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 STOCK TRANSFER** 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 Stock Transfer** 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 Stock Transfer application.

Should you have any questions, I will be the direct contact regarding this Change of Stock Transfer 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 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): Stock Transfer

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 #:
   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:

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:

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:
Current facility, agency, or clinic name (if change of ownership):
Star Home Healthcare Services — Facility license number: 222222222

3. Address (number & street) of "proposed" facility, agency, or clinic: 1800 Beach Drive, Suite 777 — Telephone number: (999) 555-0695
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:**
Title: — Professional License number:

6. **a.** Name of administrator: Wain 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	80	555555555	◉ Yes	○ No	Spouse of John Doe
(2)	John Doe	20	555555555	◉ Yes	○ No	Spouse of Jane Doe
(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.

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 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 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
John Doe	Owner	03/11/2019

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:

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.

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".

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.

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.

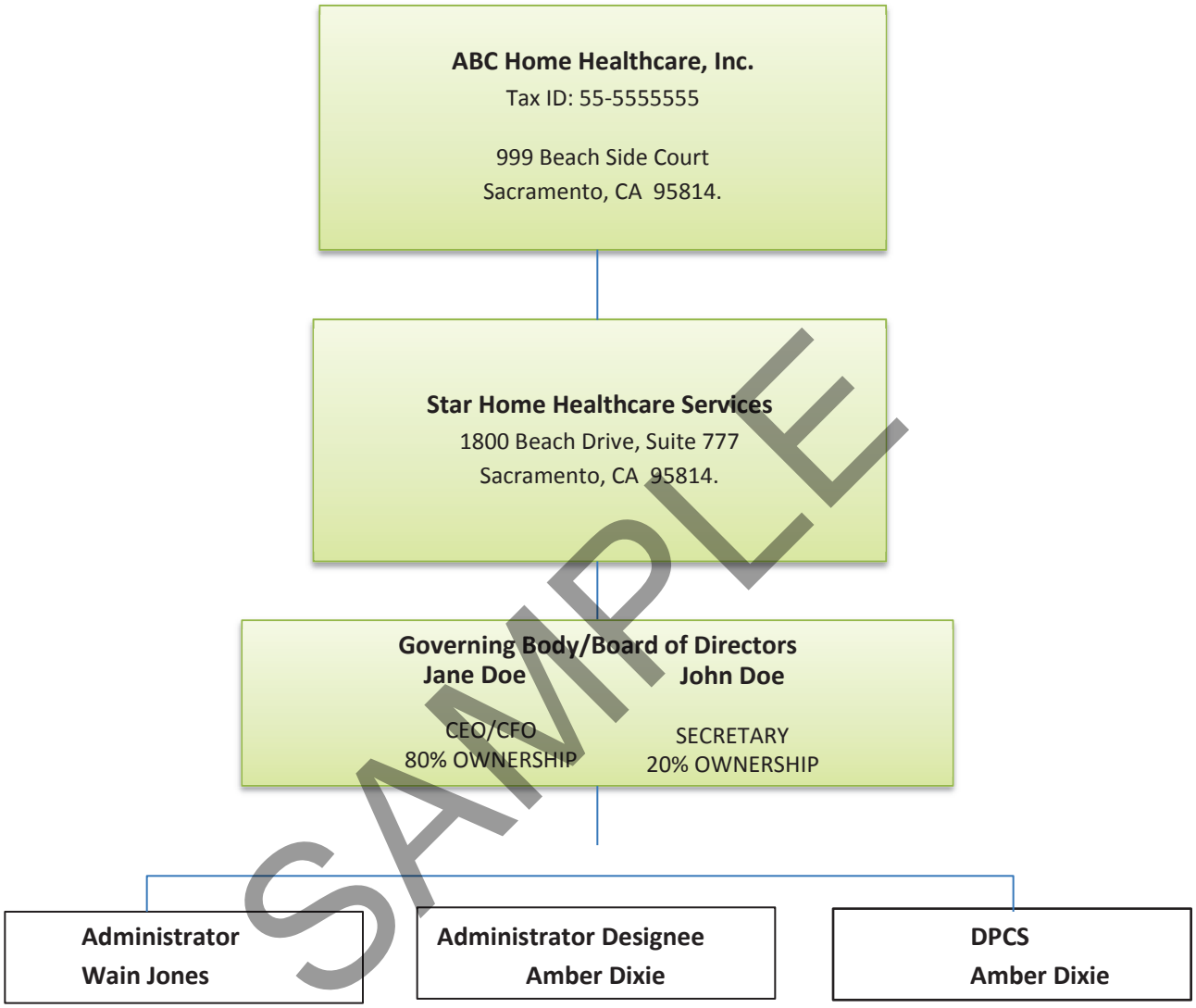
2. Provide the name, address, and percent of ownership for each person having a **5 percent** or more interest in the Management Company.

