

# Cover Letter

## ABC Healthcare Services, Inc.

999 Beach Side Court, Sacramento, CA 95814

P: (999) 555-2626

F: (999) 555-2600 Email: [JaneDoe@abchealthcare.org](mailto:JaneDoe@abchealthcare.org)

December 10, 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

**CHANGE OF OWNERSHIP** Application for Correctional Treatment Center known as Family First, located at 1800 Beach Drive, Sacramento, CA 95814, License #222222222.

To Whom It May Concern,

We are submitting a Change of Ownership application for Family First, located at 1800 Beach Drive, Sacramento, CA 95814. The licensee will change from XYZ Community Care to the new licensee ABC Healthcare Services, Inc., effective 02/01/2020.

Enclosed are the required application forms and supporting documents needed to process my Change of Ownership application.

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

### **Emergency Contact Information (available 365/24/7)**

Name: Jane Doe

Email: [JaneDoe@abchealthcare.org](mailto:JaneDoe@abchealthcare.org)

Phone: (999) 555-2626

Fax: (999) 555-2600

Alternate Email: [JaneDoe@cmail.com](mailto:JaneDoe@cmail.com)

Phone (Text Messages): (999) 555-5555

Sincerely,

*Jane Doe*

Jane Doe, CEO

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                                         c. Management company (see Sections C1-5, F, and Attachment E-1)  
 b. Change of Ownership (see #2 below)     d. Other change (see Section A4): \_\_\_\_\_

**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: 02/01/2020

3. Amount of fee enclosed: \$ \_\_\_\_\_

4. Type of Change (check all that apply):

- |   |  |
|---|--|
| <input type="checkbox"/> a. Not applicable<br><input type="checkbox"/> b. Change of capacity (see # 8 below)<br><input type="checkbox"/> c. Change of location<br><input type="checkbox"/> d. Change of services _____<br><input type="checkbox"/> e. Change of facility type _____ | <input type="checkbox"/> f. Change of bed classification _____<br><input type="checkbox"/> g. Change of name<br><input type="checkbox"/> h. Construction of new or replacement facility<br><input type="checkbox"/> i. Stock transfer<br><input type="checkbox"/> j. Other (specify) _____ |
|---|--|

5. Type of facility, agency, or clinic (check one)

- |  |  |
|--|--|
| <input checked="checked" type="radio"/> a. Skilled Nursing Facility (SNF)<br><input type="radio"/> b. Intermediate Care Facility (ICF)<br><input type="radio"/> c. ICF/Developmentally Disabled (ICF/DD)<br><input type="radio"/> d. ICF/DD-Habilitative (ICF/DD-H)<br><input type="radio"/> e. ICF/DD-Nursing (ICF/DD-N)<br><input type="radio"/> f. Primary care clinic – Free<br><input type="radio"/> g. Primary care clinic – Community<br><input type="radio"/> h. Surgical clinic | <input type="radio"/> i. Rural health clinic (for Certification “only”)<br><input type="radio"/> j. General acute care hospital<br><input type="radio"/> k. Adult day health care center<br><input type="radio"/> l. Home Health Agency (HHA)<br><input type="radio"/> m. Hospice<br><input type="radio"/> n. Chronic dialysis clinic<br><input checked="checked" type="radio"/> o. Other (specify) <u>Correctional Treatment Center</u> |
|--|--|

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: 10

b. Proposed facility bed capacity: 10

9. Age range of clients: 0-110

10. Days and hours of operation: Mon-Fri, 8am to 5pm

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:

2. Federal employer's tax ID number:

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):  Telephone number:   
City, State, & Zip:  E-Mail:  Fax number:

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?  Yes  
 If "yes", proceed to **Section E** (below).  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?  Yes  
 If "yes", **submit** a copy of the "interim" management agreement.  No

2. Name of "proposed" facility, agency, or clinic:   
**Current facility, agency, or clinic name (if change of ownership):**  
 Facility license number:

3. Address (number & street) of "proposed" facility, agency, or clinic:  Telephone number:   
 City, State, & Zip:

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

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

6. a. Name of administrator:  Date of hire:   
 Professional License number:  Expiration date:   
 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) <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes	<input type="radio"/> No	<input type="text"/>
(2) <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes	<input type="radio"/> No	<input type="text"/>
(3) <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes	<input type="radio"/> No	<input type="text"/>
(4) <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes	<input type="radio"/> No	<input type="text"/>
(5) <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes	<input type="radio"/> No	<input type="text"/>

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:   
 Address (number & street):   
 City, State, & Zip:

**Lessee** name: \_\_\_\_\_  
 Address (number & street): \_\_\_\_\_  
 City, State, & Zip: \_\_\_\_\_

**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
	<input type="text" value="CEO"/>	<input type="text" value="12/01/2019"/>
Signature	Title	Date
	<input type="text"/>	<input type="text"/>
Signature	Title	Date
	<input type="text"/>	<input type="text"/>
Signature	Title	Date
	<input type="text"/>	<input type="text"/>

**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**

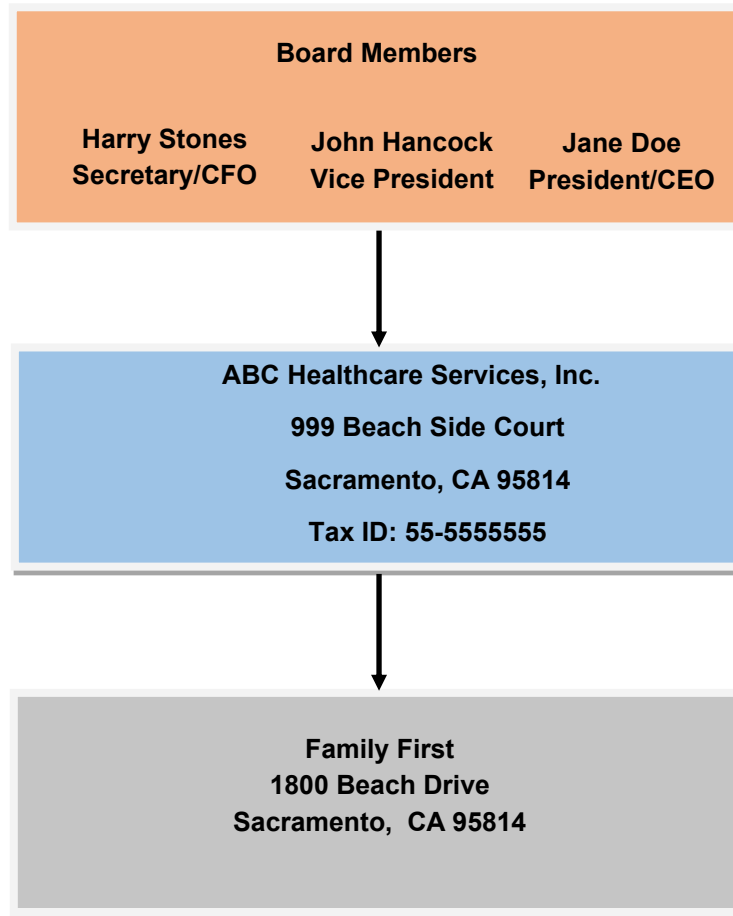
**MANAGEMENT COMPANY INFORMATION ONLY FOR SNF's OR ICF's**

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.

Insert OSHPD or  
Local Building Authority  
Title 24 Clearance  
Here

Insert  
OSHPD Certificate of Occupancy or  
Construction Final  
Here

# Organization Chart



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	Date of Birth
Wain Jones	06/27/1970
Business address (number, street, apartment/suite number or letter if applicable)	City, State, & Zip
1800 Beach Drive	Sacramento, CA 95814
Title in relation to this facility	
Administrator	
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 <b>each clinic</b> and the number of hours spent in each licensed clinic per week.	
40 hours	

