APPLICATION CHECKLIST
Health Care Licensing Application
AMBULATORY SURGICAL CENTER

Applicants **must** include the following attachments as stated in Chapters 408, Part II, and 395, Florida Statutes (F.S.), and Chapters 59A-35 and 59A-5, Florida Administrative Code (F.A.C). Applications must be received **at least 60 days prior to** the expiration of the current license or effective date of a change of ownership to avoid a late fee. If the renewal application is received by the Agency less than 60 days prior to the expiration date, it is subject to a late fee as set forth in statute. The applicant will receive notice of the amount of the late fee as part of the application process or by separate notice. ***The application will be withdrawn from review if all the required documents and fees are not included with this application or received within 21 days of an omission notice.***

All forms listed below may be obtained from the website: http://ahca.myflorida.com/HQAlicensureforms. Send completed applications to: Agency for Health Care Administration, Hospital and Outpatient Services Unit, 2727 Mahan Drive, Mail Stop 31, Tallahassee, FL 32308.

NOTE TO ALL APPLICANTS: The Agency will verify that all applicants, licensees and controlling interests subject to Chapters 607, 608 or 617, Florida Statutes related to Business Organizations have complied with applicable Department of State registration and filing requirements. The principal and mailing addresses submitted with any application must be the same as the addresses that appear as registered with the Department of State, Division of Corporations.

A. Initials, Renewals and Change of Ownership Applications Must Include:

☐ The biennial licensure fee (**$1,679.82**) - Please make check or money order payable to the *Agency for Health Care Administration (AHCA).* All fees are nonrefundable. ***Additional fees may apply. Refer to Section 2 of this application.*** *NOTE: Starter and temporary checks are not accepted.*

☐ Health Care Licensing Application, Ambulatory Surgical Centers , AHCA Form 3130-2001. **NOTE:** *All Agency correspondence will be sent to the mailing address provided in Section 1A of the application. If an applicant or licensee is required to register or file with the Florida Secretary of State Division of Corporations, the principal, fictitious name and mailing address provided in Section 1 of this application must be the same as the information registered with the Division of Corporations as provided in Section 59A-35.060(4), Florida Administrative Code.*

☐ Health Care Licensing Application Addendum, AHCA Form 3110-1024 - Complete the information that is applicable, write "NA" on the items that are not applicable, sign, date and send with the application (refer to Sections 3 & 4 of the application for further details).

☐ Background Screening:

A Level 2 background screening for the Administrator and Financial Officer is required every 5 years.

All screening results must be sent to the Agency for Health Care Administration for review and employment determinations. If you choose to use a LiveScan source other than the Agency's contracted vendor you must identify the Agency for Health Care Administration as the recipient of the screening results to ensure the results are reviewed by the Agency. If the Agency does not receive the results, additional screening and fees may be required. For additional information, including finding a LiveScan vendor and screening a person who is out of state, please visit the Agency's background screening website at http://ahca.myflorida.com/backgroundscreening.

The ☐ Administrator and/or ☐ Financial Officer submitted a new Level 2 screening through a LiveScan vendor.

The ☐ Administrator and/or ☐ Financial Officer submitted a Level 2 screening within the previous 5 years and results are on file with the Agency for Health Care Administration, Department of Children and Families, Department of Health, Department of Elder Affairs, Agency for Persons with Disabilities or Department of Financial Services (if the applicant has a certificate of authority or provisional certificate of authority to operate a continuing care retirement community). An Affidavit of Compliance with Background Screening Requirements, AHCA Form 3100-0008, is also enclosed.

B. Additional Information Needed for INITIAL Applications:

☐ Proof of compliance with local zoning requirements.

☐ Proof of compliance with fictitious name registration, if applicable.

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

☐ Proof of the licensee's right to occupy the building such as a copy of a lease, sublease agreement, or deed.

NOTE: Proof of successful completion of the 100% physical plant inspection conducted by the Agency's Bureau of Plans and Construction is required. This information is transmitted by an internal Agency memo, but may be supplied to the facility upon satisfactory completion of the 100% Plans and Construction inspection.

C. Additional Information Needed for RENEWAL Applications:

☐ $300 Health Care Facility Fee Assessment ($150 annual assessment x 2).

Pursuant to Rule 59C-1.022(4), Florida Administrative Code, the annual assessment from all facilities shall be collected prospectively for a two year (biennial) period. For renewal applications, the biennial assessment shall be calculated at the time of the licensure renewal and shall be due at the time of filing of the renewal application.

D. Additional Information Needed for CHANGE OF OWNERSHIP Applications:

☐ Proof of the licensee's right to occupy the building such as a copy of the lease, sublease agreement, or deed.

