

# **COVER LETTER**

# ABC Medical Hospice, LLC

999 Beach Side Court, Sacramento, CA 95814

P: (999) 555-2626 F: (999) 555-2600

Email: WainJones@abcmedicalhospiceLLC.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

To Whom It May Concern,

This is a submission for Change of Administrator Designee.

New Administrator Designee: Amber Dixie

Facility/Agency Name: ABC Medical Hospice, LLC

Facility address: 999 Beach Side Court, Sacramento, CA 95814

Facility ID number: 123456789

Licensee Name: ABC Medical Hospice, LLC

• License Number: 22222222

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

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

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

Name: Wain Jones

Email: WainJones@abcmedicalhospiceLLC.org

Alternate Email: WainJones@cmail.com

Phone: (999) 555-2626

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

Fax: (999) 555-2600

Sincerely,

Wain Jones

Wain Jones, Managing Member ABC Medical Hospice, LLC



# **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
Dixie, Amber		03/03/1970
Business address (number, street, apartment/su	ite number or letter if ap	pplicable) City, State, & Zip
999 Beach Side Court		Sacramento, CA 95814
Title in relation to this facility		
Administrator Designee, Member/Owner 49%		
Have you applied for ANY license for a health fa	cility 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		
than one licensed clinic, list the name of each c	<b>linic</b> and the number of	hours spent in each licensed clinic per week.
40		
B. Criminal Record		
<ol> <li>Have you ever been convicted of an offense t</li> <li>Has there been a judgment against you for M professional/technical licensing entity?</li> </ol>	•	, ,
If yes to questions 1 or 2 above, please explain a	and provide dates and c	onviction information (attach additional pages if
necessary):	<u>'</u>	( 1 0
Ticocosai y J.		
C. Professional Licenses/Certificates Clinics and optional for Health fac	•	nt is mandatory for Primary Care
TYPE	PERIOD HELD	ISSUING AGENCY
NHA 2222		Public Health
RN 8888888		BRN

		Name and address of employer	Job title
From:	5/13/2018	ABC Medical Hospice, LLC	Administrator Designee
To:	Present	1800 Beach Drive, Sacramento, CA 95814	
From:	1/29/2010	Get Well Hospital	Administrator Designee
To:	5/12/2018	1234 Healthy Avenue, Suite 1A, Sacramento, CA 95810	
From:	3/2/2007	Care Free Medical Center	HR Director
To:	1/28/2010	9876 Pain Free Drive, Elk Grove, CA 95624	
From:			
To:			
1.	•	w are for "individuals" and do not pertain to the facility een involved with a business entity that operated a health t If YES, complete Section F (below) and the "Facility	facility or community care facility?
1.	Have you ever be	een involved with a business entity that operated a health of the time of time of time of the time of time	Information Sheet" (attached).  any of the following facility types? Information Sheet" (attached).
1. 2.	Have you ever be Yes No  Have you ever op Yes No  Have you ever he	een involved with a business entity that operated a health of the second	facility or community care facility?  Information Sheet" (attached).  any of the following facility types?  Information Sheet" (attached).  E Care E Elderly  y of the facility types above?
1. 2.	Have you ever be Yes No  Have you ever op Yes No  Have you ever he	een involved with a business entity that operated a health of the term of the	facility or community care facility?  Information Sheet" (attached).  any of the following facility types?  Information Sheet" (attached).  E Care E Elderly  y of the facility types above?

Signature: Date: 3/11/18

### RELEASE OF INFORMATION STATEMENT

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

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.

HS 215A (2/08) 2

best of my knowledge.

