

**AHCA USE ONLY:**

File #:

Application #:

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**Health Care Licensing Application**

**Health Care 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 The application will be withdrawn from review if all the required documents and fees are not included with your application or received within 21 days of an omission notice*.* **Applications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 Period 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 400, Part X, Florida Statutes (F.S.), and Chapters 59A-35 and 58A-33, Florida Administrative Code (F.A.C.), an application is hereby made to operate a health care clinic as indicated below:

**1. Provider / Licensee Information**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **A. PROVIDER INFORMATION** – Please complete the following for the health care 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) | | Medicare # (CMS CCN)  (if applicable) | | | Florida Medicaid #  (if applicable) | |
| Name of Health Care Clinic (if operated under a fictitious name, enter as it appears in Florida Division of Corporations) | | | | | | | |
| Street Address | | | | | | | |
| City | | County | | | State | | Zip |
| Telephone Number | | Fax Number | | | | | |
| Mailing Address or  Same as above | | | | | | | |
| City | | County | | | Stat | | 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 | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **B. LICENSEE INFORMATION** – Pease complete the following for the entity seeking to operate the health care clinic. | | | | | |
| Licensee Name (this is the owner of the health care 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 -** For this application | |
| Contact Person for this application | Contact Telephone Number |
| Contact e-mail address or  Do not have e-mail | |

**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 a Health Care 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 - check all that apply: Proposed Effective Date:

Fee Required No Fee Required

Provider Name  Personnel

Provider Address  Medical/Clinic Director

Qualifications/Services  Clinical Staff

Clinic type (mobile, portable and MRI only)  Management Company

Duplicate License  Change of Controlling Interest, less than 51%

Qualifications/Services

Clinic services

**B. LICENSURE FEES**

|  |  |  |
| --- | --- | --- |
| **ACTION** | **FEE** | **TOTAL FEES** |
| License Fee (Initial, Renewal and Change of Ownership): | $2,000.00 | $ |
| Biennial Assessment Fee | $300.00 | $ |
| Change During Licensure Period/Replacement License only | $25.00 | $ |
| Other: |  | $ |
| **TOTAL FEES INCLUDED WITH APPLICATION** | | **$** |
| **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 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.**

**DEFINITIONS:**

**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/.](http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/.%20)](http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/Rqrd_Screening.shtml.%20)

1. **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.

If any controlling interests are qualify as a nonimmigrant alien according to 8 U.S.C. §1101 the Nonimmigrant Alien box must be selected next to their name.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **FULL NAME of INDIVIDUAL or ENTITY** | **PRIMARY ADDRESS** | **TELEPHONE NUMBER** | **EIN**  **(No SSNs)** | **% OWNERSHIP** | **EFFECTIVE DATE** | **END DATE** | **NONIMMIGRANT ALIEN** |
|  |  |  |  |  |  |  |  |
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1. **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** |  |  |  |  |  |
| **Board Member/Officer** |  |  |  |  |  |
| **Board Member/Officer** |  |  |  |  |  |

**4. Management Company Control**

**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/.](http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/.%20)](http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/Rqrd_Screening.shtml.%20)

1. **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.

If any controlling interests are qualify as a nonimmigrant alien according to 8 U.S.C. §1101 the Nonimmigrant Alien box must be selected next to their name.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **FULL NAME of INDIVIDUAL or ENTITY** | **PRIMARY ADDRESS** | **TELEPHONE NUMBER** | **EIN**  **(No SSNs)** | **% OWNERSHIP** | **EFFECTIVE DATE** | **END DATE** | **NONIMMIGRANT ALIEN** |
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1. **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. o 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** |  |  |  |  |  |

**5. Personnel**

1. **Please provide information for the individual(s) who perform the following roles. Special note:** the administrator and financial officer are required pursuant to section 408.809, F.S. to have an Agency screening through the Care Provider Background Screening Clearinghouse or submit the Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, if background screening was 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.. To verify who is to be screened, visit [[http://ahca.myflorida.com/MCHQ/Central\_Services/Background\_Screening/.](http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/.%20)](http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/Rqrd_Screening.shtml.%20)

|  |  |  |
| --- | --- | --- |
| **INFORMATION** | **ADMINISTRATOR/MANAGING EMPLOYEE** | **FINANCIAL OFFICER / PERSON RESPONSIBLE FOR FINANCIAL OPERATIONS** |
| **Full Name** |  |  |
| **Date of Birth** |  |  |
| **Effective Date** |  |  |
| **End Date** |  |  |
| **Telephone Number** |  |  |
| **E-mail Address** |  |  |
| **Personal/Primary Address** |  |  |

