**AHCA USE ONLY:**

File #: _____
Application #: _____
Check #: _____
Check Amt: _____
Batch #: _____

# Health Care Licensing Application
# Hospital

The Agency for Health Care Administration (AHCA) has implemented the **ONLINE LICENSING SYSTEM,** which allows the electronic submission of initial, renewal, and change during licensure period applications and fees, along with the ability to upload supporting documentation. To submit online please go to: https://ahca.myflorida.com/health-care-policy-and-oversight/online-licensure-information/online-licensing-system

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 The application will be withdrawn from review if all the required documents and fees are not included with your application or received within 21 days of an omission notice.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 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.** Please fill in all blanks or mark N/A if not applicable.

Under the authority of Chapters 408 Part II, and 395 Florida Statutes (F.S.), and Chapters 59A-35, and 59A-3, Florida Administrative Code (F.A.C.), an application is hereby made to operate a hospital as indicated below:

## 1. Provider / Licensee Information

**A. PROVIDER INFORMATION –** Please complete the following for the hospital name and location. Provider name, address and telephone number will be listed on https://quality.healthfinder.fl.gov/index.html.

| License Number (if applicable) | National Provider Identifier (NPI) | Florida Medicaid Number (if applicable) |
|---|---|---|
| Name of Hospital (if operated under a fictitious name, enter as it is filed with the Florida Division of Corporations) | | |
| Street Address | | |
| City | State | Zip |
| Telephone Number | County | |
| E-mail Address | **Note**: By providing your e-mail address you agree to accept e-mail correspondence from the Agency | |
| Provider Home Website | | |
| Provider Transparency Website in accordance with section 395.301, F.S. | | |
| Mailing Address or ☐ Same as above | | |
| City | County | State / Zip |
| Telephone Number | Email Address | |

**B. PROPERTY OWNER INFORMATION –** Complete the following for the owner of the property if different from the licensee.

Does an individual or entity other than the licensee own the property where the principal office is located?

If ☐ NO, skip to **Section 1.C. – Contact Person**

If ☐ YES, please provide the following information:

| Full Name of Property Owner | |
|---|---|
| ☐ Owned ☐ Leased | Telephone Number |
| Primary Address | Effective Date |

| C. **CONTACT PERSON -** Please complete the following for the contact person for this application. | |
|---|---|
| Contact Person for this application | Contact Telephone Number |
| 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. |

| D. **LICENSEE INFORMATION** –Please complete the following for the entity seeking to operate the hospital. | | |
|---|---|---|
| Licensee Name (This is the owner of the hospital) | | Federal Employer Identification Number (EIN) |
| Mailing Address or ☐ Same as above | | |
| City | State | Zip |
| Telephone 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 | | |

## 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 section 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 hospital? YES ☐ NO ☐

If YES, please provide the name of the agency (if different), the EIN # and the date the prior license expired or closed:

| NAME: | EIN # | Date Expired/Closed: |
|---|---|---|
| | | |

☐ Renewal licensure

☐ Change of Ownership **Proposed Effective Date**: _____

- ☐ Licensee sale or transfer of ownership to a different individual/entity
- ☐ Transfer or assignment of 51% or more ownership, shares, membership, or controlling interest of the licensee

The hospital will ☐ keep the existing license number or ☐ use license number _____ pursuant to section 395.003(2), F.S.

☐ Change During Licensure Period (check all that apply): **Proposed Effective Date**: _____

Fee Required

- ☐ Provider Name
- Provider Address:
  - ☐ Hospital Address
  - ☐ Additional Addresses ☐ Add ☐ Delete
- ☐ Expiration Date pursuant to section 408.806(9), F.S.
- Services/Qualifications:
  - ☐ Licensed Programs ☐ Add ☐ Delete
  - ☐ Emergency Services ☐ Add ☐ Delete ☐ Exemption Request
  - ☐ Trauma Center Designation ☐ Add ☐ Delete
- Beds/Capacity: ☐ Increase ☐ Decrease ☐ Bed Type Conversion ☐ Classification Change

