Sample Only

Cover Letter

ABC Healthcare Services, Inc.
999 Beach Side Court, Sacramento, CA 95814
P: (999) 555-2626
F: (999) 555-2600
Email: ABChealthcareservices@gmail.com

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 Program Director** application.

Facility Name: **ABC Adult Day Health Center**
Facility Address**: 1800 Beach Drive, Sacramento, CA 95814**
Facility ID Number: **123456789**
Licensee Name: **ABC Healthcare Services, Inc.**
License Number: **222222222**

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: Jane Doe
Email: ABChealthcareservices@gmail.com
Alternate Email: JaneDoe@cmail.com
Phone: (999) 555-2626
Phone (Text Messages): (999) 555-5555
Fax: (999) 555-2600

Sincerely,

Jane Doe

Jane Doe, Owner
ABC Healthcare Services, Inc.

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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: Amber Dixie

Date of Birth: 03/03/1970

Business address (number, street, apartment/suite number or letter if applicable): 1800 Beach Drive

City, State, & Zip: Sacramento, CA 95814

Title in relation to this facility: Program 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 **each clinic** and the number of hours spent in each licensed clinic per week.

40

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B. Criminal Record

1. Have you ever been convicted of an offense that is still on your record, whether misdemeanor or felony? ○ **Yes** ◉ **No**

2. Has there been a judgment against you for Medicare or Medicaid (Medi-Cal) fraud or by a health care professional/technical licensing entity? ○ **Yes** ◉ **No**

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

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

TYPE	PERIOD HELD	ISSUING AGENCY
RN	06/1996 - Present	Board of Registered Nurse

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.

	Dates	Name and address of employer	Job title
From:	5/13/2019	ABC Healthcare Services, Inc.	Program Director
To:	Present	1800 Beach Drive, Sacramento, CA 95814	
From:	1/29/2010	Get Well Hospital	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.

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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:**
ABC Adult Day Health Center	1800 Beach Drive, Sacramento	CA	95814

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	( ) Corporation:	( ) Agent
( ) COMMUNITY CARE FACILITY		( ) Director
( ) General Acute Care Hospital	( ) Individual:	( ) Licensee
( ) Health Facility		( ) Manager of "parent" organization
( ) HHA	(•) LLC:	( ) Managing employee of a HHA
( ) Hospice	Tax ID/EIN:55-5555555	( ) Member
( ) ICF	( ) Management Company:	( ) Officer of corporation
( ) ICF/DD		( ) Owner
( ) ICF/DD-H	( ) Partnership:	( ) Partner
( ) ICF/DD-N		( ) Sole Proprietorship
( ) ICF	( ) OTHER Business Entity (explain):	( ) Stockholder -- Ownership %:
( ) Residential Care for the Elderly		( ) Trustee
( ) SNF	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	(•) OTHER Nature of Involvement (explain): Program Director
( ) OTHER FACILITY TYPE (explain):	( ) Yes (•) No	Dates of involvement: From: 05/13/2019 To: Present

Facility name:	**Facility address (number, street, city):**	**State:**	**Zip code:**
Get Well Hospital	1234 Healthy Avenue, Suite 1A, Sacramento	CA	95810

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	(•) Corporation:	( ) Agent
( ) COMMUNITY CARE FACILITY	Tax ID/EIN- 123456789	( ) Director
(•) General Acute Care Hospital	( ) Individual:	( ) Licensee
( ) Health Facility		( ) Manager of "parent" organization
( ) HHA	( ) LLC:	( ) Managing employee of a HHA
( ) Hospice		( ) Member
( ) ICF	( ) Management Company:	( ) Officer of corporation
( ) ICF/DD		( ) Owner
( ) ICF/DD-H	( ) Partnership:	( ) Partner
( ) ICF/DD-N		( ) Sole Proprietorship
( ) ICF	( ) OTHER Business Entity (explain):	( ) Stockholder -- Ownership %:
( ) Residential Care for the Elderly		( ) Trustee
( ) SNF	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	(•) OTHER Nature of Involvement (explain): Administrator
( ) OTHER FACILITY TYPE (explain):	( ) Yes (•) No	Dates of involvement: From: 01/28/2010 To: 05/12/2018

