SAMPLE

COVER LETTER

ABC Home Healthcare, Inc.
999 Beach Side Court, Sacramento, CA 95814
P: (999) 555-2626
F: (999) 555-2600
Email: JaneDoe@abchhealthcare.org

March 03, 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: **INITIAL ADD BRANCH** Application for Home Health Agency

To Whom It May Concern,

We are submitting an Initial application to add a Home Health Agency Branch Office known as Star Home Healthcare Services. Listed below are the Parent and proposed Branch Office information:

Parent Location
Star Home Healthcare Services
999 Beach Side Court
Sacramento, CA 95814
License Number: 333333333

Branch Location
Star Home Healthcare Services
1800 Playa Del Rey Drive, Ste. 777
Sacramento, CA 95814

Enclosed are the required documents to support processing my initial branch office application.

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

Emergency Contact Information (available 365/24/7)
Name: Jane Doe
Email: JaneDoe@abchhealthcare.org
Phone: (999) 555-2626
Fax: (999) 555-2600

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

Sincerely,

Jane Doe

Jane Doe, Owner
ABC Home Healthcare, Inc.

SAMPLE

SAMPLE

HS 200

LICENSURE & CERTIFICATION APPLICATION

FOR DEPARTMENTAL USE ONLY	
Proposed name of facility/agency/clinic:	

A. APPLICATION INFORMATION

1. Type of application (check one):
   - ○ **a.** Initial
   - ○ **b.** Change of Ownership (see #2 below)
   - ○ **c.** Management company (see Sections C1-5, F, and Attachment E-1)
   - ◉ **d.** Other change (see Section A4): ADD BRANCH

2. **Change of Ownership Only - For Certification Purposes:**
   We wish to make certain that our records correctly show the effective date of the ownership change for certification. This date should reflect the actual date on which you took charge of the financial management of the facility rather than the date of sale or date of state license change. Effective date of change:

3. Amount of fee enclosed: $

4. Type of Change (check all that apply):
   - ☑ **a.** Not applicable
   - ☐ **b.** Change of capacity (see # 8 below)
   - ☐ **c.** Change of location
   - ☐ **d.** Change of services
   - ☐ **e.** Change of facility type
   - ☐ **f.** Change of bed classification
   - ☐ **g.** Change of name
   - ☐ **h.** Construction of new or replacement facility
   - ☐ **i.** Stock transfer
   - ☐ **j.** Other (specify)

5. Type of facility, agency, or clinic (check one)
   - ○ **a.** Skilled Nursing Facility (SNF)
   - ○ **b.** Intermediate Care Facility (ICF)
   - ○ **c.** ICF/Developmentally Disabled (ICF/DD)
   - ○ **d.** ICF/DD-Habilitative (ICF/DD-H)
   - ○ **e.** ICF/DD-Nursing (ICF/DD-N)
   - ○ **f.** Primary care clinic – Free
   - ○ **g.** Primary care clinic – Community
   - ○ **h.** Surgical clinic
   - ○ **i.** Rural health clinic (for Certification "only")
   - ○ **j.** General acute care hospital
   - ○ **k.** Adult day health care center
   - ◉ **l.** Home Health Agency (HHA)
   - ○ **m.** Hospice
   - ○ **n.** Chronic dialysis clinic
   - ○ **o.** Other (specify)

6. **a.** Do you wish to apply for the Medicare program? ◉ Yes ○ No Medicare Provider #: 44-4444
   b. Fiscal Intermediary choice: Fiscal Intermediary

7. Do you wish to apply for the Medi-Cal (Medicaid) program? ◉ Yes ○ No

8. **a.** Current facility bed capacity: N/A
   b. Proposed facility bed capacity: N/A

9. Age range of clients: 0-110

10. Days and hours of operation: Monday - Friday, 8:00am - 5:00pm

11. Is construction required? ○ Yes ◉ No
    If "yes", submit copy of "OSHPD" form (see instructions on page 6)
    If "yes", date construction to begin:
    If "yes", date construction to be completed:

SAMPLE

B. LICENSEE INFORMATION

1. Licensee name: ABC Home Healthcare, Inc.

2. Federal employer's tax ID number: 555555555

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): 999 Beach Side Court

Telephone number: (999) 555-2626

City, State, & Zip: Sacramento, CA 95814-7402

E-Mail: JaneDoe@abchhealthcare.org

Fax number: (999) 555-2600

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:

SAMPLE

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? If "yes", proceed to **Section E** (below). ○ Yes ◉ 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? If "yes", ***submit*** a copy of the "interim" management agreement. ○ Yes ◉ No

2. Name of **"proposed" facility**, agency, or clinic: Star Home Healthcare Services - Branch
   Current facility, agency, or clinic name (if change of ownership): _____ Facility license number: 333333333

3. Address (number & street) of "proposed" facility, agency, or clinic: 1800 Playa Del Rey Drive, Suite 777 Telephone number: (999) 555-1234
   City, State, & Zip: Sacramento, CA 95814-7402

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

5. **Name of person to be in charge of facility, agency, or clinic:** Waln Jones
   Title: Administrator Professional License number: N/A

6. **a.** Name of administrator: Waln Jones Date of hire: 05/13/2015
   Professional License number: N/A Expiration date: _____
   b. Name of director of nursing: Amber Dixie Date of hire: 05/31/2015
   Professional License number: RN 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)	Jane Doe	100	555555555	○ Yes	○ No	
(2)				○ Yes	○ No	
(3)				○ Yes	○ No	
(4)				○ Yes	○ No	
(5)				○ Yes	○ 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.

SAMPLE

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: Sandy Beach Plaza, Inc.
Address (number & street): 554 Crystal Beach Blvd., Suite 10
City, State, & Zip: Sacramento, CA 95814

Lessee name: ABC Home Healthcare, Inc.
Address (number & street): 999 Beach Slce Court
City, State, & Zip: Sacramento, CA 95814

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
Jane Doe	Owner	03/11/2019
Signature	Title	Date
Signature	Title	Date
Signature	Title	Date

SAMPLE

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: _____

SAMPLE

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.

SAMPLE

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".

SAMPLE

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.

SAMPLE

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.

IRS DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE
CINCINNATI OH 45999-0023

Date of this notice:
07-07-2017 Employer
Identification Number:
55-5555555

Form: SS-4

Number of this notice: CP 575 A
For assistance you may call us at:
1-800-829-4933

IF YOU WRITE, ATTACH THE
STUB AT THE END OF THIS NOTICE.

ABC Home Healthcare, Inc.
Jane Doe
999 Beach Side Court
Sacramento, CA 95814

SAMPLE

WE ASSIGNED YOU AN EMPLOYER IDENTIFICATION NUMBER

Thank vou for applying for an Employer Identification Number (EIN). We assigned you EIN 55-5555555. This EIN will identify you, your business accounts, tax returns, and documents, even if you have no employees. Please keep this notice in your permanent records.

When filing tax documents, payments, and related correspondence, it is very important that you use your EIN and complete name and address exactly as shown above. Any variation may cause a delay in processing, result in incorrect information in your account, or even cause you to be assigned more than one EIN. If the information is not correct as shown above, please make the correction using the attached tear off stub and return it to us.

Based on the information received from you or your representative, you must file the following form(s) by the date(s) shown.

Form 941	10/31/2017
Form 940	01/31/2018
Form 1065	03/15/2018

If you have questions about the form(s) or the due date(s) shown, you can call us at the phone number or write to us at the address shown at the top of this notice. If you need help in determining your annual accounting period (tax year), see Publication 538, *Accounting Periods and Methods*.

We assigned you a tax classification based on information obtained from you or your representative. It is not a legal determination of your tax classification, and is not binding on the IRS. If you want a legal determination of your tax classification, you may request a private letter ruling from the IRS under the guidelines in Revenue Procedure 2004-1, 2004-1 I.R.B. 1 (or superseding Revenue Procedure for the year at issue). Note: Certain tax classification elections can be requested by filing Form 8832, *Entity Classification Election*. See Form 8832 and its instructions for additional information.

A limited liability company (LLC) may file Form 8832, *Entity Classification Election*, and elect to be classified as an association taxable as a corporation. If the LLC is eligible to be treated as a corporation that meets certain tests and it will be electing S corporation status, it must timely file Form 2553, *Election by a Small Business Corporation*. The LLC will be treated as a corporation as of the effective date of the S corporation election and does not need to file Form 8832.