No Fee Required

- ☐ Personnel
- ☐ Management Company
- ☐ Baker Act Receiving Facility Designation
  - ☐ Add ☐ Delete
- ☐ Transfer or assignment of less than 51% ownership. shares, membership, or controlling interest of the licensee
- ☐ Teaching Hospital Designation ☐ Add ☐ Delete

**B. LICENSURE FEES**

| ACTION | FEE | TOTAL FEES |
|---|---|---|
| License Fee (Initial, Renewal and Change of Ownership) | $31.46 per bed x _____ number of beds = (minimum of $1,565.13) | $ |
| Initial licensure Survey Fee (Initial applications only) | $12.00 per bed x _____ number of beds = (minimum of $400.00) | $ |
| Increase in Total Number of Licensed Beds | $31.46 per bed x _____ number of new beds = | $ |
| Biennial Assessment (Initial, Renewal and Change of Ownership)<br>Pursuant to section 408.033(2)(b)3., F.S., hospitals operated by the Department of Children and Family Services, the Department of Health, the Department of Corrections or any hospital that meets the definition of a rural hospital pursuant to section 395.602, F.S., are exempted from the health care facility assessment. | $4.00 per bed x _____ number of beds = (maximum of $1,000.00) | $ |
| Change During Licensure Period | $ 25.00 | $ |
| Other: _____ | | $ |
| **TOTAL FEES INCLUDED WITH APPLICATION** | | **$** |
| **Please make check or money order payable to the Agency for Health Care Administration (AHCA)** | | |

# 3. Controlling Interests of Licensee

**AUTHORITY:**
Pursuant to sections 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.**

**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.

**Note:** For each controlling interest an AHCA screening through the Care Provider Background Screening Clearinghouse is needed or 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 Background Screening (myflorida.com).

**INSTRUCTIONS: Attach additional application pages if needed.**
For new individual – complete all fields except the End Date.
For existing individuals – complete all fields except the Effective and End Date.
To remove an individual – complete all fields including the End Date.

**A. Individual and/or Entity Ownership of Licensee as listed in Section 1D 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. This excludes Not-for-Profit and publicly held licensees. **Note**: A written explanation will be required if the percentage of ownership interest indicated below does not equal 100%.

| FULL NAME of INDIVIDUAL or ENTITY | PERSONAL/PRIMARY ADDRESS | TELEPHONE NUMBER | EIN (No SSN) | % OWNERSHIP | EFFECTIVE DATE | END DATE |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

**B. Board Members and Officers of Licensee as listed in Section 1D above** – 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** | | | | | |

## 4. Management Company Control

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

If ☐ NO, **skip to Section 6 Personnel**

If ☐ YES, provide the following information:

| | | | |
|---|---|---|---|
| Name of Management Company | EIN (No SSN) | Telephone Number | |
| 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 | |

## 5. Management Company Controlling Interest

**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.

**Note:** For each controlling interest an AHCA screening through the Care Provider Background Screening Clearinghouse is needed or 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 Background Screening (myflorida.com).

**INSTRUCTIONS: Attach additional application pages if needed.**
For new individual – complete all fields except the End Date.
For existing individuals – complete all fields except the Effective and End Date.
To remove an individual – complete all fields including the End Date.

**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 SSN) | % 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** | | | | | |

## 6. Personnel

**A. Please provide information for the individual(s) who perform the following roles. Note:** For the administrator and financial officer, an AHCA screening through the Care Provider Background Screening Clearinghouse is needed or 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 Background Screening (myflorida.com).

**INSTRUCTIONS: Attach additional application pages if needed.**
For new individual – complete all fields except the End Date.
For existing individuals – complete all fields except the Effective and End Date.
To remove an individual – complete all fields including the End Date.