### 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	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	Administrator
To:	Present	1800 Beach Drive, Sacramento, CA 95814	
From:	1/28/2010	Get Well Community Care	Administrator
To:	5/12/2015	1234 Healthy Avenue, Suite 1A, Sacramento, CA 95810	
From:	3/2/2007	Care Free Community Care	Director of Nursing
To:	1/27/2010	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: 11/11/2019

**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.**

<b>Facility name:</b> Family First		<b>Facility address (number, street, city):</b> 1800 Beach Drive, Sacramento		<b>State:</b> CA	<b>Zip code:</b> 95814
Type of Facility	"Type" of Business Entity	Individual's "Nature" of Involvement			
<input type="radio"/> Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the entity:	<input checked="" type="radio"/> Administrator of Clinic, SNF or ICF			
<input type="radio"/> Clinic	<input type="radio"/> Corporation:	<input type="radio"/> Agent			
<input type="radio"/> COMMUNITY CARE FACILITY		<input type="radio"/> Director			
<input type="radio"/> General Acute Care Hospital	<input type="radio"/> Individual:	<input type="radio"/> Licensee			
<input type="radio"/> Health Facility		<input type="radio"/> Manager of "parent" organization			
<input type="radio"/> HHA	<input type="radio"/> LLC:	<input type="radio"/> Managing employee of a HHA			
<input type="radio"/> Hospice		<input type="radio"/> Member			
<input type="radio"/> ICF	<input type="radio"/> Management Company:	<input type="radio"/> Officer of corporation			
<input type="radio"/> ICF/DD		<input type="radio"/> Owner			
<input type="radio"/> ICF/DD-H	<input type="radio"/> Partnership:	<input type="radio"/> Partner			
<input type="radio"/> ICF/DD-N		<input type="radio"/> Sole Proprietorship			
<input type="radio"/> ICF	<input checked="" type="radio"/> OTHER Business Entity (explain):	<input type="radio"/> Stockholder -- Ownership %: _____			
<input type="radio"/> Residential Care for the Elderly	Public Agency- ABC Healthcare Services, Inc. EIN:55-5555555	<input type="radio"/> Trustee			
<input type="radio"/> SNF	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	<input type="radio"/> OTHER Nature of Involvement (explain): _____			
<input checked="" type="radio"/> OTHER FACILITY TYPE (explain): Correctional Treatment Center	<input type="radio"/> Yes _____	Dates of involvement:			
	<input checked="" type="radio"/> No _____	From: 5/13/2015			
		To: Present			

<b>Facility name:</b>		<b>Facility address (number, street, city):</b>		<b>State:</b>	<b>Zip code:</b>
Type of Facility	"Type" of Business Entity	Individual's "Nature" of Involvement			
<input type="radio"/> Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the entity:	<input type="radio"/> Administrator of Clinic, SNF or ICF			
<input type="radio"/> Clinic	<input type="radio"/> Corporation:	<input type="radio"/> Agent			
<input type="radio"/> COMMUNITY CARE FACILITY		<input type="radio"/> Director			
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<input type="radio"/> ICF/DD-H	<input type="radio"/> Partnership:	<input type="radio"/> Partner			
<input type="radio"/> ICF/DD-N		<input type="radio"/> Sole Proprietorship			
<input type="radio"/> ICF	<input type="radio"/> OTHER Business Entity (explain):	<input type="radio"/> Stockholder -- Ownership %: _____			
<input type="radio"/> Residential Care for the Elderly		<input type="radio"/> Trustee			
<input type="radio"/> SNF	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	<input type="radio"/> OTHER Nature of Involvement (explain): _____			
<input type="radio"/> OTHER FACILITY TYPE (explain):	<input type="radio"/> Yes _____	Dates of involvement:			
	<input checked="" type="radio"/> No _____	From: _____			
		To: _____			

<b>Facility name:</b>		<b>Facility address (number, street, city):</b>		<b>State:</b>	<b>Zip code:</b>
Type of Facility	"Type" of Business Entity	Individual's "Nature" of Involvement			
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<input type="radio"/> ICF/DD-N		<input type="radio"/> Sole Proprietorship			
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<input type="radio"/> OTHER FACILITY TYPE (explain):	<input type="radio"/> Yes _____	Dates of involvement:			
	<input checked="" type="radio"/> No _____	From: _____			
		To: _____			

