

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 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 GOVERNING BOARD** Application for Star Home Healthcare Services, located at 1800 Beach Drive, Suite 777, Sacramento, CA 95814 License #222222222

To Whom It May Concern,

We are submitting a **Change of Governing Board** application for Star Home Healthcare Services, located at 1800 Beach Drive, Suite 777, Sacramento, CA 95814.

I enclosed the required application forms and supporting documents needed to process my Change of Governing Board application.

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

Emergency Contact Information (available 365/24/7)

Name: Jane Doe

Email: <u>JaneDoe@abchhealthcare.org</u> Alternate Email: <u>JaneDoe@cmail.com</u>
Phone: (999) 555-2626 Phone (Text Messages): (999) 555-5555

Fax: (999) 555-2600

Sincerely,

Jane Doe

Jane Doe, Owner ABC Home Healthcare, Inc.



HS 200

LICENSURE & CERTIFICATION APPLICATION

FOR DEPARTMENTAL USE ONLY

Proposed name of facility/agency/clinic:
A. APPLICATION INFORMATION
1. Type of application (check one): Oa. Initial Ob. Change of Ownership (see #2 below) Oc. Management company (see Sections C1-5, F, and Attachment E-1) Od. Other change (see Section A4): Change of Governing Board
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 b. Construction of new or replacement facility d. Change of services c. Change of services d. Change of facility type d. Change of facility typ
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
6. a. Do you wish to apply for the Medicare program? Yes No Medicare Provider #: b. Fiscal Intermediary choice: Fiscal Intermediary
7. Do you wish to apply for the Medi-Cal (Medicaid) program? OYes ONo
8. a. Current facility bed capacity: N/A b. Proposed facility bed capacity: N/A
9. Age range of clients:
10. Days and hours of operation: Monday - Friday. 8:00am - 5:00pm
11. Is construction required?

B. LICENSEE INFORMATION

Licensee name: ABC Home Healthcare, Inc.				
2. Federal employer's tax ID number: 555555555				
	nty			
4. Licensee address (number & street):	Telephone number:			
999 Beach Side Court City, State, & Zip:	(999) 555-2626 E-Mail: Fax number:			
Sacramento, CA 95814-7402	JaneDoe@abchhealthcare.org (999) 555-2600			
	the has been licensed for, operated, managed, held a 5% or clude facilities both in and outside of California. Submit and 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:			
	not) or, for agency or clinic resolved by settlement, receiver on taken, please <u>submit</u> additional information, including all			
 Is the licensee a <u>subsidiary</u> of another organization? If "yes", complete the information below and <u>submit</u> an organization. 	Yes O No rganizational chart:			
Parent organization name:				
Parent federal tax ID Number:				
P.O. Box or number & street:				
City, State, & Zip:				

C. FACILITY, AGENCY OR CLINIC INFORMATION

	 anagement Agreement (this only applies to SNF's & ICF's): a. Is the facility, agency, or clinic going to be operated under a management contract/agreement between the proposed owner and a management company? 	OYes
	If "yes", proceed to <u>Section E</u> (below).	No
	b. Is there an "interim" management agreement, between the proposed owner and the current owner, to run the facility, agency, or clinic until the change of ownership is completed?	○ Yes
	If "yes", submit a copy of the "interim" management agreement.	⊙ No
2.	Name of "proposed" facility, agency, or clinic: Current facility, agency, or clinic name (if change of ownership): Star Home Healthcare Services Facility license number: 2222222222	
3.	Address (number & street) of "proposed" facility, agency, or clinic: 1800 Beach Drive, Suite 777 (999) 555-0695	number:
	City, State, & Zip: Sacramento, CA 95814-7402	
4.	Mailing address, if different from above: Number & Street: Telephone	
	City, State, & Zip: E-mail address:	
5.	Name of person to be in charge of facility, agency, or clinic: Title: Professional License number:	
6.	a. Name of administrator: Professional License number: N/A Expiration date: Date of hire: 05/13/2015 Expiration date: Date of hire: 05/31/2015 Expiration date: 11/30/2019	
7.	List persons having <u>5 percent</u> or more direct or indirect (42 CFR, Section 455.102) interest in the own facility if applying for skilled nursing or intermediate care licensure, and <u>10 percent</u> for all other facility or clinics. Provide federal employer's tax ID number. Are any of these persons (listed below) related as spouse, parent, child or sibling? <u>Submit</u> an attachment for additional names that includes all or information listed below.	ties, agencies, to one another
١.)	nship
8.	Financial resources Only applies to SNF and ICF: <u>Submit</u> evidence, i.e., bank statements, line of credit, certificate(s) of deposit, satisfactory to the de the licensee possesses financial resources sufficient to operate the facility for a period of at least 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 care facilities within 300 feet of this facility? (H&S Code, Section 1267.9) b. Are there any congregate living health facilities within 1,000 feet of this facility? Yes No D	on't know
10	Program Plan Only applies to ICF/DD, ICF/DD-H and ICF/DD-N (H&S Code, Section 1275.3(b)	• •
	Has the program plan been approved by the Department of Developmental Services? Yes If "yes", <i>Submit</i> a copy of the approval letter. The "current licensee" can grant permission for their F be used for 6 months if they <i>submit</i> a letter to CDPH. If "no", the application package will be delayed the approved program letter is received.	

