COVER LETTER

ABC Community Care
999 Beach Side Court, Sacramento, CA 95814
P: (999) 555-2626
F: (999) 555-2600
Email: JaneDoe@abccommunitycare.org

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

RE: **CHANGE OF DIRECTOR OF NURSING**
Application for Family First, located at 1800 Beach Drive, Sacramento, CA 95814,
License #222222222

To Whom It May Concern,

We are submitting a **Change of Director of Nursing** application for Family First, located at 1800 Beach Drive, Sacramento, CA 95814.

As of May 31, 2015, Family First appointed Amber Dixie as the Director of Nursing. I enclosed the required application forms and supporting documents needed to process my Change of Director of Nursing application.

Should you have any questions, I will be the direct contact regarding this Change of Director of Nursing application.

Emergency Contact Information (available 365/24/7)
Name: Jane Doe

Email: JaneDoe@abccommunitycare.org
Phone: (999) 555-2626
Fax: (999) 555-2600

Alternate Email: JaneDoe@cmail.com
Phone (Text Messages): (999) 555-5555

Jane Doe

Jane Doe, Executive Director
ABC Community Care

HS 215A

FOR DEPARTMENTAL USE ONLY	
District:	*ELMS Facility Number:*
Proposed name of facility/agency/clinic:	

APPLICANT INDIVIDUAL INFORMATION

This form is intended for any individual owning the applicant facility or for any individual involved (now or in the past) with any health or community care facility. **Refer to the INSTRUCTION SHEET to see who needs to complete this form.**

This HS 215A form needs to be completed as part of an application package plus it needs to be completed for disclosure purposes when changes are reported in officers, directors, purchase of stock, etc., as required by law, **even though no change in legal ownership is occurring.**

A. Identifying Information

Name: Amber Dixie

Date of Birth: 06/27/1970

Business address (number, street, apartment/suite number or letter if applicable): 1800 Beach Drive

City, State, & Zip: Sacramento, CA 95814

Title in relation to this facility: Director of Nursing

Have you applied for ANY license for a health facility or community care facility using any name other than your true full name? If yes, list all other names.

No

If an Administrator for proposed clinic, list hours that will be spent at the clinic each week. If an Administrator at more than one licensed clinic, list the name of **each clinic** and the number of hours spent in each licensed clinic per week.

Family First - 40 hours per week

B. Criminal Record

1. Have you ever been convicted of an offense that is still on your record, whether misdemeanor or felony? ○ **Yes** ◉ **No**

2. Has there been a judgment against you for Medicare or Medicaid (Medi-Cal) fraud or by a health care professional/technical licensing entity? ○ **Yes** ◉ **No**

If yes to questions 1 or 2 above, please explain and provide dates and conviction information (attach additional pages if necessary):

C. Professional Licenses/Certificates – This requirement is mandatory for Primary Care Clinics and optional for Health facilities.

TYPE	PERIOD HELD	ISSUING AGENCY
RN 777777	06/1996- Present	Board of Registered Nursing

D. Employment/Business Summary (for last 10 years). Please list any additional experience that qualifies you to operate this type of facility. Begin with your most recent job. Attach additional pages if necessary.

		Name and address of employer	Job title
From:	5/13/2015	Family First	Medical Director
To:	Present	1800 Beach Drive, Sacramento CA 95814	
From:	01/28/2010	Get Well Home Health, Inc.	Administrator/DPCS
To:	05/30/2015	1234 Health Avenue, Suite 1A, Sacramento, CA 95810	
From:	03/02/2007	Care Free Home Health, LLC	Director of Nursing
To:	01/28/2010	9876 Pain Free Drive, Elk Grove CA 95624	
From:			
To:			

E. Facility, Agency, Clinic Involvement (in or out of California)

The questions below are for "individuals" and do not pertain to the facility that is applying for licensure.

1. **Have** you ever been involved with a business entity that operated a health facility or community care facility?
   (•) **Yes** ( ) **No** **If YES, complete Section F (below) and the "Facility Information Sheet" (attached).**

2. Have you ever operated or managed (including management agreements) any of the following facility types?
   (•) **Yes** ( ) **No** **If YES, complete Section F (below) and the "Facility Information Sheet" (attached).**

Adult Day Health Care Center	ICF/DD
Clinics	ICF/DD-H
COMMUNITY CARE FACILITY	ICF-DD-N
General Acute Care Hospital	Intermediate Care Facility
Health Facility	Pediatric Day Health & Respite Care
Home Health Agency	Residential Care Facility for the Elderly
Hospice	Skilled Nursing Facility
	Other

3. Have you ever held a **5 percent** or more beneficial ownership interest in any of the facility types above?
   ( ) **Yes** (•) **No** **If YES, complete Section F (below) and the "Facility Information Sheet" (attached).**

F. Adverse Actions

Have you been affiliated with any facility, either past or present, that has been identified as having one or more of the following adverse actions? ( ) **Yes** (•) **No** **If YES, check all applicable:**

- [ ] Had a final Medi-Cal decertification action taken
- [ ] Placed on probation
- [ ] Receiver appointed
- [ ] Resolved by settlement
- [ ] Revocation action filed
- [ ] Revoked (whether stayed or not)
- [ ] Suspension

If yes, please explain (including facility name and address). Attach additional pages if necessary:

I declare under penalty of perjury that the statements on this form and any accompanying attachments are correct to the best of my knowledge.

