Cover Letter

ABC Healthcare Services, Inc.
999 Beach Side Court, Sacramento, CA 95814
P: (999) 555-2626
F: (999) 555-2600
Email: ABChealthcareservices@gmail.com

March 15, 2019

VIA PRIORITY MAIL:

California Department of Public Health
Licensing and Certification
P. O. Box 997377, MS 3207
Sacramento, CA 95899
Attn: Centralized Applications Branch

To Whom It May Concern,

We are submitting this **Change of Service** *(Hours/Days of Operation)* application.

Facility Name: **ABC Adult Day Health Center**
Facility Address**: 1800 Beach Drive, Sacramento, CA 95814**
Facility ID Number: **123456789**
Licensee Name: **ABC Healthcare Services, Inc.**
License Number: **222222222**

I enclosed the required application forms and supporting documents needed to process this change.

Should you have any questions, I will be the direct contact regarding this change.

Emergency Contact Information (available 365/24/7)
Name: Jane Doe
Email: ABChealthcareservices@gmail.com
Alternate Email: JaneDoe@cmail.com
Phone: (999) 555-2626
Phone (Text Messages): (999) 555-5555
Fax: (999) 555-2600

Sincerely,

Jane Doe, Owner
ABC Healthcare Services, Inc.

HS 200

LICENSURE & CERTIFICATION APPLICATION

FOR DEPARTMENTAL USE ONLY	
Proposed name of facility/agency/clinic:	

A. APPLICATION INFORMATION

1. Type of application (check one):
   - ○ **a.** Initial
   - ○ **b.** Change of Ownership (see #2 below)
   - ○ **c.** Management company (see Sections C1-5, F, and Attachment E-1)
   - ◉ **d.** Other change (see Section A4): Change of hours/days of oper

2. **Change of Ownership Only - For Certification Purposes:**
   We wish to make certain that our records correctly show the effective date of the ownership change for certification. This date should reflect the actual date on which you took charge of the financial management of the facility rather than the date of sale or date of state license change. Effective date of change:

3. Amount of fee enclosed: $

4. Type of Change (check all that apply):
   - ☐ **a.** Not applicable
   - ☐ **b.** Change of capacity (see # 8 below)
   - ☐ **c.** Change of location
   - ☑ **d.** Change of services Hours/days
   - ☐ **e.** Change of facility type
   - ☐ **f.** Change of bed classification
   - ☐ **g.** Change of name
   - ☐ **h.** Construction of new or replacement facility
   - ☐ **i.** Stock transfer
   - ☐ **j.** Other (specify)

5. Type of facility, agency, or clinic (check one)
   - ○ **a.** Skilled Nursing Facility (SNF)
   - ○ **b.** Intermediate Care Facility (ICF)
   - ○ **c.** ICF/Developmentally Disabled (ICF/DD)
   - ○ **d.** ICF/DD-Habilitative (ICF/DD-H)
   - ○ **e.** ICF/DD-Nursing (ICF/DD-N)
   - ○ **f.** Primary care clinic – Free
   - ○ **g.** Primary care clinic – Community
   - ○ **h.** Surgical clinic
   - ○ **i.** Rural health clinic (for Certification "only")
   - ○ **j.** General acute care hospital
   - ◉ **k.** Adult day health care center
   - ○ **l.** Home Health Agency (HHA)
   - ○ **m.** Hospice
   - ○ **n.** Chronic dialysis clinic
   - ○ **o.** Other (specify)

6. **a.** Do you wish to apply for the Medicare program? ○ Yes ◉ No Medicare Provider #:
   b. Fiscal Intermediary choice:

7. Do you wish to apply for the Medi-Cal (Medicaid) program? ○ Yes ◉ No

8. **a.** Current facility bed capacity: N/A
   b. Proposed facility bed capacity: N/A

9. Age range of clients: 55 and over

10. Days and hours of operation: Mon-Thurs: 8am-5pm / Service Hrs: 8:30am-3pm

11. Is construction required? ○ Yes ◉ No
    If "yes", submit copy of "OSHPD" form (see instructions on page 6)
    If "yes", date construction to begin:
    If "yes", date construction to be completed:

