Sample

COVER LETTER

ABC Community Care 999 Beach Side Court Sacramento CA 95814

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

Email: JaneDoe@abccommunitycare.org

March 15, 2019

VIA PRIORITY MAIL:

California Department of Public Health Licensing and Certification P. O. Box 997377, MS 3207 Sacramento, CA 95899 Attn: Centralized Applications Branch

RE: **CHANGE OF ADMINISTRATOR** Application for Family First, located at 1800 Beach Drive, Sacramento, CA 95814.

To Whom It May Concern,

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

As of May 13, 2015, Family First appointed Wain Jones as the Administrator. I enclosed the required application forms and supporting documents needed to process my Change of Administrator application.

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: Jane Doe

Email: <u>JaneDoe@abccommunitycare.org</u>
Phone: (999) 555-2626

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

Fax: (999) 555-2600

Sincerely,

Jane Doe

Jane Doe, Owner ABC Community Care Sample

HS 215A

FOR DEPARTMENTAL USE ONLY	
District: ELMS Facility Number:	
Proposed name of facility/ag	gency/clinic:

APPLICANT INDIVIDUAL INFORMATION

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

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

A. Identifying Information		•
Name		Date of Birth
Wain Jones		06/27 970
Business address (number, street, apartment,	suite number or letter if applic	City, State, & Zip
1800 Beach Drive		Sacramento, CA 95814
Title in relation to this facility		•
Administrator		
Have you applied for ANY license for a health name? If yes, list all other names.	facility or community care fac	Mity using any name other than your true full
No		
If an Administrator for proposed clinic, list hou		
than one licensed clinic, list the name of each	clinic and the number of hol	urs spent in each licensed clinic per week.
Family First- 40 hours per week		
<u> </u>		
B. Criminal Record		
 Have you ever been convicted of an offens Has there been a judgment against you or professional/technical licensing entity? 		
If yes to questions 1 or 2 above, please expla	in and provide dates and conv	viction information (attach additional pages if
necessary):		
C. Professional Licenses/Certificat Clinics and optional for Health fa	-	s mandatory for Primary Care
TYPE	PERIOD HELD	ISSUING AGENCY

