

**COVER LETTER**

## ABC Medical Center, LLC

999 Beach Side Court, Sacramento, CA 95814

P: (999) 555-2626

F: (999) 555-2600

Email: [JaneDoe@abcmedicalLLC.org](mailto:JaneDoe@abcmedicalLLC.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 General Acute Care Hospital known as Star Hospital, 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 Star Hospital, located at 1800 Beach Drive, Sacramento, CA 95814.

As of May 31, 2015, Star Hospital appointed Amber Dixie as the Director of Nursing. Ms. Dixie's professional license number is RN 777777.

I enclosed the required application forms and supporting documents needed to process my Change of Director of Nursing request.

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@abcmedicalLLC.org](mailto:JaneDoe@abcmedicalLLC.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, Owner

ABC Medical Center, LLC

HS 215A

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>
Amber Dixie	01/01/1982
<b>Business address (number, street, apartment/suite number or letter if applicable)</b>	<b>City, State, &amp; Zip</b>
1800 Beach Drive	Sacramento, CA 95814
<b>Title in relation to this facility</b>	
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.	
N/A	
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.	
N/A	

### 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		

**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: <input type="text"/>	See attached resume	<input type="text"/>
To: <input type="text"/>	<input type="text"/>	<input type="text"/>
From: <input type="text"/>	<input type="text"/>	<input type="text"/>
To: <input type="text"/>	<input type="text"/>	<input type="text"/>
From: <input type="text"/>	<input type="text"/>	<input type="text"/>
To: <input type="text"/>	<input type="text"/>	<input type="text"/>
From: <input type="text"/>	<input type="text"/>	<input type="text"/>
To: <input type="text"/>	<input type="text"/>	<input type="text"/>

**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:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Had a final Medi-Cal decertification action taken | <input type="checkbox"/> Placed on probation     | <input type="checkbox"/> Receiver appointed              |
| <input type="checkbox"/> Resolved by settlement                            | <input type="checkbox"/> Revocation action filed | <input type="checkbox"/> Revoked (whether stayed or not) |
|  |  | <input type="checkbox"/> 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: 03/15/2019

**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> Star Hospital		<b>Facility address (number, street, city):</b> 1800 Beach Drive Sacramento		<b>State:</b> CA	<b>Zip code:</b> 95814
<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	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		
<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	ABC Medical Center, LLC EIN: 55-5555555		<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 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 _____		Administrator _____		
_____	<input type="radio"/> No _____		Dates of involvement:		
_____			From: 05/13/2015 _____		
			To: Present _____		

<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	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		
<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 type="radio"/> OTHER Business Entity (explain):		<input type="radio"/> Stockholder -- Ownership %: _____		
<input type="radio"/> Residential Care for the Elderly	_____		<input type="radio"/> Trustee		
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<input type="radio"/> OTHER FACILITY TYPE (explain):	<input type="radio"/> Yes _____		_____		
_____	<input type="radio"/> No _____		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	For EACH business entity, identify the name & EIN of the entity:		<input type="radio"/> Administrator of Clinic, SNF or ICF		
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<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 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 _____		_____		
_____	<input type="radio"/> No _____		Dates of involvement:		
_____			From: _____		
			To: _____		

<input type="text"/>		<b>Facility address (number, street, city):</b> <input type="text"/>	<b>State:</b> <input type="text"/>	<b>Zip code:</b> <input type="text"/>
Type of Facility	"Type" of Business Entity	Individual's "Nature" of Involvement		
<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): <input type="text"/> <input type="text"/>	For EACH business entity, identify the name & EIN of the entity: <input type="radio"/> Corporation: <input type="text"/> <input type="radio"/> Individual: <input type="text"/> <input type="radio"/> LLC: <input type="text"/> <input type="radio"/> Management Company: <input type="text"/> <input type="radio"/> Partnership: <input type="text"/> <input type="radio"/> OTHER Business Entity (explain): <input type="text"/> Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain. <input type="radio"/> Yes <input type="text"/> <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="text"/> <input type="radio"/> Trustee <input type="radio"/> OTHER Nature of Involvement (explain): <input type="text"/> Dates of involvement: From: <input type="text"/> To: <input type="text"/>		

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<input type="text"/>		<b>Facility address (number, street, city):</b> <input type="text"/>	<b>State:</b> <input type="text"/>	<b>Zip code:</b> <input type="text"/>
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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.
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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.



# Amber Dixie

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982 Flamingo Ave. Sacramento, CA 95841 | 999-555-6795 | amber.dixie@gmail.com

## Education

### **NURSING UNIVERISTY | 1998**

- Master of Science in Nursing
- Licensed Registered Nurse – License #777777

## Experience

### **DIRECTOR OF NURSING**

**MAY 2015 – PRESENT**

Starr Hospital, 1800 Beach Drive, Sacramento, CA 95814

- Serve as Director of Nursing of 500 bed Acute Care Hospital
- 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 hospital activities to ensure quality patient care
- Oversee daily operations of clinical, research and academic administration

### **DIRECTOR OF NURSING**

**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  
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CURRENT  
LICENSE  
FROM THE  
DEPARTMENT  
OF  
CONSUMER  
AFFAIRS HERE