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D. PROPERTY INFORMATION

1. Property ownership: Check one and <u>submit</u> 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 Side 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 <u>SUBMIT</u> 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
John Doe	Owner	03/11/2019
Signature	Title	Date
Signature	Title	Date

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.	Sub	mit a copy of the Manageme	nt Agreement with this application.	
	Add	ne of management company: ress (number & street): , State, & Zip:		EIN:
	Add	ne of facility to be managed: ress (number & street): State, & Zip:		EIN:
2.			n for each individual having a <u>5 percent</u> or more interest for additional names that includes all of the required information	
	(1)	Individual's name: Address (number & street): City, State, & Zip:		% Owner:
	(2)	Individual's name: Address (number & street): City, State, & Zip:		% Owner:
	(3)	Individual's name: Address (number & street): City, State, & Zip:		% Owner:
	(4)	Individual's name: Address (number & street): City, State, & Zip:		% Owner:
3.		o <u>mit</u> an attachment for addition	gencies, or clinics with which you have entered into a manal facility, agency, or clinic names that includes all of the red	
	(1)	Facility, agency, or clinic nar Address (number & street): City, State, & Zip:	Dates of involvement:	
	(2)	Facility, agency, or clinic nar Address (number & street): City, State, & Zip:	Dates of involvement:	
	(3)	Facility, agency, or clinic nar Address (number & street): City, State, & Zip:	Dates of involvement:	
	(4)	Facility, agency, or clinic nar Address (number & street): [City, State, & Zip:	Dates of involvement:	

INSTRUCTIONS

SNF or ICF Management Company Application: See Attachment E-1 below.

Type or print clearly. Return original and maintain a copy for your records. The Licensee's name must be consistent throughout all documents submitted. Submit all supplemental paperwork requested to complete your application. Do not leave items blank. If not applicable, mark N/A.

A. APPLICATION INFORMATION

- 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.
- (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).
- Check "yes" if requesting participation in Medi-Cal (Medicaid).
- (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".
 - 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.
- Enter days and hours of facility operation. 10.

11.	Enter date construction is to begin, and date construction is to be completed (not applicable for
	ICF/DD, ICF/DD-N, ICF/DD-H facilities).
	Submit a copy of the form "Construction Advisory Board" (form OSH-FDD 377)
	if OSHPD has approved construction.
	Submit a copy of the above form to the local district office prior to the survey
	if OSHPD has not yet approved construction.

B. LICENSEE INFORMATION

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	tederal	empl	oyer's	tax	Iυ	numb	er.
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۷.	Enter the lederal employer's tax 1D 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 Colifornia.
	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 EAC	CILITY, AGENCY, OR CLINIC INFORMATION
	Management Agreement:
1.	
	(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
۷.	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).
7 . 5.	Provide the name and title of the individual to be in charge of the facility, agency, or clinic as well as any
J.	professional license number (if applicable).
6.	Administrator:
٥.	(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 <u>5 percent</u> or more interest in the ownership of this facility, if
	applying for SNF or ICF licensure. For all other facility, agency, or clinic types, provide the name(s) of
	those having 10 percent or more interest in the ownership. Specify how these persons are related to
	one another as spouse, parent, child or sibling.
	Submit an attachment for all additional names. This attachment must include all of the
	required information.
8.	Financial Resources: Only applies to SNF, ICF, and ICF/DD:
	Submit evidence, satisfactory to the Department, that the licensee has sufficient financial
	resources to operate the facility for at least 45 days (bank statement, certificate of deposit
	etc.). The amount is determined by multiplying 45 days X number of beds X rate.
9.	Over-concentration Only applies to ICF/DD, ICF/DD-H and ICF/DD-N:
	(a) Are there other ICF/DD, ICF/DD-H, ICF/DD-N residential care, pediatric day health, or respite care
	facilities within 300 feet of this facility? Check "yes", "don't know" or "no".
	(b) Are there any congregate living health facilities within 1,000 feet of this facility?
	Check "yes", "don't know" or "no".