Signature: *Date:* 3/11/19

RELEASE OF INFORMATION STATEMENT

The information provided on this form is mandatory and is necessary for licensure approval. It will be used to determine individual applicant's 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 the Health and Safety Code. 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.

FACILITY INFORMATION SHEET

You are required to complete the following for **each** facility (including all facilities in all business entities) with which you have a current relationship or have had a past relationship (going back 3 years). **Refer to the INSTRUCTION SHEET.**

Facility name:	Facility address (number, street, city):	State:	Zip code:
Family First	1800 Beach Drive, Sacramento	CA	95814

Type of Facility

- ○ Adult Day Health Care Center
- ◉ Clinic
- ○ COMMUNITY CARE FACILITY
- ○ General Acute Care Hospital
- ○ Health Facility
- ○ HHA
- ○ Hospice
- ○ ICF
- ○ ICF/DD
- ○ ICF/DD-H
- ○ ICF/DD-N
- ○ ICF
- ○ Residential Care for the Elderly
- ○ SNF
- ○ OTHER FACILITY TYPE (explain):

"Type" of Business Entity

For EACH business entity, identify the name & EIN of the entity:

- ◉ Corporation: ABC Community Care EIN:55-5555555
- ○ Individual:
- ○ LLC:
- ○ Management Company:
- ○ Partnership:
- ○ OTHER Business Entity (explain):

Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.

- ○ Yes
- ◉ No

Individual's "Nature" of Involvement

- ○ Administrator of Clinic, SNF or ICF
- ○ Agent
- ○ Director
- ○ Licensee
- ○ Manager of "parent" organization
- ○ Managing employee of a HHA
- ○ Member
- ○ Officer of corporation
- ○ Owner
- ○ Partner
- ○ Sole Proprietorship
- ○ Stockholder -- Ownership %:
- ○ Trustee
- ◉ OTHER Nature of Involvement (explain): Medical Director

Dates of involvement:
From: 5/13/2015
To: Present

Facility name:	Facility address (number, street, city):	State:	Zip code:
Get Well Home Health, Inc	1234 Health Avenue, Suite 1A	CA	95810

Type of Facility

- ○ Adult Day Health Care Center
- ○ Clinic
- ○ COMMUNITY CARE FACILITY
- ○ General Acute Care Hospital
- ○ Health Facility
- ◉ HHA
- ○ Hospice
- ○ ICF
- ○ ICF/DD
- ○ ICF/DD-H
- ○ ICF/DD-N
- ○ ICF
- ○ Residential Care for the Elderly
- ○ SNF
- ○ OTHER FACILITY TYPE (explain):

"Type" of Business Entity

For EACH business entity, identify the name & EIN of the entity:

- ◉ Corporation: Get Well Home Health, Inc EIN 33-3333333
- ○ Individual:
- ○ LLC:
- ○ Management Company:
- ○ Partnership:
- ○ OTHER Business Entity (explain):

Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.

- ○ Yes
- ○ No

Individual's "Nature" of Involvement

- ○ Administrator of Clinic, SNF or ICF
- ○ Agent
- ○ Director
- ○ Licensee
- ○ Manager of "parent" organization
- ○ Managing employee of a HHA
- ○ Member
- ○ Officer of corporation
- ○ Owner
- ○ Partner
- ○ Sole Proprietorship
- ○ Stockholder -- Ownership %:
- ○ Trustee
- ◉ OTHER Nature of Involvement (explain): Administrator/DPCS

Dates of involvement:
From: 01/28/2010
To: 05/30/2015

Facility name:	Facility address (number, street, city):	State:	Zip code:
Care Free Home Health, LLC		CA	

Type of Facility

- ○ Adult Day Health Care Center
- ○ Clinic
- ○ COMMUNITY CARE FACILITY
- ○ General Acute Care Hospital
- ○ Health Facility
- ◉ HHA
- ○ Hospice
- ○ ICF
- ○ ICF/DD
- ○ ICF/DD-H
- ○ ICF/DD-N
- ○ ICF
- ○ Residential Care for the Elderly
- ○ SNF
- ○ OTHER FACILITY TYPE (explain):

"Type" of Business Entity

For EACH business entity, identify the name & EIN of the entity:

- ○ Corporation:
- ○ Individual:
- ◉ LLC: Care Free Home Health, LLC
- ○ Management Company:
- ○ Partnership:
- ○ OTHER Business Entity (explain):

Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.