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		Name a	nd address of employer		Job title
rom:	5/13/2015	Family First		Ad	dministrator
Го:	Present	1800 Beach Drive, Sacramento	o CA 95814		
From:	1/29/2010	Get Well Hospital		Ac	dministrator
Го:	5/12/2015	1234 Healthy Avenue, Suite 1	A, Sacramento, CA 95810		
rom:	3/2/2007	Care Free Medical Center		D	Director of Nursing
Го:	1/28/2010	9876 Pain Free Drive, Elk Gro	ve CA 95624		
rom:					
Го:					
. Fa	cility, Agency, Cl	inic Involvement (i	n or out of California)		
The	e questions below ar	e for "individuals" and	d do not pertain to the facility	that is applyi	ing for licensure.
1.	Have you ever been	involved with a business	s entity that operated a health fa	acility or comm	nunity care facility?
			on F (below) and the "Facility		
	<u> </u>				
2	Have you ever oners	ted or managed (includi	ing management agreements) a	ny of the follo	wing facility types?
2.			ing management agreements) a		
	● Yes ○ No If	YES, complete Section			
	Yes No If	YES, complete Sectional Day Health Care Centernics	on F (below) and the Facility		
	Yes No If	YES, complete Section Ult Day Health Care Centernics UMMUNITY CARE FACILITY	ICFIDD IC		
	Yes No If	YES, complete Section ult Day Health Care Centernics MMUNITY CARE FACILITY neral Acute Care Hospital	ICF/DD-H ICF/DD-H ICF/DD-H ICF/DD-H ICF/DD-H ICF/DD-H ICF/DD-H	Information S	
	Yes No If	YES, complete Section Ult Day Health Care Centernics UMMUNITY CARE FACILITY Ineral Acute Care Hospital Inalth Facility Ineral Health Agency	ICF/DD-H ICF/DD-H INTERMEDIATE CARE Facility Note: mediate Care Facility Rediatric Day Health & Respite Residential Care Facility for the	Information S	
	Yes No If	YES, complete Section Ult Day Health Care Centernics UMMUNITY CARE FACILITY Ineral Acute Care Hospital Inalth Facility	ICF/DD-N Intermediate Care Facility Nediatric Day Health & Respite Residential Care Facility for the Skilled Nursing Facility	Information S	
1	Yes No If	YES, complete Section ult Day Health Care Centernics MMUNITY CARE FACILITY neral Acute Care Hospital alth Facility me Health Agency spice	ICF/DD ICF/DD IN Intermediate Care Facility Intermediate Care Facility Padiatric Day Health & Respite Residential Care Facility for the Skilled Nursing Facility Other	Information S Care Elderly	Sheet" (attached).
1	Yes No If	YES, complete Section uit Day Health Care Centernics MMUNITY CARE FACILITY neral Acute Care Hospital alth Facility me Health Agency spice	ICF/DD-N Intermediate Care Facility Nediatric Day Health & Respite Residential Care Facility for the Skilled Nursing Facility	Care Elderly	Sheet" (attached).
3.	Yes No If	YES, complete Section uit Day Health Care Centernics MMUNITY CARE FACILITY neral Acute Care Hospital alth Facility me Health Agency spice	ICF/DD ICF/DD-H ICF/DD-H ICF/DD-H ICF/DD-N Intermediate Care Facility Pediatric Day Health & Respite Residential Care Facility for the Skilled Nursing Facility Other neficial ownership interest in any	Care Elderly	Sheet" (attached).
3. Ad	Ad Cli CC Ge He Ho Ho Ves No If YI Verse Actions	YES, complete Section ult Day Health Care Centernics MMUNITY CARE FACILITY neral Acute Care Hospital alth Facility me Health Agency spice 1 5 percent or more ben ES, complete Section F	ICFIDD ICFIDD ICFIDD ICFIDD ICFIDD INTERMEDIATE Residential Care Facility Residential Care Facility for the Skilled Nursing Facility Other Intermediate Care Facility Information of the Skilled Nursing Facility Other Intermediate Care Facility Information of the Skilled Nursing Facility Other Intermediate Care Facility Information of the Skilled Nursing Facility Intermediate Care Facility Information of the Skilled Nursing Facility Intermediate Care Facility Information of the Skilled Nursing Facility	Care Elderly of the facility prmation She	types above?
3. . Ad	Ad Cli CC Ge He Ho Ho Ves No If YI Verse Actions	YES, complete Section ult Day Health Care Center nics MMUNITY CARE FACILITY neral Acute Care Hospital alth Facility me Health Agency spice 5 percent or more ben ES, complete Section Facility, either particularly in the property of the pr	ICF/DD ICF/DD IN Intermediate Care Facility Intermediate Care Facility Padiatric Day Health & Respite Residential Care Facility for the Skilled Nursing Facility Other neficial ownership interest in any F (below) and the "Facility Info	Care Elderly of the facility prmation She	types above?
3. Ad Have follow	Have you ever held a Yes No If YI Iverse Actions ve you been affiliated vowing adverse actions	YES, complete Section ult Day Health Care Center nics MMUNITY CARE FACILITY neral Acute Care Hospital alth Facility me Health Agency spice 5 percent or more ben ES, complete Section Facility, either particularly in the property of the pr	ICF/DD-H ICF/DD-H ICF/DD-H Intermediate Care Facility Rediatric Day Health & Respite Residential Care Facility for the Skilled Nursing Facility Other Deficial ownership interest in any F (below) and the "Facility Info	Care Elderly of the facility prmation She	types above? eet" (attached). ving one or more of t
3. Ad Hav follo	Have you ever held a Yes No If YI Iverse Actions ve you been affiliated vowing adverse actions	WES, complete Section uit Day Health Care Centernics MMUNITY CARE FACILITY neral Acute Care Hospital alth Facility me Health Agency spice 1 5 percent or more ben ES, complete Section F With any facility, either page ecertification action take	ICF/DD-N ICF/DD-N Intermediate Care Facility Pediatric Day Health & Respite Residential Care Facility for the Skilled Nursing Facility Other neficial ownership interest in any F (below) and the "Facility Infermediate Care Facility for the Skilled Nursing Facility Other neficial ownership interest in any F (below) and the "Facility Infermediate or present, that has been identify the state of t	Care Elderly or the facility ormation She	types above? eet" (attached).
3. Ad Have following the Fermi state of the Fermi	Have you ever held a Yes No If YI Iverse Actions we you been affiliated wowing adverse actions had a final Medi-Cal de Resolved by settlement	WES, complete Section with Day Health Care Centernics MMUNITY CARE FACILITY neral Acute Care Hospital alth Facility me Health Agency spice 5 percent or more ben ES, complete Section F with any facility, either page executification action take t Revocation action	ICF/DD-N ICF/DD-N Intermediate Care Facility Pediatric Day Health & Respite Residential Care Facility for the Skilled Nursing Facility Other neficial ownership interest in any F (below) and the "Facility Infermediate Care Facility for the Skilled Nursing Facility Other neficial ownership interest in any F (below) and the "Facility Infermediate or present, that has been identify the state of t	Care Elderly of the facility ormation She entified as have a given by a give	types above? eet" (attached). ving one or more of to suspension

