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 ADMINISTRATOR** 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 Administrator** application for Star Home Healthcare Services, located at 1800 Beach Drive, Suite 777, Sacramento, CA 95814.

As of May 13, 2015, Star Home Healthcare Services appointed Wain Jones as the Administrator.

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

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

Emergency Contact Information (available 365/24/7)
Name: Jane Doe
Email: JaneDoe@abchhealthcare.org Alternate Email: JaneDoe@cmail.com
Phone: (999) 555-2626 Phone (Text Messages): (999) 555-5555
Fax: (999) 555-2600

Sincerely,

Jane Doe

Jane Doe, Owner
ABC Home Healthcare, Inc.

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: Wain Jones

Date of Birth: 06/27/1970

Business address (number, street, apartment/suite number or letter if applicable): 1800 Beach Drive Suite 777

City, State, & Zip: Sacramento, CA 95814

Title in relation to this facility: Administrator

Have you applied for ANY license for a health facility or community care facility using any name other than your true full name? If yes, list all other names.

No

If an Administrator for proposed clinic, list hours that will be spent at the clinic each week. If an Administrator at more than one licensed clinic, list the name of **each clinic** and the number of hours spent in each licensed clinic per week.

B. Criminal Record

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

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

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

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

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

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

		Name and address of employer	Job title
From:	5/13/2015	Star Home Health Services	Administrator
To:	Present	1800 Beach Drive, Sacramento, CA 95814	
From:	1/29/2010	Get Well Home Health, Inc.	Administrator/DPCS
To:	5/12/2015	1234 Healthy Avenue, Suite 1A, Sacramento, CA 95810	
From:	3/2/2007	Care Free Home Health,LLC	DPCS
To:	1/28/2010	9876 Pain Free Drive, Elk Grove, CA 95624	
From:			
To:			

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

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

1. **Have** you ever been involved with a business entity that operated a health facility or community care facility?
   (●) **Yes** ( ) **No** **If YES, complete Section F (below) and the "Facility Information Sheet" (attached).**

2. Have you ever operated or managed (including management agreements) any of the following facility types?
   (●) **Yes** ( ) **No** **If YES, complete Section F (below) and the "Facility Information Sheet" (attached).**

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

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

F. Adverse Actions

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

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

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

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

Signature: *Date:* 3/15/19

RELEASE OF INFORMATION STATEMENT

The information provided on this form is mandatory and is necessary for licensure approval. It will be used to determine individual applicant's or applicant facility's ability to provide health services. The information is requested by the California Department of Public Health, Licensing and Certification, in accordance with the Health and Safety Code. Failure to provide the information as requested may result in nonissuance of a license or license revocation. The information is considered public information and will be made available to the public upon request. The information shall be included and maintained in the individual facility's public files located in Licensing and Certification district offices.

FACILITY INFORMATION SHEET

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

Facility name:	Facility address (number, street, city):	State:	Zip code:
Star Home Healthcare Services	1800 Beach Drive, Sacramento	CA	95814

Type of Facility	"Type" of Business Entity	Individual's "Nature" of Involvement
○ Adult Day Health Care Center	For EACH business entity, identify the name & EIN of the entity:	○ Administrator of Clinic, SNF or ICF
○ Clinic	○ Corporation:	○ Agent
○ COMMUNITY CARE FACILITY		○ Director
◉ General Acute Care Hospital	○ Individual:	○ Licensee
○ Health Facility		○ Manager of "parent" organization
○ HHA	◉ LLC:	○ Managing employee of a HHA
○ Hospice	ABC Medical Center, LLC EIN:55-5555555	○ Member
○ ICF	○ Management Company:	○ Officer of corporation
○ ICF/DD		○ Owner
○ ICF/DD-H	○ Partnership:	○ Partner
○ ICF/DD-N		○ Sole Proprietorship
○ ICF	○ OTHER Business Entity (explain):	○ Stockholder -- Ownership %:
○ Residential Care for the Elderly		○ Trustee
○ SNF	Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.	◉ OTHER Nature of Involvement (explain):
○ OTHER FACILITY TYPE (explain):	○ Yes	Member
	◉ No	Dates of involvement:
		From: 5/13/2015
		To: Present

Facility name:	Facility address (number, street, city):	State:	Zip code:

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

Facility name:	Facility address (number, street, city):	State:	Zip code:

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

Facility name:	Facility address (number, street, city):	State:	Zip code:

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

Facility name:	Facility address (number, street, city):	State:	Zip code:

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

Facility name:	Facility address (number, street, city):	State:	Zip code:

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

INSTRUCTIONS FOR HS 215A

The HS 215A must contain an original signature and date. The date of this form should be within the last three months.
This form is intended for the following:

1. Any individual owning an applicant facility;
2. Each agent, each partner, each director, each member, each managing employee of a HHA, each officer of a corporation;
3. Each agent, each partner, each director, each officer, each member or manager of a parent organization of licensee applicant;
4. Each manager, each member of a limited liability company;
5. Administrators;
6. Each person having a beneficial interest of 5 percent or more in the applicant corporation, applicant limited liability company, applicant partnership, applicant management company, applicant facility or private agency; and
7. Each officer and each director of the parent of the management company.

District office and ELMS Number	To be completed by the California Department of Public Health
Proposed name of facility/agency/clinic	Enter the name of your facility as it appears on your application (HS 200).

