DEPARTMENT OF HEALTH
AMBULATORY SURGICAL TREATMENT CENTER
APPLICATION

AMBULATORY SURGICAL TREATMENT CENTER APPLICATION

To: Health Regulations and Licensing Administration
899 North Capitol Street, NE
2nd Floor
Washington, DC 20002

We, (1) Takina Wilson and (2) _____

Resident at (1) [redacted]

(2) _____
Street Address City State Zip Code

Officers of the center named below, certifying that we are twenty-one years of age or older and of reputable and responsible character do hereby apply for a license to maintain and operate a center during the 2021 calendar year subject to the provisions of District of Columbia Law 2-66, and to any regulations and standards adopted thereunder.

Name of ambulatory surgical treatment center: Carol Whitehill Moses Center

Location: 1225 4th St NE Washington DC 202-763-7404 20002
Street Address City State Tele. Zip Code

Name of person in charge: Laura Meyers

Medical director or principal physician: Dr. Serina Floyd

[redacted]
Street Address City State Zip Code

Name of organization owning and conducting center: Planned Parenthood of Metropolitan Washington DC , Inc

Type of organization: Non-Profit Corp. X , Private Corp. _____
(Attach lists of board officers and members)

Class of institution for which application is made: (Check one)

[ ] General Surgery [ ] Family Planning [X] Other (Specify)

Transfer agreement with a hospital within twenty minutes ambulance time [X] Yes [ ] No

Name of hospital: Washington Hospital Center

Number of surgical procedures performed in the previous fiscal year 0 (2800 projected)

Application and license fee* of 585.00 drawn payable to: "D.C. Treasurer" is attached to this application. (Fee is not refundable.) There is also attached documentary evidence of financial responsibility on the part of the applicant institution in the sum of not less than One Hundred Thousand Dollars ($100,000.00) per occurrence and Three Hundred Thousand Dollars in the aggregate which become readily available for the benefit of any person who may become aggrieved as the result of the center.

Signatures of Applicants (1) Takina Wilson Title Vice President of Health Programs

(2) [signature] Title Vice President of Health Programs

Sworn and subscribed to before me this 9th day of Jan, 2021

Notary Public for the District of Columbia

My commission expires 09.14.2023

NOTE: THIS FORM FOR APPLICATION OF ASSOCIATION OR OTHER NON-INDIVIDUAL APPLICANT

* Refer to license fees for ambulatory surgical centers for correct fee

DISTRICT OF COLUMBIA * THOMAS M. DAVIS * NOTARY PUBLIC Exp. - 09 14/23

[signature]

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DOH
DEPARTMENT OF HEALTH
Promote. Prevent. Protect.

Government of the District of Columbia
Department of Health

WE ARE WASHINGTON DC

Health Regulation and Licensing Administration

"CLEAN HANDS" SELF-CERTIFICATION FORM

TO THE APPLICANT:

Please read the following statement carefully before signing. A false statement on this Certification requires that the Department proceed immediately to revoke the license or permit for which you are now applying and fine you $1,000.00. This Self-Certification Form is required by the "Clean Hands Before Receiving A License or Permit Act of 1996", effective May 11, 1996, as amended, (D.C. Law 11-118; D.C. Official Code § 47-2861 *et seq.*) (2015).

I, Laura Meyers certify that as of 01/11/2021,
Print Name Clearly **Date**

(1) I do not owe more than $100 to the District of Columbia Government in outstanding fines, penalties, or interest assessed pursuant to the following acts or any regulations promulgated under the authority of any of the following acts, the:

(A) Litter Control Administrative Act of 1985, effective March 25, 1986 (D.C. Law 6-100; D.C. Official Code § 8-801 *et seq.*);

(B) Illegal Dumping Enforcement Act of 1994, effective May 20, 1994 (D.C. Law 10-117; D.C. Official Code § 8-901 *et seq.*);

(C) District of Columbia Traffic Adjudication Act of 1978, effective September 12, 1978 (D.C. Law 2-104; D.C. Official Code § 50-2301.01 *et seq.*);

(D) Department of Consumer and Regulatory Affairs Civil Infractions Act of 1985, effective October 5, 1985 (D.C. Law 6-42; D.C. Official Code § 2-1801.01 *et seq.*);

(E) District of Columbia Taxicab Commission Establishment Act of 1985, effective March 25, 1986 (D.C. Law 6-97; D.C. Official Code § 50-301 *et seq.*); or

(F) The Compulsory/No-Fault Motor Vehicle Insurance Act of 1982, effective September 18, 1982 (D.C. Law 4-155; D.C. Official Code § 31-2401 *et seq.*);

I also certify that I do not owe:

(2) More than $100 to the District of Columbia Government in past due taxes;

(3) Fines assessed to car dealers pursuant to § 50-1501.02(i);

(4) Parking fines or penalties assessed by another jurisdiction; provided, that a reciprocity agreement is in effect between the jurisdiction and the District;

(5) Past due District of Columbia Water and Sewer Authority service charges or fees;

(6) A vehicle conveyance fee, as that term is defined in § 50-2302.01(i);

(7) The District more than $ 100 in outstanding fines, penalties, or interest;

And, I further certify that:

(8) I have filed required District tax returns; [and]

(9) I do not owe the District any past due fines, penalties, or past due restitution on behalf of an employee due to a violation of Chapter 13 of Title 32, Chapter 1A of Title 32, Chapter 10 of Title 32, or Subchapter X-A of Chapter 2 of Title 2.