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

**B. Safety Liaison –** Provide the requested information for the individual who will serve as primary contact during emergency operations pursuant to section 408.821, F.S.

| INFORMATION | SAFETY LIAISON |
|---|---|
| **Full Name** | |
| **Effective Date** | |
| **End Date** | |
| **Telephone Number** | |
| **Email Address** | |
| **Personal/Primary Address** | |

# 7. 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, 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.

**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 5 years and the termination occurred at least 20 years before the date of the application. YES ☐ NO ☐

# 8. 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 |
| | ☐ | | | | ☐ | ☐ |
| | ☐ | | | | ☐ | ☐ |
| | ☐ | | | | ☐ | ☐ |

**Please attach a copy of the approved repayment plan if applicable.**

## 9. Federal Certification

**Does the provider participate in or intend to participate in the:**

Medicaid program? YES ☐ NO ☐

Medicare program? YES ☐ NO ☐

**If you plan to participate in Medicaid:**

Visit the Agency's website at: https://ahca.myflorida.com/medicaid to obtain information and an application for enrollment in Medicaid.

**If you plan to participate in Medicare:**

The Medicare Provider Application (CMS Form 855) is available from the Medicare Administrative Contractor or on the Centers for Medicare and Medicaid Services (CMS) website at: https://www.cms.gov/medicare/cms-forms/cms-forms?redirect=/cmsforms/. The form must be sent directly to the chosen Medicare Administrative Contractor for review.
For initial Medicare enrollment and change of ownership, the applicant must submit a completed CMS Form 1561, confirmation of submission of the documents required by the Office of Civil Rights, and the information collected on the Hospital/CAH Database Worksheet to AHCA.

## 10. Bed Capacity

**Note for bed change applications:** A letter of approval or other documents as appropriate from the Agency for Health Care Administration's Office of Plans and Construction will be required **before** a bed change can be approved. In addition, successful completion of a life safety survey may be required.

| HOSPITAL BED UTILIZATION | CURRENT BED COUNT | INCREASE | DECREASE | FINAL BED COUNT |
|---|---|---|---|---|
| Acute Care | | | | |
| Skilled Nursing Unit | | | | |
| Comprehensive Medical Rehabilitation | | | | |
| Adult Psychiatric | | | | |
| Child Psychiatric | | | | |
| Adult Substance Abuse | | | | |
| Child Substance Abuse | | | | |
| Neonatal Intensive Care Unit | | | | |
| Intensive Residential Treatment Facility | | | | |
| Long Term Care | | | | |
| **TOTAL BED CAPACITY:** | | | | |

## 11. Classification and Teaching Hospital Designation

**Please provide the following information:**

**A. Classification:** Is this a change from the current classification? ☐ Yes ☐ No

**Class I Hospital**

- ☐ General Acute Care Hospital
- ☐ Long Term Care Hospital
- ☐ Rural Hospital (☐ Critical Access Hospital)

**Class II Specialty Hospital**

- ☐ Specialty Hospital for Children
- ☐ Specialty Hospital for Women

**Class III Specialty Hospital**

- ☐ Specialty Medical Hospital
- ☐ Specialty Rehabilitation Hospital
- ☐ Specialty Psychiatric Hospital
- ☐ Specialty Substance Abuse Hospital

**Class IV Specialty Hospital**

- ☐ Intensive Residential Treatment Facility

**Class V Specialty Hospital**

- ☐ Rural Emergency Hospital

**B. Teaching Hospital Designation**

☐ **The Hospital is not designated as a teaching hospital.** Skip to section 12 Licensed Programs.

By marking one or more of the following boxes, the authorized representative submitting this application attests that the hospital met and continues to meet the requirements as provided in the referenced statutes.

☐ **Statutory Teaching Hospital per s. 408.07, F.S.**

☐ The hospital is currently designated as a Statutory Teaching Hospital by the Secretary of the Agency.

For initial designation, submit a petition to the Secretary of the Agency as described in rule 59A-3.066(10), F.A.C.

☐ **Behavioral Health Teaching Hospital per Chapter 395, Part VI, F.S.**

☐ The hospital is currently designated as a Behavioral Health Teaching Hospital.

☐ Initial designation on or after July 1, 2025, the hospital must be designated as a Statutory Teaching Hospital and attach documentation verifying the requirements of (b) through (e) of s. 395.902(2), F.S. are met.

☐ Accredited psychiatric residency program.

☐ Accredited postdoctoral clinical psychology fellowship program.

☐ Provides services for behavioral health as defined at s. 395.902(1)(b), F.S.