B. LICENSEE INFORMATION

1. Licensee name: ABC Healthcare Services, Inc.

2. Federal employer's tax ID number: 555555555

3. Owner type (check one): ***Submit*** organizational chart for b, c, d, and e.

- ○ **a.** Sole proprietorship (Individual)
- ◉ **b.** Profit corporation
- ○ **c.** Nonprofit corporation
- ○ **d.** Limited Liability Company (LLC)
- ○ **e.** Partnership – General
- ○ **f.** Partnership – Limited
- ○ **g.** City
- ○ **h.** County
- ○ **i.** State agency
- ○ **j.** Other agency (specify)
- ○ **k.** Public agency (specify)

4. Licensee address (number & street): 999 Beach Side Court

Telephone number: (999) 555-2626

City, State, & Zip: Sacramento, CA 95814

E-Mail: ABChealthcareservices@gmail.com

Fax number: (999) 555-2600

5. a. Identify other facilities, agencies, or clinics the licensee has been licensed for, operated, managed, held a **5%** or more interest in, or served as a director or officer. Include facilities both in and outside of California. ***Submit*** an attachment for additional facilities that includes all of the required information listed below.

(1) Facility Name: | Facility Type:

Facility address (number & street): | City, State, & Zip:

(2) Facility Name: | Facility Type:

Facility address (number & street): | City, State, & Zip:

(3) Facility Name: | Facility Type:

Facility address (number & street): | City, State, & Zip:

(4) Facility Name: | Facility Type:

Facility address (number & street): | City, State, & Zip:

5. b. If any facility, agency, or clinic identified in 5.a. has had a license revocation action filed, license placed on probation, suspended, or revoked (whether stayed or not) or, for agency or clinic resolved by settlement, receiver appointed, or had a final Medi-Cal decertification action taken, please ***submit*** additional information, including all ownership and facility information, date and any final action.

6. Is the licensee a **subsidiary** of another organization? ○ Yes ◉ No
If "yes", complete the information below and ***submit*** an organizational chart:

Parent organization name:

Parent federal tax ID Number:

P.O. Box or number & street:

City, State, & Zip:

C. FACILITY, AGENCY OR CLINIC INFORMATION

Management Agreement (this only applies to SNF's & ICF's):

1. **a.** Is the facility, agency, or clinic going to be operated under a management contract/agreement between the proposed owner and a management company? If "yes", proceed to **Section E** (below). ○ Yes ◉ No

   b. Is there an "interim" management agreement, between the proposed owner and the current owner, to run the facility, agency, or clinic until the change of ownership is completed? If "yes", ***submit*** a copy of the "interim" management agreement. ○ Yes ◉ No

2. Name of **"proposed" facility**, agency, or clinic:
   Current facility, agency, or clinic name (if change of ownership):
   ABC Adult Day Health Center Facility license number: 123456789

3. Address (number & street) of "proposed" facility, agency, or clinic: 1800 Beach Drive Telephone number: (999) 555-0695
   City, State, & Zip: Sacramento, CA 95814

4. Mailing address, if different from above:
   Number & Street: Telephone number:
   City, State, & Zip: Fax number: E-mail address:

5. **Name of person to be in charge of facility, agency, or clinic:** Wain Jones
   Title: Administrator Professional License number: 88888888

6. **a.** Name of administrator: Wain Jones Date of hire: 05/13/2019
   Professional License number: 88888888 Expiration date: 10/31/2020
   b. Name of director of nursing: Date of hire:
   Professional License number: Expiration date:

7. List persons having **5 percent** or more direct or indirect (42 CFR, Section 455.102) interest in the ownership of this facility if applying for skilled nursing or intermediate care licensure, and **10 percent** for all other facilities, agencies, or clinics. Provide federal employer's tax ID number. Are any of these persons (listed below) related to one another as spouse, parent, child or sibling? ***Submit*** an attachment for additional names that includes all of the required information listed below.

	Name of individual	% Owned	EIN Number	Are they related to one another as a spouse, parent, child or sibling?		Relationship
(1)	Jane Doe	100	55-5555555	○ Yes	○ No	
(2)				○ Yes	○ No	
(3)				○ Yes	○ No	
(4)				○ Yes	○ No	
(5)				○ Yes	○ No	

8. **Financial resources -- Only applies to SNF and ICF:**
   Submit evidence, i.e., bank statements, line of credit, certificate(s) of deposit, satisfactory to the department(s) that the licensee possesses financial resources sufficient to operate the facility for a period of at least 45 days. (The amount is determined by multiplying 45 days X number of beds X rate).