If you are required to deposit for employment taxes (Forms 941, 943, 940, 944, 945, CT-1, or 1042), excise taxes (Form 720), or income taxes (Form 1120), you will receive a Welcome Package shortly, which includes instructions for making your deposits electronically through the Electronic Federal Tax Payment System (EFTPS). A Personal Identification Number (PIN) for EFTPS will also be sent to you under separate cover. Please activate the PIN once you receive it, even if you have requested the services of a tax professional or representative. For more information about EFTPS, refer to Publication 966, *Electronic Choices to Pay All Your Federal Taxes*. If you need to make a deposit immediately, you will need to make arrangements with your Financial Institution to complete a wire transfer.

The IRS is committed to helping all taxpayers comply with their tax filing obligations. If you need help completing your returns or meeting your tax obligations, Authorized e-file Providers, such as Reporting Agents (payroll service providers) are available to assist you. Visit the IRS Web site at www.irs.gov for a list of companies that offer IRS e-file for business products and services. The list provides addresses, telephone numbers, and links to their Web sites.

To obtain tax forms and publications, including those referenced in this notice, visit our Web site at www.irs.gov. If you do not have access to the Internet, call 1-800-829-3676 (TTY/TDD 1-800-829-4059) or visit your local IRS office.

IMPORTANT REMINDERS:

* Keep a copy of this notice in your permanent records. **This notice is issued only one time and the IRS will not be able to generate a duplicate copy for you.** You may give a copy of this document to anyone asking for proof of your EIN.

* Use this EIN and your name exactly as they appear at the top of this notice on all your federal tax forms.

* Refer to this EIN on your tax-related correspondence and documents.

If you have questions about your EIN, you can call us at the phone number or write to us at the address shown at the top of this notice. If you write, please tear off the stub at the bottom of this notice and send it along with your letter. If you do not need to write us, do not complete and return the stub.

Your name control associated with this EIN is HONO. You will need to provide this information, along with your EIN, if you file your returns electronically.

Thank you for your cooperation.

SAMPLE

(IRS USE ONLY) '575A 07-07-2017 HONO B 9999999999 SS-4

SAMPLE

Keep this part for your records. CP 575 A (Rev. 7-2007)

Return this part with any correspondence so we may identify your account. Please correct any errors in your name or address.

CP 575 A

9999999999

Your Telephone Number ( ) -

Best Time to Call

DATE OF THIS NOTICE: 07-07-2017

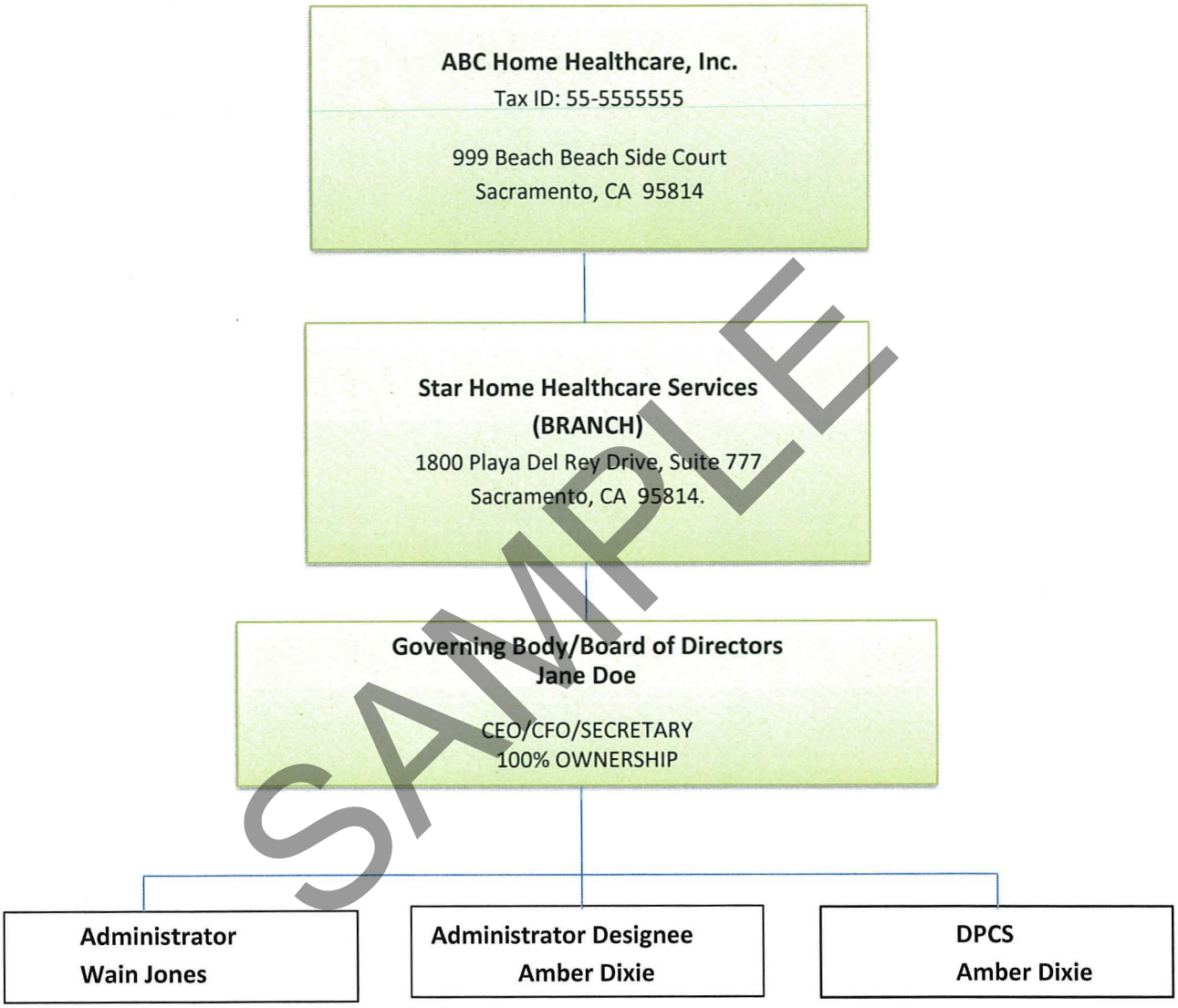
EMPLOYER IDENTIFICATION NUMBER: 55-5555555