☐ Established and maintains an affiliation with a university in this state with one of the accredited Florida-based medical schools listed under s. 458.3145(1)(i)1.-6., 8., or 10., to create and maintain integrated workforce development programs for students of the university's colleges or schools of medicine, nursing, psychology, social work, or public health related to the entire continuum of behavioral health care, including, at a minimum, screening, therapeutic and supportive services, community outpatient care, crisis stabilization, short-term residential treatment, and long-term care. NOTE: For purposes of this designation, the medical schools identified above may affiliate with only one hospital.

☐ A plan to create and maintain integrated workforce development programs with the affiliated university's colleges or schools and to supervise clinical care provided by students participating in such programs.

☐ **Family Practice Teaching Hospital per Chapter 395, Part V, F.S.**

☐ The hospital is currently designated as a Family Practice Teaching Hospital.

☐ Initial designation, the hospital must attach documentation verifying compliance with s. 395.806, F.S.

_____ Number of approved family practice resident slots.

_____ Number of filled family practice resident slots.

_____ Percent of approved family practice resident slots filled.

_____ Number of approved resident slots in other programs.

_____ Percent of filled family practice resident slots to filled slots of other programs.

# 12. Licensed Programs

**A. Burn Unit.** Each hospital operating a burn unit must maintain compliance with the rules adopted by the Agency that establish licensure standards governing burn units.

Please select one option below:

☐ The Hospital does not operate a Burn Unit.

☐ Verified Burn Unit. The hospital has been verified by the American Burn Association (ABA) for adherence to the ABA Verification Criteria. Attach a copy of the current verification certificate from the American Burn Association.

☐ Provisional Burn Unit. The hospital is in partial compliance with the ABA Verification Criteria but has not received verification from the American Burn Association. Burn unit services will begin/began on _____.

**B. Stroke Centers.** Each hospital listed as a stroke center by the Agency must be certified as a stroke center by a nationally recognized accrediting organization. The following accrediting organizations are recognized by the Agency as offering stroke center certifications: Center for Improvement in Healthcare Quality; DNV GL Healthcare; Healthcare Facilities Accreditation Program; and The Joint Commission. Attach a copy of the current stroke center certificate.

Please select only one option below:

☐ The Hospital is not a Stroke Center

By marking one of the following boxes, the authorized representative submitting this application attests that the hospital is certified as the selected Stroke Center by a nationally recognized accrediting organization.

☐ The hospital is certified as an acute stroke ready center by a nationally recognized accrediting organization.

☐ The hospital is certified as a primary stroke center by a nationally recognized accrediting organization.

☐ The hospital is certified as a thrombectomy-capable stroke center by a nationally recognized accrediting organization.

☐ The hospital is certified as a comprehensive stroke center by a nationally recognized accrediting organization.

**C. Adult Cardiovascular Services.** Each hospital providing adult cardiovascular services must maintain compliance with the rules adopted by the Agency that establish licensure standards governing adult cardiovascular services.

Please select only one option below:

☐ The Hospital does not provide Adult Cardiovascular Services

By selecting one of the following options, the authorized representative submitting this application attests the hospital meets the criteria specified in rule, including compliance with the incorporated national guidelines, minimum volume requirements, physical plant requirements, transfer agreements and transfer times, data reporting as applicable to the level of service, and the hospital has a formalized plan to provide adult cardiovascular services to Medicaid and charity care patients.

☐ **Adult Inpatient Diagnostic Cardiac Catheterization Services as specified in Rule 59A-3.246(1), F.A.C.**

☐ **Level I Adult Cardiovascular Services as specified in Rule 59A-3.246(2), F.A.C.**

For initial designation, complete one of the following for the most recent 12-month period begin date _____ and end date _____:

1. _____ Number of adult inpatient diagnostic cardiac catheterizations and _____ number of adult outpatient diagnostic cardiac catheterization sessions, or

2. _____ Number of patient discharges and transfers of patients with the principal diagnosis of ischemic heart disease.

For continuation of services, provide a list of national registries in which the hospital participates and documentation of meeting or exceeding benchmarks reported by the registry as specified in section 395.1055(18)(g), F.S.