RELEASE OF INFORMATION STATEMENT

Date: 3/11/2019

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.

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Signature:

FACILITY INFORMATION SHEET

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

Facility name:		Facility address (number, street, city):		State:	Zip code:
Family First		1800 Beach Drive, Sacramento		CA	95814
Type of Facility		"Type" of Business Entity	Individual's "Nat	ure" of Invo	lvement
Adult Day Health Care Center	For EACH busin	ess entity, identify the name & EIN of the entity:	Administrator of Clinic	SNF or ICE	=
O Clinic	Corporation		O Agent	,	
O COMMUNITY CARE FACILITY	ABC Communit		ODirector		
General Acute Care Hospital	♠ Individual:		Licensee		
Mealth Facility			Manager of "parent" of	rganization	
O HHA	O LLC:		Managing employee	of a HHA	
OHospice			O Member		
O ICF	Managemer	nt Company:	Officer of corporation		
O ICF/DD			Owner Owner		
O ICF/DD-H	Partnership	:	Partner		
O ICF/DD-N	1		Sole Proprietorship		
O ICF	OTHER Bus	siness Entity (explain):	Stockholder Owner	rship %: 📙	
Residential Care for the Elderly	1	D : E ('C "DADENT" : ' ' I	Trustee		
SNF		bove Business Entities a "PARENT" organization to the	OTHER Nature of Inv	olvement (ex	(plain):
OTHER FACILITY TYPE (explain):	applicant facility	? If Yes, explain.	Administrator		
1	Yes No		Dates of involvement: From: 5/13/2015		
1	1 0 110		From: 5/13/2015 To: Present		
			TO: IF-resent		
			•		
Facility name:		Foolity odd noo (number of the life)		Chata	7im and
Facility name:		Facility address (number, street, city):		State:	Zip code:
					<u> </u>
Type of Facility		"Type" of Business Entity	Individual's "Nat	ure" of Invo	lvement
Adult Day Health Care Center	For EACH busin	ess entity, identify the name & FIN of the entity:	Administrator of Clinic	, SNF or ICF	=
Clinic	Corporation		_		
O COMMUNITY CARE FACILITY	<u> </u>		Director		
General Acute Care Hospital	Individual:		Licensee		
Health Facility	1-		Manager of "parent" of		
O HHA	LLC:		Managing employee	of a HHA	
O Hospice	1		Member		
O ICF	Managemer O	nt Company:	Officer of corporation		
O ICF/DD	1 2 2 1 11		Owner		
O ICF/DD-H	O Partnership		Partner		
O ICF/DD-N	OTUED D	. 5.60	Sole Proprietorship	1: 0/	
O ICF	O OTHER BUS	siness Entity (explain):	Stockholder Owner	rsnip %: <u>I</u>	
Residential Care for the Elderly	Are any of the al	ove Business Entities a "PARENT" organization to the	Trustee	-1	1-:
O SNF		? If Yes, explain.	OTHER Nature of Inv	oivement (ex	(piain):
OTHER FACILITY TYPE (explain):	O Yes	: Toli CS, CApiani.	Datas of involvement:		
	0 NO		Dates of involvement: From:		
-			To:		
			10.		
Escility name:		Equility address (number street site)		Ctoto	7in codo
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 busin	ess entity, identify the name & EIN of the entity:	Administrator of Clinic	, SNF or ICF	=
Clinic	O Corporation		O Agent		
O COMMUNITY CARE FACILITY			ODirector		
General Acute Care Hospital	Individual:		Licensee		
Health Facility			Manager of "parent" of	rganization	
OHHA	O LLC:		Managing employee		
Hospice			O Member		
OICF	O Managemer	nt Company:	Officer of corporation		
O ICF/DD			Owner		

Trustee

From:

O Partner
O Sole Proprietorship

Dates of involvement:

O Stockholder -- Ownership %:

OTHER Nature of Involvement (explain):

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O Partnership:

Yes [No

OTHER Business Entity (explain):

applicant facility? If Yes, explain.