9. **Over-concentration -- Only applies to ICF/DD, ICF/DD-H and ICF/DD-N:**
   a. Are there any ICF/DD, ICF/DD-H, ICF/DD-N, RCF (residential care facility), or pediatric day health or respite care facilities within 300 feet of this facility? (H&S Code, Section 1267.9) ○ Yes ○ No ○ Don't know
   b. Are there any congregate living health facilities within 1,000 feet of this facility? ○ Yes ○ No ○ Don't know

10. **Program Plan -- Only applies to ICF/DD, ICF/DD-H and ICF/DD-N (H&S Code, Section 1275.3(b)(3))**
    Has the program plan been approved by the Department of Developmental Services? ○ Yes ○ No
    If "yes", ***Submit*** a copy of the approval letter. The "current licensee" can grant permission for their Program Plan to be used for 6 months if they ***submit*** a letter to CDPH. If "no", the application package will be delayed until a copy of the approved program letter is received.

D. PROPERTY INFORMATION

1. Property ownership: Check one and ***submit*** evidence of control of property: ○ Own ○ Rent ◉ Lease ○ Sublease ○ Other (specify):

2. **Owner of Record** name in the real estate: 123 Properties, LLC
   Address (number & street): 123 Boxview Street
   City, State, & Zip: Sacramento, CA 95814

   Lessee name: ABC Healthcare Services, Inc.
   Address (number & street): 1800 Beach Drive
   City, State, & Zip: Sacramento, CA 95814

   Sub-Lessee name:
   Address (number & street):
   City, State, & Zip:

E. MANAGEMENT COMPANY

If the proposed facility, agency, or clinic will be operated by a management company, under a management contract between the proposed owner and a management company, complete Attachment E-1 (next page). NOTE: if the facility is a SNF or ICF, the management company will have to SUBMIT a separate application to the Department, unless previously approved.

F. I (we) Accept responsibility to:

a. Comply with local ordinances concerning zoning, sanitation, building, and other appropriate ordinances.
b. Comply with the Labor Code on employment practices concerning nondiscrimination, liability insurance, wages, hour and working conditions.
c. Comply with Health and Safety Code and regulations concerning licensing and fire safety.

I (we) declare under penalty of perjury that the statements on this application and on the accompanying attachments are correct to my (our) knowledge.

Signature	Title	Date
	Owner	05/01/2019
Signature	**Title**	**Date**
Signature	**Title**	**Date**
Signature	**Title**	**Date**

Release of Information Statement

This information shall be provided to the state department upon initial licensure. ***Any changes must be provided to the state department within 10 days of the change***. The information shall be made available to the public upon request and shall be included in the public file of the facility.

The information provided on this form is mandatory and is necessary for licensure approval. It will be used to determine individual applicants or applicant facility's ability to provide health services. The information is requested by the California Department of Public Health, Licensing and Certification, in accordance with Health and Safety Code, Sections 1212, 1253, 1265, 1267.5, and 1728, and California Code of Regulations (CCR), Title 22, Sections 70107, 71107, 73205, 74105, 75022, 76205, and 78205.

Failure to provide the information as requested may result in nonissuance of a license or license revocation.

The information is considered public information and will be made available to the public upon request. The information shall be included and maintained in the individual facility's public files located in Licensing and Certification district offices.

ATTACHMENT E-1

MANAGEMENT COMPANY INFORMATION ONLY FOR SNF's or ICF's

1. ***Submit*** a copy of the Management Agreement with this application.

Name of management company: EIN:
Address (number & street):
City, State, & Zip:

Name of facility to be managed: EIN:
Address (number & street):
City, State, & Zip:

2. Provide the following information for ***each*** individual having a **5 percent** or more interest in the management company. ***Submit*** an attachment for additional names that includes all of the required information listed below.

(1) Individual's name: % Owner:
Address (number & street):
City, State, & Zip:

(2) Individual's name: % Owner:
Address (number & street):
City, State, & Zip:

(3) Individual's name: % Owner:
Address (number & street):
City, State, & Zip:

(4) Individual's name: % Owner:
Address (number & street):
City, State, & Zip:

3. Provide a list of all facilities, agencies, or clinics with which you have entered into a management agreement. ***Submit*** an attachment for additional facility, agency, or clinic names that includes all of the required information listed below.