Sample Only

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	( ) Corporation:	( ) Agent
( ) COMMUNITY CARE FACILITY		( ) Director
( ) General Acute Care Hospital	( ) Individual:	( ) Licensee
( ) Health Facility		( ) Manager of "parent" organization
( ) HHA	( ) LLC:	( ) Managing employee of a HHA
( ) Hospice		( ) Member
( ) ICF	( ) Management Company:	( ) Officer of corporation
( ) ICF/DD		( ) Owner
( ) ICF/DD-H	( ) Partnership:	( ) Partner
( ) ICF/DD-N		( ) Sole Proprietorship
( ) ICF	( ) OTHER Business Entity (explain):	( ) Stockholder -- Ownership %:
( ) Residential Care for the Elderly		( ) Trustee
( ) SNF	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	( ) OTHER Nature of Involvement (explain):
( ) OTHER FACILITY TYPE (explain):	( ) Yes ( ) No	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
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
COMMUNITY CARE FACILITY		Director
General Acute Care Hospital	Individual:	Licensee
Health Facility		Manager of "parent" organization
HHA	LLC:	Managing employee of a HHA
Hospice		Member
ICF	Management Company:	Officer of corporation
ICF/DD		Owner
ICF/DD-H	Partnership:	Partner
ICF/DD-N		Sole Proprietorship
ICF	OTHER Business Entity (explain):	Stockholder -- Ownership %:
Residential Care for the Elderly		Trustee
SNF	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	OTHER Nature of Involvement (explain):
OTHER FACILITY TYPE (explain):	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	Corporation:	Agent
COMMUNITY CARE FACILITY		Director
General Acute Care Hospital	Individual:	Licensee
Health Facility		Manager of "parent" organization
HHA	LLC:	Managing employee of a HHA
Hospice		Member
ICF	Management Company:	Officer of corporation
ICF/DD		Owner
ICF/DD-H	Partnership:	Partner
ICF/DD-N		Sole Proprietorship
ICF	OTHER Business Entity (explain):	Stockholder -- Ownership %:
Residential Care for the Elderly		Trustee
SNF	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	OTHER Nature of Involvement (explain):
OTHER FACILITY TYPE (explain):	Yes	Dates of involvement:
	No	From:
		To:

Sample Only

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	Corporation:	Agent
COMMUNITY CARE FACILITY		Director
General Acute Care Hospital	Individual:	Licensee
Health Facility		Manager of "parent" organization
HHA	LLC:	Managing employee of a HHA
Hospice		Member
ICF	Management Company:	Officer of corporation
ICF/DD		Owner
ICF/DD-H	Partnership:	Partner
ICF/DD-N		Sole Proprietorship
ICF	OTHER Business Entity (explain):	Stockholder -- Ownership %:
Residential Care for the Elderly		Trustee
SNF	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	OTHER Nature of Involvement (explain):
OTHER FACILITY TYPE (explain):	Yes	Dates of involvement:
	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;
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.

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.

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Amber Dixie

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

Education

NURSING UNIVERSITY I 1996

- Master of Science in Business

Experience

Program Director **MAY 2019 - PRESENT**

ABC Adult Day Health Center. 1800 Beach Drive, Sacramento, CA 95814

- Serve as Administrator for ADHC
- 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 2019**

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

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

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

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CDA 278

ADMINISTRATOR AND PROGRAM DIRECTOR INFORMATION

Attach a resume and supporting documents such as a degree, licensure or registration. If a foreign degree, submit equivalency evaluation documentation. For more space, attach an additional page. Type or print clearly.

