Provider:
Beta ASCC

Provider Type:
Adult Day Care Center

File#: 12962745
License #:
Expires:

Application:
Type: Initial Licensure
Status: Unopened
Application Received Date:

= Entered
= Entry Required

Provider/Facility Information
- Details
- Property Ownership
- Contact Person

Licensee Information

Controlling Interests

Management Company Information

Personnel

Required Disclosure

Facility and Service Provisions

Specialty Services

Days and Hours of Operation

Supporting Documents

Finalize Submission

Logged in as : stocka

Dashboard | OL Help | Documents | Logout

Provider/Facility Information

Under the authority of Chapters 408, Part II and 429, Part III, Florida Statutes (F.S.), and Chapters 59A-35 and 59A-16, Florida Administrative Code (F.A.C.), an application is hereby made to operate an adult day care center as indicated below.

Pursuant to sections 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.

- *Provider NPI cannot be blank. Please enter number or check None or Pending checkbox below the field.*
- *Phone number is incomplete.*
- *Provider Fax # cannot be blank. Please check None checkbox below the field.*
- *Provider Website information cannot be blank. Please enter a website or check None checkbox below the field.*

Provider/Facility Information

License # ______ National Provider Identifier ______
☐ None ☐ Pending

Medicaid # ______ Medicare # (CMS CCN) ______

Name of Adult Day Care Center (If operated under a fictitious name, enter as it is filed with the Florida Division of Corporations.)

Beta ASCC

Provider/Facility Location Address

Edit Address

Provider Location Address
2727 MAHAN DR
TALLAHASSEE, FL 32308
US - United States
County - LEON

Telephone (___) ___-____ Ext ______ Fax # (___) ___-____
☐ None

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

adcc@adcc.com
☐ None

Provider/Facility Website
______
☐ None

Health Care Licensing Online Application
Adult Day Care Center
AHCA Form 3180-1004 OL, August 2023
59A-35.060, Florida Administrative Code

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

☑ Check if same as Provider/Facility Location Address

Edit Address

Address
2727 MAHAN DR
TALLAHASSEE, FL 32308
US - United States
County - LEON

Telephone (___) ___-____ Ext ______ Email Address adcc@adcc.com
☐ None

Undo | Save | Next >>

Property Ownership

There are missing and/or invalid entries. Please correct them.

- *Select a property ownership type.*

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

- ◯ Own
- ◯ Lease

Undo | Save | << Back | Next >>

Provider/Facility Information

- *Contact first name must not be blank.*
- *Contact last name must not be blank.*
- *Phone number is incomplete.*
- *If there is no Fax # please check the None check box below it.*
- *If there is no Email address please check the None check box below it.*

Provider/Facility Contact Person for this Application

First Name | Middle Name | Last Name | Suffix

Telephone (___) ___-____ | Ext | Fax # (___) ___-____

☐ None

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

☐ None

Undo | Save | << Back | Next >>

Licensee Information

- *Individual information is incomplete*
- *Phone number is incomplete.*
- *Licensee Email cannot be blank. Please enter an email or check None checkbox below the field.*
- *If Licensee does not have Fax number then please select the None check box below the field.*
- *Licensee mailing address line 1 must not be blank. Licensee mailing address city must not be blank. Licensee mailing address zip must not be blank.*

Description of Licensee (select only one option below)

(•) For Profit ( ) Not for Profit ( ) Public

Ownership Types

Individual

Individual Licensee Details

Licensee Name

First Name | Middle Name | Last Name | Suffix

Tax ID | Type

Mailing Address

Edit Address

Address

Telephone: (___) ___-____ | Ext | Fax #: (___) ___-____ | Email Address

Fax: ☐ None | Email: ☐ None

Undo | Save | << Back | Next >>

Controlling Interests of Licensee

- *You have selected 'Individual' as the licensee's ownership type. Therefore, you are unable to add Controlling Interests. Select 'Next' to proceed.*

Undo   Save   << Back   Next >>

Management Company Information

- *You have selected 'Individual' as the licensee's ownership type. Therefore, you are unable to add a Management Company. Select 'Next' to proceed.*

Undo | Save | << Back | Next >>

Management Company Controlling Interest

- *There is no Management Company associated with this application. Therefore, you are unable to add Management Company Controlling Interests. Select "Next" to proceed.*

Undo | Save | << Back | Next >>

Personnel

- *One Center Operator should be entered for this application.*
- *One Financial Officer should be entered for this application.*

Personnel

Note: For the center operator 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 the Background Screening site.

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

- Center Operator
- 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'.

No Individuals exist!

Undo | Save | << Back | Next >>

Personnel

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.

No Individuals exist!

Undo | Save | << Back | Next >>

Required Disclosure

- *Either Yes or No must be selected.*

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 section 408.809, F.S.?

◯ Yes ◯ No

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Required Disclosure

- *Either Yes or No must be selected.*

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?

◯ Yes ◯ No

Undo Save << Back Next >>

Required Disclosure

- *All questions related to Felonies/Terminations must be answered.*

Felonies/ Terminations

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:

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 occured at least 20 years before the date of the application?