FORM: SS-4 NOBOD

INTERNAL REVENUE SERVICE
CINCINNATI OH 45999-0023

ABC Home Healthcare, Inc.
Jane Doe
999 Beach Side Court
Sacramento, CA 95814

Organization Chart



SAMPLE

INSERT
CONTROL
OF
PROPERTY
HERE

SAMPLE

INSERT
FLOOR
PLAN
HERE

SAMPLE

SAMPLE

SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

E. Vehicle Information

If the mobile health care services are rendered inside a vehicle, such as a mobile home or trailer, furnish the following vehicle information. Do not furnish information about ambulance vehicles, or vehicles that are used only to transport medical equipment (e.g., when the equipment is transported in a van but is used in a fixed setting, such as a doctor's office). If more than three vehicles are used, copy and complete this section as needed.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE FOR EACH VEHICLE	TYPE OF VEHICLE (van, mobile home, trailer, etc.)	VEHICLE IDENTIFICATION NUMBER
☐ CHANGE ☐ ADD ☐ DELETE		
Effective Date:		
☐ CHANGE ☐ ADD ☐ DELETE		
Effective Date:		
☐ CHANGE ☐ ADD ☐ DELETE		
Effective Date:		

For each vehicle, submit a copy of all health care related permits/licenses/registrations.

F. Geographic Location For Mobile or Portable Providers where the Base of Operations and/or Vehicle Renders Services

For home health agencies (HHAs) and mobile/portable providers, furnish information identifying the geographic area(s) where health care services are rendered.

NOTE: If you provide mobile health care services in more than one State and those States are serviced by different Medicare fee-for-service contractors, complete a separate enrollment application (CMS-855A) for each Medicare fee-for-service contractor's jurisdiction.

1. INITIAL REPORTING AND/OR ADDITIONS

If you are reporting or adding an entire State, it is not necessary to report each city/town. Simply check the box below and specify the State.

☐ Entire State of _____

If services are provided in selected cities/towns, provide the locations below. Only list ZIP codes if you are not servicing the entire city/town.