Are any of the above Business Entities a "PARENT" organization to the

O ICF/DD-N O ICF

Residential Care for the Elderly
SNF
OTHER FACILITY TYPE (explain):

Facility name:	Facility address (number, street, city):		State:	Zip code:
Type of Facility	"Type" of Business Entity	Individual's "Nati	ire" of Invo	Ivement
Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the entity:	Administrator of Clinic	, SNF or ICF	-
Clinic	Corporation:	Agent		
O COMMUNITY CARE FACILITY	la dicident	Director		
General Acute Care Hospital Health Facility	Individual:	Licensee Manager of "parent" or	ranization	
OHHA	O LLC:	Managing employee o	f a HHA	
O Hospice	<u> </u>	Member	141111/1	
O ICF	Management Company:	Officer of corporation		
O ICF/DD		Owner		
O ICF/DD-H	Partnership:	Partner		
O ICF/DD-N	OTHER Business Entity (explain):	Sole Proprietorship Stockholder Owner	abin 0/ .	
Residential Care for the Elderly	OTHER Business Entity (explain).	Trustee	SIIIP %: <u>I</u>	
O SNF	Are any of the above Business Entities a "PARENT" organization to the	OTHER Nature of Invo	olvement (ex	plain):
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:
Towns of Facilities	"Town I of Dunings Fully	Individual's "Nati		
Type of Facility	"Type" of Business Entity			
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:	Agent		
COMMUNITY CARE FACILITY General Acute Care Hospital	O Individual:	O Director C Licensee		
Health Facility	o individual:	Manager of "parent" of	rganization	
OHHA	O LLC:	Managing employee o		
O Hospice	<u> </u>	O Member		
OICF	Management Company:	Officer of corporation		
O ICF/DD		Owner		
O ICF/DD-H	Partnership:	Partner		
O ICF/DD-N	O OTHER Business Entry (explain)	Sole Proprietorship Stockholder Owner	ohin %:	
Residential Care for the Elderly		Trustee	SI II P 70. 1	
O SNF	Are any of the above Business Entities a "PARENT" organization to the	OTHER Nature of Invo	olvement (ex	plain):
OTHER FACILITY TYPE (explain):	applicant facility? If Yes, explain.		,	
	O Yes	Dates of involvement:		
	Ŏ No	From:		
		To:		
Facility name:	Facility address (number, street, city):		State:	Zip code:
Type of Facility	"Type" of Business Entity	Individual's "Natu	ire" of Invo	lvement
Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the entity:	Administrator of Clinic	SNF or ICE	
O Clinic	O Corporation:	OAgent	, 0.11. 0. 101	
O COMMUNITY CARE FACILITY		Director		
General Acute Care Hospital	O Individual:	OLicensee		
Health Facility		Manager of "parent" o		
O HHA	O LLC:	Managing employee o	f a HHA	
Hospice	04	Officer of corporation		
O ICF O ICF/DD	Management Company:	Outlicer of corporation Owner		
O ICF/DD-H	O Partnership:	Partner		
OICF/DD-N	<u> </u>	Sole Proprietorship		
OICF	OTHER Business Entity (explain):	OStockholder Owner	ship %:	
Residential Care for the Elderly		O Trustee		
SNF	Are any of the above Business Entities a "PARENT" organization to the	OTHER Nature of Inve	olvement (ex	kplain):
OTHER FACILITY TYPE (explain):	applicant facility? If Yes, explain. Yes			
	No Yes I	Dates of involvement: From:		
,		From: I		

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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,
- 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).

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.
011	
City	City where business is located.
State	State where business is located.
<u> </u>	
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 ther 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 sates and conviction information. If not applicable, please enter 'N/A'.

C. PROFESSIONAL LICENSES/CERTIFICATES

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

D. EMPLOYMENT/BUSINESS SUMMARY (FOR LAST 10) BARS). 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.

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