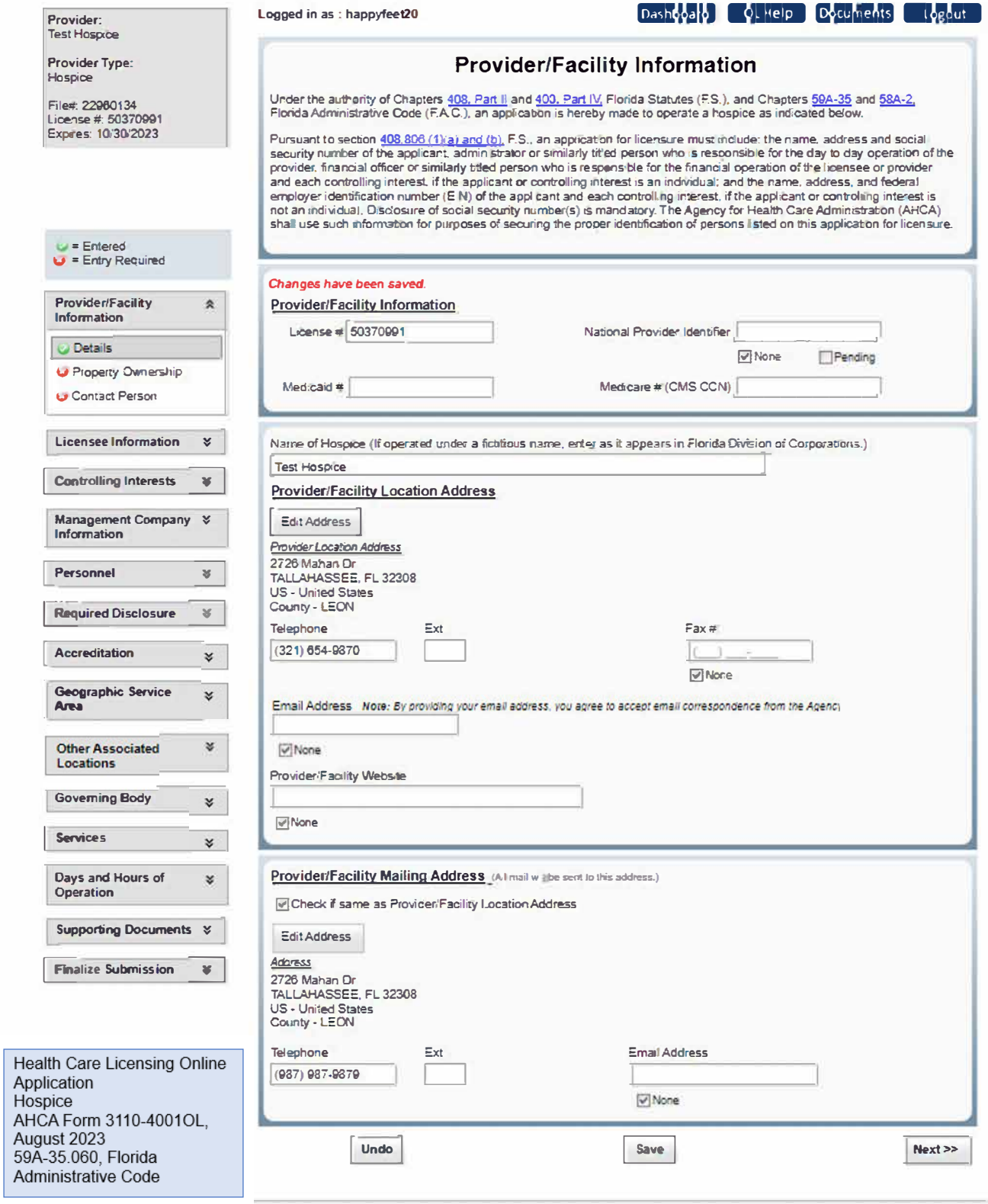

Health Care Licensing Online Application
Hospice
AHCA Form 3110-4001OL, August 2023
59A-35.060, Florida Administrative Code

Property Ownership

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

- ○ Own
- ◉ Lease

To add a property owner(s) -
Utilizing the picklist below, either choose an individual/entity that is already associated with this application or select 'New Property Owner - Individual' or 'New Property Owner - Entity' .