(1) Facility, agency, or clinic name:
Address (number & street):
City, State, & Zip: Dates of involvement:

(2) Facility, agency, or clinic name:
Address (number & street):
City, State, & Zip: Dates of involvement:

(3) Facility, agency, or clinic name:
Address (number & street):
City, State, & Zip: Dates of involvement:

(4) Facility, agency, or clinic name:
Address (number & street):
City, State, & Zip: Dates of involvement:

INSTRUCTIONS

SNF or ICF Management Company Application: See Attachment E-1 below.

Type or print clearly. Return original and maintain a copy for your records. The Licensee's name must be consistent throughout all documents submitted. ***Submit*** all supplemental paperwork requested to complete your application. **Do not leave items blank. If not applicable, mark N/A.**

A. APPLICATION INFORMATION

1. Type of application: select items a, b, c, or d.
   If b is selected, provide effective date of change in number 2.
   If c is selected, complete Sections C1-5; F, and Attachment E-1.
   If d is selected you must select an option in number 4 -- "Type of Change."
2. Provide actual date applicant took charge of the financial management of facility.
   This date is used to show effective date of the ownership change for certification purposes only.
3. Amount of fee enclosed: enter the amount of money enclosed with this application.
   If no fee is required, enter "N/A". (Refer to fee schedule for appropriate fee requirements.)
4. Type of change: check all that apply.
5. Type of facility, agency, or clinic: select the appropriate category.
6. (a) Check "yes" if requesting certification for Medicare. ICF/DD, ICF/DD-N, ICF/DD-H facilities and primary care clinics that are not certified as rural health clinics are not eligible for Medicare.
   (b) If "yes" to item 6(a), provide name of fiscal intermediary under item 6(b).
7. Check "yes" if requesting participation in Medi-Cal (Medicaid).
8. (a) Current facility bed capacity: enter the total number of persons for whom care can currently be provided in any 24-hour period. This figure must agree with the "Certificate of Occupancy".
   (b) Proposed facility bed capacity: enter the proposed total number of persons for whom care will be provided in any 24-hour period.
9. Enter age range of persons to receive/receiving care.
10. Enter days and hours of facility operation.
11. Enter date construction is to begin, and date construction is to be completed (not applicable for ICF/DD, ICF/DD-N, ICF/DD-H facilities).
    - ☐ ***Submit*** a copy of the form *"Construction Advisory Board "* (form OSH-FDD 377) if OSHPD has approved construction.
    - ☐ ***Submit*** a copy of the above form to the local district office *prior* to the survey if OSHPD has not yet approved construction.

B. LICENSEE INFORMATION

1. Licensee name: enter the full legal organization name (LLC, partnership, and corporation) or individual(s) responsible for the facility/agency. If "Inc." is included in your legal name, it must appear in the name. Individuals enter first, middle, and last name. Husband and wife, if joint applicants, must both be listed.

   NOTE: All individuals including owners, partners, principal officers of corporations/LLCs, members, managers, and administrators (clinics only) must complete "Applicant Individual Information" (HS 215A).

2. Enter the federal employer's tax ID number.
3. Owner Type: select one of the options and then:
   - ☐ ***Submit*** an organizational chart, for items b, c, d, or e showing entity, persons, facilities, and tax EIN numbers.
   - ☐ ***Submit*** a copy of the Internal Revenue Service and Franchise Tax Board letters of determination of nonprofit status, if item c, "nonprofit corporation" is selected, and the facility is a primary care Clinic.

4. Licensee address: enter address of legal organization (LLC, corporation, partnership) or individual(s) responsible for the facility, agency, or clinic. Provide phone number with area code, fax number, and e-mail address.

5. Other Facilities:
   (a) Identify all other facilities, agencies, or clinics the licensee (LLC, corporation, partnership, individual) has been involved in, both in and outside of California.
   ☐ ***Submit*** an attachment, if needed, for additional entities, which includes the facility, agency or clinic type (including "affiliate" clinics), name, address, nature of involvement, and dates of involvement. This attachment must include all of the required information listed.
   ☐ ***Submit*** an attachment, if needed, for any entity identified in number 5a, which has had a license revocation action filed, license placed on probation, suspended, or revoked (whether stayed or not) or, for SNFs and ICFs, resolved by settlement, receiver appointed, or has a final Medi-Cal decertification action taken. Include all ownership and facility information, dates, and any final action.

