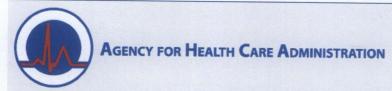


| strative Code (F.A.C.), a Int to section 408.806.(1) cial security number of the on of the provider, finance or provider and each os, and federal employer ling interest is not an ind stration shall use such in tition for licensure. When the information belower will be listed on http: der/Facility Information ense # | | tutes (F.S.), and Chapters 594 perate an abortion clinic as inc application for licensure must in liarly titled person who is respon who is responsible for the fin tor controlling interest is an inc applicant and each controlling ity number(s) is mandatory. Ti ng the proper identification of p s. Provider/Facility name, ad | A-35 and 59A-9. Florida dicated below. nclude: the name, address onsible for the day to day nancial operation of the dividual; and the name, pinterest, if the applicant or he Agency for Health Care persons listed on this |
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| the authority of Chapters strative Code (F.A.C.), a not to section 408.806 (1) clal security number of the or of the provider, finance or provider and each cos, and federal employer ling interest is not an indistration shall use such inton for licensure. When the information belower will be listed on http://der/Facility Informationers # | a 408, Part II and 390, Florida Statutes, an application is hereby made to o (a) and (b), Florida Statutes, an a he applicant, administrator or similaristicle personant of the applicant identification number (EIN) of the invidual. Disclosure of social securiformation for purposes of securification in the applicant information for purposes of securification in the application of the applicant information for purposes of securification in the application of the application of the application in the appli | tutes (F. S.), and Chapters 59A pperate an abortion clinic as line application for licensure must it liarly titled person who is responsible for the fin applicant and each controlling itly number(s) is mandatory. Ti g the proper identification of p s. Provider/Facility name, ad | A-35 and 59A-9. Florida dicated below. Include: the name, address onsible for the day to day nancial operation of the dividual; and the name, ginterest, if the applicant or he Agency for Health Care persons listed on this |
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| of Abortion Clinic (If ope | | | |
| of Abortion Clinic (If ope | | None | Pending |
| | rated under a fictitious name, ent | er as it appears in Florida Divis | sion of Corporations.) |
| der/Facility Location | Address | | |
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| Address Note: By pr | roviding your email address, you a | agree to accept email correspo | andence from the Agency. |
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| er/Facility Website | | | |
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| Provider: | Logged in as | | | Dashboard | OL Help | Documents | Logout |
| Provider Type: Abortion Clinic | | | Provider/Facility | | | | Logout |
| License #: Expires: | Provider/F | acility Contact | Person for this Application | | | | |
| Application: | First Name | acinty contact | | | | | |
| Type: Renewal Licensure Status: | riistivaille | | Middle Name | L | ast Name | | Suffix |
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| Details | _'None | | | | | | |
| Contact Person | | | | - | | | |
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| Licensee Information > | | | | | | Dack | MEXISS |
| Controlling Interests * | | | | | | | |
| Management Company Information | | | | | | | |
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| polication portion Clinic HCA Form 3110-1000 OL, ly 2016 | | | | | | | |
| A-9.020, Florida Iministrative Code | | | | | | | |

