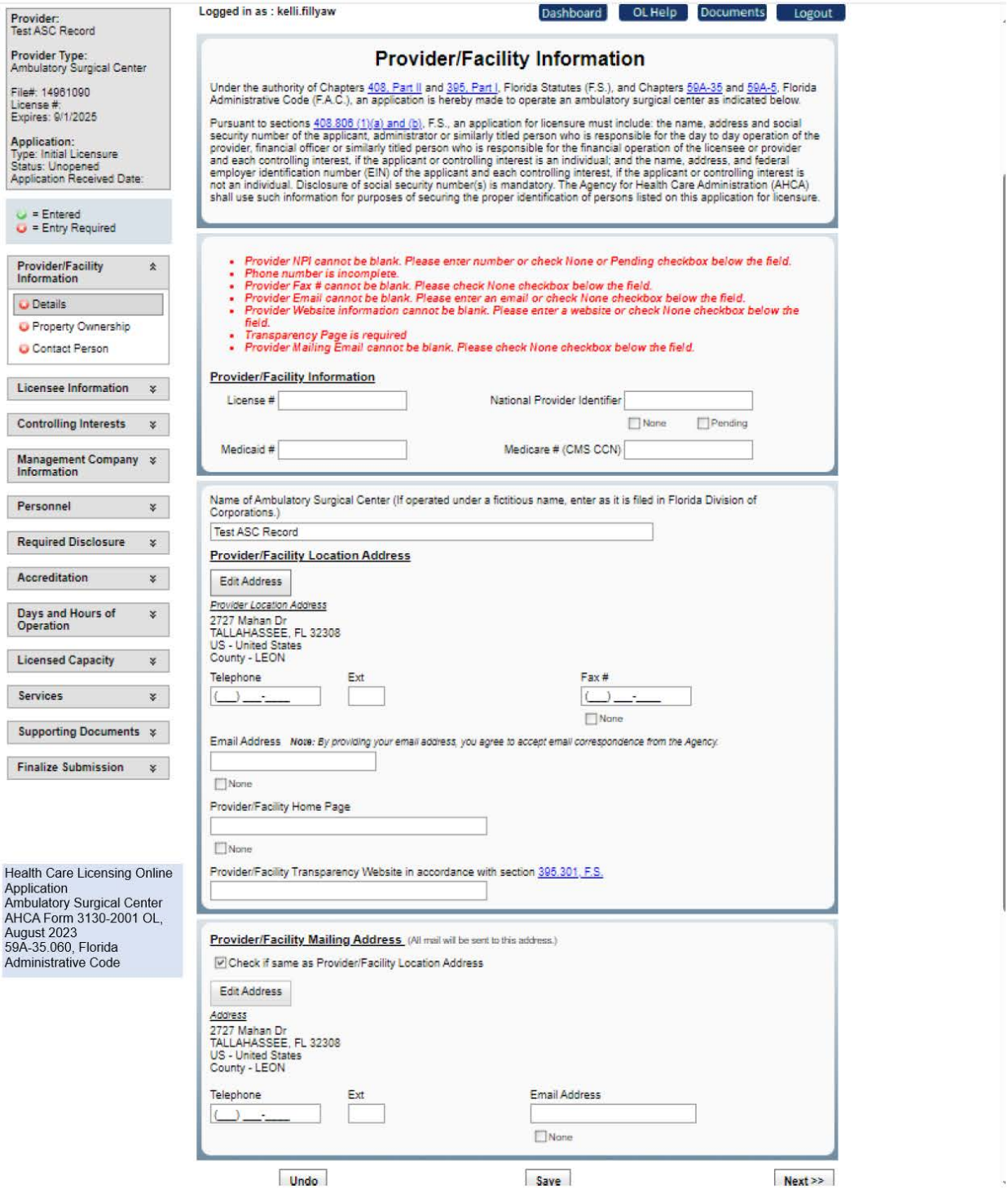
Provider:
Test ASC Record
Provider Type:
Ambulatory Surgical Center
File#: 14961090
License #:
Expires: 9/1/2025
Application:
Type: Initial Licensure
Status: Unopened
Application Received Date:
= Entered
= Entry Required
Provider/Facility Information
Details
Property Ownership
Contact Person
Licensee Information
Controlling Interests
Management Company Information
Personnel
Required Disclosure
Accreditation
Days and Hours of Operation
Licensed Capacity
Services
Supporting Documents
Finalize Submission
Health Care Licensing Online Application
Ambulatory Surgical Center
AHCA Form 3130-2001 OL, August 2023
59A-35.060, Florida Administrative Code
Logged in as : kelli.fillyaw
Dashboard
OL Help
Documents
Logout
Provider/Facility Information
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.
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 Email cannot be blank. Please enter an email or check None checkbox below the field.
Provider Website information cannot be blank. Please enter a website or check None checkbox below the field.
Transparency Page is required
Provider Mailing Email cannot be blank. Please check None checkbox below the field.
Provider/Facility Information
License #
National Provider Identifier
None
Pending
Medicaid #
Medicare # (CMS CCN)
Name of Ambulatory Surgical Center (If operated under a fictitious name, enter as it is filed in Florida Division of Corporations.)
Test ASC Record
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.
None
Provider/Facility Home Page
None
Provider/Facility Transparency Website in accordance with section 395.301, F.S.
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
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

- *Ownership Type is not selected.*
- *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.*
- *Select description of Licensee. (Profit, Non Profit or Public)*

Description of Licensee (select only one option below)

○ For Profit ○ Not for Profit ○ Public

Ownership Types

Mailing Address

Edit Address

Address

Telephone	Ext	Fax #	Email Address
(___) ___-____		(___) ___-____	
		☐ None	☐ None

Undo | Save | << Back | Next >>

Controlling Interests of Licensee

- *Select either Yes or No option.*

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.