10.	Program Plan Only applies to ICF/DD, ICF/DD-H and ICF/DD-N:
	Indicate if the program plan has been approved by the Department of Developmental Services. The
	"current licensee" can grant permission for their Program Plan to be used for 6 months if a letter is submitted to CDPH. If "no" is checked, the application package will be held until a copy of the
	approved program plan letter is received.
	Submit a letter to CDPH from the "current" licensee that the "proposed" licensee has their
	permission to use the "current" licensee's Program Plan for up to 6 months, if applicable.
	Submit a copy of the Program Plan approval letter, if "yes".
D. PR	OPERTY 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. MA	NAGEMENT COMPANY INFORMATION
	omplete Sections A1, C1-5, F & ATTACHMENT E-1)
-	
г от	ATEMENT OF RECONCIDIUMES
	ATEMENT OF RESPONSIBILITIES Dication must be signed by licensee or authorized representative.
7 (2)	shouldn't must be signed by meensee of additionized representative.
	ATTACHMENT E-1
MAN	AGEMENT 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 <u>5 percent</u> or more
	interest in the Management Company.
	<u>Submit</u> 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.
٥.	Submit an attachment for additional facilities, agencies, or clinics. This attachment must
	include all of the required information.

Organization Chart

ABC Home Healthcare, Inc.

Tax ID: 55-555555

999 Beach Side Court Sacramento, CA 95814.

Star Home Healthcare Services

1800 Beach Drive, Suite 777 Sacramento, CA 95814.

Governing Body/Board of Directors Jane Doe John Doe

CEO/CFO 80% OWNERSHIP

Secretary 20% OWNERSHIP

Administrator Wain Jones

Administrator Designee
Amber Dixie

DPCS Amber Dixie



CMS 325

CRIMINAL RECORD CLEARANCE SUBMISSIONS

CLEAF	2
VLLAI	•

Licensee name ABC Home Healthcare, Inc.			Date 03/03/2019	Star Home	e Healthcare Services				
Facility address 1800 Beach Drive, Suite 777						City Sacramento, 0	CA 958	14	
									USE ONLY Conviction
LAST NAME	FIRST NAME	DATE OF BIRTH (mm/dd/yy)	SOCIAL SECU NUMBER		POSITION/TITLE	DATE OF HIRE (mm/dd/yy)	Yes	No	Date Clearance Obtained
Doe	Jane	07/07/1977	XXX-XX-XX	XX	Owner	03/03/2015			
Doe	John	06/27/1970	XXX-XX-XX	XX	Owner	03/11/2019			
		\sim V			HAL Verification:	Signature			Date

ICF-DD INSTRUCTIONS: List all personnel of ICF/DD, ICF/DD-H and ICF/DD-N. The list must include but is not limited to the following individuals: all current and future direct care employees, including licensee personnel (including owners, all board officers, directors, LLC managers/members); administrator; any adults living at the facility; and consultants who are directly providing programs and/or nursing services to clients. If the consultants are "independent contractors" and not an employee of the facility, they are exempt from these fingerprints; however, the applicant must submit a written statement to that effect; pursuant to § 1265.5 of the Health and Safety Code. The following criteria exempts consultants from background checks: 1) Is employed as a consultant and acts as direct care staff, 2) Is a registered nurse, licensed vocational nurse, physical therapist, occupational therapist, or speech-language pathologist, 3) Has obtained a criminal record clearance as a prerequisite to holding a license or certificate to provide direct care services, 4) Has a license or certification to provide direct care services that is in good standing with the appropriate licensing or certification board, 5) Is providing time-limited specialized clinical care or services, and 6) Is not alone with a client.

HHA INSTRUCTIONS: The list must include owner(s) of the private agency if they are individuals and owner(s) of the private agency is a corporation, partnership or association having a 5% or more ownership and the administrator of the HHA. If the Administrator is a Doctor or Registered Nurse he or she is subject to the same requirements for a criminal records clearance.

INFORMATION COLLECTION AND ACCESS: PRIVACY STATEMENT

*Social Security Number Disclosure: Pursuant to Section 666(a)(13) of Title 42 of the United States Code and California Family Code section 17520, subdivision (d), the California Department of Public Health (CDPH) is required to collect social security numbers from all applicants for intermediate care facility licenses. Disclosure of your social security number is mandatory for purposes of establishing, modifying, or enforcing child support orders upon request by the Department of Child Support Services and for reporting disciplinary actions to the Health Integrity and Protection Data Bank as required by 45 CFR §§ 61.1 et seq. Failure to provide your social security number will result in the return of your application. Your social security number will be used by CDPH for internal identification, and may be used to obtain criminal records or background clearances, to verify information on your application, to verify certification with another state's certification authority, for exam identification, for identification purposes in national disciplinary databases or as the basis of a disciplinary action against you.