6. Subsidiary: check "yes" if the licensee is a subsidiary of another organization and complete the information requested.
   ☐ ***Submit*** a detailed organizational chart, including parent and all subsidiary information, and federal tax ID numbers.

C. FACILITY, AGENCY, OR CLINIC INFORMATION

1. Management Agreement:
   (a) Check "yes" if the facility, agency, or clinic is going to be operated under a management contract/agreement, between the proposed owner and a management company. Proceed to Section "E" (below).
   (b) Check "yes" if there is an "interim" management agreement, between the proposed owner and the current owner, to run the facility until the change of ownership is completed.
   ☐ ***Submit*** a copy of the "interim" management agreement, if applicable.

2. Facility, agency, or clinic name: Enter the name used to designate the single facility, agency or clinic under the license being requested. Also, provide the current facility, agency, or clinic name, and current license number (if different). Change of ownership usually results in a name change.

3. Provide facility, agency, or clinic address, including phone number with area code, fax number, and e-mail.

4. Provide facility, agency, or clinic mailing address, if different from number 3 (above).

5. Provide the name and title of the individual to be in charge of the facility, agency, or clinic as well as any professional license number (if applicable).

6. Administrator:
   (a) Provide the name of the facility administrator, date of hire, license number, and license expiration date.
   (b) Provide the name of the director of nursing services (if applicable), date of hire, license number, and license expiration date.

7. Provide name(s) of all individuals having a **5 percent** or more interest in the ownership of this facility, if applying for SNF or ICF licensure. For all other facility, agency, or clinic types, provide the name(s) of those having **10 percent** or more interest in the ownership. Specify how these persons are related to one another as spouse, parent, child or sibling.
   ☐ ***Submit*** an attachment for all additional names. This attachment must include all of the required information.

8. Financial Resources: Only applies to SNF, ICF, and ICF/DD:
   ☐ ***Submit*** evidence, satisfactory to the Department, that the licensee has sufficient financial resources to operate the facility for at least 45 days (bank statement, certificate of deposit etc.). The amount is determined by multiplying 45 days X number of beds X rate.

9. Over-concentration -- Only applies to ICF/DD, ICF/DD-H and ICF/DD-N:
   (a) Are there other ICF/DD, ICF/DD-H, ICF/DD-N residential care, pediatric day health, or respite care facilities within 300 feet of this facility? Check "yes", "don't know" or "no".
   (b) Are there any congregate living health facilities within 1,000 feet of this facility? Check "yes", "don't know" or "no".

10. Program Plan -- Only applies to ICF/DD, ICF/DD-H and ICF/DD-N:
Indicate if the program plan has been approved by the Department of Developmental Services. The "current licensee" can grant permission for their Program Plan to be used for 6 months if a letter is submitted to CDPH. If "no" is checked, the application package will be held until a copy of the approved program plan letter is received.

☐ ***Submit*** a letter to CDPH from the "current" licensee that the "proposed" licensee has their permission to use the "current" licensee's Program Plan for up to 6 months, if applicable.

☐ ***Submit*** a copy of the Program Plan approval letter, if "yes".

D. PROPERTY INFORMATION

1. Licensee must show evidence of control of property.

☐ ***Submit*** **a** copy of the deed and/or bill of sale, if property is owned.

☐ ***Submit*** a copy of the rental agreement, if property is rented.

☐ ***Submit*** a copy of the lease agreement, if property is leased.

☐ ***Submit*** a copy of the original lease plus a copy of the sublease, if property is subleased.

☐ ***Submit*** appropriate evidence if "other" is checked.

2. Provide name and address of the Owner of Record, Lessee and Sub-lessee as applicable.

E. MANAGEMENT COMPANY INFORMATION
(Complete Sections A1, C1-5, F & ATTACHMENT E-1)

F. STATEMENT OF RESPONSIBILITIES
Application must be signed by licensee or authorized representative.

ATTACHMENT E-1

MANAGEMENT COMPANY INFORMATION ONLY FOR SNF's OR ICF's

1. If the proposed facility, agency, or clinic will be operated by a management company, under a management contract between the proposed owner and a management company, provide the name, address, and federal tax ID number of Management Company and name of facility to be managed.