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| Abortion Clinic License # | Provider: | Logged in as : | Dashi | ooard OL Help | Documents Logout |
|--|--|---|--------------------|------------------------|-------------------|
| Description of licensee (select only one option below) Description of licensee (select only one option below) | Provider Type: Abortion Clinic | | Licensee Informa | tion | |
| Application: Type: Renewal Licensure Status: Date Received: Provider/Facility information Entity Licensee Details Licensee Information Licensee Information Licensee Details Controlling Interests Management Company information Edit Address Address Address Address Address Telephone Ext Fax # Email Address None None None | File#: License #: Expires: | Description of licenses (select only of | no entire heleval. | | |
| Status: Date Received: Status: Date Received: Date Received: Status: Date Received: | Application: | | | | |
| Entity Licensee Details Entity Licensee Details Licensee Information Licensee Information Licensee Details Controlling Interests Mailing Address Edit Address Management Company Information Personnel Required Disclosure Telephone Ext Fax # Email Address None None None | Status: | Ownership Types | | | |
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| Provider Type: Abortion Clinic | | Controlling In | terests of I | _icense |) | | |
| File#: License #: Expires: | | | | | | | |
| Application: Type: Renewal Licensure Status: Date Received: | | | | | | | |
| = Entered = Entry Required | Controlling Interests, as de as an officer of, is on the boa person or entity that serves a management company or ott provider. The term does not i | ard of directors of, or has a s as an officer of, is on the boo her entity, related or unrelat | o% or greater owners ard of directors of, or ed, with which the an | hip interest in t | he applican | t or licensee; | or a |
| Provider/Facility Information * | Do any individuals or entities less than 5% ownership? | | | licensee, or, fo | inction as a | board memb | er with |
| ○ Licensee Information ❖ | → Yes → No | | | | | | |
| Controlling Interests * | To <u>add</u> a controlling interest - Utilizing the pick list below, ei Controlling Interest - Individua | ther choose an individual/er | itity that is already as | sociated with t | nis applicati | on or select 'I | New |
| Controlling Interests | Conditing Interest - Individual | in or New Condoning Intere | st - Enuty . | | | | |
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| Required Disclosure * | Color Rollore and enter an | | | ne licensee en | | | |
| Procedures/Transfer | D 5.810.6 | Full Name of Individual/ | | Tax ID | Effective Date | End Date | <u>%</u> |
| Agreement | Remove Edit/View | | SSN | | | | 100.00 |
| Days and Hours of Operation * | | | | Total | 100.00 emoved: | (-) Added: | (+) |
| Supporting Documents * | If the percentage of ownersh | nip interest indicated above | re does not equal 10 | 00%, please ex | plain why i | in the space | below: |
| Finalize Submission \$ | | | | | | | ^ |
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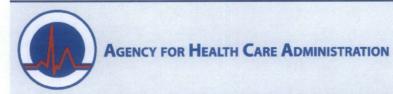




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| Provider Type: Abortion Clinic | | | Ma | ınag | ement C | ompany | Control | lling In | terest | | |
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| = Entered = Entry Required | | | | | r 'New Controll | ividual/entity that i ing Interest - Entity | | clated with t | nis applicatio | on or selec | T New |
| Provider/Facility Information | * | | existing contro | | | | | | | | |
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| Provider Type: Abortion Clinic | | Per | sonnel | | | |
| File#: License #: Expires: | | | | | | |
| Application: Type: Renewal Licensure Status: Date Received: | Personnel Note: For the administrator and Clearinghouse (Clearinghouse) | | | | | |
| = Entered = Entry Required | AHCA Form 3100-0008 if back, for a certificate of authority to o be screened, visit http://ahca.m | ground screening was conc perate a continuing care re | ducted by the Depart tirement community | ment of Financial Se under Chapter <u>651.</u> | ervices for an a F.S. To verify i | pplicant vho is to |
| Provider/Facility | Provide the information for the i Administrator / Facility Ma Financial Officer | | he following roles: | | | |
| ↓ Licensee Information ⇒ | To <u>add</u> an individual - Utilizing the pick list below | w, either choose an individ | ual that is already as: | sociated with this ap | plication or sel | ect 'New |
| Controlling Interests \$ | Individual'. | | | | | |
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| Management Company Information | To edit an existing individ | dual - | | | | |
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| Company \$ Information | Select "Edit/View [*] and edi To <u>remove</u> an existing in Select "Remove" and ent | dual - lit as needed. | relationship with the | licensee ended. Roles | Effective Date | End Date |
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| Provider Type: Abortion Clinic | | | Required Disc | closure | | |
| File#: License #: Expires: | | | | | | |
| Application: Type: Renewal Licensure | Convicti | | | | | |
| Status: Date Received: | Pursuant | to subsection 408.809 is or offenses prohibite | F.S., the applicant shall submit to ted by sections 435.04 and 408.809(4 | the agency a description 4), F.S., for each controlli | and explanation of any ng interest. | 1 |
| = Entered = Entry Required | Has the a of this app | pplicant or any individ blication been convicted | ual listed in the Controlling Interests od of any level 2 offense pursuant to | or Management Compar subsection 408.809, Flo | ny Controlling Interests rida Statutes?) | sections |
| Provider/Facility Information | ♦ O Yes | S ○ No | | | | |
| ⊘ Licensee Information | ¥ Undo | | Save | | << Back | Next >> |
| Controlling Interests | * | | | | | |
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| Occupations | | | | | | |
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LICENSURE & REGULATION FIND A FACILITY REPORT FRAUD ABOUT US MEDICAID HOME Dashboard OL Help Documents Logout Logged in as: Provider: Provider Type: Abortion Clinic **Required Disclosure** File#: License #: Expires: Application: Type: Renewal Licensure Status **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. Date Received: Has the applicant or any individual/entity listed in the Controlling Interests or Management Company Controlling Interests sections of this application been excluded, suspended, terminated or involuntarily withdrawn from participation in Medicare or Medicaid in any state? = Entered G = Entry Required Provider/Facility Information O Yes O No ○ Licensee Information ⇒ Undo Save << Back Next >> **Controlling Interests** Management Company Information * * Personnel Required Disclosure * Convictions **©** Exclusions Felonies/Terminations Procedures/Transfer Agreement Days and Hours of Supporting Documents > **Finalize Submission** Health Care Licensing Online Heatin Care Licensing Onlin Application Abortion Clinic AHCA Form 3110-1000 OL, July 2016 59A-9.020, Florida Administrative Code



