

Provider:
|

Provider Type:
Birth Center

File#:
License #:
Expires:

Application:
Type: Renewal Licensure
Status:
Application Received Date:

- = Entered
- = Entry Required

Provider/Facility Information ^

Details

Contact Person

Property Ownership

Licensee Information v

Controlling Interests v

Management Company Information v

Personnel v

Required Disclosure v

General Information v

Accreditation v

Days and Hours of Operation v

Supporting Documents v

Finalize Submission v

Health Care Licensing Online
Application
Birth Center
AHCA Form 3130-3001 OL,
January 2022
59A-11, Florida Administrative
Code

Provider/Facility Information

Under the authority of Chapters [408, Part II](#) and [383](#), Florida Statutes (F.S.), and Chapters [59A-35](#) and [59A-11](#), Florida Administrative Code (F.A.C.), an application is hereby made to operate a birth center as indicated below.

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, administrator or similarly titled person who is responsible for the day to day operation of the provider, financial officer or similarly titled person who is responsible for the financial operation of the licensee or provider 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 (AHCA) shall use such information for purposes of securing the proper identification of persons listed on this application for licensure.

Review the information below and make any necessary edits. The Provider/Facility name, address, and telephone number will be listed on Florida Health Finder (<http://www.floridahealthfinder.gov>).

Provider/Facility Information

License # National Provider Identifier

None Pending

Medicaid # Medicare # (CMS CCN)

Name of Birth Center (If operated under a fictitious name, enter as it appears in Florida Division of Corporations.)

Provider/Facility Location Address

Provider Location Address

Telephone Ext Fax #

None

Email Address *Note: By providing your email address, you agree to accept email correspondence from the Agency.*

None

Provider/Facility Website

None

Provider/Facility Mailing Address (All mail will be sent to this address.)

Check if same as Provider/Facility Location Address

Address

1525 EDGEWATER BEACH DR
LAKELAND, FL 33805-4737
US - United States
County - POLK

Telephone Ext Email Address

(863) 680-2229 None BETA5742@BETA.COM

None

Provider:

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Provider/Facility Information

Provider/Facility Contact Person for this Application

First Name	Middle Name	Last Name	Suffix
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Telephone	Ext	Fax #	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
		<input type="checkbox"/> None	

Contact Email Address (By providing your email address, you agree to accept email correspondence from the Agency.)

None

- = Entered
- = Entry Required

Provider/Facility Information ⌵

Details

Contact Person

Property Ownership

Licensee Information ⌵

Controlling Interests ⌵

Management Company Information ⌵

Personnel ⌵

Required Disclosure ⌵

General Information ⌵

Accreditation ⌵

Days and Hours of Operation ⌵

Supporting Documents ⌵

Finalize Submission ⌵

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Property Ownership

Does the licensee own or lease this facility? If leased, you may provide the name of the property owner by following the instructions below.

- Own
 Lease

- = Entered
 = Entry Required

Undo

Save

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Provider/Facility Information ^

Details

Contact Person

Property Ownership

Licensee Information v

Controlling Interests v

Management

Company Information v

Personnel v

Required Disclosure v

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Accreditation v

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Expires:



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Type:
Status:
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Licensee Information

Description of licensee (select only one option below) 

For Profit Not for Profit Public

Ownership Types

-  = Entered
-  = Entry Required

-  **Provider/Facility Information** 
-  **Licensee Information** 
-  **Licensee Details**
-  **Controlling Interests** 
-  **Management Company Information** 
-  **Personnel** 
-  **Required Disclosure** 
-  **General Information** 
-  **Accreditation** 
-  **Days and Hours of Operation** 
-  **Supporting Documents** 
- Finalize Submission** 

Entity Licensee Details

Licensee Name (may be same as provider name)

Federal Employer Identification # (EIN)

Mailing Address

Address

Telephone <input type="text"/>	Ext <input type="text"/>	Fax # <input type="text"/>	Email Address <input type="text"/>
		<input type="checkbox"/> None	<input type="checkbox"/> None

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Application Received Date:

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- = Entry Required

Provider/Facility Information ▾

Licensee Information ▾

Controlling Interests ▲

Controlling Interests

Management Company Information ▾

Personnel ▾

Required Disclosure ▾

General Information ▾

Accreditation ▾

Days and Hours of Operation ▾

Supporting Documents ▾

Finalize Submission ▾

Controlling Interests of Licensee

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 the 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 must be screened, visit the [Background Screening](#) site.