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

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

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

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

### A. IDENTIFYING INFORMATION

<b>Name</b>	Please enter your full legal name.
<b>Date of birth</b>	Day/Month/Year
<b>Business Address</b>	Location of your business; number, street, apartment/suite number or letter if applicable.
<b>City</b>	City where business is located.
<b>State</b>	State where business is located.
<b>Zip code</b>	Zip code where business is located
<b>Title in relation to this facility</b>	Your title in relation to this facility.
<b>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.</b>	Please list hours spent at each clinic per week. If your title is not administrator, please list N/A.
<b>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.</b>	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

<b>Type</b>	Type of licenses or certificate that you hold.
<b>Period held</b>	Dates that you held your license.
<b>Issuing Agency</b>	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.

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

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

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

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

### FACILITY INFORMATION SHEET

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

# Wain Jones

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

## Education

### **NURSING UNIVERSITY | 1995**

- Master of Science in Nursing
- Licensed Registered Nurse – License #88888888

## Experience

### **ADMINISTRATOR**

**MAY 2015 – PRESENT**

Family First, 1800 Beach Drive, Sacramento, CA 95814

- Serve as Administrator of top rated Primary Care Clinic
- Primary Focus on Business Development, Strategic Planning Initiatives and Operations
- Physician Liaison
- Oversight of Managers monthly actual and budgeted financials
- Provide leadership and direction of all aspects of primary care clinic activities to ensure quality patient care
- Oversee daily operations of clinical, research and academic administration

### **ADMINISTRATOR**

**JANUARY 2010 – MAY 2015**

Get Well Community Care, 1234 Healthy Avenue, Suite 1A, Sacramento, CA 95814

- Ensure consistent and effective execution of key systems and processes
- Manage budget and operations of the primary care clinic
- 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 primary care clinic

### **DIRECTOR OF NURSING**

**MARCH 2007 – JANUARY 2010**

Care Free Community Care, 5678 Pain Free Drive, Sacramento, CA 95814

- 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

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

## 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

<b>Name</b>	<b>Date of Birth</b>
Jane Doe	07/07/1977
<b>Business address (number, street, apartment/suite number or letter if applicable)</b>	<b>City, State, &amp; Zip</b>
999 Beach Side Court	Sacramento, CA 95814
<b>Title in relation to this facility</b>	
CEO/President	
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 <b>each clinic</b> and the number of hours spent in each licensed clinic 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

**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	CEO/President
To:	Present	1800 Beach Drive, Sacramento, CA 95814	
From:	1/28/2010	Get Well Community Care	Director of Operations
To:	5/12/2015	1234 Healthy Avenue, Suite 1A, Sacramento, CA 95810	
From:	3/2/2007	Care Free Community Care	Administrator
To:	1/27/2010	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.

- 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).
- 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

- 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: 11/11/2019

**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.**

<b>Facility name:</b> Family First		<b>Facility address (number, street, city):</b> 1800 Beach Drive, Sacramento		<b>State:</b> CA	<b>Zip code:</b> 95814
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<input type="radio"/> HHA	<input type="radio"/> LLC:	<input type="radio"/> Managing employee of a HHA			
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<input type="radio"/> ICF/DD-N		<input type="radio"/> Sole Proprietorship			
<input type="radio"/> ICF	<input checked="" type="radio"/> OTHER Business Entity (explain):	<input type="radio"/> Stockholder -- Ownership %: _____			
<input type="radio"/> Residential Care for the Elderly	ABC Healthcare Services, Inc. EIN:55-5555555	<input type="radio"/> Trustee			
<input type="radio"/> SNF	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	<input type="radio"/> OTHER Nature of Involvement (explain): _____			
<input checked="" type="radio"/> OTHER FACILITY TYPE (explain):	<input type="radio"/> Yes _____	Dates of involvement:			
Correctional Treatment Center	<input type="radio"/> No _____	From: 5/13/2015			
		To: Present			