| ABOUT US MEDICAID | LICENSURE & REGULATION | FIND A FACILITY | REPORT FRAUD | |
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| | Required Disc | closure | | |
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| Felonies/ Terminations Pursuant to section 408.815 controlling interest of the ap | 5(4), F.S., has the applicant or a controll | ing interest in the applicant, o | or any entity in which a ever been: | |
| chapter <u>817</u> , chapter <u>893</u> , <u>2</u> | 1 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1 | 395-1396, Medicaid fraud, M | ony under chapter <u>409</u> , ledicare fraud or insuranc | ce |
| Yes No | years prior to the date of this application | ", | | |
| 2. Terminated for cause from | m the Medicare program or a state Medic | caid program. | | |
| ◯ Yes ◯ No | | | | |
| If yes, has applicant be years and the terminati | en in good standing with the Medicare p ion occured at least 20 years before the | rogram or a state Medicaid p date of the application. | orogram for the most rece | ent 5 |
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| | Felonies/ Terminations Pursuant to section 408.81 controlling interest of the appropriate of the approximation of | Felonies/ Terminations Pursuant to section 408.815(4), F.S., has the applicant or a controll controlling interest of the applicant was an owner or officer when the state of the applicant was an owner or officer when the state of the applicant was an owner or officer when the state of the applicant was an owner or officer when the state of the state of the state of the state of this application. 1. Convicted of, or entered a plea of guilty or note contendere to, reschapter 817, chapter 893, 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1 fraud, within the previous 15 years prior to the date of this application. 1. Yes No 2. Terminated for cause from the Medicare program or a state Medicare progra | Pursuant to section 408.815(4), F.S., has the applicant or a controlling interest in the applicant, controlling interest of the applicant was an owner or officer when the following actions occurred of the applicant was an owner or officer when the following actions occurred of the applicant was an owner or officer when the following actions occurred of the application of the application of the chapter 817, chapter 893, 21 U.S.C. ss. 801-970, or 42 U.S.C. ss. 1395-1396, Medicaid fraud, Mitraud, within the previous 15 years prior to the date of this application; Order No 2. Terminated for cause from the Medicare program or a state Medicaid program. Order No If yes, has applicant been in good standing with the Medicare program or a state Medicaid program and the termination occurred at least 20 years before the date of the application. | Required Disclosure 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 insurant 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 receivers and the termination occurred at least 20 years before the date of the application. |