☐ Proof of compliance with fictitious name registration, if applicable.

☐ Proof of new or continued accreditation, if applicable.

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

☐ A signed agreement to correct all outstanding physical plant deficiencies incurred by the previous owner.

☐ A signed agreement to pay any outstanding payments owed to the Agency. The agreement must include who will pay and when payment will be made.

☐ A signed agreement to pay any outstanding payments owed to the Agency. The agreement must include who will pay and when payment will be made.

NOTE: A change of ownership application will not be approved until proof of closing is received, which must include an effective date and signatures of both the buyer and seller.

E. Change During License Period:

1. *Request to add/decrease the number of Class C Operating Rooms/Recovery Beds/Procedure Rooms*

☐ The change to the physical plant must receive approval from the Agency's Bureau of Plans and Construction in advance.

☐ Complete and submit Sections 1, 2 and 10 through 11 of the Health Care Licensing Application, Ambulatory Surgical Centers, AHCA Form 3130-2001.

☐ $25.00 fee for replacement license or reissue of license due to change during licensure period. Please make check or money order payable to the *Agency for Health Care Administration (AHCA).* All fees are nonrefundable.

2. Request to change the name or address of provider:

☐ Complete and submit Sections 1, 2 and 10 of the Health Care Licensing Application, Ambulatory Surgical Centers, AHCA Form 3130-2001.

☐ $25.00 fee for replacement license or reissue of license due to change during licensure period. Please make check or money order payable to the *Agency for Health Care Administration (AHCA).* All fees are nonrefundable.

3. *Request to change Administrator, Financial Officer, Risk Manager(s) or Patient Safety Officer:*

For a Change in Administrator or Financial Officer:

☐ Complete and submit Sections 1A, 2, 8A and 10 of the Health Care Licensing Application, Ambulatory Surgical Centers, AHCA Form 3130-2001.

☐ Complete and submit Section 1A of the Health Care Licensing Application Addendum, AHCA Form 3110-1024, sign, date and send with application.

☐ No fee required.

For a Change in Risk Manager(s) or Patient Safety Officer:

☐ Complete and submit Sections 1A, 2, 8B and 10 of the Health Care Licensing Application, Ambulatory Surgical Centers, AHCA Form 3130-2001.

☐ No fee required.

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

The Agency for Health Care Administration scans all documents for electronic storage. In an effort to facilitate this process, we ask that you please remember to:

- Please place checks or money orders on top of the application
- Include license number or case number on your check
- Do not submit carbon copies of documents
- Do not fold any of the documents being submitted
- No staples, paperclips, binder clips, folders, or notebooks
- Please ***do not bind any*** of the documents submitted to the Agency.

AHCA USE ONLY:

File #: _____
Application #: _____
Check #: _____
Check Amt: _____
Batch #: _____

Health Care Licensing Application
AMBULATORY SURGICAL CENTER

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

1. Provider / Licensee Information

A. Provider Information – please complete the following for the ambulatory surgical center name and location.
Provider name, address and telephone number will be listed on http://www.floridahealthfinder.gov/

License # (for renewal & change of ownership applications)	**National Provider Identifier** (NPI) (if applicable)	**Medicare #** (CMS CCN)	**Medicaid #**

Name of Ambulatory Surgical Center (include fictitious name, if applicable)

Street Address

City	County	State	Zip

Telephone Number	Fax Number	E-mail Address	Provider Website

Mailing Address or ☐ Same as above (All mail will be sent to this location)

City	State	Zip

Contact Person for this application	Contact Telephone Number

Contact e-mail address or ☐ Do not have e-mail	***NOTE:*** By providing your e-mail address you agree to accept e-mail correspondence from the Agency

B. Licensee Information – please complete the following for the entity seeking to operate the ambulatory surgical center.

Licensee Name (may be same as provider name above)	Federal Employer Identification Number (EIN)

Mailing Address or ☐ Same as above

City	State	Zip

Telephone Number	Fax Number	E-mail Address

Description of Licensee (check one):

For Profit	Not for Profit	Public
☐ Corporation	☐ Corporation	☐ State
☐ Limited Liability Company	☐ Religious Affiliation	☐ City/County
☐ Partnership	☐ Other	☐ Hospital District
☐ Individual		
☐ Sole Proprietor		
☐ Other		

2. Application Type and Fees

Indicate the type of application with an "X." **Applications will not be processed if all applicable fees are not included.** ***Pursuant to subsection 408.805(4), Florida Statutes, fees are nonrefundable.*** Renewal and Change of Ownership applications must be received 60 days prior to the expiration of the license or the proposed effective date of the change to avoid a late fine. If the renewal application is received by the Agency less than 60 days prior to the expiration date, it is subject to a late fee as set forth in statute. The applicant will receive notice of the amount of the late fee as part of the application process or by separate notice.