☐ **Level II Adult Cardiovascular Services as specified in Rule 59A-3.246(3), F.A.C**

For initial designation, complete one of the following for the most recent 12-month period begin date _____ and end date _____:

1. _____ Total number of adult inpatient and outpatient cardiac catheterizations and _____ Number of therapeutic cardiac catheterizations, or

2. _____ Number of patient discharges with the principal diagnosis of ischemic heart disease.

For continuation of services, provide a list of national registries in which the hospital participates and documentation of meeting or exceeding benchmarks reported by the registry as specified in section 395.1055(18)(g), F.S.

**D. Transplant Services.**

Please select only one option below:

☐ The Hospital does not provide Transplant Services.

☐ The hospital provides the following Transplant Services. Initial designation requires submission of the supplemental information listed at https://ahca.myflorida.com/health-care-policy-and-oversight/bureau-of-health-facility-regulation/hospital-outpatient-services-unit/hospitals. Except for bone marrow programs, initial designation also requires evidence of application for Medicare certification as described in Title 42 CFR Part 482 Subpart E (§ 482.68 - § 482.104) for the comparable Medicare transplant program. By entering a transplant service program for initial designation, the authorized representative submitting this application attests the hospital will be eligible for an initial Medicare certification survey within one year from initial licensure of each transplant program.

Mark the services applied for and/or provided:

**Instructions:**

To add a new transplant program, check 'Add' for the appropriate program and age group.
For existing transplant program, check 'Continue' for the appropriate program and age group.
For closed transplant program, check 'Remove' for the appropriate program and age group to remove the program from the license.

| TRANSPLANT PROGRAM | ADULT | | | PEDIATRIC | | |
|---|---|---|---|---|---|---|
| | Add | Continue | Remove | Add | Continue | Remove |
| Heart | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Intestines | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Kidney | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Liver | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Lung | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Pancreas and Islet Cells | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Bone Marrow | | | | | | |
| Autologous | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Allogeneic | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**E. Neonatal Intensive Care Services.** Each hospital providing neonatal intensive care services must maintain compliance with the rules adopted by the Agency that establish licensure standards governing neonatal intensive care services.

Please select only one option below.

By selecting Level II, Level III, or Level IV Neonatal Intensive Care Services, the authorized representative submitting this application attests the hospital meets the standards specified in Rule 59A-3.249, F.A.C. for the level of service indicated, including emergency transportation, transfer agreements, qualified medical director, qualified neonatal nursing and respiratory care personnel, pediatric medical subspecialties available onsite or via telemedicine as applicable per level of service , onsite pediatric medical and surgical services, as applicable per level of service, and neonatal beds with the specified equipment available.

Mark the highest level of service applied for or provided.

☐ The hospital does not provide Neonatal Intensive Care Services , or all current services will cease on the effective date provided in section 2 of this application.

☐ The hospital provides Level II Neonatal Intensive Care Services only.

☐ The hospital provides Level III Neonatal Intensive Care Services.

☐ The hospital provides Level IV Neonatal Intensive Care Services.

## 13. Accreditation

The applicant participates with one or more of the accrediting organizations below or ☐ Not accredited.

| ACCREDITING ORGANIZATION | | ACCREDITATION ID | FEDERALLY DEEMED | EFFECTIVE DATE | EXPIRATION DATE | SURVEY END DATE |
|---|---|---|---|---|---|---|
| ☐ | Center for Improvement in Healthcare Qualify (CIHQ) | | ☐ | | | |
| ☐ | DNV GL Healthcare, Inc | | ☐ | | | |
| ☐ | Accreditation Commission for Health Care (ACHC) | | ☐ | | | |
| ☐ | The Joint Commission (JC) | | ☐ | | | |
| ☐ | Commission on Accreditation of Rehabilitation Facilities (CARF) For Class IV hospitals only | | | | | |

**Note**: If accredited, provide a copy of the full accreditation survey, award letter and any follow up letters to or from the accrediting organization.

☐ I understand that the complete accreditation report must be submitted to the Agency for review if the accreditation report is to be accepted in lieu of a complete licensure inspection and such reports used to meet licensure requirements are considered public documents subject to disclosure per Chapter 119, F.S. A complete accreditation report includes correspondence from the accrediting organization containing the dates of the survey, any citations to which the accreditation organization requires a response, the facility's response.