- ○ Yes
- ○ No

Individual's "Nature" of Involvement

- ○ Administrator of Clinic, SNF or ICF
- ○ Agent
- ○ Director
- ○ Licensee
- ○ Manager of "parent" organization
- ○ Managing employee of a HHA
- ○ Member
- ○ Officer of corporation
- ○ Owner
- ○ Partner
- ○ Sole Proprietorship
- ○ Stockholder -- Ownership %:
- ○ Trustee
- ◉ OTHER Nature of Involvement (explain): Director of Nursing

Dates of involvement:
From: 03/02/2007
To: 01/28/2010

Facility name:	Facility address (number, street, city):	State:	Zip code:

Type of Facility	"Type" of Business Entity	Individual's "Nature" of Involvement
◯ Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the entity:	◯ Administrator of Clinic, SNF or ICF
◯ Clinic	◯ Corporation:	◯ Agent
◯ COMMUNITY CARE FACILITY		◯ Director
◯ General Acute Care Hospital	◯ Individual:	◯ Licensee
◯ Health Facility		◯ Manager of "parent" organization
◯ HHA	◯ LLC:	◯ Managing employee of a HHA
◯ Hospice		◯ Member
◯ ICF	◯ Management Company:	◯ Officer of corporation
◯ ICF/DD		◯ Owner
◯ ICF/DD-H	◯ Partnership:	◯ Partner
◯ ICF/DD-N		◯ Sole Proprietorship
◯ ICF	◯ OTHER Business Entity (explain):	◯ Stockholder -- Ownership %:
◯ Residential Care for the Elderly		◯ Trustee
◯ SNF	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	◯ OTHER Nature of Involvement (explain):
◯ OTHER FACILITY TYPE (explain):	◯ Yes	Dates of involvement:
	◯ No	From:
		To:

Facility name:	Facility address (number, street, city):	State:	Zip code:

Type of Facility	"Type" of Business Entity	Individual's "Nature" of Involvement
◯ Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the entity:	◯ Administrator of Clinic, SNF or ICF
◯ Clinic	◯ Corporation:	◯ Agent
◯ COMMUNITY CARE FACILITY		◯ Director
◯ General Acute Care Hospital	◯ Individual:	◯ Licensee
◯ Health Facility		◯ Manager of "parent" organization
◯ HHA	◯ LLC:	◯ Managing employee of a HHA
◯ Hospice		◯ Member
◯ ICF	◯ Management Company:	◯ Officer of corporation
◯ ICF/DD		◯ Owner
◯ ICF/DD-H	◯ Partnership:	◯ Partner
◯ ICF/DD-N		◯ Sole Proprietorship
◯ ICF	◯ OTHER Business Entity (explain):	◯ Stockholder -- Ownership %:
◯ Residential Care for the Elderly		◯ Trustee
◯ SNF	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	◯ OTHER Nature of Involvement (explain):
◯ OTHER FACILITY TYPE (explain):	◯ Yes	Dates of involvement:
	◯ No	From:
		To:

Facility name:	Facility address (number, street, city):	State:	Zip code:

Type of Facility	"Type" of Business Entity	Individual's "Nature" of Involvement
◯ Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the entity:	◯ Administrator of Clinic, SNF or ICF
◯ Clinic	◯ Corporation:	◯ Agent
◯ COMMUNITY CARE FACILITY		◯ Director
◯ General Acute Care Hospital	◯ Individual:	◯ Licensee
◯ Health Facility		◯ Manager of "parent" organization
◯ HHA	◯ LLC:	◯ Managing employee of a HHA
◯ Hospice		◯ Member
◯ ICF	◯ Management Company:	◯ Officer of corporation
◯ ICF/DD		◯ Owner
◯ ICF/DD-H	◯ Partnership:	◯ Partner
◯ ICF/DD-N		◯ Sole Proprietorship
◯ ICF	◯ OTHER Business Entity (explain):	◯ Stockholder -- Ownership %:
◯ Residential Care for the Elderly		◯ Trustee
◯ SNF	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	◯ OTHER Nature of Involvement (explain):
◯ OTHER FACILITY TYPE (explain):	◯ Yes	Dates of involvement:
	◯ No	From:
		To:

INSTRUCTIONS FOR HS 215A

The HS 215A must contain an original signature and date. The date of this form should be within the last three months.
This form is intended for the following:

1. Any individual owning an applicant facility;
2. Each agent, each partner, each director, each member, each managing employee of a HHA, each officer of a corporation;
3. Each agent, each partner, each director, each officer, each member or manager of a parent organization of licensee applicant;
4. Each manager, each member of a limited liability company;
5. Administrators;
6. Each person having a beneficial interest of 5 percent or more in the applicant corporation, applicant limited liability company, applicant partnership, applicant management company, applicant facility or private agency; and
7. Each officer and each director of the parent of the management company.