<b>Facility name:</b>		<b>Facility address (number, street, city):</b>		<b>State:</b>	<b>Zip code:</b>
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<input type="radio"/> SNF	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	<input type="radio"/> OTHER Nature of Involvement (explain): _____			
<input checked="" type="radio"/> OTHER FACILITY TYPE (explain):	<input type="radio"/> Yes _____	Dates of involvement:			
	<input type="radio"/> No _____	From: _____			
		To: _____			

<b>Facility name:</b>		<b>Facility address (number, street, city):</b>		<b>State:</b>	<b>Zip code:</b>
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	<input type="radio"/> No _____	From: _____			
		To: _____			

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

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

<b>Facility name:</b>		<b>Facility address (number, street, city):</b>		<b>State:</b>	<b>Zip code:</b>
<b>Type of Facility</b>	<b>"Type" of Business Entity</b>		<b>Individual's "Nature" of Involvement</b>		
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## 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.

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

### A. IDENTIFYING INFORMATION

<b>Name</b>	Please enter your full legal name.
<b>Date of birth</b>	Day/Month/Year
<b>Business Address</b>	Location of your business; number, street, apartment/suite number or letter if applicable.
<b>City</b>	City where business is located.
<b>State</b>	State where business is located.
<b>Zip code</b>	Zip code where business is located
<b>Title in relation to this facility</b>	Your title in relation to this facility.
<b>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.</b>	Please list hours spent at each clinic per week. If your title is not administrator, please list N/A.
<b>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.</b>	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

<b>Type</b>	Type of licenses or certificate that you hold.
<b>Period held</b>	Dates that you held your license.
<b>Issuing Agency</b>	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.

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

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

<b>Questions No. 1-3</b>	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

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

Insert Governing  
Board Letter Here

(Proof of appointment of  
Administrator and Medical Director)

Insert  
Proof of Administrator Qualifications  
Here

Insert  
Professional Licenses  
Here

HS 309

## ADMINISTRATIVE ORGANIZATION

Page one is for corporations only. See page two for other organizations.

### CORPORATION

1. Name (as filed with Secretary of State)	2. Administrator
--	------------------

3. Incorporation date	4. Place of incorporation
-----------------------	---------------------------

5. Please attach (1) a copy of Articles of Incorporation and any amendments, (2) a copy of by-laws and any amendments, (3) a copy of resolution authorizing the filing of this application.

6. Principal Office of Business

Address	City	ZIP code	County	Phone number
---------	------	----------	--------	--------------

7. Foreign (out-of-state) applicants complete the following:

a. Name of California Representative				
Address	City	ZIP code	Phone number	

b. Please attach a copy of authorization of a foreign corporation to do business in California.

8. If applicant has ever owned or operated a facility, please list the name of each facility, address, size, type of care provided, and the dates and duration of ownership or operation. (if more space is needed, please attach a separate list.)

9. Governing Board of Directors

Size of Board	Term of office	Frequency of meetings	Method of selection
---------------	----------------	-----------------------	---------------------

10. Board Officers

Office	Name	Term Expires

### 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 applicants or applicant facility's ability to provide health services. The information is requested by the 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, 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.



## ORGANIZATIONAL STRUCTURE

See page one for corporations.

### PUBLIC AGENCY

1. Check type of public agency:       Federal       State       County       City       Other, specify below

2. Agency providing services:

Name <b>ABC Healthcare Services, Inc.</b>	Address <b>999 Beach Side Court, Sacramento, CA 95814</b>
Mailing Address (if different from above)	

Contact person <b>Jane Doe</b>	Title <b>CEO/President</b>	Phone number <b>999-555-2626</b>
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3. District or area to be served: (attach map if necessary)

Specify geographic area

**Sacramento County**

4. Required supplemental materials: Attach a copy of Resolution or legal document authorizing this application.

5. (1267.5 Health and Safety Code)

For profit corporations and partnerships, list the name(s) and business address of each person having a beneficial ownership interest of 10 percent or more in the applicant corporation or partnership. If person is a minor, identify and indicate by name and address who exercises rights during minor's minority.