Do any individuals or entities possess 5% or greater ownership interest in the licensee, or, function as a board member or officer?

- Yes No

To **add** a controlling interest - Utilizing the picklist below, either choose an individual/entity that is already associated with this application or select 'New Controlling Interest - Individual' or 'New Controlling Interest - Entity'.

▾

To **edit** an existing controlling interest - Select "Edit/View" and edit as needed.

To **remove** an existing controlling interest - Select "Remove" and enter the date the controlling interest's relationship with the licensee ended.

		Full Name of Individual/Entity	Type	Tax ID	Effective Date	End Date	%
Remove	Edit/View		SSN				
Remove	Edit/View		SSN				

Total 100.00

Removed: Added:

If the percentage of ownership interest indicated above does not equal 100%, please explain why in the space below:

Individual Ownership of Licensee

<input type="button" value="Edit Individual"/>	<i>Board Member/Officer</i>	<input type="checkbox"/>	<i>% Ownership Interest</i>	<input type="text"/>
--	-----------------------------	--------------------------	-----------------------------	----------------------

Owner/Board Member

<i>Effective Date</i>	<input type="text"/>	<input type="button" value="v"/>
<i>End Date</i>	<input type="text"/>	<input type="button" value="v"/>

Personal Mailing Address

Mailing Address

<i>Telephone #</i>	<input type="text" value="() -"/>	<i>Ext</i>	<input type="text"/>
--------------------	------------------------------------	------------	----------------------

Email Address

None

<input type="button" value="Done"/>	<input type="button" value="Cancel"/>
-------------------------------------	---------------------------------------

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- Provider/Facility Information** ⌵
- Licensee Information** ⌵
- Controlling Interests** ⌵
- Management Company Information** ⬆
- Management Company Information
- Management Company Controlling Interest
- Personnel** ⌵
- Required Disclosure** ⌵
- General Information** ⌵
- Accreditation** ⌵
- Days and Hours of Operation** ⌵
- Supporting Documents** ⌵
- Finalize Submission** ⌵

Management Company Information

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

Yes No

To **add** a management company -

Utilizing the picklist below, either select an entity that is already associated with this application or select 'New Management Company'.

Undo

Save

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Management Company Controlling Interest

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Application:
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- = Entered
- = Entry Required

Provider/Facility Information ▾

Licensee Information ▾

Controlling Interests ▾

Management Company Information ▲

Management Company Information

Management Company Controlling Interest

Personnel ▾

Required Disclosure ▾

General Information ▾

Accreditation ▾

Days and Hours of Operation ▾

Supporting Documents ▾

Finalize Submission ▾

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 the 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 must be screened, visit the Background Screening site.

To **add** a controlling interest - Utilizing the picklist below, either choose an individual/entity that is already associated with this application or select 'New Controlling Interest - Individual' or 'New Controlling Interest - Entity' .

▾

Undo

Save

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Individual Ownership of Management Company

Board Member/Officer *% Ownership Interest*

Owner/Board Member

Effective Date *End Date*

Personal Mailing Address

Mailing Address

Telephone # *Ext*

Email Address

None

Provider:

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Birth Center

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Expires:

Application:
Type:
Status:
Application Received Date:

Personnel

Personnel

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 must be screened, visit the [Background Screening](#) site.

Provide the information for the individual(s) who perform the following roles:

- Administrator
- Financial Officer

To **add** an individual - Utilizing the picklist below, either choose an individual that is already associated with this application or select 'New Individual'.

To **edit** an existing individual - Select "Edit/View" and edit as needed.

To **remove** an existing individual - Select "Remove" and enter the date the individual's relationship with the licensee ended.

	Full Name of Individual	Type	Tax ID	Roles	Effective Date	End Date
Remove		SSN		Financial Officer		
Edit/View				Administrator		

Removed: (-) Added: (+)

Undo

Save

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- Provider/Facility Information
- Licensee Information
- Controlling Interests
- Management Company Information
- Personnel
 - Administration
 - Safety Liaison
- Required Disclosure
- General Information
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Personnel

Provider:

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Birth Center

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- = Entered
- = Entry Required

Provider/Facility Information ▾

Licensee Information ▾

Controlling Interests ▾

Management Company Information ▾

Personnel ▲

Administration

Safety Liaison

Required Disclosure ▾

General Information ▾

Accreditation ▾

Days and Hours of Operation ▾

Supporting Documents ▾

Finalize Submission ▾

B. Safety Liaison

Please provide the requested information for the individual who will serve as primary contact during emergency operation pursuant to section 408.821, F.S.