#### **FACILITY INFORMATION SHEET**

You are required to complete the following for <u>each</u> 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.** 

Type of Facility  "Type" of Business Entity  Administrator of Clinic, SNF or ICF  Clinic  Corporation:  General Acute Care Hospital  Health Facility  HHA  Hospice  ICF/DD-H  ICF/DD-H  ICF/DD-N  COTHER Business Entity (explain):  Administrator of Clinic, SNF or ICF  Administrator of Clinic, Lice Interest or ICF  Administrator of Clinic, Lice I	Facility name:	Facility address (number, street, city):			Zip code:
Adult Day Health Care Center  Clinic  COMMUNITY CARE FACILITY  General Acute Care Hospital Health Facility Health Facility Hospice CICF/DD CICF/DD CICF/DD CICF/DD-N C	Star Hospital	1800 Beach Drive, Sacramento		CA	95814
Collinic COMMUNITY CARE FACILITY General Acute Care Hospital Health Facility Health Facility Licensee Manager of "parent" organization Manager of "parent" organization Managing employee of a HHA  LLC: Managing employee of a HHA Mespice Member  OICF Member OICF/DD  ICF/DD-H OICF/DD-N  ICF/DD-N  ICF/DD-N  ICF OTHER Business Entity (explain):  Agent Director  Olicensee Manager of "parent" organization Owner  Officer of corporation Owner  Owner  Oanership %:  Trustee OTHER Nature of Involvement (explain): Member	Type of Facility	"Type" of Business Entity	Individual's "Nati	ire" of Invo	olvement
COMMUNITY CARE FACILITY  General Acute Care Hospital Health Facility  Health Facility  LLC: Hospice  ABC Medical Center, LLC EIN:55-5555555  Management Company:  OIF/DD-H  OICF/DD-H  OICF/DD-N  OICF/DD-N  OICF  Residential Care for the Elderly  SNF  OTHER Business Entity (explain):  OTHER FACILITY TYPE (explain):  Director  Licensee  Manager of "parent" organization  OManage of "parent" organization  Omember  Officer of corporation  Owner  Owner  Oother FACILITY Type (explain):  OTHER Nature of Involvement (explain):  Member	Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the entity:	Administrator of Clinic	, SNF or IC	F
General Acute Care Hospital Health Facility HHA Hospice CICF CICF/DD CICF/DD CICF/DD CICF/DD-N C	Clinic	O Corporation:	Agent		
Health Facility  HHA  LLC:  Manager of "parent" organization  Managing employee of a HHA  Member  Management Company:  Officer of corporation  Owner  Ocry/DD-H  Ocry/DD-N  Occording  Ocry/DD-N  Occording  Occo	COMMUNITY CARE FACILITY		O Director		
HHA       ⑤ LLC:       ⑥ Managing employee of a HHA         ○ Hospice       △ Member       ⑥ Member         ○ ICF       ⑥ Management Company:       ○ Officer of corporation         ○ ICF/DD-H       ○ Partnership:       ○ Partner         ○ ICF/DD-N       ○ OTHER Business Entity (explain):       ○ Sole Proprietorship         ○ ICF       ○ OTHER Business Entity (explain):       ○ Stockholder Ownership %:         ○ SNF       Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.       ○ OTHER Nature of Involvement (explain):	General Acute Care Hospital	O Individual:	Licensee		
Hospice  ABC Medical Center, LLC EIN:55-5555555  Member  Olfficer of corporation Owner Output	Health Facility		Manager of "parent" or	rganization	
OTHER FACILITY TYPE (explain):  Management Company:  Officer of corporation Omega Owner  Owner  Outpub Outp	O HHA	O LLC:	Managing employee o	f a HHA	
Owner  ICF/DD-H  ICF/DD-N  ICF/DD-N  OTHER Business Entity (explain):  OTHER Business Entity (explain):  OTHER Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	OHospice	ABC Medical Center, LLC EIN:55-5555555	Member		
Partnership:   Partnership:   Partnership:   Sole Proprietorship	O ICF	Management Company:	Officer of corporation		
O ICF/DD-N O ICF O Residential Care for the Elderly O SNF O THER Business Entity (explain): O Residential Care for the Elderly O SNF Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.  O THER Nature of Involvement (explain): Member	O ICF/DD		Owner		
OTHER Business Entity (explain): OResidential Care for the Elderly OSNF Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.  OTHER Business Entity (explain): OTHER Business Ent	O ICF/DD-H	O Partnership:	Partner		
Residential Care for the Elderly  SNF  Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.  OTHER FACILITY TYPE (explain):  Member	O ICF/DD-N		Sole Proprietorship		
SNF Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.  OTHER FACILITY TYPE (explain):  Member	O ICF	OTHER Business Entity (explain):	Stockholder Owner	ship %: 🛭	
OTHER FACILITY TYPE (explain): applicant facility? If Yes, explain.	Residential Care for the Elderly		Trustee		
G o THE CONTROLL TO THE CONTROLL TO	SNF	,	OTHER Nature of Involution	olvement (ex	xplain):
	OTHER FACILITY TYPE (explain):		Member		
		Q Yes	Dates of involvement:		
		⊙ No	From: 5/13/2015		
To: Present			To: Present		