District office and ELMS Number	To be completed by the California Department of Public Health
Proposed name of facility/agency/clinic	Enter the name of your facility as it appears on your application (HS 200).

A. IDENTIFYING INFORMATION

Name	Please enter your full legal name.
Date of birth	Day/Month/Year
Business Address	Location of your business; number, street, apartment/suite number or letter if applicable.
City	City where business is located.
State	State where business is located.
Zip code	Zip code where business is located
Title in relation to this facility	Your title in relation to this facility.
If an Administrator for proposed clinic, list hours that will be spent at the clinic each week. If an Administrator at more than one licensed clinic, list the name of each clinic and the number of hours spent in each licensed clinic per week.	Please list hours spent at each clinic per week. If your title is not administrator, please list N/A.
Have you applied for any license for a health facility or community care facility regardless of your role or title using any name other than your true full name? If yes, list all other names.	Please answer yes or no. If yes, list any other names you have used if you have ever applied for a health facility or community care facility license.

B. CRIMINAL RECORD

Please check appropriate box. If you have checked 'yes', please provide dates and conviction information. If not applicable, please enter 'N/A'.

C. PROFESSIONAL LICENSES/CERTIFICATES

Type	Type of licenses or certificate that you hold.
Period held	Dates that you held your license.
Issuing Agency	Agency that issued you a license and/or certificate.

D. EMPLOYMENT/BUSINESS SUMMARY (FOR LAST 10 YEARS). Please list any additional experience that qualifies you to operate this type of facility. If self employed, never worked or now retired, indicate the 'From' and 'To' dates. Begin with your most recent job. Attach additional pages if necessary.

Dates (From/To)	Dates that you were employed in position from the start to the end date.
Name and Address of Employer(s)	Name and street, city, state address of the employer.
Job Title	Title that you held within your company/place of employment.

E. FACILITY, AGENCY, CLINIC INVOLVEMENT (IN OR OUT OF CALIFORNIA)

Questions No. 1-3	Please check appropriate box(es). If you have checked yes, you must fill out the attached "Facility Information Sheet" and complete Section F.

F. ADVERSE ACTIONS

Please check appropriate box. If box is checked yes, please explain and include facility information.

FACILITY INFORMATION SHEET

Facility Name	Name of Facility that correlates to the checkboxes you have checked as 'yes' in Section E.
Facility address	Number and street address of the facility involved.
City	City where facility is located.
State	State where facility is located.
ZIP code	Zip code where facility is located.
Type of Facility	Check appropriate health facility.
"Type" of Business Entity	Check appropriate business entity and identify if this entity is a "parent" corporation to the applicant facility.
Individual "Nature" of Involvement	Check appropriate position held at that facility.

Amber Dixie

955 Delta Rd. Sacramento, CA 95841 | 999-555-2222 | Amber_Dixie@msn.com

Education

NURSING UNIVERISTY | 1995

- Master of Science in Nursing
- Licensed Registered Nurse – License #8888888
- Nursing Home Administrator – License #NHA2222

Experience

DIRECTOR OF NURSING **MAY 2015 – PRESENT**

Family First, 1800 Beach Drive, Sacramento, CA 95814

- Serve as Director of Nursing at Family First
- Primary Focus on Business Development, Strategic Planning Initiatives and Operations
- Physician Liaison
- Oversight of Clinic monthly actual and budgeted financials
- Provide leadership and direction of all aspects of center activities to ensure quality patient care
- Oversee daily operations of clinical, research

ADMINISTRATOR **JANUARY 2010 – MAY 2015**

Get Well Hospital, 1234 Healthy Avenue, Suite 1A, Sacramento, CA 95810

- Ensure consistent and effective execution of key systems and processes
- Manage budget and operations of the hospital
- Ensure quality patient care and compliance with established objectives
- Participate with medical staff and senior management in the development and implementation of strategic plans
- Manage employee relations and implement policies and procedures
- Coordinate, implement and monitor processes to ensure the integration of strategic direction and operational goals
- Develop, oversee and execute an annual marketing plan for the hospital

DIRECTOR OF NURSING **MARCH 2007 – JANUARY 2010**

Care Free Medical Center, 9876 Pain Free Drive, Elk Grove, CA 95624

- Coordinate services provided to patients through supervision and management of staff
- Attract, retain and manage nursing staff

- Make effective use of organizational resources
- Participate with leaders from the governing body, management, and medical staff to collaborate in the accomplishment of the vision, mission, values and strategic goals of the organization
- Provide expertise, education, guidance, and professional development to staff and management in order to support daily operations

INSERT PROFESSIONAL LICENSE COPY HERE