Yes No

Undo Save << Back Next >>

Facility and Service Provisions

- *All services must be answered.*
- *Applicant must answer both questions under 1.*

1. Provide/Verify the capacity and square footage below.

Maximum participant capacity 0

Total square footage available for participants (in feet) 0

2. Identify the frequency with which optional services are provided by the center.

Note: These basic services are required: providing a protective setting that is as non-institutional as possible; therapeutic programs of social and health activities and services, leisure activities, self-care training, rest, nutritional services and respite care.

Optional Services

Social Activities

Speech Therapy

Physical Therapy

Occupational Therapy

Modified Diet

Adult Day Health Care

Undo Save << Back Next >>

Specialty Services

- *Must select at least one option.*

Specialty Services

◯ The center does not provide any specialty services.

◯ The center provides Specialized Alzheimer's Services.

Undo Save << Back Next >>

Days and Hours of Operation

- *At least five days of the week must have five hours or more between opening and closing.*
- *Enter opening and closing times.*

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 or denial of an application.

Note: Pursuant to section 59A-16.106, F.A.C., the facility must make services available for a minimum of five hours per day five days a week, excluding legal holidays posted by the facility.

Day	Opening Time	Closing Time
MONDAY		
TUESDAY		
WEDNESDAY		
THURSDAY		
FRIDAY		
SATURDAY		
SUNDAY		

Undo   Save   << Back   Next >>

Supporting Documents

Applicants **MUST** include the following attachments as stated in Chapters 408, Part II and 429, Part III, F.S. and Chapters 59A-35 and 59A-16, 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.

- *Proof of General Liability Insurance Coverage*
  - *Carrier is required*
  - *Policy number is required*
  - *Aggregate policy amount is required*
  - *Effective date is required*
  - *Expiry date is required*
  - *Occurrence policy amount is required*
  - *Upload document is required/check the document mailed checkbox.*
- *Fire Safety Inspection Report*
  - *Upload document is required/check the document mailed checkbox.*
- *Financial Ability to Operate*
  - *Upload document is required/check the document mailed checkbox.*
- *Documentation signed by the appropriate local government official, which states that the applicant has met zoning requirement*
  - *Upload document is required/check the document mailed checkbox.*
- *Department of Health Septic System or Water Supply Evaluation Report*
  - *Upload document is required/check the document mailed checkbox.*

Proof of General Liability Insurance Coverage

Carrier [ ]

Policy # [ ]

Effective Date [ ] Expiry Date [ ]

Aggregate Policy Amount $0.00 Occurrence Policy Amount $0.00

☐ 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.

[ ] Browse...

Fire Safety Inspection Report

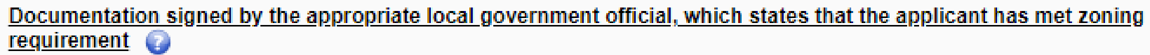
☐ An electronic or scanned copy of the document is not available. A hard copy along with the Document Mailer (available for printing upon completing your application) will be mailed to the Agency immediately. I acknowledge that failure to send the required supporting documents to the Agency in a timely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

[ ] Browse...

Financial Ability to Operate

☐ 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.

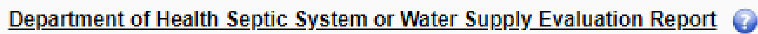
[ ] Browse...



Documentation signed by the appropriate local government official, which states that the applicant has met zoning requirement

☐ 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.

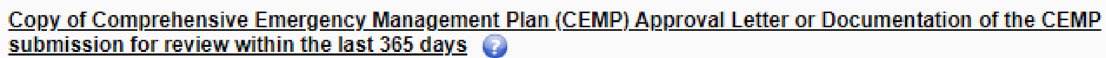
[ ] Browse...



Department of Health Septic System or Water Supply Evaluation Report

☐ 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.

[ ] Browse...



Copy of Comprehensive Emergency Management Plan (CEMP) Approval Letter or Documentation of the CEMP submission for review within the last 365 days

☐ 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.

[ ] Browse...

Department of Health Food Service Inspection Report

☐ 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.

[ ] Browse...

Affidavit of Compliance for Specialty License

☐ 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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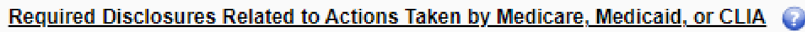

Required Disclosures Related to Actions Taken by Medicare, Medicaid, or CLIA

☐ 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.

[ ] Browse...

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.

[ ] Browse...

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.

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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.

1. Provider/Facility Information
   a. Details
   b. Property Ownership
   c. Contact Person

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. Facility and Service Provisions
   a. Facility and Service Provisions

8. Specialty Services
   a. Specialty Services

9. Days and Hours of Operation
   a. Days and Hours of Operation

10. Supporting Documents
    a. Supporting Documents

I **ANGEL STOCK**, 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 section 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), Florida Statutes, 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), Florida Statutes, 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, Florida Statutes.

ANGEL STOCK	**ANALYST**	**09/22/2023**
Signature of Licensee or Authorized Representative	Title	Date

☐ I agree

Biennial Licensure Fee and Other Amounts Due Upon Submission of Application

- The biennial licensure fee is $172.55
- Other amounts due (fines, assessment, fees, etc.) will be detailed in the application

Selecting the 'Submit Application' you will no longer be able to make changes to your application.

Submit Application