CDPH 325 (01/13) 1



HS 215A

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

APPLICANT INDIVIDUAL INFORMATION

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

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

A. Identifying Information		
Name		Date of Birth
John Doe		1/9/1971
Business address (number, street, apartment/s	uite number or letter if app	olicable) City, State, & Zip
999 Beach Side Court		Sacramento, CA 95814
Title in relation to this facility		
20% Owner/Secretary Have you applied for ANY license for a health for same? If yes, list all other names.	acility or community care f	facility using any name other than your true full
No If an Administrator for proposed clinic, list hours than one licensed clinic, list the name of each o		
B. Criminal Record		
 Have you ever been convicted of an offense Has there been a judgment against you for Market professional/technical licensing entity? 		, ,
f yes to questions 1 or 2 above, please explain necessary):	and provide dates and co	onviction information (attach additional pages if
C. Professional Licenses/Certificate Clinics and optional for Health fac	-	t is mandatory for Primary Care
TYPE	PERIOD HELD	ISSUING AGENCY

		Name and address of employer	Job title
rom:	3/11/2019	Star Home Healthcare Services	Secretary
Го:	Present	1800 Beach Drive, Suite 777 Sacramento, CA 95814	
rom:	11/5/2011	West Coast Health System	Chief Financial Officer
Го:	Present	554 Crystal Blvd, Suite 10, Sacramento, CA 95814	
rom:	6/30/2008	Vibrant Medical Center	Director
0:	11/4/2011	1440 Vibrant Lake Lane, Folsom, CA 95762	
rom:	6/29/2008	Grand Memorial Home Health	Administrator
0:	2/18/2000	567 Oak Drive, Woodland, CA 95776	
2.	Yes No I Have you ever opera	involved with a business entity that operated a health facility of YES, complete Section F (below) and the "Facility Informated or managed (including management agreements) any contents.	rmation Sheet" (attached). of the following facility types?
2.	Yes No I Have you ever opera Yes No I	f YES, complete Section F (below) and the "Facility Info ated or managed (including management agreements) any of f YES, complete Section F (below) and the "Facility Info dult Day Health Care Center linics ICF/DD INCF/DD-H ICF-DD-N ICF-DD-N Intermediate Care Facility Pediatric Day Health & Respite Care ICF-DD-N Intermediate Care Facility Pediatric Day Health & Respite Care Section F (below) and the "Facility Info ICF-DD INCF/DD-H ICF-DD-N INTERMEDIATE INTERMEDIATE Residential Care Facility for the Elde Skilled Nursing Facility	rmation Sheet" (attached). of the following facility types? rmation Sheet" (attached).
2.	Have you ever held Have you ever operate Yes No A CI G He Have you ever held Yes No If Y	f YES, complete Section F (below) and the "Facility Info ated or managed (including management agreements) any of f YES, complete Section F (below) and the "Facility Info dult Day Health Care Center linics OMMUNITY CARE FACILITY eneral Acute Care Hospital ealth Facility Dealth Facility Pediatric Day Health & Respite Care Residential Care Facility for the Elde	rmation Sheet" (attached). of the following facility types? rmation Sheet" (attached).
2. 3.	Have you ever operations Yes No I Ad Ci Gi Gi Hi Have you ever held a Yes No If Y Iverse Actions	f YES, complete Section F (below) and the "Facility Info ated or managed (including management agreements) any of f YES, complete Section F (below) and the "Facility Info dult Day Health Care Center ICF/DD inics ICF/DD-H ICF-DD-N eneral Acute Care Hospital Intermediate Care Facility ealth Facility Pediatric Day Health & Respite Care ome Health Agency Residential Care Facility for the Elde Skilled Nursing Facility Other a 5 percent or more beneficial ownership interest in any of the	rmation Sheet" (attached). of the following facility types? rmation Sheet" (attached). electry the facility types above? ation Sheet" (attached).

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.

HS 215A (2/08) 2

best of my knowledge.