CITY/TOWN	STATE	ZIP CODE
See Attached		

SAMPLE

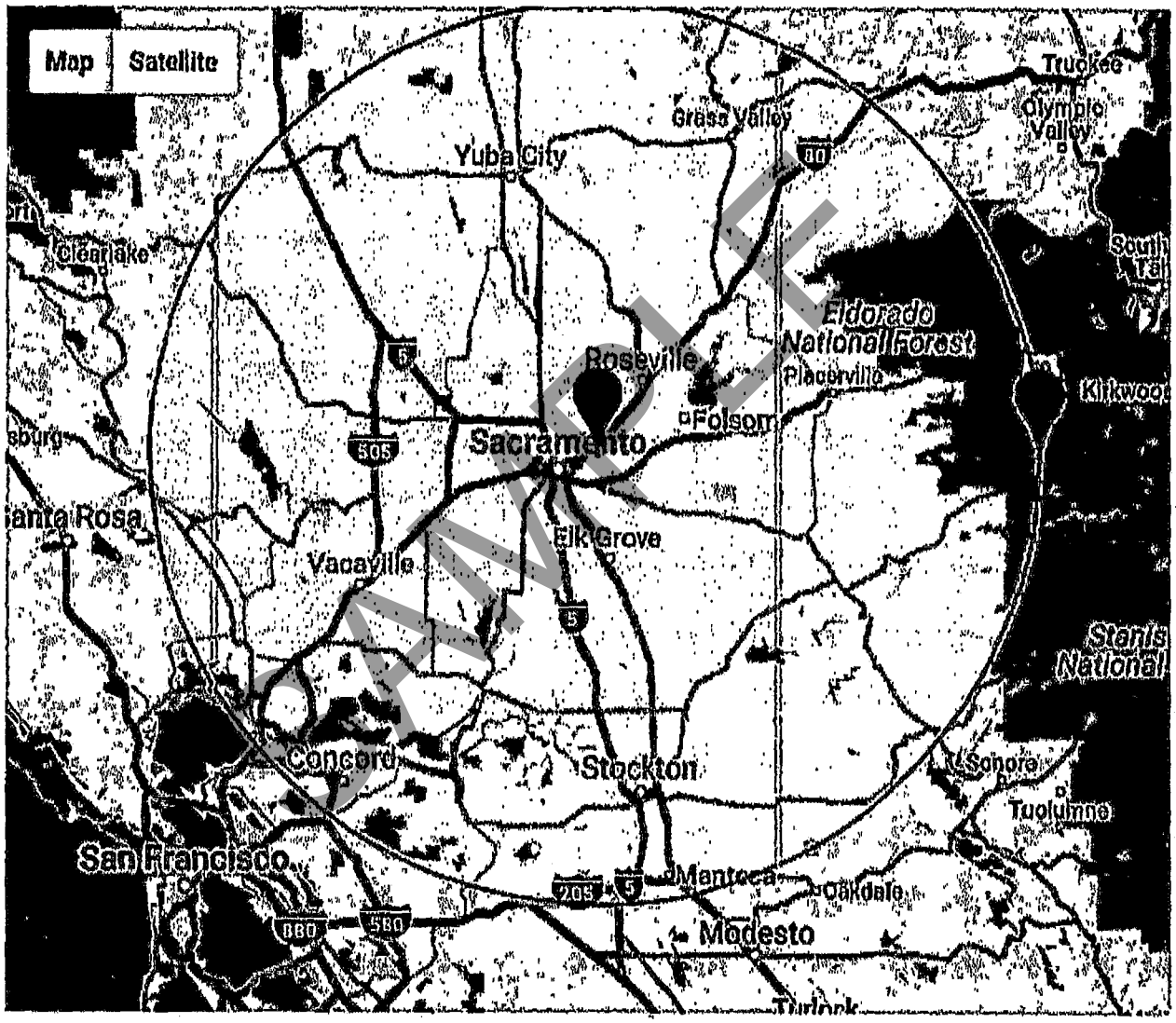
STAR HOME HEALTHCARE SERVICES

City	County	ZIP Code
Antelope	Sacramento	95843
Auburn	Placer	95602
Auburn	Placer	95603
Auburn	Placer	95604
Carmichael	Sacramento	95608
Carmichael	Sacramento	95609
Citrus Heights	Sacramento	95610
Citrus Heights	Sacramento	95611
Citrus Heights	Sacramento	95621
Clarksburg	Yolo	95612
Cool	El Dorado	95614
Davis	Yolo	95616
Davis	Yolo	95617
Davis	Yolo	95618
Diamond Springs	El Dorado	95619
Drytown	Amador	95699
El Dorado	El Dorado	95623
El Dorado Hills	El Dorado	95762
Elk Grove	Sacramento	95624
Elk Grove	Sacramento	95757
Elk Grove	Sacramento	95758
Elk Grove	Sacramento	95759
Elverta	Sacramento	95626
Fair Oaks	Sacramento	95628
Folsom	Sacramento	95630
Folsom	Sacramento	95763
Galt	Sacramento	95632
Granite Bay	Placer	95746
Herald	Sacramento	95638
Hood	Sacramento	95639
Ione	Amador	95640
Lincoln	Placer	95648
Loomis	Placer	95650
Lotus	El Dorado	95651
Mather	Sacramento	95655
Mcclellan	Sacramento	95652
Newcastle	Placer	95658
North Highlands	Sacramento	95660
Orangevale	Sacramento	95662
Penryn	Placer	95663
Pilot Hill	El Dorado	95664
Placerville	El Dorado	95667
Pleasant Grove	Sutter	95668
Plymouth	Amador	95669
Rancho Cordova	Sacramento	95670