### PARTNERSHIPS

Attach a copy of partnership agreement.

First partner <input type="checkbox"/> Limited <input type="checkbox"/> General	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="padding: 2px;">Name</td></tr> <tr><td style="padding: 2px;">Business address</td></tr> </table>	Name	Business address
Name			
Business address			
Second partner <input type="checkbox"/> Limited <input type="checkbox"/> General	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="padding: 2px;">Name</td></tr> <tr><td style="padding: 2px;">Business address</td></tr> </table>	Name	Business address
Name			
Business address			

For additional partners, use space above or attach a separate sheet.

### OTHER ASSOCIATIONS/BUSINESS ENTITIES

Other associations/business entities, i.e., limited liability companies, etc., must also provide a similar list of persons legally responsible for the organization, appropriate legal documents which set forth legal responsibility of the organization, and accountability for operating the facility.

### 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 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, 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 files located in Licensing and Certification district offices.



**Secretary of State**  
**Registry of Public Agencies**  
 (Government Code section 53051)

SF-405

**FILED**  
**Secretary of State**  
**State of California**

**JUNE 05 1995**

**IMPORTANT — Read Instructions before completing this form.**

There is **No Fee** for a Registry of Public Agencies filing

**Copy Fees** — First page \$1.00; each attachment page \$0.50;  
 Certification Fee - \$5.00

**This Space For Office Use Only**

**1. Type of Filing** (Check one.)

- Initial Filing (first Registry of Public Agencies filing for an agency)  
 Updated Filing (change to an existing Registry of Public Agencies record)

**2. Agency Information**

a. Full Legal Name of Public Agency <b>ABC Healthcare Services, Inc.</b>	
b. Nature of Update (complete if Updated Filing)	
c. County <b>Sacramento</b>	d. Official Mailing Address <b>999 Beach Side Court, Sacramento, CA 95814</b>

**3. Chairperson, President, or Other Presiding Officer**

a. Name <b>Jane Doe</b>	b. Title <b>President</b>
c. Business or Residence Address <b>999 Beach Side Court, Sacramento, CA 95814</b>	

**4. Clerk or Secretary**

a. Name <b>Harry Stones</b>	b. Title <b>Secretary</b>
c. Business or Residence Address <b>999 Beach Side Court, Sacramento, CA 95814</b>	

**5. Other Members of the Governing Board** (Enter as many as applicable. Attach additional pages for additional members.)

Name <b>John Hancock</b>	Business or Residence Address <b>999 Beach Side Court, Sacramento, CA 95814</b>
Name	Business or Residence Address
Name	Business or Residence Address
Name	Business or Residence Address
Name	Business or Residence Address

**6. Date and Sign Below** (Additional members set forth on attached pages, if any, are incorporated herein by reference and made part of this Form SF-405, Registry of Public Agencies.)

<u>06/04/1995</u> Date	<u>Jane Doe</u> Signature	<u>Jane Doe</u> Type or Print Name
---------------------------	------------------------------	---------------------------------------

Insert  
Copy of Signed Resolution  
Here

**STD 850**

**FIRE SAFETY INSPECTION REQUEST****See instructions on reverse.**

STD. 850 (REV. 4-2000)