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| Provider: | Logged in as: | Da | shboard OL Help | Documents Logout |
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| Provider Type: Abortion Clinic | | Procedures Per | formed | |
| File#: License #: Expires: | | | | |
| Application: Type: Renewal Licensure Status: | Indicate the procedures perfo | rmed at the clinic: s the period of time from fertilization throu | igh the end of the 11th w | eek of gestation. |
| Date Received: | | ch is the period of time from the beginning | | |
| | Note: If second trimester abo | rtions are performed, a medical director n | nust be added. | |
| Provider/Facility | To <u>edit</u> the existing director - Select 'Edit/View' and edit as | | | |
| ↓ Licensee Information ⇒ | To <u>remove</u> the existing direct Select 'Remove' and enter the | tor - e applicable end date. | | |
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| Management Company Information Personnel Required Disclosure Procedures/Transfer | | | Licens | Date CHU Date Date CHU Date |
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REPORT FRAUD **ABOUT US** MEDICAID LICENSURE & REGULATION FIND A FACILITY HOME Dashboard OL Help Documents Logout Logged in as : Provider: **Provider Type: Transfer Agreement/Admitting Privileges** Abortion Clinic File#: License #: Expires: Check all that apply: Application: Type: Renewal Licensure Status: All the physicians performing abortions have admitting privileges at a hospital within reasonable proximity. Date Received: ☐ The abortion clinic has a transfer agreement with a hospital within reasonable proximity. If checked, provide the Hospital(s) information below: = Entered
= Entry Required Provider/Facility Information Undo Save << Back Next >> **○** Licensee Information Controlling Interests Management Company > * Personnel Required Disclosure * Procedures/Transfer Agreement Procedures Performed Transfer Agreement/Admitting Privileges Days and Hours of Operation Supporting Documents * **Finalize Submission** *

Health Care Licensing Online Application Abortion Clinic AHCA Form 3130-1000 OL, July 2016 59A-9.020, Florida Administrative Code





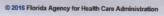
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| Provider: | Logged in as : | | Dashboard OL Help | Documents Logout |
| Provider Type: Abortion Clinic | | Days and Hours | of Operation | |
| File#: .icense #; Expires: | | | | |
| pplication: ype: Renewal Licensure tatus late Received | List the regular operating Note - Site inspections b hours may result | y surveyors will occur during the busines | s hours submitted. Failure to be | open during the listed |
| | Day | <u>OpeningTime</u> | Closing Time | By Appointment |
| = Entry Required | MONDAY | V | ~ | |
| Provider/Facility * | TUESDAY | <u> </u> | _ | |
| Information | WEDNESDAY | ▼ | $\overline{\lor}$ | |
| ↓ Licensee Information * | THURSDAY | | | |
| Controlling Interests \$ | FRIDAY | | | |
| Management | | | | |
| Company × Information | SATURDAY | | _ | |
| Personnel * | SUNDAY | V | <u> </u> | |
| Required Disclosure * | Undo | Save | | << Back Next >> |
| Procedures/Transfer & Agreement | | | | |
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| Days and Hours of Operation | | | | |
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|---|---|-----------------------------|---------------------------------------|--|---------------------------------|------------------------------|------------------------|-----------------|---------|
| rovider Type: bortion Clinic | | | | Suppor | ting Do | cuments | | | |
| ile#; lcense #; xpires: | | Applicants M Chapter 59/ | MUST include the A-35 and 59A-9, F | following attachments Florida Administrative C | as stated in Cha ode (F.A.C) | apters <u>408 Part II</u> an | d <u>390</u> , Florida | Statutes (F. | S.) and |
| pplication: ype: Renewal Licensure tatus: | | .DOC, .PDF | , .TIFF, .TXT, .JP | uggested for uploading PG, .XLS, and .PPT. OT permitted for upload | | | | | |
| Date Received: | | The upload | and submission p | process will fail if any of | these unpermit | ed file types are sel | ected. | 1.00. | |
| = Entered = Entry Required | | Approved F | Repayment Plan | | | 72 | | | |
| Provider/Facility Information | * | for printi | ng upon completi | copy of the document ing your application) will ting documents to the A | be mailed to th | e Agency immediate | ely. I acknowle | edge that faile | ire to |
| Licensee Information | * | | | | Browse | | | | |
| Controlling Interests | * | Additional I | Documentation | | | | | | |
| Management Company Information | * | for printi | ng upon completi | copy of the document is ing your application) will ting documents to the A | be mailed to th | e Agency immediate | ely. Lacknowle | doe that faile | ire to |
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| Supporting Documents | | Undo | | | Save | | | << Back | Next >> |
| Finalize Submission | * | | | | | | | | |
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Health Care Licensing Online Application Abortion Clinic AHCA Form 3110-1000 OL, July 2016 59A-9.020, Florida Administrative Code