1. **Medical or Clinic Director - Pursuant to section 400.991(3), F.S., an application for licensure must include the name,** residence and business addresses, phone number, social security number, and license number of the medical or clinic director. Disclosure of social security number is mandatory. 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. NOTE: A licensed health care clinic may not operate or be maintained without the day-to-day supervision of a single medical or clinic director as defined in section 400.9905(5), F.S.

|  |  |  |  |
| --- | --- | --- | --- |
| **INFORMATION** | **MEDICAL DIRECTOR OR**  **CLINIC DIRECTOR** | | |
| **Full Name** |  | **Florida License Number (Dept. of Health)** | |
| **Effective Date** |  | **End Date** | |
| **E-mail Address** |  | **Telephone Number** | |
| **Hours & Days at Clinic:** |  | | |
| **Personal Address** |  | | |
| **Business Address** |  | | |
| **Status** | Employee  Contracted | | |
| **Provides health care services for the clinic** | Yes  No | | |
| **Serves as Medical/Clinic Director at other health care clinics? If YES, provide the following information for each below:** | Yes  No | | |
| **Clinic Name:**  **Street Address:**  **Number of employees:**  **Hours & Days at Clinic:** |  | | **License Number** |
|  | | |
|  | | |
|  | | |
| **Clinic Name:**  **Street Address:**  **Number of employees:**  **Hours & Days at Clinic:** |  | | **License Number** |
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| --- | --- | --- |
| **Clinic Name:**  **Street Address:**  **Number of employees:**  **Hours & Days at Clinic:** |  | **License Number** |
|  | |
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|  | |
| **Clinic Name:**  **Street Address:**  **Number of employees:**  **Hours & Days at Clinic:** |  | **License Number** |
|  | |
|  | |
|  | |

1. **Other Personnel** - Licensed health care practitioners and all personnel who provide personal care services to clients or with access to clients funds (attach additional sheets if necessary)

|  |  |
| --- | --- |
| Full Name | FL License / Registration Type |
| Position / Title | FL License / Registration Number |
|  | |
| Full Name | FL License / Registration Type |
| Position / Title | FL License / Registration Number |
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| Position / Title | FL License / Registration Number |
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**6. Required Disclosure**

**The following disclosures are required:**

1. 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, 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, enclose the following information:

The full legal name of the individual and postion held

Description and explantion of any convictions

1. 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.

1. 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

1. In the past five (5) years, has the applicant or any controlling interest owned any entity that provides health or residential care in Florida or any other state? YES  NO     
     
   If Yes: Has any entity the applicant or controlling interest owned been closed due to financial inability to operate; had a receiver appointed or a license denied, suspended, or revoked; was subject to a moratorium; or had an injunctive proceeding initiated against it: YES  NO
2. Nonimmigrant Aliens - If the applicant or any controlling interests are nonimmigrant aliens according to 8 U.S.C. §1101, then a surety bond of at least $500,000 must be filed, payable to AHCA that guarantees the health care clinic will act in full conformity with all legal requirements for operation (408.8065(2), F.S.).

|  |  |
| --- | --- |
| Are there any nonimmigrant aliens listed as a licensee or controlling interest in this application? | |
| YES - Include documentation of the surety bond with this application | NO |

**7. Provider Fines and Financial Information**

Pursuant to section 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** |
|  |  |  |  |  |  |  |
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**Please attach a copy of the approved repayment plan if applicable.**

**8. Clinic Type and Services**

1. **CLINIC TYPE:** Check only one.

Services are provided at the street address identified in section 1 (fixed location).

Mobile Clinic – a movable or detached self-contained health care unit, such as a vehicle or trailer, within or from which direct health care services are provided [s. 400.9905(6) & 400.991(1) F.S.]

Portable Equipment Provider – a single administrative office from which treatment, services and/or diagnostic testing is provided to individuals in multiple locations [s. 400.9905(7) & 400.991(1) F.S.]

1. **REIMBURSEMENTS:** Received or intends to receive reimbursement from (check all that apply):

Medicare and/or Medicaid – please enter provider numbers in Section 1A, if applicable, or indicate “pending”

Commercial insurance plans (HMO, PPO, EPO, etc.)

Automobile Personal Injury Protection (PIP) Insurance. Refer to subsection 627.736(5)(h), F.S.

Other payor source not listed above

Individuals pay for services by cash, check, credit card or debit card

None apply

1. **DESIGNATIONS:** Check all that apply.

Urgent Care Center – Refer to definition at subsection 395.002(29), F.S.

Pain Management Clinic – Refer to sections 458.3265 and 459.0137, F.S.

For renewal and change applications, list the pain management registration number issued by the Department of Health:

Office Surgery Center – Refer to sections 458.309 and 459.005, F.S.