Signature:

FACILITY INFORMATION SHEET

You are required to complete the following for <u>each</u> 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.**

Type of Facility "Type" of Business Entity Adult Day Health Care Center Clinic Community Care Facility General Acute Care Hospital Health Facility Hospice ICF/DD-H ICF/DD-H ICF/DD-H OCF/DD-H OCF/DD-N OCHER Business Entity (explain): OCHER Facility Type (explain): OCHER Facility Type (explain): OCHER Business Entitities a "PARENT" organization to the applicant facility? Individuement (explain): Secretary Dates of involvement CA 95814 95814 95814 95814 95814 95814 95814 95814 96814 9	Facility name:	Facility address (number, street, city):	Facility address (number, street, city):		
Adult Day Health Care Center Clinic Community Care Facility General Acute Care Hospital Health Facility Health Facility Hospice Cicroporation: Community Care Facility Manager of "parent" organization Managing employee of a HHA Manager of "parent" organization Manager of "parent" organization Managing employee of a HHA Member Officer of corporation Owner Cicr/DD-H Cicr/DD-H Cicr/DD-N Cicr/DD-N Cicr/DD-N Cicr Community (explain): Communi	Star Home Healthcare Services	1800 Beach Drive, Suite 777 Sacramento	1800 Beach Drive, Suite 777 Sacramento		
Community Care Facility General Acute Care Hospital Health Facility Health Facility Health Facility Health Facility Hospice ICF/DD-H ICF/DD-H ICF/DD-H ICF/DD-H ICF/DD-H ICF/DD-N ICF/DD-	Type of Facility	"Type" of Business Entity	Individual's "Nati	ire" of Invo	lvement
O COMMUNITY CARE FACILITY O General Acute Care Hospital O Health Facility O Health Facility O Hospice O ICF O ICF/DD O Management Company: O ICF/DD-H O ICF/DD-N O ICF/DD-N O ICF O OTHER Business Entity (explain): O OTHER FACILITY TYPE (explain): O OTHER FACILITY TYPE (explain): O No O Director O Licensee O Manager of "parent" organization O Officer of corporation O Owner O Ovner O OTHER Business Entity (explain): O OTHER Business Entity (explain): O OTHER Nature of Involvement (explain): O OTHER Nature of Involvement (explain): O OTHER Nature of Involvement: From: 8/11/2019	Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the entity:	Administrator of Clinic	SNF or ICF	
General Acute Care Hospital Health Facility Health Facility HHA Hospice ICF Officer Owner ICF/DD-H ICF/DD-N ICF/DD-N ICF OTHER Business Entity (explain): OTHER FACILITY TYPE (explain): OTHER Secretary Dates of involvement (explain): OTHER Secretary Dates of involvement: From: 8/11/2019	Clinic		Agent		
Health Facility HHA Hospice ICF ICF/DD ICF/DD-H ICF/DD-N ICF/DD-N ICF Residential Care for the Elderly SNF OTHER FACILITY TYPE (explain): Partnership: OTHER FACILITY TYPE (explain): Partnership: OTHER Business Entities a "PARENT" organization to the applicant facility? If Yes, explain. No Manager of "parent" organization Managing employee of a HHA Officer of corporation Owner Partnership: Partner Sole Proprietorship Stockholder Ownership %: 20% Trustee OTHER Nature of Involvement (explain): Secretary Dates of involvement: From: 8/11/2019	COMMUNITY CARE FACILITY	ABC Home Healthcare, Inc. EIN: 55-555555	O Director		
○ HHA ○ LLC: ○ Managing employee of a HHA ○ Hospice ○ Member ○ ICF ○ Management Company: ○ Officer of corporation ○ Owner ○ Owner ○ ICF/DD-H ○ Partnership: ○ Partner ○ ICF/DD-N ○ OTHER Business Entity (explain): ○ Sole Proprietorship ○ Sole Proprietorship ○ Stockholder Ownership %: 20% ○ SNF ○ Trustee ○ OTHER Nature of Involvement (explain): ○ OTHER FACILITY TYPE (explain): ○ OTHER Nature of Involvement (explain): ○ Secretary ○ Dates of involvement: ○ No Secretary	General Acute Care Hospital	O Individual:	Licensee		
Hospice ICF ICF/DD ICF/DD-H ICF/DD-N ICF OTHER Business Entity (explain): OTHER FACILITY TYPE (explain): OTHER FACILITY TYPE (explain): No Member Officer of corporation Owner Sole Proprietorship Sole Proprietorship OTHER Nature of Involvement (explain): Secretary Dates of involvement: From: 8/11/2019	Health Facility		Manager of "parent" or	ganization	
Officer of corporation Owner OCF/DD-H OCF/DD-N O	O HHA	O LLC:	Managing employee o	f a HHA	
Owner O ICF/DD-H O ICF/DD-N O ICF/DD-N O ICF O OTHER Business Entity (explain): O Trustee O OTHER FACILITY TYPE (explain): OTHER FACILITY TYPE (explain): O Yes O No O Owner O Owner O Owner O Partnership: O Partner O Sole Proprietorship O Stockholder Ownership %: O OTHER Nature of Involvement (explain): Secretary Dates of involvement: From: 8/11/2019	O Hospice				
CF/DD-H	O ICF	Management Company:	Officer of corporation		
OTHER Business Entity (explain): OTHER Business Entity (explain): OTHER FACILITY TYPE (explain):	O ICF/DD		Owner		
OTHER Business Entity (explain): Residential Care for the Elderly SNF OTHER FACILITY TYPE (explain): OTHER FACILITY TYPE (explain): Yes No OTHER Business Entity (explain): OTHER Business Entity (explain	O ICF/DD-H	O Partnership:	Partner		
Residential Care for the Elderly SNF OTHER FACILITY TYPE (explain): Yes No OTHER FACILITY TYPE (explain): No Trustee OTHER Nature of Involvement (explain): Secretary Dates of involvement: From: 8/11/2019	O ICF/DD-N		Sole Proprietorship		
Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain. OTHER FACILITY TYPE (explain): Yes No OTHER Nature of Involvement (explain): Secretary Dates of involvement: From: 8/11/2019	O ICF	OTHER Business Entity (explain):	Stockholder Owners	ship %: 🔼	10%
OTHER FACILITY TYPE (explain): Secretary	Residential Care for the Elderly		Trustee		
Yes Dates of involvement: From: 8/11/2019	SNF	Are any of the above Business Entities a "PARENT" organization to the	OTHER Nature of Invo	lvement (ex	plain):
No No <u>8/11/2019</u>	OTHER FACILITY TYPE (explain):		Secretary		
To: Present		⊙ No	From: 3/11/2019		
10. <u>11 tostit</u>			To: Present		