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

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

Facility name:	Facility address (number, street, city):		State:	Zip code:	
Type of Facility	"Type" of Business Entity	Individual's "Nat	ure" of Invo	lvement	
Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the er		, SNF or ICI	=	
Clinic	O Corporation:	Agent			
COMMUNITY CARE FACILITY		O Director			
General Acute Care Hospital Health Facility	O Individual:	Licensee  Manager of "parent" of	Manager of "parent" organization		
O HHA	O LLC:	Managing employee	rgariization nf a HHΔ		
O Hospice	<b>9</b> EEO.	Member	, a i ii i/ t		
OICF	Management Company:	Officer of corporation			
O ICF/DD		Owner			
O ICF/DD-H	O Partnership:	Partner			
O ICF/DD-N	OTHER Business Entity (explain):	Sole Proprietorship	Stockholder Ownership %:		
Residential Care for the Elderly	OTHER Business Entity (explain):	Trustee	Trustee		
O SNF	Are any of the above Business Entities a "PARENT" organize	cation to the OTHER Nature of Inv	olvement (ex	(plain):	
OTHER FACILITY TYPE (explain):	applicant facility? If Yes, explain.	<u> </u>		tpiani).	
	O Yes	Dates of involvement:			
	No No	From:			
		То:			
Facility name:	Facility address (number, street, city):		State:	Zip code:	
Type of Facility	"Type" of Duckeys Father	Individually (Olof	<u> </u>		
Type of Facility	"Type" of Business Entity	Individual's "Nat	ure" of invo	orvement	
Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the en		, SNF or ICF	=	
Clinic	O Corporation:	Agent			
O COMMUNITY CARE FACILITY		ODirector			
General Acute Care Hospital	O Individual:	O Licensee	ition		
Health Facility HHA	O LLC:	Manager of "parent" of "Manager of "parent" of "Manager of "parent" of "parent			
O Hospice	O LLC.	Member	лаппн		
OICF	O Management Company:	Officer of corporation			
O ICF/DD		Owner			
O ICF/DD-H	O Partnership:	Partner			
O ICF/DD-N	O OTHER D. A. S. S. M. A. S. M.	Sole Proprietorship			
○ ICF ○ Residential Care for the Elderly	OTHER Business Entity (explain):	Stockholder Owner  Trustee	ship %: L		
O SNF	Are any of the above Business Entities a "PARENT" organiz	ration to the OTHER Nature of Inv	olvement (e)	(nlain):	
OTHER FACILITY TYPE (explain):	applicant facility? If Yes, explain.	OTTIEN NATURE OF THE	orvernent (ex	cpiairi).	
	O Yes	Dates of involvement:			
	No	From:			
		To:			
Facility name:	Facility address (number, street, city):		State:	Zip code:	
Type of Facility	"Type" of Business Entity	Individual'a "Not	uro" of love	hromont	
Type of Facility	"Type" of Business Entity	Individual's "Nat			
Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the er	,	, SNF or ICF	=	
O Clinic	O Corporation:	Agent			
COMMUNITY CARE FACILITY General Acute Care Hospital	O Individual:	□ Director □ Licensee			
Health Facility	individual.	Manager of "parent" of	rganization		
OHHA	O LLC:	Managing employee			
O Hospice		OMember			
OICF	Management Company:	Officer of corporation			
O ICF/DD		Owner			
O ICF/DD-H	O Partnership:	O Partner			
O ICF/DD-N	OTHER Business Entity (explain):	O Sole Proprietorship	robin 0/ ·		
O ICF Residential Care for the Elderly	UTHER BUSINESS ENTITY (explain):	Stockholder Owner  Trustee	snip %: <u> </u>		
O SNF	Are any of the above Business Entities a "PARENT" organiz	cation to the OTHER Nature of Inv	olvement (a	vnlain).	
OTHER FACILITY TYPE (explain):	applicant facility? If Yes, explain.	OTTIEN Nature of IIIV	OLACITICHE (G)	Apiaiii).	
	O Yes	Dates of involvement:			
	Ŏ No	From:			
		To:			