AGENCY CONTACT'S NAME <b>Departmental Use Only</b>		TELEPHONE NUMBER <b>Departmental Use Only</b>		REQUEST DATE <b>CAB</b>	PROGRAM <b>Departmental Use Only</b>	
EVALUATOR'S NAME <b>Departmental Use Only</b>		REQUESTING AGENCY FACILITY NUMBER <b>Departmental Use Only</b>			REQUEST CODE <b>Departmental Use Only</b>	
<b>LICENSING AGENCY NAME AND ADDRESS</b> <div style="border: 1px solid black; padding: 5px; width: fit-content;">           California Department of Public Health            Licensing and Certification Program            Centralized Applications Branch            P.O. Box 997377, MS 3207            Sacramento, CA 95899-7377         </div>					<b>CODES</b>	
					1. ORIGINAL    A. FIRE CLEARANCE 2. RENEWAL    B. LIFE SAFETY 3. CAPACITY CHANGE 4. OWNERSHIP CHANGE 5. ADDRESS CHANGE 6. NAME CHANGE 7. OTHER	
<b>AMBULATORY</b>		<b>NONAMBULATORY</b>		<b>BEDRIDDEN</b>		<b>TOTAL CAPACITY</b>
CAPACITY <b>50</b>	PREVIOUS CAPACITY	CAPACITY	PREVIOUS CAPACITY	CAPACITY	PREVIOUS CAPACITY	<b>50</b>
FACILITY NAME <b>Family First</b>					LICENSE CATEGORY <b>Correctional Treatment Center</b>	
STREET ADDRESS ( <i>Actual Location</i> ) <b>1800 Beach Drive</b>					NUMBER OF BUILDINGS <b>1</b>	
CITY <b>Sacramento, CA 95814</b>					RESTRAINT <b>None</b>	
FACILITY CONTACT PERSON'S NAME <b>Wain Jones</b>			FACILITY CONTACT PERSON'S TELEPHONE NUMBER <b>999-555-2626</b>		HOURS <b>M-F: 8am-5pm</b>	
SPECIAL CONDITIONS						

**TO BE COMPLETED BY INSPECTING AUTHORITY**

<b>FIRE AUTHORITY NAME AND ADDRESS</b> <div style="border: 1px solid black; padding: 5px; width: fit-content;"> </div>				CLEARANCE /DENIAL CODE
				<b>CODES</b>
INSPECTOR'S NAME ( <i>Typed or Printed</i> ) TELEPHONE NUMBER CFIRS NUMBER OCCUPANCY CLASS  INSPECTION DATE INSPECTOR'S SIGNATURE ( <i>Typed or Printed</i> )				1. FIRE CLEARANCE GRANTED
				2. FIRE CLEARANCE DENIED
				A. EXITS
				B. CONSTRUCTION
				C. FIRE ALARM
				D. SPRINKLERS
				E. HOUSEKEEPING
F. SPECIAL HAZARD				
G. OTHER				
EXPLAIN DENIAL OR LIST SPECIAL CONDITIONS				

**FIRE SAFETY INSPECTION REQUEST**

STD. 850 (REV. 4-2000) (REVERSE)

**INSTRUCTIONS**

This form is designed for use with a window envelope  
**Licensing or Requesting Agencies--Complete the following 19 sections on this form  
before submitting it to the fire authority having jurisdiction.**

- 1. AGENCY CONTACT, 2. TELEPHONE NUMBER, 5. EVALUATOR.** Enter the name and telephone number of agency contact person.
- 3. PROGRAM.** Licensing agency use.
- 4. REQUEST DATE.** Enter date request was prepared.
- 6. REQUESTING AGENCY FACILITY NUMBER.** This is the file number assigned by the licensing agency.
- 7. REQUEST CODE.** Use the seven codes shown and insert the appropriate number in the box following "Request Code". If NAME CHANGE, please list previous name. Insert date of original request is other than an original.
- 8. AGENCY NAME AND ADDRESS.** Enter the name and address of the licensing facility requesting the inspection.
- 9. AMBULATORY--NONAMBULATORY--BEDRIDDEN.**

Capacity: Insert in the appropriate section, the capacity of licensed ambulatory or nonambulatory occupants covered by this request.

Previous Capacity: If request is for renewal or capacity change, insert capacity of previous clearance.