## 14. Clinical Laboratory and Radiology Services

Pursuant to sections 395.009 and 395.0091, F.S. minimum standards are required for clinical laboratory test results and diagnostic X-ray results as a prerequisite for issuance or renewal of a license.

Mark the following boxes as appropriate.

☐ Minimum standards are established for acceptance of results of diagnostic X rays performed by or for the hospital. These standards require licensure or registration of the source of ionizing radiation under the provisions of Chapter 404, F.S..

☐ All clinical laboratory tests performed by or for the hospital are performed by a clinical laboratory appropriately certified by the Centers for Medicare and Medicaid Services under the federal Clinical Laboratory Improvement Amendments and the federal rules adopted thereunder.

- ☐ Alternate-site testing is performed within the hospital premises. The tests performed at each location are listed on the attached AHCA Form 3130-8013.
- ☐ Alternate-site testing is not performed within the hospital premises.

## 15. Additional Addresses

**A. OFFSITE OUTPATIENT FACILITY.** Provide the following information regarding the non-emergency, non-surgical offsite outpatient facilities, excluding urgent care centers. Attach additional sheets if necessary. For new locations, attach proof of ownership/right to occupy and proof of compliance with local zoning requirements. **Note:** Approval from the Agency's Office of Plans and Construction or verification of exemption from project review pursuant to section 395.0163(1)(b), F.S. must be received **before** a new address is added to the license.

| NAME | STREET ADDRESS | CITY | ZIP | PHONE # | DATE | |
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**B. URGENT CARE CENTER.** Provide the following information regarding outpatient locations meeting the definition of urgent care center in section 395.002, F.S. Attach additional sheets if necessary. For new locations, attach proof of ownership/right to occupy and proof of compliance with local zoning requirements. **Note:** Approval from the Agency's Office of Plans and Construction or verification of exemption from project review pursuant to section 395.0163(1)(b), F.S. must be received **before** a new address is added to the license.

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**C. SURGICAL OUTPATIENT CENTER**. Provide the following information regarding non-emergency outpatient facilities providing surgical treatments requiring general anesthesia or IV conscious sedation or cardiac catheterization services. Attach additional sheets if necessary. For new locations, attach proof of ownership/right to occupy and proof of compliance with local zoning requirements. **Note:** Approval must be granted from the Agency for Health Care Administration's Plans and Construction **before** a new location can be approved.

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**D. HOSPITAL-BASED OFF-CAMPUS EMERGENCY DEPARTMENT.** Provide the following information regarding hospital-based off-campus emergency departments. Emergency services offered offsite must be available 24 hours per day, 7 days per week offering the same services as the emergency department located on the hospital premises. In addition, please complete section 15 **Hospital Emergency Services** of this application. Attach additional sheets if necessary. For new locations, attach proof of ownership/right to occupy and proof of compliance with local zoning requirements. **Note:** Approval must be granted from the Agency for Health Care Administration's Office of Plans and Construction **before** a new location can be approved.

| NAME | STREET ADDRESS | CITY | ZIP | PHONE # | DATE | |
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# 16. Hospital Emergency Services

**Please indicate the emergency services provided. Mark the appropriate box for each service.**

☐ No dedicated emergency department.

☐ Emergency services are offered via an emergency department located within the hospital and/or off site if indicated in section 15D of this application.
Effective July 1, 2025: Attach the hospital's nonemergency care access plan (NCAP) per section 395.1055(1)(j), F.S.

☐ Hospital has an Emergency 2 Way Radio System pursuant to section 395.1031, F.S.

☐ Request for emergency service exemption per section 395.1041(3)(d)3, F.S. Attach AHCA Form 3000-1.

☐ Baker Act Receiving Facility designation from the Department of Children and Families. Attach certificate.

