State of California - Health and Human Services Agency

California Department of Public Health (CDPH)
Nursing Home Administrator Program (NHAP)
MS 3302
P.O. Box 997416
Sacramento, CA 95899-7416
(916) 552-8780 FAX (916) 552-8777
NHAP@cdph.ca.gov

NHA/FACILITY PROFILE SHEET

Please complete and return profile sheet to NHAP, within thirty (30) days of change(s):

ADMINISTRATOR'S NAME	NHA LICENSE NUMBER

SECTION I

☐ **FACILITY EMPLOYMENT INFORMATION**

DATES		EMPLOYED	NAME OF NURSING HOME	ADDRESS OF NURSING HOME
FROM	TO			
		☐ Yes ☐ No		
		☐ Yes ☐ No		
		☐ Yes ☐ No		

SECTION II

☐ **CHANGE OF ADDRESS INFORMATION**

NHA'S NAME *(Last)*	*(First)*	*(M.I.)*	DATE OF BIRTH
NHA'S ADDRESS *(Number and Street)*	*(City)*	*(State)*	*(Zip Code)*
NHA LICENSE NUMBER	TELEPHONE NUMBER ( ) -	SOCIAL SECURITY NUMBER* ___-___-____	EFFECTIVE DATE OF CHANGE

*Social Security Number Disclosure: Pursuant to Section 666(a)(13) of Title 42 of the United States Code and California Family Code, Section 17520, Subdivision (d), the California Department of Public Health (CDPH), is required to collect social security numbers from all applicants for nursing home administrator licenses. Disclosure of your social security number is mandatory for purposes of establishing, modifying, or enforcing child support orders upon request by the Department of Child Support Services and for reporting disciplinary actions to the Health Integrity and Protection Data Bank as required by 45 CFR, Section 61.1 et seq. Failure to provide your social security number will result in the return of your application. Your social security number will be used by CDPH for internal identification, and may be used to verify information on your application, to verify certification with another state's certification authority, for exam identification, for identification purposes in national disciplinary databases or as the basis of a disciplinary action against you.

OLD ADDRESS INFORMATION

ADDRESS (Number and Street)	*(City)*	*(State)*	*(Zip Code)*

SECTION III

☐ **NAME CHANGE -** (Attach appropriate documentation verifying the change (e.g. copy of driver's license, marriage license, passport, etc.)

NHA's NAME *(Last)*	*(First)*		*(Middle)*
NHA's ADDRESS *(Number and Street)*	*(City)*	*(State)*	*(Zip Code)*
NHA LICENSE NUMBER	TELEPHONE NUMBER *(Home)* ( ) -	TELEPHONE NUMBER *(Business)* ( ) -	

Maintenance of the information requested on this application form is authorized by Section 1416.34(h) and Section 1416.60 of the Health and Safety Code. No items of information are voluntary; all are required. **Failure to provide any of the required information will result in the application being rejected as incomplete.**

I certify under the penalty of perjury laws of the State of California that the information obtained in this document is both true and correct.

Signature of Administrator Date

FOR OFFICE USE ONLY

NHAP STAFF INITIALS _____

DATE RECEIVED _____

DATE UPDATED AND FILED _____