Facility name:	Facility address (number, street, city):	State: Zip code:
West Coast Health System	554 Crystal Blvd, Suite 10, 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	O Corporation:	
O COMMUNITY CARE FACILITY	West Coast Health System, Inc. EIN: 12-2222222	ODirector
General Acute Care Hospital	O Individual:	OLicensee
Health Facility		Manager of "parent" organization
O HHA	O LLC:	Managing employee of a HHA
OHospice		OMember
O ICF	O Management Company:	Officer of corporation
O ICF/DD		Owner
O ICF/DD-H	O Partnership:	Partner
O ICF/DD-N		Sole Proprietorship
O ICF	OTHER Business Entity (explain):	Stockholder Ownership %: 30%
Residential Care for the Elderly		Trustee
SNF	Are any of the above Business Entities a "PARENT" organization to the	OTHER Nature of Involvement (explain):
OTHER FACILITY TYPE (explain):	applicant facility? If Yes, explain.	Chief Financial Officer
	Q Yes	Dates of involvement:
	⊙ No	From: 11/5/2011
		To: Present

Facility name:	Facility address (number, street, city):	Facility address (number, street, city):		
Type of Facility	"Type" of Business Entity	Individual's "Nat	ure" of Invo	lvement
Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the entity:	Administrator of Clinic, SNF or ICF		
Clinic	O Corporation:	Agent		
COMMUNITY CARE FACILITY		O Director		
General Acute Care Hospital	_	Licensee		
Health Facility		Manager of "parent" o	rganization	
O HHA	O LLC:	Managing employee of	of a HHA	
OHospice		Member		
OICF	Management Company:	Officer of corporation		
Ŏ ICF/DD		Owner		
O ICF/DD-H	O Partnership:	Partner		
O ICF/DD-N		Sole Proprietorship		
OICF	OTHER Business Entity (explain):	Stockholder Owner	ship %: 🗀	
Residential Care for the Elderly		Trustee		
O SNF	Are any of the above Business Entities a "PARENT" organization to the	OTHER Nature of Inve	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:
Type of Facility	"Type" of Business Entity	Individual's "Nat	ure" of Invo	Ivement
	For EACH business entity, identify the name & EIN of the entity:			
O Adult Day Health Care Center O Clinic	O Corporation:	Administrator of Clinic Agent	, SNF OF ICE	•
O COMMUNITY CARE FACILITY	Corporation.	Director		
General Acute Care Hospital	O Individual:	Licensee		
Health Facility		Manager of "parent" o	rganization	
OHHA	O LLC:	Managing employee of		
OHospice		Member		
O ICF	Management Company:	Officer of corporation		
O ICF/DD	O De de contra	Owner		
O ICF/DD-H O ICF/DD-N	Partnership:	Partner Sole Proprietorship		
OICF	OTHER Business Entity (explain):	O Stockholder Owner	rehin %:	
Residential Care for the Elderly	OTTIEN Business Entity (explain).	Trustee	3111p /0	
OSNF	Are any of the above Business Entities a "PARENT" organization to the	OTHER Nature of Inventor	olvement (ex	plain):
OTHER FACILITY TYPE (explain):	applicant facility? If Yes, explain.			,
	O Yes	Dates of involvement:		
	No No	From:		
		To:		
Facility name:	Facility address (number, street, city):		State:	Zip code:
r domey name.	Tubility dudition (Hamber, Surost, Sity).			
Type of Facility	"Type" of Business Entity	Individual's "Nat	ure" of Invo	lyement
Type of Facility				
Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the entity:	Administrator of Clinic	, SNF or ICF	
Clinic	O Corporation:	Agent		
O COMMUNITY CARE FACILITY		ODirector		
General Acute Care Hospital Health Facility	O Individual:	OLicensee Manager of "parent" o	racnization	
O HHA	O LLC:	Managing employee of		
O Hospice	O LLC.	O Member	л а ппн	
OICF	O Management Company:	Officer of corporation		
O ICF/DD	G management company.	Owner		