☐ Trauma Center designation issued from the Department of Health, Office of Trauma, if applicable. Indicate level:

☐ Provisional Level 1 ☐ Provisional Level 2 ☐ Provisional Pediatric
☐ Level 1 ☐ Level 2 ☐ Pediatric

Dedicated emergency department. Mark the below boxes as appropriate.

| SERVICE | NOT PROVIDED | PROVIDED ON SITE 24 HOURS PER DAY, 7 DAYS PER WEEK | PROVIDED THROUGH A COMBINATION OF ONSITE AND TRANSFER AGREEMENT(S) WITH ANOTHER HOSPITAL(S) 24 HOURS PER DAY, 7 DAYS PER WEEK | PROVIDED THROUGH TRANSFER AGREEMENT WITH ANOTHER HOSPITAL(S) | PROVIDED ON A LIMITED BASIS BY EXEMPTION OR PARTIAL EXEMPTION |
|---|---|---|---|---|---|
| Anesthesia | ☐ | ☐ | ☐ | ☐ | ☐ |
| Burns | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cardiology | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cardiovascular Surgery | ☐ | ☐ | ☐ | ☐ | ☐ |
| Colon/Rectal Surgery | ☐ | ☐ | ☐ | ☐ | ☐ |
| Emergency Medicine | ☐ | ☐ | ☐ | ☐ | ☐ |
| Endocrinology | ☐ | ☐ | ☐ | ☐ | ☐ |
| Gastroenterology | ☐ | ☐ | ☐ | ☐ | ☐ |
| General Surgery | ☐ | ☐ | ☐ | ☐ | ☐ |
| Gynecology | ☐ | ☐ | ☐ | ☐ | ☐ |
| Hematology | ☐ | ☐ | ☐ | ☐ | ☐ |
| Hyperbaric Medicine | ☐ | ☐ | ☐ | ☐ | ☐ |
| Internal Medicine | ☐ | ☐ | ☐ | ☐ | ☐ |
| Nephrology | ☐ | ☐ | ☐ | ☐ | ☐ |
| Neurology | ☐ | ☐ | ☐ | ☐ | ☐ |
| Neurosurgery | ☐ | ☐ | ☐ | ☐ | ☐ |
| Obstetrics | ☐ | ☐ | ☐ | ☐ | ☐ |
| Ophthalmology | ☐ | ☐ | ☐ | ☐ | ☐ |
| Oral/Maxillofacial Surgery | ☐ | ☐ | ☐ | ☐ | ☐ |
| Orthopedics | ☐ | ☐ | ☐ | ☐ | ☐ |
| Otolaryngology | ☐ | ☐ | ☐ | ☐ | ☐ |
| Plastic Surgery | ☐ | ☐ | ☐ | ☐ | ☐ |
| Podiatry | ☐ | ☐ | ☐ | ☐ | ☐ |
| Psychiatry | ☐ | ☐ | ☐ | ☐ | ☐ |
| Pulmonary Medicine | ☐ | ☐ | ☐ | ☐ | ☐ |
| Radiology | ☐ | ☐ | ☐ | ☐ | ☐ |
| Thoracic Surgery | ☐ | ☐ | ☐ | ☐ | ☐ |
| Urology | ☐ | ☐ | ☐ | ☐ | ☐ |
| Vascular Surgery | ☐ | ☐ | ☐ | ☐ | ☐ |

## 17. Professional Liability Coverage

**AUTHORITY:** Pursuant to section 395.1061(2), F.S., Each hospital, unless exempted under paragraph (3)(b), must demonstrate financial responsibility for maintaining professional liability coverage to pay claims and costs ancillary thereto arising out of the rendering of or failure to render medical care or services and for bodily injury or property damage to the person or property of any patient arising out of the activities of the hospital or arising out of the activities of covered individuals, to the satisfaction of the Agency for Health Care Administration.

Please complete the applicable section of this form and return it with the appropriate documentation. ***Please be advised – a policy binder is not sufficient proof of coverage.***

☐ An escrow account in an amount equivalent to $10,000 per claim for each hospital bed, not to exceed a $2,500,000 annual aggregate.

☐ Professional liability coverage in an amount equivalent to $10,000 or more per claim for each hospital bed, from a private insurer, the Joint Underwriting Association established under section 627.351(4); or through a plan of self-insurance as provided in section 627.357, F.S., not to exceed a $2,500,000 annual aggregate. Include proof of funding any self-insurance retention.