#### **INSTRUCTIONS FOR HS 215A**

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

- 1. Any individual owning an applicant facility;
- 2. Each agent, each partner, each director, each member, each managing employee of a HHA, each officer of a corporation;
- 3. Each agent, each partner, each director, each officer, each member or manager of a parent organization of licensee applicant;
- 4. Each manager, each member of a limited liability company,
- Administrators:
- 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

. Each officer and each director of the parent of the management company.

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

	IDENITIES (INC.	INTEGRALATION.
Α.	IDENTIFYING	INFORMATION

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

#### 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

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

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

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

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

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

#### F. ADVERSE ACTIONS

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

#### FACILITY INFORMATION SHEET

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

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
Dixie, Amber		06/27/1970
Business address (number, street, apartment/s	uite number or letter <u>if</u> ap	pplicable) City, State, & Zip
999 Beach Side Court		Sacramento, CA 95814
Title in relation to this facility		
Member/Owner 49%, and Director of Patient Care Services		
Have you applied for ANY license for a health f	acility or community care	facility using any name other than your true
name? If yes, list all other names.		
No If an Administrator for proposed clinic, list hours than one licensed clinic, list the name of <b>each</b> o		
B. Criminal Record		
<ol> <li>Have you ever been convicted of an offense</li> <li>Has there been a judgment against you for N professional/technical licensing entity?</li> </ol>		
If yes to questions 1 or 2 above, please explain	and provide dates and co	onviction information (attach additional page
necessary):		
Hecessary).		
C. Professional Licenses/Certificate Clinics and optional for Health fac	-	nt is mandatory for Primary Care
TYPE	PERIOD HELD	ISSUING AGENCY
RN 111112	06/1996 - Present	Public Health
	1	
	<u> </u>	<u> </u>