Safety Liaison

To **add** an Individual - Utilizing the picklist below, either choose an individual that is already associated with this application or select "New Individual".

To **verify** Individual's information - Select "Edit/View" and edit as needed.

To **remove** an existing Individual - Select "Remove" and enter the applicable end date.

Undo

Save

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- Provider/Facility Information** ▾
- Licensee Information** ▾
- Controlling Interests** ▾
- Management Company Information** ▾
- Personnel** ▾
- Required Disclosure** ⬆
- Convictions**
- Exclusions
- Felonies/Terminations
- General Information** ▾
- Accreditation** ▾
- Days and Hours of Operation** ▾
- Supporting Documents** ▾
- Finalize Submission** ▾

Required Disclosure

Convictions

Pursuant to section 408.809, F.S., the applicant shall submit to the agency a description and explanation of any convictions or offenses prohibited by sections 435.04 and 408.809(4), F.S., for each controlling interest.

Has the applicant or any individual listed in the Controlling Interests or Management Company Controlling Interests sections of this application been convicted of any level 2 offense pursuant to subsection 408.809, Florida Statutes?

Yes No

Undo

Save

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Required Disclosure

Exclusions

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 listed in the Controlling Interests or Management Company Controlling Interests sections of this application been excluded, suspended, terminated or involuntarily withdrawn from participation in Medicare or Medicaid in any state?

- = Entered
- = Entry Required

Yes No

Provider/Facility Information ⌵

Undo

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Licensee Information ⌵

Controlling Interests ⌵

Management Company Information ⌵

Personnel ⌵

Required Disclosure ⬆

- Convictions
- Exclusions**
- Felonies/Terminations

General Information ⌵

Accreditation ⌵

Days and Hours of Operation ⌵

Supporting Documents ⌵

Finalize Submission ⌵

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Provider/Facility Information ▾

Licensee Information ▾

Controlling Interests ▾

Management Company Information ▾

Personnel ▾

Required Disclosure ⤴

- Convictions
- Exclusions
- Felonies/Terminations**

General Information ▾

Accreditation ▾

Days and Hours of Operation ▾

Supporting Documents ▾

Finalize Submission ▾

Required Disclosure

Felonies/ Terminations

Pursuant to section 403.815(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:

1. 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

2. 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

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General Information

Enter number of Birthing Rooms.

1. Number of Birthing Rooms

Undo

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- = Entered
- = Entry Required

Provider/Facility Information ⌵

Licensee Information ⌵

Controlling Interests ⌵

Management Company Information ⌵

Personnel ⌵

Required Disclosure ⌵

General Information ⌵

General Information

Accreditation ⌵

Days and Hours of Operation ⌵

Supporting Documents ⌵

Finalize Submission ⌵

Provider:

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Accreditation

Please check the appropriate accrediting organization(s) below. If accredited, provide a copy of the full accreditation survey, award letter, and any follow up letters to or from the accrediting body in the Supporting Documents section of this application. Please review Chapter 394.741, F.S. for additional information.

Not Accredited

Accrediting Organization	Accrediting Org ID	Accreditation Effective Date	Accreditation Expiration Date	Survey Date
<input type="checkbox"/> Accreditation Association for Ambulatory Health Care (AAAHC)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Commission for the Accreditation of Freestanding Birth Centers (CABC)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Joint Commission (JC)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Note – If accredited, you will be required to include documentation from the accrediting organization in the Supporting Documents section of this application. Documentation must include:

1. Name of accrediting organization
2. Accrediting type and status
3. Effective and expiration dates of accreditation
4. Effective and expiration dates of deemed status (if applicable)
5. Accrediting organization's report of findings (survey report)
6. Provider's response to the accrediting organization's report of findings (if a plan of correction was required)
7. Accrediting organization's final determination (such as an acceptance of the plan of correction)

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

- = Entered
- = Entry Required

Provider/Facility Information

Licensee Information

Controlling Interests

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Accreditation

Days and Hours of Operation

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Finalize Submission

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Provider:

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Birth Center

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Days and 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.