A. IDENTIFYING INFORMATION

Name	Please enter your full legal name.
Date of birth	Day/Month/Year
Business Address	Location of your business; number, street, apartment/suite number or letter if applicable.
City	City where business is located.
State	State where business is located.
Zip code	Zip code where business is located
Title in relation to this facility	Your title in relation to this facility.
If an Administrator for proposed clinic, list hours that will be spent at the clinic each week. If an Administrator at more than one licensed clinic, list the name of each clinic and the number of hours spent in each licensed clinic per week.	Please list hours spent at each clinic per week. If your title is not administrator, please list N/A.
Have you applied for any license for a health facility or community care facility regardless of your role or title using any name other than your true full name? If yes, list all other names.	Please answer yes or no. If yes, list any other names you have used if you have ever applied for a health facility or community care facility license.

B. CRIMINAL RECORD
Please check appropriate box. If you have checked 'yes', please provide dates and conviction information. If not applicable, please enter 'N/A'.

C. PROFESSIONAL LICENSES/CERTIFICATES

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

D. EMPLOYMENT/BUSINESS SUMMARY (FOR LAST 10 YEARS). Please list any additional experience that qualifies you to operate this type of facility. If self employed, never worked or now retired, indicate the 'From' and 'To' dates. Begin with your most recent job. Attach additional pages if necessary.

Dates (From/To)	Dates that you were employed in position from the start to the end date.
Name and Address of Employer(s)	Name and street, city, state address of the employer.
Job Title	Title that you held within your company/place of employment.

E. FACILITY, AGENCY, CLINIC INVOLVEMENT (IN OR OUT OF CALIFORNIA)

Questions No. 1-3	Please check appropriate box(es). If you have checked yes, you must fill out the attached "Facility Information Sheet" and complete Section F.

F. ADVERSE ACTIONS
Please check appropriate box. If box is checked yes, please explain and include facility information.

FACILITY INFORMATION SHEET

Facility Name	Name of Facility that correlates to the checkboxes you have checked as 'yes' in Section E.
Facility address	Number and street address of the facility involved.
City	City where facility is located.
State	State where facility is located.
ZIP code	Zip code where facility is located.
Type of Facility	Check appropriate health facility.
"Type" of Business Entity	Check appropriate business entity and identify if this entity is a "parent" corporation to the applicant facility.
Individual "Nature" of Involvement	Check appropriate position held at that facility.

INSERT
RESUME
HERE

CDPH 325

CRIMINAL RECORD CLEARANCE SUBMISSIONS

Licensee name	Date	Facility name
ABC Home Healthcare, Inc.	03/03/2019	Star Home Healthcare Services

Facility address	City
1800 Beach Drive, Suite 777	Sacramento, CA 95814

LAST NAME	FIRST NAME	DATE OF BIRTH (mm/dd/yy)	SOCIAL SECURITY NUMBER	POSITION/TITLE	DATE OF HIRE (mm/dd/yy)	L&C USE ONLY Prior Conviction Yes	No	Date Clearance Obtained
Jones	Wain	06/27/1970	XXX-XX-XXXX	Administrator	05/13/2015			
								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.

BCIA 8016

STATE OF CALIFORNIA
BCIA 8016
(orig. 4/01; rev. 6/09)

DEPARTMENT OF JUSTICE

SAMPLE FOR CERTIFICATION OF HOME HEALTH LICENSEE

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

A1226
ORI (Code assigned by DOJ)

Certification
Authorized Applicant Type

Home Health Licensee (HHL)
Type of License/Certification/Permit OR Working Title (Maximum 30 characters - if assigned by DOJ, use exact title assigned)

Contributing Agency Information:

California Department of Public Health (CDPH)
Agency Authorized to Receive Criminal Record Information

03314
Mail Code (five-digit code assigned by DOJ)

MS 3301, P.O. Box 997416
Street Address or P.O. Box

(Leave blank)
Contact Name (mandatory for all school submissions)

Sacramento | CA | 95899-7416
City | State | Zip Code

(Leave blank)
Contact Telephone Number

Applicant Information:

Your last name
Last Name

Your first name & middle initial
First Name | Middle Initial | Suffix

Other Name (AKA or Alias): Other last names known as
Last

Other first names known as
First Name | Suffix

Date of Birth
Date of Birth

Sex: (Check one) ☐ Male ☐ Female

California Driver's License Number
Driver's License Number

Height | Weight | Color | Color
Height | Weight | Eye Color | Hair Color

Billing Number: Not Applicable
(Agency Billing Number)

Place of Birth
Place of Birth (State or Country)

*Social Security Number (Required by CDPH)
Social Security Number

Misc. Number: Your telephone number
(Other Identification Number)

Home Address: Your mailing address
Street Address or P.O. Box | City | State | Zip Code

Your Number: *Social Security Number (Required by CDPH)
OCA Number (Agency Identification Number)

Level of Service: ☒ DOJ ☐ FBI

If re-submission, list ATI number:
(Must provide proof of Rejection)

Original ATI Number

Employer (Additional response for agencies specified by statute):

(Leave blank)
Employer Name

Mail Code (five-digit code assigned by DOJ)

Street Address or P.O. Box

City | State | Zip Code

Telephone Number (optional)

Live Scan Transaction Completed By:

Name of Operator

Date

Transmitting Agency | LSID | ATI Number | Amount Collected/Billed

BCIA 8016 (Rev 07/11) SAMPLE

ORIGINAL - Live Scan Operator SECOND COPY - Applicant THIRD COPY (if needed) - Requesting Agency

NOTE TO APPLICANT: *Please input your Social Security Number (SSN) where required. The submission of your SSN will allow results to be transmitted from DOJ to CDPH accurately and timely. Failure to submit your SSN could cause delay in your certification.