To edit Property Owner's information -
Select "Edit/View"and edit as needed.

To remove an existing Property Owner -
Select "Remove" and enter the applicable end date.

No Property Owner!

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

Licensee Information

- *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.*

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
SCROOGE		MCDUCK	Sr

Tax ID

XXX-XX-4864

Type

SSN

Mailing Address

Edit Address

Address

30 E PALM CIR
LAKE PLACID, FL 33852-6110
US - United States
County - HIGHLANDS

Telephone	Ext	Fax #	Email Address
(570) 587-0786		(___) ___-____	
		☐ None	☐ None

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

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' .

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

Management Company Information

- *If the Yes option is selected, then at least one Management Company must be added.*

Does a company other than the licensee manage the licensed/registered 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'.

Management Company Controlling Interest

- *Add at least one Management Company Controlling Interest.*

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' .

Personnel

- *SCROOGE MCDUCK Sr*
  - *Email address is required.*

A. Provider/Facility Administration

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	Edit/View	SCROOGE MCDUCK Sr	SSN	XXX-XX-4864		Administrator	09/01/2023	
						Financial Officer	09/01/2023	

Removed: (-) Added: (+)

Personnel

- *One Medical Director should be entered for this application*
- *One Nursing Supervisor should be entered for this application*

B. Medical Staff

Provide the information for the individuals who perform the following roles:

- Medical Director
- Nursing Supervisor

Notes -

- *If the medical director has changed since the last application was submitted, enclose verification that this physician has admission privileges at one or more hospitals commonly serving patients in the hospice's service area per 58A-2.014(1), F.A.C, in the Supporting Documents section of this application.*
- *Section 58A-2.0141(1), F.A.C., requires the hospice employ a supervising registered nurse with supervisory or hospice experience that has completed a hospice training program sponsored by the employing hospice.*

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

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!

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

Select an individual from this list

No individual exists!

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

Select an individual/entity from this list

No individual/entity exists!

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

Accreditation

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

If this hospice is currently accredited with deemed status through one or more of the accrediting organizations recognized by the Agency for Health Care Administration, make the appropriate selection(s), and provide the requested information.

Otherwise, select "Not Accredited with Deemed Status".

☐ Not Accredited with Deemed Status

Accrediting Organization	Accreditation ID	Accreditation with Deemed Status Effective Date	Accreditation with Deemed Status End Date	Survey End Date
☐ Accreditation Commission for Health Care (ACHC)				
☐ Community Health Accreditation Program (CHAP)				
☐ 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.

Geographic Service Area

Indicate each county this hospice will serve by selecting the appropriate checkboxes below.

Counties Served

☐ ALACHUA	☐ BAKER	☐ BAY	☐ BRADFORD	☑ BREVARD
☐ BROWARD	☐ CALHOUN	☐ CHARLOTTE	☐ CITRUS	☐ CLAY
☐ COLLIER	☐ COLUMBIA	☐ DESOTO	☐ DIXIE	☐ DUVAL
☐ ESCAMBIA	☐ FLAGLER	☐ FRANKLIN	☐ GADSDEN	☐ GILCHRIST
☐ GLADES	☐ GULF	☐ HAMILTON	☐ HARDEE	☐ HENDRY
☐ HERNANDO	☐ HIGHLANDS	☐ HILLSBOROUGH	☐ HOLMES	☐ INDIAN RIVER
☐ JACKSON	☐ JEFFERSON	☐ LAFAYETTE	☐ LAKE	☐ LEE
☑ LEON	☐ LEVY	☐ LIBERTY	☐ MADISON	☐ MANATEE
☐ MARION	☐ MARTIN	☐ MIAMI-DADE	☐ MONROE	☐ NASSAU
☑ OKALOOSA	☐ OKEECHOBEE	☐ ORANGE	☐ OSCEOLA	☐ PALM BEACH
☐ PASCO	☐ PINELLAS	☐ POLK	☐ PUTNAM	☐ SANTA ROSA
☐ SARASOTA	☐ SEMINOLE	☐ ST. JOHNS	☐ ST. LUCIE	☐ SUMTER
☐ SUWANNEE	☐ TAYLOR	☐ UNION	☐ VOLUSIA	☐ WAKULLA
☐ WALTON	☐ WASHINGTON			