O ICF/DD-H	O Partnership:	Partner		
O ICF/DD-N		Sole Proprietorship		
O ICF	OTHER Business Entity (explain):	Stockholder Owner	ship %: 🗀	
Residential Care for the Elderly	Account (Head to De Service (DADENT) and a few to the	Trustee		
O SNF	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain:	OTHER Nature of Inventor	olvement (ex	plain):
OTHER FACILITY TYPE (explain):	Yes Yes	Detec of involvement		
	No 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 "Nat	ure" of Invo	Ivement
Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the entity:	Administrator of Clinic		
O Clinic	O Corporation:	OAgent	,	
O COMMUNITY CARE FACILITY		Director		
General Acute Care Hospital	O Individual:	OLicensee		
Health Facility		Manager of "parent" o		
OHHA	O LLC:	Managing employee of	of a HHA	
O Hospice		O Member		
O ICF O ICF/DD	Management Company:	Officer of corporation Owner		
O ICF/DD-H	O Partnership:	Partner		
O ICF/DD-N	T artifolding.	O Sole Proprietorship		
OICF	OTHER Business Entity (explain):	OStockholder Owner	ship %:	
Residential Care for the Elderly		O Trustee		
O SNF	Are any of the above Business Entities a "PARENT" organization to the	OTHER Nature of Inv	olvement (ex	(plain):
OTHER FACILITY TYPE (explain):	applicant facility? If Yes, explain.			
	Yes No	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;
- 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.
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	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 any other 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 dates and conviction information. If not applicable, please enter 'N/A'.

C. PROFESSIONAL LICENSES/CERTIFICATES

Туре	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.

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.

Insert
Resume
Here



HS 309

ADMINISTRATIVE ORGANIZATION

Page one is for corporations only. See page two for other organizations.

			CORPORATI	ON			
	Name (as filed with Secretary of State) ABC Home Healthcare, Inc.			dministrator ne Doe			·
3.	Incorporation date 05/20/2014	4. Place of incorporation California					
5.	Please attach (1) a copy of Articles of the filing of this application.	Incorporation and any ar	mendments, (2) a c	opy of by-laws a	nd any amend	dments, (3) a	copy of resolution authorizing
6.	. Principal Office of Business						
	Address 999 Beach Side Court	City Sacra	mento	ZIP code 95814	County Sacram	nento	Phone number (999) 555-2626
7. Foreign (out-of-state) applicants complete the following:							
	a. Name of California Representative	Address		City		ZIP code	Phone number
	b. Please attach a copy of authorizat	on of a foreign corporation	on to do business i	n California.			
8.	8. If applicant has ever owned or operated a facility, please list the name of each facility, address, size, type of care provided, and the dates and duration of ownership or operation. (if more space is needed, please attach a separate list.)						
9.	9. Governing Board of Directors						
	Size of Board Term of offic 2 1 Year	9	Frequency of meet Annually	ngs Method Vote	of selection		
10.	Board Officers						
	Office			Na	ame		Term Expires
	CEO			Jane	e Doe		03/03/2020
	CFO			Jane	Doe		03/03/2020
	SECRETA	RY		Johr	n Doe	· · · · · · · · · · · · · · · · · · ·	03/03/2020

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 applicants or applicant facility's ability to provide health services. The information is requested by the 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, 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.