		Name	and address of employer	Job title
From	5/13/2015	Star Hospital	1 7	Director of Patient Care Services
To:	Present	1800 Beach Drive, Sacram	nento, CA 95814	
From	1/29/2010	Get Well Hospital		Director of Patient Care Services
To:	5/12/2015	1234 Healthy Avenue, Suit	te 1A, Sacramento, CA 95810	
From	3/2/2007	Care Free Medical Center		Director of Patient Care Services
To:	1/28/2010	9876 Pain Free Drive, Elk 0	Grove, CA 95624	
From	:			
To:				
E. Fa	acility, Agency, C	linic Involvement	(in or out of California)	
Th	e questions below a	re for "individuals" ar	nd do not pertain to the facility th	nat is applying for licensure.
1.	Have you ever been	n involved with a busine	ess entity that operated a health fac	ility or community care facility?
				formation Sheet" (attached).
			ion i (bolow) and the i dointy in	` ,
2	Have you ever oner	-		
2.		ated or managed (inclu	ding management agreements) an	y of the following facility types?
2.	Yes No	ated or managed (includent of the complete Section of the complete Section of the complete Section of the complete of the comp		y of the following facility types?
2.	Yes No	ated or managed (includent of the complete Section of	ding management agreements) any ion F (below) and the "Facility In	y of the following facility types?
2.	Yes No	ated or managed (includent of the complete Section of	ding management agreements) any ion F (below) and the "Facility In ICF/DD ICF/DD-H Y ICF-DD-N	y of the following facility types?
2.	Yes No	ated or managed (includent of the control of the co	ding management agreements) any ion F (below) and the "Facility In ICF/DD ICF/DD-H Y ICF-DD-N Intermediate Care Facility	y of the following facility types? formation Sheet" (attached).
2.	Yes No	ated or managed (includent of the control of the co	ding management agreements) any ion F (below) and the "Facility In ICF/DD ICF/DD-H Y ICF-DD-N Intermediate Care Facility Pediatric Day Health & Respite C	y of the following facility types? formation Sheet" (attached).
2.	Yes No	ated or managed (includent of the control of the co	ding management agreements) any ion F (below) and the "Facility In ICF/DD ICF/DD-H Y ICF-DD-N Intermediate Care Facility	y of the following facility types? formation Sheet" (attached).
2.	Yes No	ated or managed (includent of the content of the co	ding management agreements) any ion F (below) and the "Facility In ICF/DD ICF/DD-H Y ICF-DD-N Intermediate Care Facility Pediatric Day Health & Respite C	y of the following facility types? formation Sheet" (attached).
	Yes No  A C C C C C C C C C C C C C C C C C C	ated or managed (includent YES, complete Section of Yes, complete Secti	ding management agreements) any ion F (below) and the "Facility In ICF/DD ICF/DD-H Y ICF-DD-N Intermediate Care Facility Pediatric Day Health & Respite Control Residential Care Facility Other Peneficial ownership interest in any control of the Intermediate Care Facility Other	y of the following facility types?  formation Sheet" (attached).  Care Elderly  of the facility types above?
3.	Yes No  A C C C C C C C C C C C C C C C C C C	ated or managed (includent YES, complete Section of Yes, complete Secti	ding management agreements) any ion F (below) and the "Facility In ICF/DD ICF/DD-H ICF-DD-N Intermediate Care Facility Pediatric Day Health & Respite C Residential Care Facility for the E Skilled Nursing Facility Other	y of the following facility types?  formation Sheet" (attached).  Care Elderly  of the facility types above?
3.	Yes No  A C C C C C C C C C C C C C C C C C C	ated or managed (includent YES, complete Section of Yes, complete Secti	ding management agreements) any ion F (below) and the "Facility In ICF/DD ICF/DD-H Y ICF-DD-N Intermediate Care Facility Pediatric Day Health & Respite Control Residential Care Facility Other Peneficial ownership interest in any control of the Intermediate Care Facility Other	y of the following facility types?  formation Sheet" (attached).  Care Elderly  of the facility types above?