Total Capacity: Show total licensed capacity. If the facility is intended to house part ambulatory, nonambulatory, and part bedridden, show the total of the three types of occupants.
- 10. FACILITY NAME.** Insert the name of the facility as it will appear on the license. List identifying sub name if known (i.e., Hacienda Corp/Medina Lodge).
- 11. LICENSE CATEGORY.** Insert the category of license being sought as it will appear on the license certificate.
- 12. ADDRESS.** Insert street address and city only. A post office box is not acceptable as only location.
- 13. NUMBER OF BUILDINGS.** Insert the total number of buildings to be used for housing of the occupants covered by the license.
- 14. RESTRAINT.** Indicate if physical restraint (locked in a room or the building) is to be used in the housing of the occupants.
- 15. FACILITY CONTACT PERSON--TELEPHONE NUMBER.** Indicate the name and telephone number of the responsible individual at the facility to be contacted by the fire authority.
- 16. HOURS.** Indicate the number of hours the occupants are housed at the facility (less than 24 or 24+).
- 17. SPECIAL CONDITIONS.** Indicate any conditions unique to this request. As an example, if the inspection request is for one building in a multi-building facility.

**FIRE AUTHORITY CONDUCTING THE INSPECTION--COMPLETE THE FOLLOWING:**

- 18. FIRE AUTHORITY, NAME AND ADDRESS.** Insert the name and address of the fire authority where the facility is located.
- 19. CLEARANCE/DENIAL CODE.** Use the two codes: 1 for clearance granted, and 2 for clearance denied. If denied, also include the appropriate letter code. As an example, Denial based upon exiting would be coded 2A.
- 20. INSPECTOR'S NAME.** Print the initial of the inspector's first name and full last name; insert the telephone number where the inspector may be contacted.
- 21. CFIRS I.D. NUMBER.** Insert the fire department's number assigned by California Fire Incident Reporting System.
- 22. OCCUPANCY CLASSIFICATION.** Use California Building Code occupancy classifications and insert the occupancy determined by the inspector.
- 23. INSPECTION DATE.** Enter the actual date of the inspection.
- 24. INSPECTOR'S SIGNATURE.** To be signed by the inspector conducting the inspection.
- 25. EXPLAIN DENIAL OR SPECIAL CONDITIONS.** If clearance code #2 is used, briefly explain reason. This space is also to be used to specify any additional limitations placed by the fire authority, such as the use of certain floors or sleeping rooms approved for nonambulatory clients.

**CDPH 609**

**BED OR SERVICE REQUEST**

Date 12/1/2019
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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 Family First	Type Correctional Treatment Center		
Address (number, street) 1800 Beach Drive	City Sacramento	State CA	ZIP code 95814

Please enter the number of beds requested for each category:

**EXISTING BEDS**

- Acute Respiratory Care Services
- Burn Center
- Cardiovascular Surgery Service
- Coronary Care Unit
- General Acute Care (Unspecified)
- General Nursing (Long-Term)
- Intensive Care (Newborn)
- Intensive Care Unit
- Pediatric Service
- Perinatal Unit
- Psychiatric Unit
- Rehabilitation Center
- Renal Transplant Center
- Respiratory Care Service
- Skilled Nursing Service (DP)
- Other (specify) \_\_\_\_\_
- Other (specify) \_\_\_\_\_

**REQUESTED BEDS**

- Acute Respiratory Care Services
- Burn Center
- Cardiovascular Surgery Service
- Coronary Care Unit
- <sup>10</sup> General Acute Care (Unspecified)
- General Nursing (Long-Term)
- Intensive Care (Newborn)
- Intensive Care Unit
- Pediatric Service
- Perinatal Unit
- Psychiatric Unit
- Rehabilitation Center
- Renal Transplant Center
- Respiratory Care Service
- Skilled Nursing Service (DP)
- Other (specify) \_\_\_\_\_
- Other (specify) \_\_\_\_\_

**APPROVED CAPACITY**

**APPROVED CAPACITY** (For Departmental use only)

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

**EXISTING SERVICES**

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

**REQUESTED SERVICES**

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



For CHOWS, Insert One  
of The Following:

Purchase Agreement

Operating Transfer  
Agreement

Insert Letter from Prospective  
Licensee Stating Where  
Medical Records will be  
Stored, with Address, and  
that Records will be Made  
Available to Previous  
Licensee.