☐ ***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.

Organization Chart



Insert
Stock Purchase Agreement
Here

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: John Doe

Date of Birth: 1/9/1971

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: 20% Owner/Secretary

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

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:	3/11/2019	Star Home Healthcare Services	Secretary
To:	Present	1800 Beach Drive, Suite 777 Sacramento, CA 95814	
From:	11/5/2011	West Coast Health System	Chief Financial Officer
To:	Present	554 Crystal Blvd, Suite 10, Sacramento, CA 95814	
From:	6/30/2008	Vibrant Medical Center	Director
To:	11/4/2011	1440 Vibrant Lake Lane, Folsom, CA 95762	
From:	6/29/2008	Grand Memorial Home Health	Administrator
To:	2/18/2000	567 Oak Drive, Woodland, CA 95776	

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

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

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

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

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

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

F. Adverse Actions

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

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

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

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

Signature: *Date:* 3/11/19

RELEASE OF INFORMATION STATEMENT

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

FACILITY INFORMATION SHEET

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

Facility name:	Facility address (number, street, city):	State:	Zip code:
Star Home Healthcare Services	1800 Beach Drive, Suite 777 Sacramento	CA	95814

Type of Facility

- ○ Adult Day Health Care Center
- ○ Clinic
- ○ COMMUNITY CARE FACILITY
- ○ General Acute Care Hospital
- ○ Health Facility
- ◉ HHA
- ○ Hospice
- ○ ICF
- ○ ICF/DD
- ○ ICF/DD-H
- ○ ICF/DD-N
- ○ ICF
- ○ Residential Care for the Elderly
- ○ SNF
- ○ OTHER FACILITY TYPE (explain):

"Type" of Business Entity

For EACH business entity, identify the name & EIN of the entity:

- ◉ Corporation: ABC Home Healthcare, Inc. EIN: 55-5555555
- ○ Individual:
- ○ LLC:
- ○ Management Company:
- ○ Partnership:
- ○ OTHER Business Entity (explain):

Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.

- ○ Yes
- ◉ No

Individual's "Nature" of Involvement

- ○ Administrator of Clinic, SNF or ICF
- ○ Agent
- ○ Director
- ○ Licensee
- ○ Manager of "parent" organization
- ○ Managing employee of a HHA
- ○ Member
- ○ Officer of corporation
- ○ Owner
- ○ Partner
- ○ Sole Proprietorship
- ◉ Stockholder -- Ownership %: 20%
- ○ Trustee
- ◉ OTHER Nature of Involvement (explain): Secretary

Dates of involvement:
From: 3/11/2019
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

- ○ Adult Day Health Care Center
- ○ Clinic
- ○ COMMUNITY CARE FACILITY
- ○ General Acute Care Hospital
- ○ Health Facility
- ◉ HHA
- ○ Hospice
- ○ ICF
- ○ ICF/DD
- ○ ICF/DD-H
- ○ ICF/DD-N
- ○ ICF
- ○ Residential Care for the Elderly
- ○ SNF
- ○ OTHER FACILITY TYPE (explain):

"Type" of Business Entity

For EACH business entity, identify the name & EIN of the entity:

- ◉ Corporation: West Coast Health System, Inc. EIN: 12-2222222
- ○ Individual:
- ○ LLC:
- ○ Management Company:
- ○ Partnership:
- ○ OTHER Business Entity (explain):

Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.