ABOUT US MEDICAID LICENSURE & REGULATION FIND A FACILITY REPORT FRAUD HOME Logged in as : Dashboard OL Help Documents Logout Provider: Provider Type: **Finalize Application** File#: License #: 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. Expires: Application: Type: Renewal Licensure Status: Date Received: 1. Provider/Facility Information 95. Personnel a. Details b. Contact Person a. Administration = Entered = Entry Required 6. Required Disclosure ©2. Licensee Information a. Licensee Details a. Convictions b. Exclusions Provider/Facility c. Felonies/Terminations Information × 3. Controlling Interests 7. Procedures/Transfer Agreement a. Procedures Performed b. Transfer Agreement/Admitting Privileges a. Controlling Interests **⊘** Licensee Information Management Company Information

 Management Company Information
 Management Company Controlling Interest

 Controlling Interests 8. Days and Hours of Operation a. Days and Hours of Operation Management Company * 9. Supporting Documents a. Supporting Documents Personnel * Required Disclosure * After completing all sections of your application, click the button below to submit your uploaded documents to the Agency and make payment (if necessary). Procedures/Transfer Agreement Submit Application Days and Hours of Operation × **⊘** Supporting Documents **⋄ Finalize Submission** Finalize Application Health Care Licensing Online

Application
Application
Clinic
AHCA Form 3110-1000 OL,
July 2016
59A-9.020, Florida Administrative Code



REPORT FRAUD LICENSURE & REGULATION FIND A FACILITY HOME **ABOUT US** MEDICAID Dashboard OL Help Documents Logout Logged in as : **Payment Summary** Provider Type: Abortion Clinic If you exit this application without selecting a payment method, you will not be able to License #: return to this page without first contacting the Agency. You must provide payment before your application can be accepted by the Agency. Review the information below, and select one of the payment methods at the bottom of the page. Application: Type: Renewal Licensure Type Total Amount Current Due Payment Description **Due Date** Date Received: 1 Application Fee Biennial Assessment 13BA = Entered
= Entry Required Total * Amounts shown may not reflect recent payments. Provider/Facility Note - You may submit your application without paying all outstanding amounts, but you will not receive your license until they are settled. If you choose not to pay a particular amount at this time, uncheck the box to the Details left of the amount. Contact Person Biennial Licensure Fee and Other Amounts Due Upon Submission of Application The biennial licensure fee is \$ \$550.50 The blennial health care assessment fee is \$300
 Other amounts due (fines, assessment, fees, etc.) will be detailed in the application ○ Controlling Interests × attest as follows: Management Company * (1) Pursuant to section 837.06, Florida Statutes (F.S.), I have not knowingly made a false statement with the intent to mislead the Agency in the performance of its official duty. Personnel * (2) Pursuant to section 408.815, Florida Statues (F.S.), 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. Required Disclosure × (3) Pursuant to section 408.806, Florida Statues (F.S.), under penalty of perjury, the applicant is in compliance with the provisions of section 408.806 and Chapter 435, Florida Statutes (F.S.). Procedures/Transfer (4) Pursuant to section 408.809 and 435.05. Florida Statutes (F.S.), 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 (F.S.), and has agreed to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer. Days and Hours of Operation (5) Pursuant to section 435.05, Florida Statutes (F.S.), the applicant has conducted a level 2 background screening through the Agency on every employee required to be screened under Chapter 498, Part II or Chapter 435, Florida Statutes (F.S.), 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. **⊘** Supporting Documents **⋄ Finalize Submission** 10/21/2016 Title Signature of Licensee or Authorized Representative Date ☐ I agree Health Care Licensing Online Application Abortion Clinic AHCA Form 3130-1000 OL, July 2016 59A-9.020, Florida Administrative Code CHECK gtre Myuage son 23449 \$527 Pay By Mail Pay Online Note - Your application will not be considered received until payment has been received. Selecting the "Pay by Mail" option will delay the Agency's receipt of your application, resulting in the assessment of late fees if payment is not received by the due date.