ORGANIZATIONAL STRUCTURE

Se	e page one for d	corporations.						
				F	UBLIC AGE	NCY		
1.	Check type of	public agency:	⊘ Federal	O State	⊘ County	City	Other, specify below	,
2.	Agency providi	ing services:						
	Name	• • • • • • • • • • • • • • • • • • • •		Addres	SS			
	Mailing Address	(if different from above	9)					
	Contact person			Title				Phone number
3.	District or area	to be served: (atta	ch map if necess	sary)				
	Specify Geegrar	ohic Area						
<u> </u>	Required supp	lemental materials:	Attach a copy of	f Resolution o	r legal documen	t authorizing t	his application.	
	 Required supplemental materials: Attach a copy of Resolution or legal document authorizing this application. (1267.5 Health and Safety Code) For profit corporations and partnerships, list the name(s) and business address of each person having a beneficial ownership interest of 10 percent or more in the applicant corporation or partnership. If person is a minor, identify and indicate by name and address who exercises rights during minor's minority. 							
	Jane Doe-	- 999 Beach S	Side Court, S	Sacramen	to, CA 958	14 - 80%	OWNER	
	John Doe-	999 Beach S	ide Court, S		o, CA 9581		WNER	
Λ ++ c	ach a convert of ne	arthorobin agroomo	24		PARTNERS	ПІГО		
	ach a copy of pa	artnership agreemer Limited General	Name Business addre	SS				
Sed	cond partner	☐ Limited ☐ General	Name Business addre	ss				
For	additional part	ners, use space abo	ove or attach a se	eparate sheet.				
	 		ОТН	ER ASSO	CIATIONS/BI	USINESS E	NTITIES	
Oth	Other associations/business entities, i.e., limited liability companies, etc., must also provide a similar list of persons legally responsible for the organization.							

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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 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, 76205, and 78205.

RELEASE OF INFORMATION STATEMENT

Failure to provide the information as requested may result in nonissuance of a license or license revocation.

appropriate legal documents which set forth legal responsibility of the organization, and accountability for operating the facility.

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 files located in Licensing and Certification district offices.

Alex Padilla California Secretary of State

Q Business Search - Entity Detail

The California Business Search is updated daily and reflects work processed through Thursday, March 14, 2019. Please refer to document <u>Processing Times</u> for the received dates of filings currently being processed. The data provided is not a complete or certified record of an entity. Not all images are available online.

ABC HOME HEALTHCARE, INC.

Registration Date:

Jurisdiction:
Entity Type:
Status:
Agent for Service of Process:

To find the most current California registered
Corporate Agent for Service of Process address and
authorized employee(s) information, click the link
above and then select the most current 1505
Certificate.

Entity Mailing Address:

Document Type	ţ1	File Date 1F	PDF
		07/03/2014	
SI-COMPLETE		06/09/2014	
REGISTRATION	Bearright and TE (1997) and A (1997) and A (1997)	05/20/2014	

^{*} Indicates the Information is not contained in the California Secretary of State's database.

Note: If the agent for service of process is a corporation, the address of the agent may be requested by ordering a status report.

- For information on checking or reserving a name, refer to Name Availability.
- If the image is not available online, for information on ordering a copy refer to <u>information Requests</u>.
- For information on ordering certificates, status reports, certified copies of documents and copies of documents not currently available in the Business Search or to request a more extensive search for records, refer to <u>Information Requests</u>.
- · For help with searching an entity name, refer to Search Tips.

INSERT BY-LAWS HERE

INSERT ARTICLES OF INCORPORATION HERE

ABC Home Healthcare, Inc.

999 Beach Side Court, Sacramento, CA 95814
DBA Star Home Healthcare Services

Attachment to HS 309, item 10

March 15, 2019

I hereby certify that the following is an excerpt of the minutes of the Board of ABC Home Healthcare, Inc. duly convened on March 15, 2019.

The Governing Body formed to assume full legal authority and responsibilities for the operations of the company, including the authority for the program, policies, and procedures.

The Governing Board appoints John Doe to the Board and affords him the responsibilities and rights to function in their position.

Governing Board Roster for ABC Home Healthcare, Inc.

<u>Name</u>	Title
Jane Doe	CEO/CFO
John Doe	Secretary

Date: 03/15/2019

Jane Doe

Jane Doe, Owner, CEO, CFO ABC Home Healthcare, Inc.

John Doe

John Doe, Secretary ABC Home Healthcare, Inc.