I understand the Department will move to immediately revoke each license or permit for which I am applying that contains a false certification, and to fine me $1,000.00 for each false certification.

I understand that the Department may conduct an investigation to ascertain the veracity of this certification.

I further understand that this Certification is required to accompany my application for a license or permit, and that by completing this Certification, I am not guaranteed that my license or permit will be approved.

Laura Meyers

PRINT NAME

Laura Meyers

SIGNATURE OF APPLICANT

01/11/2021

Government of the District of Columbia
Department of Health

Health Regulation and Licensing Administration

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Laura Meyers

PRINT NAME

Laura Meyers

SIGNATURE OF APPLICANT

01/11/2021

Planned Parenthood of Metropolitan Washington, D.C.
Board of Directors

Name	Office	Beginning of 1st Term	Expected end of Final Term
Arnold, Lydia P.		June 1, 2018	May 31, 2024
Cooper, Jeff	Treasurer	June 1, 2017	May 31, 2023
Crumes, Michele France		July 1, 2020	May 31, 2026
Dixon, Shontelle		June 1, 2018	May 31, 2024
Dreyfus, Jennifer		June 1, 2017	May 31, 2023
Ford, Imani		June 1, 2018	May 31, 2024
González, Adrián		June 1, 2019	May 31, 2025
Large, Anne	Honorary (non-voting) Board Member	January 1, 2013	January 1, 2019
Livingston, Catherine (Cathy)		June 1, 2018	May 31, 2024
Luray, Jennifer (Jenny)	Chair	June 1, 2015	May 31, 2021

Rubiner, Laurie		June 1, 2019	May 31, 2025
Sanabria, María Jose (Majo)		June 1, 2018	May 31, 2024
Shiferaw, Eden		July 1, 2020	May 21, 2026
Taylor, Amy	Secretary	June 1, 2016	May 31, 2022
Taylor, Audrey	Honorary (non-voting) Board Member	June 1, 2014	May 31, 2020
Thomas, Dana	Vice Chair	June 1, 2018	May 31, 2024
Thomas, John		June 1, 2016	May 31, 2022
Waxman, Judith G.		June 1, 2017	May 31, 2023
Meyers, Laura	President & CEO	N/A	

DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION

INSTRUCTION FOR COMPLETING DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT (DC-1513)

Completion and submission of this form is a condition of participation, certification, or recertification under any of the programs established by Titles V, XVIII, XIX, AND XX, or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the District of Columbia state agency under any of the above-titled programs, a full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in a refusal by the D.C. State Agency to enter into an agreement or contract with any such institution or in termination of existing agreements.

SPECIAL INSTRUCTIONS FOR TITLE XX PROVIDERS

All title XX providers must complete Part II (a) and (b) of this form. Only those Title XX providers rendering medical, remedial, or health related homemaker services must complete Parts II and III. Title V providers must complete Parts II and III.

General Instructions

For definitions, procedures and requirements, refer to the appropriate Regulations:

Title V	**-42CFR 51a.144**
Title XVIII	**-42CFR 420.200-206**
Title XIX	**-42CFR 455.100-106**
Title XX	**-45CFR 228.72-73**

Please answer all questions as of the current date. If the yes block for any item is checked, list requested additional information under the Remarks Section on page 2, referencing the item number to be continued. If additional space is needed use an attached sheet.

Return the original copy to the State agency: retain the photocopy for your files.

DETAILED INSTRUCTIONS

These instructions are designed to clarify certain questions on the from. Instructions are listed in question order for easy reference. No instructions have been given for questions considered self-explanatory.

IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.

Item I – Under identifying information specify in what capacity the entity is doing business as (DBA), example, name of trade or corporation.

Item II- Self-explanatory

Item III- List the names of all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination amounting to an ownership interest of 5 percent or more in the disclosing entity.

Direct ownership interest is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. A disclosing entity is defined as a Medicare provider or supplier, or other entity that furnishes services or arranges for furnishing services under Medicaid or the Maternal and Child Health program, or health related services under the social services program.

Indirect ownership interest is defined, as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity .The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership and must be reported.

Controlling interest is defined as the operational direction or management of a disclosing entity, which may be maintained, by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity (i.e. joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved, to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

Items IV-VII- Changes in Provider Status

Change in provider status is defined as any change in management control. Examples of such changes would include: a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the ownership partnership which under applicable State law is not considered a change in ownership, or the hiring or dismissing of any employees with 5 percent or more financial interest in the facility or in an owning corporation or any change of ownership.

For Items IV-VII, if the yes box is checked, list additional information requested under Remarks. Clearly identify which item is being continued.