○ Yes ○ No

Undo | Save | << Back | Next >>

Management Company Information

- *Select either Yes or No option.*

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

◯ Yes ◯ No

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 Administrator / Managing Employee should be entered for this application.*
- *One Financial Officer should be entered for this application.*

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 / Managing Employee
- 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

Undo | Save | << Back | Next >>

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

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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

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Accreditation

- *Either select an Accrediting Organization or check the Not Accredited check box.*

If this ambulatory surgical center is accredited, select the appropriate accrediting organization(s), and provide the additional accreditation information.

If this ambulatory surgical center is not accredited, select the "Not Accredited" option.

☐ Not Accredited

Accrediting Organization	Accrediting Org ID	Accreditation Effective Date	Accreditation Expiration Date	Deemed Status
☐ American Association for Accreditation of Ambulatory Surg Fac (AAAASF)				
☐ Accreditation Association for Ambulatory Health Care (AAAHC)				
☐ Accreditation Commission for Healthcare (ACHC)				
☐ Insitute for Medical Quality (IMQ)				
☐ The Joint Commission (JC)				

***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.

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

Undo | Save | << Back | Next >>

Days and Hours of Operation

- *Either select 24 hour checkbox or enter opening and closing times or select By Appointment option.*

List the regular operating hours.

Note - Site inspections by Agency surveyors will occur during the business hours submitted. Failure to be open during the listed hours may result in a fine or the denial of an application.

☐ Indicate if the regular operating hours are 24 hours/7 days a week. Otherwise, enter them below.

Day	Opening Time	Closing Time	By Appointment
MONDAY			☐
TUESDAY			☐
WEDNESDAY			☐
THURSDAY			☐
FRIDAY			☐
SATURDAY			☐
SUNDAY			☐

Undo | Save | << Back | Next >>

Licensed Capacity

- *OPERATING ROOMS capacity is required.*
- *PROCEDURE ROOMS capacity is required.*

- *Provide the number of Operating Rooms, Procedure Rooms and Recovery Beds.*
- *Initial applications - Enter your licensed capacity for each row in the 'Increase' column.*

LICENSED CAPACITY	CURRENT CAPACITY	INCREASE	DECREASE	FINAL CAPACITY
OPERATING ROOMS				
PROCEDURE ROOMS				
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.

Undo | Save | << Back | Next >>

Services

- *Select either Yes or No option.*

A. Emergency Services

Is this ambulatory surgical center associated with one or more hospitals that provide emergency inpatient care?

◯ Yes ◯ No

Undo | Save | << Back | Next >>

Services

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

- *Select at least one option below.*

B. Laboratory and X-Ray Services

Indicate whether laboratory and/or x-ray services are provided by the ambulatory surgical center.

◯ Not provided
◯ Laboratory and/or X-Ray Services Provided

Select the services provided. If the ambulatory surgical center provides laboratory services, supply the CLIA certification number(s) and whether the laboratory is owned or contracted.

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

☐ All clinical laboratory tests performed by or for the ambulatory surgical center 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.

Provide the applicable CLIA certification number(s):

10D - [ ] 10D - [ ] 10D - [ ]

Laboratory is : ◯ Owned ◯ Contracted

Undo | Save | << Back | Next >>

Supporting Documents

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.

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.

To upload multiple attachments for one document type: upload one by clicking 'Browse' selecting the file, clicking 'Open', and clicking 'Save'. Repeat until all attachments are uploaded.

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

☐ 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...

A copy of Articles of Incorporation, Organization or Partnership as registered with the Florida Department of State

☐ 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...

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.

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.

Browse...

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.

Browse...

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...

Undo | Save | << Back | Next >>

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. Accreditation
   a. *Accreditation*

8. Days and Hours of Operation
   a. *Days and Hours of Operation*

9. Licensed Capacity
   a. *Licensed Capacity*

10. Services
    a. *Emergency Services*
    b. *Laboratory and X-Ray Services*

11. Supporting Documents
    a. *Supporting Documents*

I **KELLI FILLYAW**, 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.

KELLI FILLYAW	**GOC III**	**11/20/2023**
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 $1,679.82
- The biennial health care assessment fee is $300
- Other amounts due (fines, assessment, fees, etc.) will be detailed in the application

InitialAppsInstructions

Biennial Licensure Fee and Other Amounts Due Upon Submission of Application

- The biennial licensure fee is $1,679.82
- The initial licensure inspection fee is $400
- The biennial health care assessment fee is $300
- 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