AHCA USE ONLY:
File #:
Application #:
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Health Care Licensing Application
Ambulatory Surgical Center

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

Applications must be received **at least 60 days prior to** the expiration of the current license or effective date of a change of ownership to avoid a late fee. If the renewal application is received by the Agency less than 60 days prior to the expiration date, it is subject to a late fee as set forth in statute. The applicant will receive notice of the amount of the late fee as part of the application process or by separate notice. *The application will be withdrawn from review if all the required documents and fees are not included with your application or received within 21 days of an omission notice.* **Applications will not be considered for review until payment has been received. Renewal and Change During Licensure applications: Supporting documentation, responses to omissions and payments may be submitted using the online system even if the application was originally mailed to the Agency.**

Under the authority of Chapters 408 Part II, and 395, Part I, Florida Statutes (F.S.), and Chapters 59A-35 and 59A-5, Florida Administrative Code (F.A.C.), an application is hereby made to operate an ambulatory surgical center as indicated below:

1. Provider / Licensee Information

A. PROVIDER INFORMATION – Please complete the following for the ambulatory surgical center 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)	Florida Medicaid # (if applicable)	
Name of Ambulatory Surgical Center (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	State	Zip
Telephone Number	E-mail Address	NOTE: By providing your e-mail address, you agree to accept e-mail correspondence from the Agency.	
Provider Home Web Site			
Provider Transparency Web Site in accordance with s. 395.301, F.S.			

B. **LICENSEE INFORMATION** – Please complete the following for the entity seeking to operate the ambulatory surgical center.		
Licensee Name (this is the owner of the ambulatory surgical center)		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** - 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. **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 2 – Application Type and Fees If ☐ YES, please provide the following information:		
Full Name Of Property Owner	Personal/Primary Address	Telephone Number

2. Application Type and Fees

Indicate the type of application with an "X." **Applications will not be processed if not all applicable fees are 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 fine. 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.

☐ Initial licensure Proposed Effective Date: _____

Was this entity previously licensed as an ambulatory surgical center? YES ☐ NO ☐

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

NAME:	EIN #	Year Expired/Closed:

☐ Renewal licensure

☐ Change of Ownership Proposed effective date: _____

☐ Change During Licensure Period- select all that apply: Proposed effective date: _____

Fee Required	No Fee Required
☐ Provider Name	☐ Personnel
☐ Provider Address	☐ Management Company
☐ Beds/Capacity	☐ Change of Controlling Interest less than 51%
☐ Operating rooms	
☐ Procedure rooms	
☐ Recovery beds	
☐ Replacement License	

ACTION	FEE	TOTAL FEES
License Fee (Initial, Renewal and Change of Ownership):	$1,679.82	$
Initial Licensure Inspection Fee (Initial applicants only)	$400.00	$
Biennial Assessment	$300.00	$
Change During Licensure Period/Replacement License	$ 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 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.

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 http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/.

A. **Individual and/or Entity Ownership of Licensee as listed in section 1B above** – Provide the information for each individual or entity (corporation, partnership, association) with 5% or greater ownership interest in the licensee. Attach additional sheets if necessary. Note: This excludes Not-for-Profit and publicly held licensees.

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

B. **Board Members and Officers of Licensee as listed in section 1B above** – Provide the information for each individual that serves as an officer or is on the board of directors. Do not include voluntary board members.

TITLE	FULL NAME	PERSONAL/PRIMARY ADDRESS	TELEPHONE NUMBER	EFFECTIVE DATE	END DATE
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					
Board Member/Officer					

4. Management Company Controlling Interests

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 SSN)	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.

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 http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/.

A. Individual and/or Entity Ownership of Management Company: Provide the information for each individual or entity (corporation, partnership, association) with 5% or greater ownership interest in the management company. Attach additional sheets if necessary.

FULL NAME of INDIVIDUAL or ENTITY	PERSONAL/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					
Board Member/Officer					
Board Member/Officer					

5. 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 http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/.

INFORMATION	ADMINISTRATOR/MANAGING EMPLOYEE	FINANCIAL OFFICER / PERSON RESPONSIBLE FOR FINANCIAL OPERATIONS
Full Name		
Date of Birth		
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 408.821, F.S.

INFORMATION	SAFETY LIAISON
Full Name	
Date of Birth	
Effective Date	
End Date	
Telephone Number	
Email Address	
Personal/Primary Address	

6. Required Disclosure

The following disclosures are required:

A. Pursuant to section 408.809, F.S., the applicant shall submit to the agency a description and explanation of any convictions of offenses prohibited by sections 435.04 and 408.809, 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 of offenses

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 five (5) years and the termination occurred at least twenty (20) years before the date of the application. YES ☐ NO ☐

7. Provider Fines and Financial Informaiton

Pursuant to subsection 408.831(1)(a), F.S., the Agency may take action against the applicant, licensee, or a licensee which shares a common controlling interest with the applicant if they have failed to pay all outstanding fines, liens, or overpayments assessed by final order of the agency or final order of the Centers for Medicare and Medicaid Services (CMS), not subject to further appeal, unless a repayment plan is approved by the agency.