Other Associated Locations

- *Select either Yes or No option.*

A. Satellite Offices

58A-2.002, F. A. C., defines a satellite office as "an office or other physical location serving as a contact point for patients, which is remote from the provider's principal office, but is not seperately licensed, and shares administration with the principal office."

Does this hospice operate any satellite offices as defined above? If yes, identify all satellite offices. Otherwise, select 'Next' to proceed.

◯ Yes ◯ No

Other Associated Locations

- *Select either Yes or No option.*

B. Freestanding Inpatient Facilities

Does this hospice operate any freestanding inpatient facilities? If yes, identify all freestanding inpatient facilities. Otherwise, select 'Next' to proceed.

◯ Yes ◯ No

Note - Do not list contracted hospital, Skilled Nursing Facility, Nursing Facility, or Intermediate Care Facility beds.

Other Associated Locations

- *Select either Yes or No option.*

C. Residential Units

Does this hospice operate any residential units? If yes, identify all residential units. Otherwise, select 'Next' to proceed.

◯ Yes ◯ No

Governing Body

- *At least seven individuals must be entered*

Section 400.610(1), F.S., states, "A hospice shall have a clearly defined governing body, consisting of a minimum of seven persons who are representative of the general population of the community served. The governing body shall have autonomous authority and responsibility for the operation of the hospice and shall meet at least quarterly."

58A-2.005(1)(a), F.A.C., further requires, "Members must reside or work in the hospice's service area as defined in paragraph 59C-1.0355(2)(k), F.A.C."

Provide the requested information for each member of the hospice's governing body.

#	First Name	Last Name	Personal/Business Address	City	Zip Code	County
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						

+ Add Rows

Services

- *Number of Employees required for Bereavement Counseling*
- *Number of Employees required for Medical Social Work*
- *Number of Employees required for Nursing*
- *Number of Employees required for Pastoral or Counseling*
- *Number of Employees required for Volunteer Coordination*

Required Direct Services

Indicate the number of employees under each of the listed services, which are required to be **directly** provided by the hospice (58A-2.002(6), F.A.C. recognizes employment on either a salary or volunteer basis).

Required Direct Service	Number of Employees
☐ Bereavement Counseling	0.00
☐ Dietary Counseling (provided by):	0.00
☐ Licensed Nutritionist/Dietician	
☐ Nutrition Counselors	
☐ Registered Dietitians	
☐ Nurses	
☐ Medical Social Work	0.00
☐ Nursing	0.00
☐ Pastoral or Counseling	0.00
☐ Volunteer Coordination	0.00

Days and Hours of Operation

- *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.

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

Supporting Documents

Applicants **MUST** include the following attachments as stated in Chapters 408 Part II and 400 Part VII, Florida Statutes (F.S.) and Chapter 59A-35 and 58A-2, Florida Administrative Code (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.

Medical Director's Proof of Hospital Admitting Privileges (if not previously reported)

☐ 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...

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...

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...

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...

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. *Medical Staff*
   c. Safety Liaison

6. Required Disclosure
   a. *Convictions*
   b. *Exclusions*
   c. *Felonies/Terminations*

7. Accreditation
   a. *Accreditation*

8. Geographic Service Area
   a. Geographic Service Area

9. Other Associated Locations
   a. *Satellite Offices*
   b. *Freestanding Inpatient Facilities*
   c. *Residential Units*

10. Governing Body
    a. *Governing Body*

11. Services
    a. *Required Direct Services*

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

13. Supporting Documents
    a. Supporting Documents

I **MANDI MANZIE**, 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.

MANDI MANZIE		**09/21/2023**
Signature of Licensee or Authorized Representative	Title	Date

☐ I agree