☐ Exempt under section 395.1061(3)(b), F.S. State Agencies, subdivisions or instrumentalities of the state. No additional documentation necessary if previously documented.

## 18. Supporting Documents

Applicants must include the following attachments as stated in Chapter 408, Part II and Chapter 395, F.S. and Chapters 59A-35 and 59A-3 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: |
|---|---|
| Proof of accreditation documentation and survey report, if applicable. For change of ownership, proof of continued accreditation under new ownership. | Renewal and Change of Ownership application types |
| Health Care Licensing Application Addendum, AHCA Form 3110-1024 | Initial, Renewal, Change of Ownership, Change of Personnel and Controlling Interest application types |
| Documentation signed by the appropriate local government official, which states that the applicant has met local zoning requirements | Initial, Addition of Offsite Location, and Address Change application types |
| Proof of legal right to occupy property may include but not limited to, copies of warranty deeds, lease or rental agreements, contracts for deeds, quitclaim deeds, or other such documentation | Initial, Change of Ownership, Address Change, and Addition of Offsite Location application types |
| Baker Act Receiving Facility certificate, if applicable. | Initial and Change During Licensure application types |
| List of the cardiovascular registries in which the hospital participates and documentation of meeting or exceeding benchmarks reported by the registry, if applicable | Renewal, Change of Adult Cardiovascular Services |
| Emergency Service Exemption Application, AHCA Form 3000-1, if applicable | Request for Emergency Service Exemption application type |
| Documentation of compliance with professional liability coverage as provided under section 395.1061, F.S. (Escrow, Professional Liability or self-insurance) | Initial, Renewal, Change of Ownership and Bed Addition application types |
| License Application Alternate-Site Testing, AHCA Form 3130-8013, if applicable | All application types |
| Current Stroke Center Certificate | Renewal, Change of Ownership and Change of Licensed Programs application types |
| Copy of Comprehensive Emergency Management Plan (CEMP) Approval Letter or Documentation of the CEMP submission for review within the last 365 days | Renewal application type |
| 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 |
| Approved repayment plan, if applicable | All application types |
| Effective July 1, 2025, nonemergency care access plan (NCAP) per 395.1055(1)(j), F.S. | Initial, Renewal, and Change of Ownership application types |
| Behavioral Health Teaching hospital designation criteria | Renewal, Change of Ownership, and Change of Services/Qualifications |
| Rural Emergency Hospital action plan and attestation | Change to Class V Specialty Hospital |

## 19. 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.

(6) Pursuant to section 408.810(12), Florida Statutes, the licensee ensures that no person holds any ownership interests, either directly or indirectly, regardless of ownership structure, who has a disqualifying offense pursuant to section 408.809, Florida Statutes or in a provider that had a license revoked or application denied pursuant to section 408.815, Florida Statutes.

(7) Pursuant to sections 408.810(14) and 408.051(3), FS, the licensee ensures that all patient information stored in an offsite physical or virtual environment, including through a third-party or subcontracted computing facility or an entity providing cloud computing services, is physically maintained in the continental United States or its territories or Canada.

(8) Pursuant to section 408.810(15), FS, the licensee ensures that controlling interests of the licensee do not hold, either directly or indirectly, regardless of ownership structure, an interest in an entity that has a business relationship with a foreign country of concern or that is subject to section 287.135, FS.

☐ This hospital offers birthing services and is in compliance with section 382.013(2)(c), Florida Statutes regarding assistance to unmarried parents who wish to execute a voluntary acknowledgement of paternity.

☐ This hospital does not offer birthing services and section 395.003(5)(c), Florida Statutes is not applicable to this application.

| Signature of Licensee or Authorized Representative | 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 TO:**

AGENCY FOR HEALTH CARE ADMINISTRATION
HOSPITAL AND OUTPATIENT SERVICES UNIT
2727 MAHAN DR., MS 31
TALLAHASSEE FL 32308-5407

**Questions?** Visit the Agency's website : https://ahca.myflorida.com/ or contact the Hospital and 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
- Do not fold any of the documents being submitted
- No staples, paperclips, binder clips, folders, or notebooks
- Please **do not bind any** of the documents submitted to the Agency.