Item IV- (a & b) If there has been a change in ownership within the last year or if you anticipate a change, indicate that date in the appropriate space.

Item V- If the answer is yes, list name of the management firm and employer identification number (EIN), or the name of the leasing organization. A management company is defined as any organization that operates and manages a business on behalf of the owner of that business, with the owner retaining ultimate legal responsibility for operation of the facility.

Item VI- If the answer is yes, identify which has changed (Administrator, Medical Director, or Director of Nursing) and the date the change was made. Be sure to include name of the new Administrator, Director of Nursing or Medical Director, as appropriate.

Item VII- A chain affiliate is any free-standing health care facility that is either owned, controlled, or operated under lease or contract by an organization consisting of two or more free-standing health care facilities organized within or across State lines which is under the ownership or through any other device, control and direction of a common party. Chain affiliates include such facilities whether public, private, charitable or proprietary. They also include subsidiary organizations and holding corporations. Provider-based facilities, such as hospital-based home health agencies, are not considered to be chain affiliates.

Item VIII -If yes, list the actual number of beds in the facility now and the previous number.

DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

Identifying Information

(a). Name of Entry	D/B/A	Provider No.	Vendor No.	Telephone No.
Planned Parenthood of Metropolitan DC, Inc		HFD06-0014		
Street Address 1225 4ht St NE		City, County, State Washington DC		Zip Code 20002

II. Answer the following questions by checking "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or corporations under Remarks on page 2. Identify each item number to be continued.

A. Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVII, XIX, or XX?

☐ Yes ☒ No

B. Are there any directors, officers, agents, or managing employees of the institution, agency or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVII, XIX, or XX?

☐ Yes ☒ No

C. Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's organization's, or agency's fiscal intermediary or carrier within the previous 12 months? (Title XVII providers only)

☐ Yes ☒ No

III. (a.) List names, addresses for individuals, or the EIN for organization having direct or indirect ownership or a controlling interest in the entity. (See instructions for definition of ownership and controlling interest.) List any additional names and addresses under "Remarks" on Page 2. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks.

Name	Address	EIN

(b) Type of Entity: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation
☐ Unincorporated Associations ☐ Other (Specify)

(c) If the disclosing entity is a corporation, list names, addresses of the Directors, and EINs for corporations under Remarks.

Check appropriate box for each of the following questions

(d) Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example, sole proprietor, partnership or members of Board of Directors.) If yes, list names, addresses of individuals and provider numbers.

☐ Yes ☒ No

Name	**Address**	**Provider Number**

DEPARTMENT OF HEALTH
HEALTH REGULATION ADMINISTRATION

IV. (a) Has there been a change in ownership or control within the last year? ☐ Yes ☒ No
If yes, give date _____

(b) Do you anticipate any change of ownership or control within the year? ☐ Yes ☒ No
If yes, when? _____

(c) Do you anticipate filing for bankruptcy within the year? ☐ Yes ☒ No
If yes, when _____

V. Is this facility operated by a management company, or leased in whole or part by another organization? ☐ Yes ☒ No
If yes, give date of change in operations _____

VI. Has there been a change in Administrator, Director of Nursing or Medical Director within the last year? ☐ Yes ☒ No

VII. (a) Is this facility chain affiliated? (If yes, list name, address of Corporation, and EIN) ☐ Yes ☒ No
Name EIN#

Address

VIII. Have you increased your bed capacity by 10% or more or by 10 beds, whichever is greater, within the last 2 years?
☐ Yes ☐ No

If yes give year change _____

Current Beds _____ Prior beds _____

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE D. C. STATE AGENCY AS APPROPRIATE.

Name of Authorized Representative (Typed)	Title
Laura Meyers	CEO
Signature	Date
Laura Meyers	01/11/2021

Remarks

Office of Finance and Treasury

Date: 2/1/2021 11:36 AM
Office: OFT-HRLA Term:OD-JXCQ9Y1
Batch: 71625 Batch Date: 2/1/2021
Cashier:OFT49
Trans #:48

DEPARTMENT OF HEALTH Rcpt: 02816955
Comment/Document: CAROL WHITEHILL MOSES
Payment Total: $877.00

Payment Distribution:
4672 HCO (3230) r5450-45300 $877.00
CK Tendered: $877.00

Thank you for your payment.
Have a nice day!

Office of Finance and Treasury

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HEALTH REGULATION AND LICENSING ADMINISTRATION
RECEIPT FORM

Government of the District of Columbia
Department of Health
Health Regulation and Licensing Administration (HRLA)
Office of Health Professional Boards
899 North Capitol Street, NE, 1st Floor
Washington, DC 20002
Call Center: 1-877-672-2174 (Phone), (202) 724-5145 (Fax)

Date 11/26/21

RECEIVED FROM: Carol Whitehill Moses Center DOB 4672

FOR: Transfer agreement BOARD: Health Facility

	Criminal Background Check		
	Check or Money Order (ONLY)	MO# / CK# / CC 7010	AMOUNT $ 877
	Clean Hands Form		