3.	Yes No  A C C C C C C C C C C C C C C C C C C	ated or managed (includent YES, complete Section If YES, complete Secti	ding management agreements) any ion F (below) and the "Facility In ICF/DD ICF/DD-H Y ICF-DD-N Intermediate Care Facility Pediatric Day Health & Respite Control Residential Care Facility Other Peneficial ownership interest in any control of the Intermediate Care Facility Other	y of the following facility types?  formation Sheet" (attached).  Care  Elderly  of the facility types above?  mation Sheet" (attached).
3. F. <b>A</b> (	Yes No  A C C C C C C C C C C C C C C C C C C	ated or managed (included of YES, complete Section of YES, complete Sec	ding management agreements) any ion F (below) and the "Facility In ICF/DD ICF/DD-H ICF-DD-N Intermediate Care Facility Pediatric Day Health & Respite Consideration Residential Care Facility for the Ending Skilled Nursing Facility Other Intermediate Care Facility Information of Skilled Nursing Facility Other Intermediate Care Facility Information of F (below) and the "Facility Information of F (below) and the "Facility Information of Icf (below) and Icf (below)	y of the following facility types?  formation Sheet" (attached).  care  Elderly  of the facility types above?  rmation Sheet" (attached).
3. Ha	Have you ever held Yes No If Yes No If Yes Ve you been affiliated owing adverse action	ated or managed (includent YES, complete Section If Yes Included Including I	ding management agreements) any ion F (below) and the "Facility In ICF/DD ICF/DD ICF/DD-H Y ICF-DD-N Intermediate Care Facility Pediatric Day Health & Respite Concept Residential Care Facility for the English Skilled Nursing Facility Other  The Peneficial ownership interest in any of the Facility Information of F (below) and the "Facility Information Placed on probation"	y of the following facility types?  formation Sheet" (attached).  care  Elderly  of the facility types above?  rmation Sheet" (attached).
3. Ha foll	Have you ever held Yes No If Yes No If Yes Ve you been affiliated owing adverse action	ated or managed (includent YES, complete Section If Yes No decertification action taken In YES, complete Section If Yes No decertification action taken If YES, complete Section If Yes No	ding management agreements) any ion F (below) and the "Facility In ICF/DD ICF/DD ICF/DD-H Y ICF-DD-N Intermediate Care Facility Pediatric Day Health & Respite Concept Residential Care Facility for the English Skilled Nursing Facility Other  The Peneficial ownership interest in any of the Facility Information of F (below) and the "Facility Information Placed on probation"	y of the following facility types?  formation Sheet" (attached).  Eare  Elderly  of the facility types above?  mation Sheet" (attached).  Tiffied as having one or more of the
3.  Ha foll	Have you ever held Yes No If Yes No If Yes No If Yes ve you been affiliated owing adverse action Had a final Medi-Cal of Resolved by settlements	ated or managed (includent of YES, complete Section of Yes, complete Se	ding management agreements) any ion F (below) and the "Facility In ICF/DD ICF/DD ICF/DD-H Y ICF-DD-N Intermediate Care Facility Pediatric Day Health & Respite Concept Residential Care Facility for the English Skilled Nursing Facility Other  The Peneficial ownership interest in any of the Facility Information of F (below) and the "Facility Information Placed on probation"	y of the following facility types?  formation Sheet" (attached).  Care Elderly  of the facility types above?  mation Sheet" (attached).  Tiffied as having one or more of the lace of the
3.  Ha foll	Have you ever held Yes No If Yes No If Yes No If Yes ve you been affiliated owing adverse action Had a final Medi-Cal of Resolved by settlements	ated or managed (includent of YES, complete Section of Yes, complete Se	ding management agreements) and ion F (below) and the "Facility In ICF/DD   ICF/DD-H   ICF-DD-N   Intermediate Care Facility   Pediatric Day Health & Respite Content   Residential Care Facility   Pediatric Day Health & Respite Content   Residential Care Facility   Other   Residential Care Facility   Other   If Yes, check all applicable:    Compare the placed on probation   Placed on probation   Revoked (whether stay)	y of the following facility types?  formation Sheet" (attached).  Care Elderly  of the facility types above?  mation Sheet" (attached).  Tiffied as having one or more of the lace of the