SAMPLE

STAR HOME HEALTHCARE SERVICES
1800 BEACH DRIVE, SUITE 777
SACRAMENTO, CA 95814

WEB-BASED MAP



SAMPLE

SAMPLE

CMS 1572

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0355

HOME HEALTH AGENCY SURVEY AND DEFICIENCIES REPORT

1. Name of Facility: Star Home Healtcare Services

11. Provider No.:

2. Street Address: 1800 Playa Del Rey Drive, Suite 777

12. Type of Survey:
[1] Initial (G2) [ ] Resurvey (G3)
1 = Standard
2 = Partial Extended
3 = Extended
4 = 1 and 2
5 = 1 and 3
6 = 1, 2 and 3

3. City and/or County: Sacramento

4. State: CA

5. Zip Code: 95814-7402

6. Telephone No. (G4): (999)555-0695

7. State/County Code: (G5)

8. State/Region Code: (G6)

13. Eligibility: (G7)
[3]
1 = Medicare
2 = Medicaid
3 = Both

9. Name of Administrator: Wain Jones

10. Discipline of Administrator: (G8)
[1]
1 = RN/LPN
2 = Physician
3 = PT/OT
4 = Speech Path/Audiologist
5 = Medical/License Social Worker
6 = Pub Adm/MBA/ACCT
7 = Lawyer
8 = Proprietor
9 = Other

14. Has there been a change of ownership since last survey? (G9)
[ ] Yes [X] No

15. A. Is this home health agency also a Medicare certified hospice? (G10)
[ ] Yes [X] No

If yes, give the hospice Medicare provider number: (G11)

B. Does this home health agency operate sub-units? (G12)
[ ] Yes [X] No

If yes, how many: (G13)

C. Is this home health agency a sub-unit? (G14)
[ ] Yes [X] No

If yes, parent agency provider number: (G15)

D. Does this home health agency or sub-unit operate branch(es)? (G16)
[ ] Yes [X] No

If yes, how many: (G17)

If yes, give official name and mailing address of each branch (include street, state and zip code):

[ ] If more space is needed, check here, use a separate page and attach.

16. Type of Agency: (G18)
[0][7]
01 = VNA
02 = Combination Government Voluntary
03 = Official Health Agency
04 = Rehab based program*
05 = Hospital based program*
06 = Skilled Nursing Facility/Nursing Facility based program*
07 = Other

*If Medicare/Medicaid certified give the provider number: (G19)

17. Type of Control: (G20)
[0][4]
Voluntary Non-Profit
01 = Religious Affiliation
02 = Private
03 = Other
For Profit
04 = Proprietary
Government
05 = State/County
06 = Combination Govt. and Voluntary
07 = Local Government

SAMPLE

HOME HEALTH AGENCY SURVEY AND DEFICIENCIES REPORT

(continued)

18. Services Offered: (G21)

1 = Provided by Agency Staff
2 = Under Arrangement
3 = Combination

1	01 = Nursing Care
2	02 = Physical Therapy
	03 = Occupational Therapy
2	04 = Speech Therapy
	05 = Medical Social Worker
	06 = Home Health Aide
	07 = Intern/Resident
	08 = Nutritional Guidance
	09 = Pharmaceutical Services
	10 = Appliance and Equipment Service
	11 = Vocational Guidance
	12 = Laboratory Services
	13 = Other

19. Staffing (List full-time equivalent):

Registered Nurse (G22)				1	.	0	0
Licensed Practical Nurse (G23)				1	.	0	0
Physical Therapist (G24)				1	.	0	0
Occupational Therapist (G25)					.		
Speech Pathologist/Audiologist (G26)				1	.	0	0
Social Worker (G27)					.		
Home Health Aide (G28)					.		
Pharmacist (G29)					.		
Dietitian (G30)					.		
All Others (G31)					.		