Are there any incidences of outstanding fines, liens or overpayments as described above? YES ☐ NO ☐

If YES, please complete the following for each incidence (attach additional sheets if necessary):

AHCA CASE NUMBER	CMS	ASSESSED AMOUNT	DATE OF RELATED INSPECTION, APPLICATION, OR OVERPAYMENT	PAYMENT DUE DATE	PENDING APPEAL OF FINAL ORDER	
					YES	NO
	☐				☐	☐
	☐				☐	☐
	☐				☐	☐

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

8. 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 http://ahca.myflorida.com/Medicaid/index.shtml in order 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: www.cms.hhs.gov/cmsforms/. The form must be sent directly to the chosen fiscal intermediary for review.

For **initial** Medicare enrollment, the following forms must be attached to the Medicare application:

- ☐ Health Insurance Benfits Agreement (Form CMS-370)
- ☐ Medicare Administrative Contrctor Choice Form
- ☐ Request for Certification in the Medicare Porgram (Form CMS-377)

9. Other Program Specific Information

A. BED CAPACITY

Number of Operating Rooms: _____
Number of Procedure Rooms: _____
Number of Recovery Beds: _____

Note: The number and type must match the determination made by the Agency's Office of Plans and Construction (initial) or the current license. Changes to counts must be verified by evidence of an approved renovation project submitted to the Agency.

B. OTHER SERVICES Please check all that apply:

☐ X-ray provided on the premises or by contract in accordance with Chapter 404, F.S.
☐ Non-Waived Laboratory provided on the premises or by contract in accordance with the federal CLIA requirements:
a. Please provide the applicable CLIA certification numbers(s): 10D- _____;10D- _____;10D- _____
b. Laboratory is ☐ Owned or ☐ Contracted

C. ACCREDITATION The applicant participates in (select accrediting organization below or ☐ Not accredited):

ACCREDITING ORGANIZATION	ACCREDITATION ID	FEDERALLY DEEMED	EFFECTIVE DATE	END DATE	SURVEY END DATE
☐ Accreditation Association for Ambulatory Health Care (AAAHC)		☐			
☐ American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)		☐			
☐ American Osteopathic Association/Healthcare Facilities Accreditation Program (AOA/HFAP)		☐			
☐ Joint Commission (JC)		☐			
☐ Institute for Medical Quality (IMQ)		☐			

NOTE: If accredited, provide a copy of the full accreditation survey, award letter and any follow up letters to or from the accrediting body. Please review s.119, F.S. for additional information.

☐ 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 annual licensure inspections 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 to each citation, the effective date of accreditation and verification of Medicare (CMS) deemed status, if applicable.

D. EMERGENCY SERVICES Please provide the name and address of the hospital(s) providing emergency inpatient care (attach additional sheets if necessary):

NAME OF HOSPITAL	STREET ADDRESS	EFFECTIVE DATE	END DATE

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
☐ Sunday			☐
☐ Monday			☐
☐ Tuesday			☐
☐ Wednesday			☐
☐ Thursday			☐
☐ Friday			☐
☐ Saturday			☐

11. Supporting Documentation

Applicants must include the following attachments as stated in Chapters 408, Part II and 395. Part I, F.S. and Chapters 59A-35 and 59A-5, 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
Accreditation and survey report if applicable	Initial, Renewal and Change of Ownership 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, Renewal, Change of Address and Change of Ownership application types
Health Care Licensing Application Addendum, AHCA Form 3110-1024	Initial, Renewal, Changes During Licensure Period and Change of Ownership application types
Documentation from the appropriate local government office showing that the applicant has met local zoning requirements	Initial and Change of Address application type
Documentation of change of ownership transaction stating effective date and executed by all parties	Change of Ownership application type
Proof of approval by the Agency's Office of Plans & Construction	Initial and Change During Licensure Period
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

NOTICE: If you are a **Medicaid** provider, you may have a separate obligation to notify the Medicaid program of a name/address change, change of ownership or other change of information. Please refer to your Medicaid handbooks for additional information about Medicaid program policy regarding changes to provider enrollment information.

RETURN THIS COMPLETED FORM WITH FEES AND ALL REQUIRED DOCUMENTS TO:

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

Questions? Review the information available at http://ahca.myflorida.com/ or contact the Hospital and Outpatient Services Unit at (850) 412-4549 or E-mail: 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