RELEASE OF INFORMATION STATEMENT

Date: 3/11/18

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.

HS 215A (2/08) 2

Signature:

#### **FACILITY INFORMATION SHEET**

You are required to complete the following for <u>each</u> 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.** 

Type of Facility  "Type" of Business Entity  Administrator of Clinic, SNF or ICF  Clinic  Corporation:  General Acute Care Hospital  Health Facility  HHA  Hospice  ICF/DD-H  ICF/DD-H  ICF/DD-N  COTHER Business Entity (explain):  Administrator of Clinic, SNF or ICF  Administrator of Clinic, Lice Interest or ICF  Administrator of Clinic, Lice I	Facility name:	Facility address (number, street, city):		State:	Zip code:
Adult Day Health Care Center  Clinic  COMMUNITY CARE FACILITY  General Acute Care Hospital Health Facility Health Facility Hospice CICF/DD CICF/DD CICF/DD CICF/DD-N C	Star Hospital	1800 Beach Drive, Sacramento		CA	95814
Collinic COMMUNITY CARE FACILITY General Acute Care Hospital Health Facility Health Facility Licensee Manager of "parent" organization Manager of "parent" organization Managing employee of a HHA  LLC: Managing employee of a HHA Mespice Member  OICF Member OICF/DD  ICF/DD-H OICF/DD-N  ICF/DD-N  ICF/DD-N  ICF OTHER Business Entity (explain):  Agent Director  Olicensee Manager of "parent" organization Owner  Officer of corporation Owner  Owner  Oanership %:  Trustee OTHER Nature of Involvement (explain): Member	Type of Facility	"Type" of Business Entity	Individual's "Nati	ire" of Invo	olvement
COMMUNITY CARE FACILITY  General Acute Care Hospital Health Facility  Health Facility  LLC: Hospice  ABC Medical Center, LLC EIN:55-5555555  Management Company:  OIF/DD-H  OICF/DD-H  OICF/DD-N  OICF/DD-N  OICF  Residential Care for the Elderly  SNF  OTHER Business Entity (explain):  OTHER FACILITY TYPE (explain):  Director  Licensee  Manager of "parent" organization  OManage of "parent" organization  Omember  Officer of corporation  Owner  Owner  Oother FACILITY Type (explain):  OTHER Nature of Involvement (explain):  Member	Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the entity:	Administrator of Clinic	, SNF or IC	F
General Acute Care Hospital Health Facility HHA Hospice CICF CICF/DD CICF/DD CICF/DD CICF/DD-N C	Clinic	O Corporation:	Agent		
Health Facility  HHA  LLC:  Manager of "parent" organization  Managing employee of a HHA  Member  Management Company:  Officer of corporation  Owner  Ocry/DD-H  Ocry/DD-N  Occording  Ocry/DD-N  Occording  Occo	COMMUNITY CARE FACILITY		O Director		
HHA       ⑤ LLC:       ⑥ Managing employee of a HHA         ○ Hospice       △ Member       ⑥ Member         ○ ICF       ⑥ Management Company:       ○ Officer of corporation         ○ ICF/DD-H       ○ Partnership:       ○ Partner         ○ ICF/DD-N       ○ OTHER Business Entity (explain):       ○ Sole Proprietorship         ○ ICF       ○ OTHER Business Entity (explain):       ○ Stockholder Ownership %:         ○ SNF       Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.       ○ OTHER Nature of Involvement (explain):	General Acute Care Hospital	O Individual:	Licensee		
Hospice  ABC Medical Center, LLC EIN:55-5555555  Member  Olfficer of corporation Owner Output	Health Facility		Manager of "parent" or	rganization	
OTHER FACILITY TYPE (explain):  Management Company:  Officer of corporation Omega Owner  Owner  Outpub Outp	O HHA	O LLC:	Managing employee o	f a HHA	
Owner  ICF/DD-H  ICF/DD-N  ICF/DD-N  OTHER Business Entity (explain):  OTHER Business Entity (explain):  OTHER Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	OHospice	ABC Medical Center, LLC EIN:55-5555555	Member		
Partnership:   Partnership:   Partnership:   Sole Proprietorship	O ICF	Management Company:	Officer of corporation		
O ICF/DD-N O ICF O Residential Care for the Elderly O SNF O THER Business Entity (explain): O Residential Care for the Elderly O SNF Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.  O THER Nature of Involvement (explain): Member	O ICF/DD		Owner		
OTHER Business Entity (explain): OResidential Care for the Elderly OSNF Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.  OTHER Business Entity (explain): OTHER Business Ent	O ICF/DD-H	O Partnership:	Partner		
Residential Care for the Elderly  SNF  Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.  OTHER FACILITY TYPE (explain):  Member	O ICF/DD-N		Sole Proprietorship		
SNF Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.  OTHER FACILITY TYPE (explain):  Member	O ICF	OTHER Business Entity (explain):	Stockholder Owner	ship %: 🛭	
OTHER FACILITY TYPE (explain): applicant facility? If Yes, explain.	Residential Care for the Elderly		Trustee		
G o THE CONTROLL TO THE CONTROLL TO	SNF	,	OTHER Nature of Involution	olvement (ex	xplain):
	OTHER FACILITY TYPE (explain):		Member		
		Q Yes	Dates of involvement:		
		⊙ No	From: 5/13/2015		
To: Present			To: Present		