- = Entered
- = Entry Required

Provider/Facility Information ⌵

Licensee Information ⌵

Controlling Interests ⌵

Management Company Information ⌵

Personnel ⌵

Required Disclosure ⌵

General Information ⌵

Accreditation ⌵

Days and Hours of Operation ⌵

Days and Hours of Operation

Supporting Documents ⌵

Finalize Submission ⌵

<u>Day</u>	<u>OpeningTime</u>	<u>Closing Time</u>	<u>By Appointment</u>
MONDAY	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
TUESDAY	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
WEDNESDAY	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
THURSDAY	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
FRIDAY	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
SATURDAY	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
SUNDAY	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

Undo

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Supporting Documents

Applicants **MUST** include the following attachments as stated in Chapters 408 Part II and 383, F.S. and Chapters 59A-35 and 59A-11, F.A.C.

The following file types are suggested for uploading and submitting electronic documents to the Agency: .DOC, .PDF, .TIFF, .TXT, .JPG, .XLS, and .PPT.

The following file types are **NOT** permitted for upload: .ZIP, .EXE, .BIN, .COM, .CMD, .SYS, .BAT, and .JS. The upload and submission process will fail if any of these unpermitted file types are selected.

- = Entered
- = Entry Required

- Provider/Facility Information** ▾
- Licensee Information** ▾
- Controlling Interests** ▾
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- Personnel** ▾
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- General Information** ▾
- Accreditation** ▾
- Days and Hours of Operation** ▾
- Supporting Documents** ⬆
- Supporting Documents**
- Finalize Submission** ▾

Accreditation Documentation

An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Facility Ownership/Lease Documentation

An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Required Disclosures Related to Actions Taken by Medicare, Medicaid, or CLIA

An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Approved Repayment Plan

An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

Additional Documentation

An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely manner could impact the issuance of a license.

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Finalize Application

Any areas marked in red are incomplete and must be completed before the application can be submitted. To submit the application, select the appropriate subsection below, or from the Applications Components list to the left, and provide the missing information.

- = Entered
- = Entry Required

- Provider/Facility Information** ▾
- Licensee Information** ▾
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- Management Company Information** ▾
- Personnel** ▾
- Required Disclosure** ▾
- General Information** ▾
- Accreditation** ▾
- Days and Hours of Operation** ▾
- Supporting Documents** ▾
- Finalize Submission** ⤴
- Finalize Application**

- 1. Provider/Facility Information
 - a. Details
 - b. Contact Person
 - c. Property Ownership
- 2. Licensee Information
 - a. Licensee Details
- 3. Controlling Interests
 - a. Controlling Interests
- 4. Management Company Information
 - a. Management Company Information
 - b. Management Company Controlling Interest
- 5. Personnel
 - a. Administration
 - b. Safety Liaison
- 6. Required Disclosure
 - a. Convictions
 - b. Exclusions
 - c. Felonies/Terminations
- 7. General Information
 - a. General Information
- 8. Accreditation
 - a. Accreditation
- 9. Days and Hours of Operation
 - a. Days and Hours of Operation
- 10. Supporting Documents
 - a. Supporting Documents

I attest as follows:

(1) Pursuant to section 337.06, 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.

Signature of Licensee or Authorized Representative

Title

Date

I agree

Health Care Licensing Online
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Biennial Licensure Fee and Other Amounts Due Upon Submission of Application

- The biennial licensure fee is \$392.80
- The biennial health care assessment fee is \$300
- Other amounts due (fines, assessment, fees, etc.) will be detailed in the application

Payment Summary

[View Payment History](#)

Provider Name:
City:
License Number:

Below are the provider's outstanding obligations to the Agency.

To make a payment:

1. Choose the items you wish to pay at this time.
2. Select Proceed.
3. When the page refreshes, choose a form of payment.
4. Select Pay Now.

Summary	
Item	Amount
	\$0.00

[Pay Later](#)

[Proceed](#)

Fees ⓘ

Select	Items
<input type="checkbox"/>	\$ Renewal Application Fee Application Number: <i>Date Due:</i>
<input type="checkbox"/>	\$ Renewal Application Late Fee Application Number: <i>Date Due:</i>
<input type="checkbox"/>	Biennial Assessment Application Number: <i>Date Due:</i>

Fines

Select	Items
There are no outstanding fines at this time.	

If you want to send your payment directly to the agency, click the 'Payment Statement' button below.

[Payment Statement](#)