☐ Initial licensure
Is this application to reactivate an expired license? YES ☐ NO ☐

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

NAME:	EIN #	Year Expired/Closed:

☐ Renewal licensure
☐ Change of ownership, proposed effective date: _____
☐ Change during licensure period, proposed effective date: _____

- ☐ Change number of operating rooms
- ☐ Change number of procedure rooms
- ☐ Change number of recovery beds
- ☐ Name change of the facility
- ☐ Address change of the facility
- ☐ Change in Administrator, Financial Officer, Risk Manager(s) or Patient Safety Officer (No fee required)

Action	Fee	TOTAL FEES
License Fee (Initial, Renewal and Change of Ownership):	$1,679.82	$
Initial Licensure Inspection Fee (initial applicants only)	$400.00	$
Biennial Assessment (Renewal applications only)	$300.00	$
Change During Licensure Period/Replacement License	$ 25.00	$
Other: _____		$
TOTAL FEES INCLUDED WITH APPLICATION:		**$**

Please make check or money order payable to the Agency for Health Care Administration (AHCA)

Note: Starter checks and temporary checks are not accepted.

3. Controlling Interests of Licensee

AUTHORITY:

Pursuant to Section 408.806(1)(a) and (b), Florida Statutes, an application for licensure must include: the name, address and Social Security number of the applicant and each controlling interest, if the applicant or controlling interest is an individual; and the name, address, and federal employer identification number (EIN) of the applicant and each controlling interest, if the applicant or controlling interest is not an individual. Disclosure of Social Security number(s) is mandatory. The Agency for Health Care Administration shall use such information for purposes of securing the proper identification of persons listed on this application for licensure. However, in an effort to protect all personal information, **do not include Social Security numbers on this form. All Social Security numbers must be entered on the Health Care Licensing Application Addendum, AHCA Form 3110-1024.**

DEFINITIONS:

Controlling interests, as defined in subsection 408.803(7), Florida Statutes, 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-percent 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-percent 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.

In Sections A and B below, provide the information for each individual or entity (corporation, partnership, association) with 5% or greater ownership interest in the licensee. Attach additional sheets if necessary.

A. Individual and/or Entity Ownership of Licensee

FULL NAME of INDIVIDUAL or ENTITY	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER	EIN (No SSNs)	% OWNERSHIP INTEREST

B. Board Members and Officers of Licensee (Excludes Voluntary Board Members)

TITLE	FULL NAME	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER
Director/CEO			
President			
Vice President			
Secretary			
Treasurer			
Other:			

4. Management Company Controlling Interests

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

If ☐ NO, skip to Section 5 – *Required Disclosure.*

If ☐ YES, provide the following information:

Name of Management Company	EIN (No SSN)	Telephone Number / Fax	
Street Address	E-mail Address		
City	County	State	Zip
Mailing Address or ☐Same as above			
City		State	Zip
Contact Person	Contact E-mail	Contact Telephone Number	

In Sections A and B below, provide the information for each individual or entity (corporation, partnership, association) with 5% or greater ownership interest in the management company. Attach additional sheets if necessary.

A. Individual and/or Entity Ownership of Management Company

FULL NAME of INDIVIDUAL or ENTITY	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER	EIN (No SSNs)	% OWNERSHIP INTEREST

B. Board Members and Officers of Management Company (Excludes Voluntary Board Members)

TITLE	FULL NAME	PERSONAL OR BUSINESS ADDRESS	TELEPHONE NUMBER
Director/CEO			
President			
Vice President			
Secretary			
Treasurer			
Other:			

5. Required Disclosure

The following disclosures are required:

A. Pursuant to subsection 408.809(1)(d), F.S., the applicant shall submit to the agency a description and explanation of any convictions of offenses prohibited by Sections 435.04 and 408.809, F.S., for each controlling interest.

Has the applicant or any individual listed in Sections 3 and 4 of this application been convicted of any level 2 offense pursuant to subsection 408.809(1)(d), Florida Statutes? (These offenses are listed on the Affidavit of Compliance with Background Screening Requirements, AHCA Form #3100-0008.) YES ☐ NO ☐

If yes, enclose the following information:

☐ The full legal name of the individual and the position held

☐ A description/explanation of the conviction(s) - If the individual has received an exemption from disqualification for the offense, include a copy

B. Pursuant to Section 408.810(2), F.S., the applicant must provide a description and explanation of any exclusions, suspensions, or terminations from the Medicare, Medicaid, or federal Clinical Laboratory Improvement Amendment (CLIA) programs.

