

Sample Only

COVER LETTER

ABC Medical Services, LLC

999 Beach Side Court, Sacramento, CA 95814

P: (999) 555-2626

F: (999) 555-2600

Email: WainJones@abcmedicalservicesLLC.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,

We are submitting this **Change of Administrator** application.

Facility Name: **ABC Medical Services, LLC**

Facility Address: **999 Beach Side Court, Sacramento, CA 95814**

Facility ID Number: **123456789**

Licensee Name: **ABC Medical Services, LLC**

License Number: **22222222**

I enclosed the required application forms and supporting documents needed to process this change.

Should you have any questions, I will be the direct contact regarding this change.

Emergency Contact Information (available 365/24/7)

Name: Wain Jones

Email: WainJones@abcmedicalservicesLLC.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 Services, LLC

Sample Only

HS 215A

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

APPLICANT INDIVIDUAL INFORMATION

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

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

A. Identifying Information

Name	Date of Birth
Dixie, Amber	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	
Administrator, Member/Owner 49%	
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 each clinic and the number of hours spent in each licensed clinic per week.	
40	

B. Criminal Record

1. Have you ever been convicted of an offense that is still on your record, whether misdemeanor or felony? Yes No
2. Has there been a judgment against you for Medicare or Medicaid (Medi-Cal) fraud or by a health care professional/technical licensing entity? Yes No

If yes to questions 1 or 2 above, please explain and provide dates and conviction information (attach additional pages if necessary):

C. Professional Licenses/Certificates – This requirement is mandatory for Primary Care Clinics and optional for Health facilities.

TYPE	PERIOD HELD	ISSUING AGENCY

D. Employment/Business Summary (for last 10 years). Please list any additional experience that qualifies you to operate this type of facility. Begin with your most recent job. Attach additional pages if necessary.

	Name and address of employer		Job title
From:	5/13/2018	ABC Medical Services, LLC	Administrator
To:	Present	999 Beach Side Ct., Sacramento, CA 95814	
From:	1/29/2010	Get Well Hospice	Administrator
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:			

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

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

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

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

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

F. Adverse Actions

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

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

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

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

Signature:

Date: 3/11/19

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: ABC Medical Services, LLC		Facility address (number, street, city): 999 Beach Side Ct., Sacramento		State: CA	Zip code: 95814
Type of Facility	"Type" of Business Entity		Individual's "Nature" of Involvement		
<input type="radio"/> Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the entity:		<input checked="" type="radio"/> Administrator of Clinic, SNF or ICF		
<input type="radio"/> Clinic	<input type="radio"/> Corporation: _____		<input type="radio"/> Agent		
<input type="radio"/> COMMUNITY CARE FACILITY	_____		<input type="radio"/> Director		
<input type="radio"/> General Acute Care Hospital	<input type="radio"/> Individual: _____		<input type="radio"/> Licensee		
<input type="radio"/> Health Facility	_____		<input type="radio"/> Manager of "parent" organization		
<input type="radio"/> HHA	<input checked="" type="radio"/> LLC: _____		<input type="radio"/> Managing employee of a HHA		
<input type="radio"/> Hospice	_____		<input type="radio"/> Member		
<input type="radio"/> ICF	<input type="radio"/> Management Company: _____		<input type="radio"/> Officer of corporation		
<input type="radio"/> ICF/DD	_____		<input type="radio"/> Owner		
<input type="radio"/> ICF/DD-H	<input type="radio"/> Partnership: _____		<input type="radio"/> Partner		
<input type="radio"/> ICF/DD-N	_____		<input type="radio"/> Sole Proprietorship		
<input type="radio"/> ICF	<input type="radio"/> OTHER Business Entity (explain): _____		<input type="radio"/> Stockholder -- Ownership %: _____		
<input type="radio"/> Residential Care for the Elderly	_____		<input type="radio"/> Trustee		
<input checked="" type="radio"/> SNF	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"/> OTHER Nature of Involvement (explain): _____		
<input type="radio"/> OTHER FACILITY TYPE (explain): _____ _____			Dates of involvement: From: _____ To: _____		

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	For EACH business entity, identify the name & EIN of the entity:		<input type="radio"/> Administrator of Clinic, SNF or ICF		
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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.

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.
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

Type	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.

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.
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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

Facility 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 | Amber.Dixie@msn.com

Education

NURSING UNIVERSITY | 1996

- Master of Science in Business

Experience

Administrator

MAY 2018 – PRESENT

ABC Medical Services, 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

JANUARY 2010 – MAY 2018

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 hospital
- Ensure quality patient care and compliance with established objectives
- Participate with medical staff and senior management in the development and implementation of strategic plans
- Manage employee relations and implement policies and procedures
- Coordinate, implement and monitor processes to ensure the integration of strategic direction and operational goals
- Develop, oversee and execute an annual marketing plan for the hospital

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