For renewal and change applications, list the office surgery registration number issued by the Department of Health:

None apply

1. **SERVICES PROVIDED FOR THE CLINIC:** (check all that apply)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Acupuncture |  |  | Hyperbaric Medicine |  |  | Physical Therapy |
|  | Advanced Practice Registered Nursing |  |  | Induced Termination of Pregnancy |  |  | Physician Services (MD/DO, including PA), excluding office surgery |
|  | Athletic Training |  |  | Infusion Therapy |  |  | Physician Services (MD/DO, including PA), including office surgery |
|  | Audiology |  |  | Mammography |  |  | Podiatry |
|  | Behavior Analysis |  |  | Massage Therapy |  |  | Psychology |
|  | Cardiac Catheterization Laboratory |  |  | Medication Therapy Management/  Pharmaceutical Counseling |  |  | Radiation Therapy |
|  | Chemotherapy |  |  | Mental Health, Counseling & Clinical Social Work Services |  |  | Renal Dialysis |
|  | Chiropractic Medicine |  |  | Naturopathy |  |  | Research/Clinical Trials |
|  | Clinical Laboratory |  |  | Nuclear Medicine |  |  | Respiratory Care |
|  | Dentistry |  |  | Nursing Services (RN, LPN, CNA) |  |  | Sleep Disorders/Studies |
|  | Diagnostic Imaging including MRI (Magnetic Resonance Imaging) |  |  | Obstetrics/Midwifery |  |  | Speech Therapy |
|  | Diagnostic Imaging excluding MRI (Magnetic Resonance Imaging) |  |  | Occupational Therapy |  |  | Sports Medicine |
|  | Dietetic/Nutrition Services/Weight Loss |  |  | Optometry |  |  | Substance/Alcohol Abuse Treatment |
|  | Electrolysis |  |  | Orthotics/Prosthetics/Pedorthics |  |  | Other: |
|  | Hearing Aid Dispensing |  |  | Pharmacy |  |  | Other: |

**9. Accreditation for MRI**

A clinic that provides magnetic resonance imaging services must provide evidence of accreditation by a nationally recognized accrediting organization that is approved by the Centers for Medicare and Medicaid Services (CMS) for magnetic resonance imaging and advanced diagnostic imaging services [refer to s. 400.9935 (7)(a), F.S.]. Mark the accrediting organization for the health care clinic named in this application and attach proof of accreditation:

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | American College of Radiology (ACR) |  |  | InterSocietal Accreditation Commission (IAC) |  |  | Joint Commission (JC) |  |  | RadSite |

**10. 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** |
| Monday |  |  |  |
| Tuesday |  |  |  |
| Wednesday |  |  |  |
| Thursday |  |  |  |
| Friday |  |  |  |
| Saturday |  |  |  |
| Sunday |  |  |  |

**11. Supporting Documents**

Applicants must include the following attachments as stated in Chapter 408, Part II, F.S. and Chapters 59A-35 and 59A-33, 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 of Ownership, and Personnel Changes application types |
| Proof of Financial Ability to Operate (AHCA Form 3100-0009) | Initial and Change of Ownership application types |
| Surety Bond, if required per section 408.8065, F.S. | Initial, Renewal, Change of Ownership, and Personnel Changes application types |
| Medical/Clinic Director Attestation, AHCA Form 3110-1028 | Initial, Renewal, Change of Ownership, and Change of Medical/Clinic Director application types |
| Medical/Clinic Director’s contract or agreement wit the clinic including the effective date of service | Initial, Change of Ownership, and change of Medical/Clinic Director application types |
| Copy of the Medical/Clinic Director’s Florida health care practitioner’s license and any other specialty certifications necessary for supervision of services provided | Initial, Change of Ownership, and change of Medical/Clinic Director application types |
| Documentation of change of ownership transaction stating effective date and executed by all parties | CHOW application type |
| Proof of new or continued MRI accreditation, or letter of intent to achieve MRI accreditation within 12 month (MRI providers only) | Initial, Renewal, Change of Ownership, adding Clinic Services application types |
| 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 |

**12. Attestation**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 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

**INSURANCE FRAUD NOTICE.—**A person who knowingly submits a false, misleading, or fraudulent application or other document when applying for licensure as a health care clinic, seeking an exemption from licensure as a health care clinic, or demonstrating compliance with Part X of Chapter 400, Florida Statutes, with the intent to use the license, exemption from licensure, or demonstration of compliance to provide services or seek reimbursement under the Florida Motor Vehicle No-Fault Law, commits a fraudulent insurance act, as defined in s. 626.989, Florida Statutes. A person who presents a claim for personal injury protection benefits knowing that the payee knowingly submitted such health care clinic application or document, commits insurance fraud, as defined in s. 817.234, Florida Statutes.

**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 53

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 or Email: hospitals@ahca.myflorida.com

***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