

SAMPLE

**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](mailto: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 of an application for **Change of Medical Director**.

- New Medical Director: **John Doe**
- Facility/Agency Name: **ABC Medical Hospice, LLC**
- Facility address: **999 Beach Side Court, Sacramento, CA 95814**
- Facility ID number: **080000000**
- Licensee Name: **ABC Medical Hospice, LLC**
- License Number: **222222222**

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

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

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

Name: Wain Jones

Email: [WainJones@abcmedicalhospiceLLC.org](mailto:WainJones@abcmedicalhospiceLLC.org)

Alternate Email: [WainJones@cmail.com](mailto: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

SAMPLE

HS 200



**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):**  
 ABC Medical Hospice, LLC Facility license number: 22222222

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

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

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

6. a. Name of administrator: Wain Jones Date of hire: 05/13/2015  
 Professional License number: \_\_\_\_\_ Expiration date: \_\_\_\_\_  
 b. Name of director of nursing: Amber Dixie Date of hire: 05/31/2015  
 Professional License number: 777777 Expiration date: 11/30/2019

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) Wain Jones	51	55-5555555	<input type="radio"/> Yes	<input checked="" type="radio"/> No	
(2) Amber Dixie	49	55-5555555	<input type="radio"/> Yes	<input checked="" type="radio"/> No	
(3)			<input type="radio"/> Yes	<input type="radio"/> No	
(4)			<input type="radio"/> Yes	<input type="radio"/> No	
(5)			<input type="radio"/> Yes	<input type="radio"/> No	

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

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

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

**D. PROPERTY INFORMATION**

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

2. **Owner of Record** name in the real estate:   
 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="Managing Member"/>	<input type="text" value="03/11/2018"/>
	<input type="text" value="Member"/>	<input type="text" value="3/11/18"/>
	<input type="text"/>	<input type="text"/>
	<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.

SAMPLE

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
Doe, John	03/03/1970
Business address (number, street, apartment/suite number or letter if applicable)	City, State, & Zip
999 Beach Side Court	Sacramento, CA 95814
Title in relation to this facility	
Medical Director	
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
A12345	06/1996 - Present	Medical Board of California

**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:	5/13/2019	ABC Medical Hospice, LLC	Medical Director
To:	Present	999 Beach Side Drive, Sacramento, CA 95814	
From:	1/29/2010	Get Well Hospice	Medical Director
To:	5/12/2015	1234 Healthy Avenue, Suite 1A, Sacramento, CA 95810	
From:	3/2/2007	Care Free Medical Center	Physician and Surgeon
To:	1/28/2010	9876 Pain Free Drive, Elk Grove, CA 95624	
From:			
To:			

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

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

1. **Have** you ever been involved with a business entity that operated a health facility or community care facility?  
 Yes  No **If YES, complete Section F (below) and the “Facility Information Sheet” (attached).**
2. Have you ever operated or managed (including management agreements) any of the following facility types?  
 Yes  No **If YES, complete Section F (below) and the “Facility Information Sheet” (attached).**

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

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

**F. Adverse Actions**

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

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

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

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

Signature:

Date: 3/11/18

**RELEASE OF INFORMATION STATEMENT**

The information provided on this form is mandatory and is necessary for licensure approval. It will be used to determine individual applicant's or applicant facility's ability to provide health services. The information is requested by the California Department of Public Health, Licensing and Certification, in accordance with the Health and Safety Code. Failure to provide the information as requested may result in nonissuance of a license or license revocation. The information is considered public information and will be made available to the public upon request. The information shall be included and maintained in the individual facility's public files located in Licensing and Certification district offices.

### FACILITY INFORMATION SHEET

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

Facility name:		Facility address (number, street, city):		State:	Zip code:
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 checked="" 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 checked="" type="radio"/> LLC: ABC Medical Center, LLC EIN:55-5555555 <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 checked="" 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 checked="" type="radio"/> OTHER Nature of Involvement (explain): Member Dates of involvement: From: 6/13/2019 To: Present	

Facility name:		Facility address (number, street, city):		State:	Zip code:
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 checked="" 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 checked="" 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 checked="" 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 checked="" type="radio"/> OTHER Nature of Involvement (explain): Office Manager Dates of involvement: From: 1/28/2010 To: 5/12/2019	

Facility name:		Facility address (number, street, city):		State:	Zip code:
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): _____ _____		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 checked="" 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.
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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.

# John Doe

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

## Education

**MEDICAL UNIVERSITY | 1996**

- Physician and Surgeon License #A12345

## Experience

**Medical Director**

**MAY 2019 – PRESENT**

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

- Duties of Medical Director

**Medical Director**

**JANUARY 2010 – MAY 2019**

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

- Duties of Medical Director

**Physician and Surgeon**

**MARCH 2005 – Present**

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

- Duties of a Physician and Surgeon