEST PALM BEACH, FL 33407

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	DANIEL N. SACKS, MD
Florida License Number (Dept. of Health)	ME80828
Effective Date	10/01/2012
End Date	NONE
Telephone Number	561-686-3859
E-mail Address	pwcsuite19@aol.com
Personal/Primary Address	100 NORTHPOINT PKWY, WEST PALM BEACH, FL 33407

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			
JUPITER MEDICAL CENTER			
Street Address		Telephone Number	
1210 SOUTH OLD DIXIE HIGHWAY		**561-263-2234**	
City	County	State	Zip
JUPITER	**PALM BEACH**	**FL**	**33458**

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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	CLOSED	CLOSED	☐
☒ Monday	**8:00AM**	**5:00PM**	☐
☒ Tuesday	**8:00AM**	**5:00PM**	☐
☒ Wednesday	**8:00AM**	**5:00PM**	☐
☒ Thursday	**8:00AM**	**5:00PM**	☐
☒ Friday	**8:30AM**	**4:30PM**	☐
☒ Saturday	**8:00AM**	**5:00PM**	☐

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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11. Attestation

I, **MONA S. REIS**, 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: **PRESIDENT** — Date: 6/17/21

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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PRESIDENTIAL
Women's Center
Excellence In Women's Healthcare
For Over 38 Years

VIA FED-EX: 8165-5847-4091

June 16, 2021

Florida Agency for Health Care Administration
Hospital and Outpatient Services Unit
2727 Mahan Drive, MS 31
Tallahassee, FL 32308-5407

Re: Presidential Women's Center, Inc.
Renewal of License # 863

Dear Sir or Madam,

Enclosed please find an application to renewal abortion clinic license # 863 held by Presidential Women's Center, Inc. Also enclosed please find a check to pay the application fees.

Please note that I anticipate a change of ownership will occur in the near future. Change of ownership application file # 13960065 is currently pending review by AHCA. Nevertheless, I am filing this renewal application to ensure there is no gap in licensure in the unlikely event that a delay arises with the pending change of ownership application.

Please contact me at (561) 686-3859 or pwcsuite19@aol.com if you require additional information. Thank you for your assistance.

Sincerely,

Mona S. Reis
President

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100 Northpoint Parkway | West Palm Beach, FL 33407
Phone: 561.686.3859 | Fax: 561.686.4755
www.presidentialcenter.com

FedEx Express Package US Airbill
FedEx Tracking Number 8165 5847 4091
Recipient's Copy
Form ID No. 0215
1 From Date 6/18/24
Sender's Name Mina S. Reis Phone 561 686-3839
Company PRESIDENTIAL WOMAN'S CENTER
Address 100 NORTHPOINT PKWY
City WEST PALM BEACH State FL ZIP 33407-1905
2 Your Internal Billing Reference
3 To Recipient's Name Agency for Health Care Adm. Phone 850 412-4549
Company Hospital + Outpatient Services Unit
Address 2727 Mahan Dr.
We cannot deliver to P.O. boxes or P.O. ZIP codes.
Address MS 31
Use this line for the HOLD location address or for continuation of your shipping address.
City Tallahassee State FL ZIP 32308-5407
4 Express Package Service
Next Business Day
FedEx First Overnight
FedEx Priority Overnight
FedEx Standard Overnight
2 or 3 Business Days
FedEx 2Day A.M.
FedEx 2Day
FedEx Express Saver
5 Packaging
FedEx Envelope* FedEx Pak* FedEx Box FedEx Tube Other
6 Special Handling and Delivery Signature Options
Saturday Delivery
No Signature Required
Direct Signature
Indirect Signature
Does this shipment contain dangerous goods?
No Yes
Dry Ice
Cargo Aircraft Only
7 Payment Bill to:
Sender Recipient Third Party
Total Packages Total Weight
fedex.com 1.800.GoFedEx 1.800.463.3339
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