☐ ***Submit*** a copy of the Management Agreement.

2. Provide the name, address, and percent of ownership for each person having a **5 percent** or more interest in the Management Company.

☐ ***Submit*** an attachment for additional names. This attachment must include all of the required information.

3. Provide a list of all facilities, agencies, or clinics that you have contracted to manage.

☐ ***Submit*** an attachment for additional facilities, agencies, or clinics. This attachment must include all of the required information.

ADH 0006

State of California -California Department of Aging
STAFFING/SERVICES ARRANGEMENT
ADH 0006 (REV. 09/14)

COMMUNITY-BASED CBAS ADULT SERVICES

Community-Based Adult Services

1. LICENSEE NAME: ABC Healthcare Services, Inc.		2. HOURS OF SERVICE: Mon- Thurs. 8:30am-3pm	3. LICENSED CAPACITY: 100	4. ADA for previous quarter:	
5. CENTER NAME: ABC Adult Day Health Center	6. Also Provides Adult Day Program Services? Yes No	7. SIGNATURE OF ADMINISTRATOR OR PROGRAM DIRECTOR: DATE:			

STAFFING	8. NAME	9. Scheduled Number of Hours per Month:	10. Date of Hire:	11. LICENSE/ REGISTRATION/ CERTIFICATION	
				Number:	Expiration Date:
ADMINISTRATOR	Wain Jones	176	5/13/19	0123457	12/31/20
PROGRAM DIRECTOR	Larry Smith	176	5/13/19		
REGISTERED NURSE(s)	Jack Long	176	6/1/19	RN 08648	12/31/20
LICENSED VOCATIONAL NURSE(s)	Sam Fish	176	6/1/19	94888	12/31/20
SOCIAL WORKER(s)	James Spike	176	6/1/19		
SOCIAL WORK ASSISTANT(s)	April Cook	80	7/1/19		
ACTIVITY COORDINATOR	Lisa He	176	7/1/19		
AIDES	Nick Lee	120	7/1/19		
PHYSICAL THERAPIST (PT)	Steve Ngo	120	7/1/19	006253	12/31/21
PT ASSISTANT	Sarah Rock	80	7/1/19		
PT AIDE(s)	Jack Reed	80	7/1/19		
OCCUPATIONAL THERAPIST (OT)	Julie Fry	120	7/1/19	PT266668	12/31/21
CERTIFIED OT ASSISTANT (COTA)	Shawn Dong	80	7/1/19		
OT AIDE(s)	Frank Link	80	7/1/19		
SPEECH THERAPIST	Ashley Brook	120	7/1/19	ST75558	12/31/21
STAFF PHYSICIAN	Nancy Light	120	7/1/19		
PSYCH CONSULTANT	Paul Quinn	120	7/1/19		
DIETITIAN	Olivia Ponder	176	7/1/19	D96550	12/31/21
DRIVERS	George Burger	176	7/1/19		
PHARMACIST	Catlin Nugget	176	7/1/19	PH77786	12/31/21
OTHER STAFF POSITIONS	Juan Lopez	176	7/1/19		

CDPH 609

State of California-Health and Human Services Agency | California Department of Public Health

BED OR SERVICE REQUEST

Date: 3/15/2019

This form is intended to identify the types of beds or services requested for adult day health center, acute psychiatric hospitals, general acute care hospitals, special hospitals and skilled nursing facilities. For new facilities, complete the column marked "Requested Beds." For existing facilities, complete both columns. The form is to accompany the application form (HS 200) for any new facility, change in capacity, service, or bed classification.

Name of facility	Type		
ABC Adult Day Health Center	ADHC		
Address (number, street)	**City**	**State**	**ZIP code**
1800 Beach Drive	Sacramento	CA	95814

Please enter the number of beds requested for each category:

EXISTING BEDS		REQUESTED BEDS	
_____	Acute Respiratory Care Services	_____	Acute Respiratory Care Services
_____	Burn Center	_____	Burn Center
_____	Cardiovascular Surgery Service	_____	Cardiovascular Surgery Service
_____	Coronary Care Unit	_____	Coronary Care Unit
_____	General Acute Care (Unspecified)	_____	General Acute Care (Unspecified)
_____	General Nursing (Long-Term)	_____	General Nursing (Long-Term)
_____	Intensive Care (Newborn)	_____	Intensive Care (Newborn)
_____	Intensive Care Unit	_____	Intensive Care Unit
_____	Pediatric Service	_____	Pediatric Service
_____	Perinatal Unit	_____	Perinatal Unit
_____	Psychiatric Unit	_____	Psychiatric Unit
_____	Rehabilitation Center	_____	Rehabilitation Center
_____	Renal Transplant Center	_____	Renal Transplant Center
_____	Respiratory Care Service	_____	Respiratory Care Service
_____	Skilled Nursing Service (DP)	_____	Skilled Nursing Service (DP)
100	Other (specify) Adult Day Health Center	150	Other (specify) Adult Day Health Center
_____	Other (specify) _____	_____	Other (specify) _____
100	**APPROVED CAPACITY**	_____	**APPROVED CAPACITY** (For Departmental use only)

Please check services which the facility currently provides or is requesting:

EXISTING SERVICES		REQUESTED SERVICES	
✓	Adult Day Program (only applies to an ADHC)	✓	Adult Day Program (only applies to an ADHC)
_____	Basic Emergency Physician on Duty	_____	Basic Emergency Physician on Duty
_____	Cardiovascular Surgery	_____	Cardiovascular Surgery
_____	Chronic Dialysis Service	_____	Chronic Dialysis Service
_____	Comprehensive Emergency	_____	Comprehensive Emergency
_____	Dental Service	_____	Dental Service
_____	Nuclear Medicine Service	_____	Nuclear Medicine Service
_____	Occupational Therapy Service	_____	Occupational Therapy Service
_____	Outpatient Service (i.e. Family Practice, Pediatrics, Primary Care, Rural Health Clinic, etc.) Specify: _____ Specify: _____	_____	Outpatient Service (i.e. Family Practice, Pediatrics, Primary Care, Rural Health Clinic, etc.) Specify: _____ Specify: _____
_____	Physical Therapy	_____	Physical Therapy
_____	Podiatric Service	_____	Podiatric Service
_____	Radiation Therapy	_____	Radiation Therapy
_____	Social Service	_____	Social Service
_____	Speech Pathology and/or Audiology Service	_____	Speech Pathology and/or Audiology Service
_____	Other (specify): _____	_____	Other (specify): _____
_____	Other (specify): _____	_____	Other (specify): _____

ADH 0007
(if applicable)

State of California-Health and Human Services Agency
California Department of Aging

PROPOSAL TO SHARE SPACE*

ADH 0007 (08/11)

APPLICANT NAME	CENTER NAME
ABC Healthcare Services, Inc.	ABC Adult Day Health Center
ADDRESS 999 Beach Side Court, Sacramento, CA 95814	ADDRESS 1800 Beach Drive, Sacramento, CA 95814
CONTACT PERSON Wain Jones	PHONE 999-555-2626

What is the building occupancy capacity which has been established for fire safety? 70

Complete the following, describing the program(s) that would share space with the ADHC Center

Program Name	Days of Operation	Hours of Operation	Occupancy or Licensed Capacity
Adult Day Health Care	M☐T☐ W☐ Th☐ F☐ S☐ Su☐	8:00 am-5:00 pm	70
AARP Counseling	M☐T☐ W☐ Th☐ F☐ S☐ Su☐	8:00 am-5:00 pm	70
	M☐T☐ W☐ Th☐ F☐ S☐ Su☐		
	M☐T☐W☐Th☐F☐S☐Su☐		

Describe how these programs will operate and share space:

AARP Counseling will occupy the space on Saturday and Sunday for counseling services including employment, health insurance, retirement benefits, housing choices.

Attach a rough sketch (floor plan) of the existing or proposed facility including:
(a) square footage of areas to be used for each program;
(b) areas for each basic ADHC service; and
(c) which space will be shared* by the programs identified above.

I hereby certify that:

- The use of the shared space does not jeopardize the welfare of the participants or other clients.
- The space used by the ADHC center is not essential to meet the other programs' licensing requirements.
- The shared use does not exceed the occupancy capacity established for fire safety.
- Each entity will schedule services and activities at separate times. (This does not apply to space used for meals or to space used by another licensed adult day services program.)

Signature of Provider or Legal Representative Date 05/01/2019

* Shared space means the mutual use of exits and entrances, offices, hallways, bathrooms, treatment rooms, and dining rooms by the adult day health center and another program(s).