Has the applicant or any individual listed in Sections 3 and 4 of this application been excluded, suspended, terminated or involuntarily withdrawn from participation in Medicare or Medicaid in any state? YES ☐ NO ☐

If yes, enclose the following information:

☐ The full legal name of the individual and the position held

☐ A description/explanation of the exclusion, suspension, termination or involuntary withdrawal.

C. Pursuant to Section 408.815(4), F.S., does the applicant or any controlling interest in an applicant have any of the following:

YES ☐ NO ☐ Convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, chapter 893, 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396, Medicaid fraud, Medicare fraud, or insurance fraud, within the previous 15 years prior to the date of this application;

YES ☐ NO ☐ Terminated for cause from the Medicare program or a state Medicaid program.

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 ☐

6. Provider Fines and Financial Information

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

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

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

Amount: $ _____ assessed by: ☐ Agency for Health Care Administration Case # _____ ☐ CMS

Date of related inspection, application or overpayment period if applicable: _____

Due date of payment: _____

Is there an appeal pending from a Final Order? YES ☐ NO ☐

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

7. Federal Certification

Does the provider participate in or intend to participate in the

Medicare program? YES ☐ NO ☐
Medicaid program? YES ☐ NO ☐

If you plan to participate in Medicare:

The Medicare Provider Application (CMS Form 855B) is available from the Medicare Administrative Contractor or on the Centers for Medicare and Medicaid Services (CMS) website at: www.cms.hhs.gov/cmsforms/. The form must be sent directly to the chosen fiscal intermediary for review.

NOTE: The following forms must be attached to this application: CMS 370 (2 originals), CMS 377, Fiscal Intermediary Choice Form, HHS 690.

If you plan to participate in Medicaid:

Visit the Agency's website at: http://ahca.myflorida.com/Medicaid/index.shtml in order to obtain information and an application for enrollment in Medicaid.

8. Personnel

A. Administrative Personnel:

TITLE	NAME	TELEPHONE NUMBER	E-MAIL
Administrator/Managing Employee			
Financial Officer			

B. Risk Management and Patient Safety:

List all Risk Managers of the ambulatory surgical center who have access to online reporting. Attach additional sheets if necessary.

NAME	FLORIDA LICENSE NUMBER	DATE OF APPOINTMENT

Provide the following information regarding the ambulatory surgical center's Patient Safety Officer.

NAME	DATE OF APPOINTMENT

9. Hours of Operation

List the regular operating hours (**NOTE:** Site inspections by surveyors will occur during the business hours submitted. Failure to be open during the listed hours may result in a fine.):

Day of the Week	Opening Time	Closing Time
☐ Sunday		
☐ Monday		
☐ Tuesday		
☐ Wednesday		
☐ Thursday		
☐ Friday		
☐ Saturday		

10. General Information

A. Bed Capacity

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

B. Accreditation

The provider is accredited by:

☐ None
☐ The Joint Commission
☐ American Osteopathic Association (AOA)
☐ Accreditation Association for Ambulatory Health Care (AAAHC)
☐ American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)

☐ The accreditation includes federal deemed status Accreditation begins _____ and ends _____

☐ I understand that the complete accreditation report must be submitted to AHCA for review if the accreditation report is to be accepted in lieu of annual licensure inspections and such reports used to meet licensure requirements are considered public documents subject to disclosure per chapter 119, F.S.

C. Other Services

Please check all that apply:

☐ X-ray provided on the premises or by contract in accordance with Chapter 404, F.S.
☐ Laboratory provided on the premises or by contract in accordance with Chapter 483, F.S.
1. Please provide the applicable registration and license numbers(s): _____; _____; _____; _____

D. Emergency Services

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

Name of Hospital	Address of Hospital

11. Attestation

I, _____, under penalty of perjury, 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, the applicant is in compliance with the provisions of section 408.806 and Chapter 435, Florida Statutes.

(4) Pursuant to sections 408.809 and 435.05, Florida Statutes, every employee of the applicant required to be screened has attested, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to Chapter 408, Part II, and Chapter 435, Florida Statutes, and has agreed to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer.

(5) Pursuant to section 435.05, Florida Statutes, the applicant has conducted a level 2 background screening through the Agency on every employee required to be screened under Chapter 408, Part II, or Chapter 435, Florida Statutes, as a condition of employment and continued employment and that every such employee has satisfied the level 2 background screening standards or obtained an exemption from disqualification from employment.

Signature of Licensee or Authorized Representative	Title	Date

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

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

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

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