Please Note: Following your selection of payment method, you will not be able to make changes or additional payments until AHCA licensure staff have completed their review.



| Номе | A | BOUT US | MEDICAID | LICENSURE & REGULA | TION FI | ND A FACILITY | REPO | RT FRAUD | |
|--|---|--|--------------------|------------------------------|-----------------|------------------|------------------|-------------|--|
| Provider: | | Logged in a | as: | | Dashbo | oard OLH | elp Docu | ments Logo | |
| Provider Type: | | Pay Online | | | | | | | |
| File#: | | | | | | | | | |
| License #: Expires: | | Item 1 | Application Fee | | Total Amount | Current Due | Payment | Due Date | |
| | | ~ | Late Fee | | | | | | |
| Application: Type: Renewal Licensure | | V | Biennial Assessmen | nt 🕝 | | | | | |
| Status: Date Received: | | | V | Total | | | | | |
| Pate Neceiveu. | | | * An | nounts shown may | not reflect i | recent pay | ments. | | |
| = Entered= Entry Required | | Div | rision_ | | | | | | |
| Provider/Facility Information | * | Transaction Amount Service Charge Total Amount | | | | | | | |
| Details | | Sel | ect Payment Metho | d | | | | | |
| Contact Person | | ○ Credit Card ○ Checking | | | | | | | |
| | | P | ay Total Amount | | | | | | |
| ⊘ Licensee Information | * | | | | | | | | |
| Controlling Interests | * | Terms, Conditons & Fees for Payments: A non-refundable convenience fee of 3.25% will be added to all credit card payments and \$0.18 on all e-check (checking) payments. Please allow 2 to 5 business days for the payments to be settled and posted. | | | | | | | |
| Management Company Information | * | Refund Policy The refund processing of your payment will begin upon receipt of the Application for Refund form. Applications for refund are processed in accordance with Florida Administrative Code 12-26.002 and Florida Administrative Code 69-44.020. We will notify you if, for any reason, we are not able to process the refund. Section 215.26. Florida Statutes, requires all requests for refunds be submitted within 3 years of the initial payment to the State of Florida. Depending upon the users's method of payment, refunds may be issued using the original method of | | | | | | | |
| Personnel | * | | | | | | | | |
| Required Disclosure | * | | ment. | oon the users's method of pa | ment, retunds m | lay be issued us | sing the origina | I method of | |
| Procedures/Transfer Agreement | * | | | | | | | | |
| Days and Hours of Operation | * | | | | | | | | |
| Supporting Documents | * | | | | | | | | |
| Finalize Submission | * | | | | | | | | |

Health Care Licensing Online Application Abortion Clinic AHCA Form 3110-1000 OL, July 2016 59A-9.020, Florida Administrative Code

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To schedule your one-time payment enter your credit card and payment information below.