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

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

Facility name:	Facility address (number, street, city):		State:	Zip code:
Type of Facility	"Type" of Business Entity	Individual's "Nat	ure" of Invo	lvement
Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the er		, SNF or ICI	=
Clinic	O Corporation:	Agent		
COMMUNITY CARE FACILITY		O Director		
General Acute Care Hospital Health Facility	O Individual:	Licensee  Manager of "parent" of	rganization	
O HHA	O LLC:	Managing employee	rgariization nf a HHΔ	
O Hospice	<b>9</b> EEO.	Member	, a i ii i/ t	
OICF	Management Company:	Officer of corporation		
O ICF/DD		Owner		
O ICF/DD-H	O Partnership:	Partner		
O ICF/DD-N	OTHER Business Entity (explain):	Sole Proprietorship	l-: 0/ .	
Residential Care for the Elderly	OTHER Business Entity (explain):	Stockholder Owner  Trustee	Snip %: 1	
O SNF	Are any of the above Business Entities a "PARENT" organize	cation to the OTHER Nature of Inv	olvement (ex	(plain):
OTHER FACILITY TYPE (explain):	applicant facility? If Yes, explain.	<u> </u>		tpiani).
	O Yes	Dates of involvement:		
	No No	From:		
		То:		
Facility name:	Facility address (number, street, city):		State:	Zip code:
Type of Facility	"Type" of Duckeys Father	Individually (Olof	<u> </u>	
Type of Facility	"Type" of Business Entity	Individual's "Nat	ure" of invo	orvement
Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the en		, SNF or ICF	=
Clinic	O Corporation:	Agent		
O COMMUNITY CARE FACILITY	21 1111	ODirector		
General Acute Care Hospital	O Individual:	O Licensee	ition	
Health Facility HHA	O LLC:	Manager of "parent" of "Manager of "parent" of "Manager of "parent" of "parent		
O Hospice	O LLC.	Member	лаппн	
OICF	O Management Company:	Officer of corporation		
O ICF/DD		Owner		
O ICF/DD-H	O Partnership:	Partner		
O ICF/DD-N	O OTHER D. A. S. S. M. A. S. M.	Sole Proprietorship		
○ ICF ○ Residential Care for the Elderly	OTHER Business Entity (explain):	Stockholder Owner  Trustee	ship %: L	
O SNF	Are any of the above Business Entities a "PARENT" organiz	ration to the OTHER Nature of Inv	olvement (e)	(nlain):
OTHER FACILITY TYPE (explain):	applicant facility? If Yes, explain.	OTTIEN NATURE OF THE	orvernent (ex	cpiairi).
	O Yes	Dates of involvement:		
	No	From:		
		To:		
Facility name:	Facility address (number, street, city):		State:	Zip code:
Type of Facility	"Type" of Business Entity	Individual'a "Not	uro" of love	hromont
Type of Facility	"Type" of Business Entity	Individual's "Nat		
Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the er	,	, SNF or ICF	=
O Clinic	O Corporation:	Agent		
COMMUNITY CARE FACILITY General Acute Care Hospital	O Individual:	□ Director □ Licensee		
Health Facility	individual.	Manager of "parent" of	rganization	
OHHA	O LLC:	Managing employee		
O Hospice		OMember		
OICF	Management Company:	Officer of corporation		
O ICF/DD		Owner		
O ICF/DD-H	O Partnership:	O Partner		
O ICF/DD-N	OTHER Business Entity (explain):	O Sole Proprietorship	robin 0/ ·	
O ICF Residential Care for the Elderly	UTHER BUSINESS ENTITY (explain):	Stockholder Owner  Trustee	snip %: <u> </u>	
O SNF	Are any of the above Business Entities a "PARENT" organiz	cation to the OTHER Nature of Inv	olvement (a	vnlain).
OTHER FACILITY TYPE (explain):	applicant facility? If Yes, explain.	OTTIEN Nature of IIIV	OLACITICHE (G)	Apiaiii).
	O Yes	Dates of involvement:		
	Ŏ No	From:		
		To:		

#### **INSTRUCTIONS FOR HS 215A**

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

- 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:
- 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

Each officer and each director of the parent of the management company.

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

#### A. IDENTIFYING INFORMATION

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

#### B. CRIMINAL RECORD

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

#### C. PROFESSIONAL LICENSES/CERTIFICATES

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

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

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

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

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

#### F. ADVERSE ACTIONS

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

#### FACILITY INFORMATION SHEET

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

# **Amber Dixie**

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

#### **Education**

#### **NURSING UNIVERSITY | 1996**

Master of Science in Business

### Experience

#### **Administrator Designee**

MAY 2019 - PRESENT

ABC Medical Hospice, LLC 999 Beach Side Ct., Sacramento, CA 95814

- Serve as Administrator of 500 bed Acute Care Facility
- 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

#### **Administrator Designee**

**JANUARY 2010 - MAY 2019** 

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

- Ensure consistent and effective execution of key systems and processes
- Manage budget and operations of the hospice
- 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

#### **HR Director**

**MARCH 2005 - 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