20. Home Health Agency provides directly: (G32)

	1 = Home Health aide training program
	2 = Home Health aide competency evaluation program
✓	3 = Both
	4 = Neither

21. Number records reviewed with home visits (G33)
Number records reviewed, no home visits (G34)
Number of home visits with no records review (G35)
Total records reviewed (G36)
Total home visits (G37)

22. Patient census since last standard survey:

Admissions:

(G38) _____ Unduplicated admissions

(G39) _____ Readmissions

Discharges

(G40) _____ Hospital discharges

(G41) _____ Nursing home discharges

(G42) _____ Goals met discharges

(G43) _____ Death discharges

(G44) _____ Total discharges

23. Surveyor summary: Based on the reviews of the patients from this home health agency including all information surveyed in the standard survey and using the Functional Assessment Instrument (FAI), this home health agency: (G45)

[ ] 1. Provides care that promotes a high potential for reaching the highest attainable levels of functioning for its patients. There is no evidence of need for a partial extended or extended survey.

[ ] 2. Provides care that promotes a moderate potential for reaching the highest level of functioning for some but not all of its patients. There are standard level deficiencies and need for a partial extended survey. If no conditions are out of compliance, a Plan of Correction will be requested for the standard level deficiencies.

[ ] 3. Provides substandard care. There are condition level deficiencies in one or more Conditions of Participation. There is an immediate need for an extended survey.

SAMPLE

HOME HEALTH AGENCY SURVEY AND DEFICIENCIES REPORT

1. NAME OF FACILITY:	4. DATE:

2. DEFICIENCIES		3. Standard _____ Extended _____ Partial Extended _____
Data Tag No.	COP/Stnd No.	COMMENTS

SAMPLE

2. DEFICIENCIES		3. Standard _____ Extended _____ Partial Extended _____
Data Tag No.	COP/Stnd No.	COMMENTS

SAMPLE

HOME HEALTH AGENCY SURVEY AND DEFICIENCIES REPORT

Record deficiencies identified on a Standard Survey, Partial Extended Survey, and/or Extended Survey on different pages, check the type of survey under item 3 and enter the date of the survey in item 4.

A. In the first column, identify the data tag number.

B. In the second column, write the regulatory citation. If it is a Condition of Participation, enter "CoP" below the regulatory citation.

C. In column three, describe the findings and evidence under "Comments."

D. Draw horizontal lines to separate identified tag numbers.

E. If more space is needed, photocopy the "Deficiencies & Comments" page and continue the recording (front and back).

F. Each surveyor must sign the certifying statement on the last page for each type survey(s) conducted (i.e., Standard Survey, Partial Extended Survey, and/or Extended Survey). If more space is needed to list deficiencies identified during a Partial Extended Survey, photocopy page.

SAMPLE

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0355. The time required to complete this information collection is estimated to average 1 hour 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports

HOME HEALTH AGENCY SURVEY AND DEFICIENCIES REPORT

A. STANDARD SURVEY

I certify that I have reviewed each HHA Condition of Participation and related Standard(s) included in the Standard survey and except as indicated on this form, the facility was found to be in compliance with the standards and/or the Conditions of Participation.

Signature: _____ Title: _____ Date: _____
Signature: _____ Title: _____ Date: _____
Signature: _____ Title: _____ Date: _____

B. PARTIAL EXTENDED SURVEY

I certify that I have reviewed each HHA Condition of Participation and related Standard(s) listed below, and except as indicated on this form, the facility was found to be in compliance with the standards and/or the Conditions of Participation.

SAMPLE

Signature: _____ Title: _____ Date: _____
Signature: _____ Title: _____ Date: _____
Signature: _____ Title: _____ Date: _____

C. EXTENDED SURVEY

I certify that I have reviewed all of the HHA Conditions of Participation and related Standard(s) not reviewed during the Standard Survey and/or Partial Extended Survey and except as indicated on this form, the facility was found in compliance with the standards and/or Conditions of Participation.

Signature: _____ Title: _____ Date: _____
Signature: _____ Title: _____ Date: _____
Signature: _____ Title: _____ Date: _____

INSERT
APPROVAL
LETTER
FROM
CMS
HERE

SAMPLE