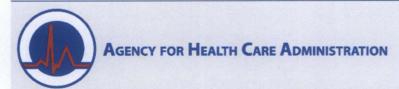
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| * Transaction Amount: | |
| * Service Fee: | |
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| * Account Number: | |
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| *Payment Account Type: | ~ |
| *Name on Credit Card: | (The name must appear as it does on the credit card account.) |
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| | Click on the image to see Credit Card Security Value locations. |
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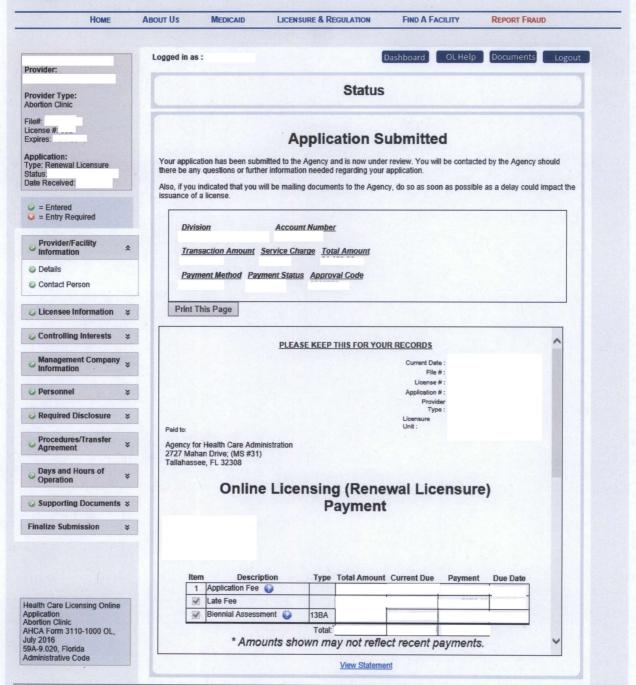
Continue Cancel



| * Service Fee: * Division Name: * Account Number: * eMail Address: * indicates a required field Payment Information for Transaction ID #: 3390 *Payment Account Type: * Personal Checking Personal Savings Business Savings Checking Savings * Name on Bank Account: * Bank Routing Number (ABA): * Banking Account Number (DDA): Please enter payment amount. For on-time posting of the payment to your account, please allow 3 business days prior to for processing. * Payment Date: * Payment Amount: | | | | |
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| Continue | | | | |
| John Doe 123 10th Avenue Whereville, NJ 00000 | | | | |
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| PAY TO THE ORDER OF DOLLARS 1. | | | | |
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The name on the account is found at the top of your check.
 The Bank Routing Number is found on the bottom of your check between the two colons.
 The Bank Account Number is found on the bottom of your check after the nine-digit bank routing number.





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LICENSURE & REGULATION FIND A FACILITY REPORT FRAUD ABOUT US MEDICAID HOME Dashboard OL Help Documents Logout Logged in as : Provider: **Status** Provider Type: File#: License #: **Application Submitted - Awaiting Payment** Application: Type: Renewal Licensure Your application has been submitted to the Agency. As a reminder, your application is <u>not considered received</u> until the appropriate payment has been received by the Agency. Be sure to include the statement with your mailed payment. Date Received: Also, if you indicated that you will be mailing documents to the Agency, do so as soon as possible as a delay could impact the issuance of a license. Once your payment and any additional documents have been received, you will be contacted by the Agency should there be any questions or further information regarding your application. = Entered = Entry Required Provider/Facility Information IN ORDER TO ENSURE THAT YOUR FUNDS ARE PROPERLY APPLIED, YOU MUST INCLUDE THIS STATEMENT WITH YOUR SUBMISSION TO THE AGENCY Details Contact Person Application # : Provider Type : **⊘** Licensee Information Unit: Controlling Interests Management Company Information Agency for Health Care Administration 2727 Mahan Drive; (MS #31) Tallahassee, FL 32308 Personnel * Online Licensing (Renewal Licensure) Required Disclosure * Statement Procedures/Transfer Agreement Days and Hours of Operation Description Type Total Amount Current Due Payment 1 Application Fee ✓ Late Fee **Finalize Submission** ✓ Biennial Assessment Total: * Amounts shown may not reflect recent payments View Statement Health Care Licensing Online Application Abortion Clinic AHCA Form 3110-1000 OL,

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