1. LICENSEE NAME: ABC Healthcare Services, Inc.
   CENTER NAME: ABC Adult Day Health Center
   POSITION: ☐ Administrator ☑ Program Director

2. IDENTIFYING INFORMATION:
   Name Amber Dixie Birthdate 03/03/1970
   Address 999 Delta Rd., Sacramento, CA 95841
   Sex: Male _____ Female X
   Any other name you have used: _____
   Social Security Number* 444-55-666 Driver License Number* D9876543

3. EDUCATION

Name and Location of College Attended	Course Study	Years Completed	Degree	Date
Nursing University, 1002 Nurse Way, Sacramento, CA 95837	Nursing	4	Master	June 1996

4. CIVIL RECORD: Were you ever convicted of an offense other than minor traffic violations?
   Yes ☐ (Attach explanatory sheet) No ☑
   Has there been judgement against you for fraud, misrepresentation, libel or slander?
   Yes ☐ (Attach explanatory sheet) No ☑
   Were you ever voluntarily committed or involuntarily detained in any facility or institution?
   Yes ☐ (Attach explanatory sheet) No ☑

5. REFERENCES: For individuals, list only persons with knowledge of your ability to provide care, or control a care facility.

	NAME	ADDRESS	RELATIONSHIP
A.	Sherry Pike	8457 Spring Drive, Sacramento, CA 95834	Colleague
B.	John Wisk	4521 Fruit Lane, Elk Grove, CA 95757	Colleague
C.	Paula Whistle	3691 Strawberry Way, Elk Grove, CA 95758	Former Supervisor

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 Department of Health Services, 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, 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.

Continued

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ADMINISTRATOR AND PROGRAM DIRECTOR INFORMATION
(Continued)

6. BUSINESS EXPERIENCE

A. Have you owned or operated any business? Yes ☐ No ☑

Type	No. of Employees	Your Title	Start	End	Reason for End

B. Do you have any professional license or certificate? Yes ☑ No ☐

Type	Period Held	Issuing Agency
Registered Nurse, Lic. #4545454	June 1996 - present	California Board of Registered Nurse

C. Are you a member of any professional/technical association? Yes ☐ No ☑

Association Name	Address

7. EMPLOYMENT SUMMARY (FOR LAST 10 YEARS) **ATTACH RESUME (Ensure that the items listed below are included on the resume)**

Dates	Name and Address of Employer	Basic Duties	Reason for Leaving
From May 2019 To Present	ABC Adult Day Health Center 1800 Beach Drive, Sacramento, CA 95814	See resume.	Current
From Jan. 2010 To May 2019	Get Well Hospital 1234 Healthy Ave., Suite 1A, Sacramento, CA 95810	See resume.	New type of health care facility.
From Mar. 2005 To Jan. 2010	Care Free Medical Center 9876 Pain Free Drive, Elk Grove, CA 95624	See resume.	New opportunity.
From To			
From To			
From To			
From To			

Note: Include activities during period of unemployment.

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

Signature____________________ Date 03/11/2019

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State of California—Health and Human Services Agency

California Department of Public Health

KAREN L. SMITH, MD, MPH
Director and State Public Health Officer

GAVIN NEWSOM
Governor

March 7, 2019

Program Director
ABC Healthcare Services, Inc.
1800 Beach Drive
Sacramento, CA 95814

RE: CRIMINAL RECORD CLEARANCE

Individual Name: Dixie, Amber
Accreditation Number: ADHC 0000026
BGC Number: 0000109

Dear Administrator,

The California Department of Public Health, Professional Certification Branch, Criminal Background Section (Department) has granted criminal record clearance on March 7, 2019 for the above named individual. You will be notified should any subsequent information be received that would change the status of the above individual's criminal record clearance.

Please retain a copy of this letter in the employee's personnel file for review by your local district office. If the individual is no longer employed at your facility, please notify the Department so we can update our records.

Sincerely,

CRIMINAL BACKGROUND SECTION

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LICENSING AND CERTIFICATION, PROFESSIONAL CERTIFICATION BRANCH, CRIMINAL BACKGROUND SECTION
MS 3304 • P.O. Box 997416 • Sacramento, CA 95899-7416
Email: cbs@cdph.ca.gov • (916) 552-8854 FAX
Internet Address: www.cdph.ca.gov