- ○ Yes
- ◉ No

Individual's "Nature" of Involvement

- ○ Administrator of Clinic, SNF or ICF
- ○ Agent
- ○ Director
- ○ Licensee
- ○ Manager of "parent" organization
- ○ Managing employee of a HHA
- ○ Member
- ○ Officer of corporation
- ○ Owner
- ○ Partner
- ○ Sole Proprietorship
- ◉ Stockholder -- Ownership %: 30%
- ○ Trustee
- ◉ OTHER Nature of Involvement (explain): Chief Financial Officer

Dates of involvement:
From: 11/5/2011
To: Present

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

Type of Facility

- ○ Adult Day Health Care Center
- ○ Clinic
- ○ COMMUNITY CARE FACILITY
- ○ General Acute Care Hospital
- ○ Health Facility
- ○ HHA
- ○ Hospice
- ○ ICF
- ○ ICF/DD
- ○ ICF/DD-H
- ○ ICF/DD-N
- ○ ICF
- ○ Residential Care for the Elderly
- ○ SNF
- ○ OTHER FACILITY TYPE (explain):

"Type" of Business Entity

For EACH business entity, identify the name & EIN of the entity:

- ○ Corporation:
- ○ Individual:
- ○ LLC:
- ○ Management Company:
- ○ Partnership:
- ○ OTHER Business Entity (explain):

Are any of the above Business Entities a "PARENT" organization to the applicant facility? If Yes, explain.

- ○ Yes
- ○ No

Individual's "Nature" of Involvement

- ○ Administrator of Clinic, SNF or ICF
- ○ Agent
- ○ Director
- ○ Licensee
- ○ Manager of "parent" organization
- ○ Managing employee of a HHA
- ○ Member
- ○ Officer of corporation
- ○ Owner
- ○ Partner
- ○ Sole Proprietorship
- ○ Stockholder -- Ownership %:
- ○ Trustee
- ○ OTHER Nature of Involvement (explain):

Dates of involvement:
From:
To:

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

Type of Facility	"Type" of Business Entity	Individual's "Nature" of Involvement
○ 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.

HS 309

ADMINISTRATIVE ORGANIZATION

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

CORPORATION

1. Name (as filed with Secretary of State)	2. Administrator
ABC Medical Hospice, LLC	Jane Doe

3. Incorporation date	4. Place of incorporation
05/20/2014	California

5. Please attach (1) a copy of Articles of Incorporation and any amendments, (2) a copy of by-laws and any amendments, (3) a copy of resolution authorizing the filing of this application.

6. Principal Office of Business

Address	City	ZIP code	County	Phone number
999 Beach Side Court	Sacramento	95814	Sacramento	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 authorization of a foreign corporation to do business in California.

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. Governing Board of Directors

Size of Board	Term of office	Frequency of meetings	Method of selection
2	1 year	Annual	Election/Vote

10. Board Officers

Office	Name	Term Expires
CEO	Jane Doe	03/03/2020
CFO	John 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

See page one for corporations.

PUBLIC AGENCY

1. Check type of public agency: ○Federal ○State ○County ○City ○Other, specify below

2. Agency providing services:

Name	Address

Mailing Address (if different from above)

Contact person	Title	Phone number

3. District or area to be served: (attach map if necessary)

Specify geographic area

4. Required supplemental materials: Attach a copy of Resolution or legal document authorizing this application.

5. (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.

80% Jane Doe - 999 Beach Side Court, Sacramento, CA 95814
20% John Doe - 999 Beach Side Court, Sacramento, CA 95814

PARTNERSHIPS

Attach a copy of partnership agreement.

First partner	☐ Limited ☐ General	Name Business address
Second partner	☐ Limited ☐ General	Name Business address

For additional partners, use space above or attach a separate sheet.

OTHER ASSOCIATIONS/BUSINESS ENTITIES

Other associations/business entities, i.e., limited liability companies, etc., must also provide a similar list of persons legally responsible for the organization, appropriate legal documents which set forth legal responsibility of the organization, and accountability for operating the facility.

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 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 files located in Licensing and Certification district offices.

Alex Padilla
California Secretary of State

Business Search - Entity Detail

The California Business Search is updated daily and reflects work processed through Thursday, March 14, 2019. Please refer to document **Processing Times** 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.

[redacted] ABC HOME HEALTHCARE, INC.

Registration Date:	05/20/2014
Jurisdiction:	CALIFORNIA
Entity Type:	DOMESTIC
Status:	[redacted]
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 Address:	[redacted]
Entity Mailing Address:	

Document Type	File Date	PDF
[redacted]	07/03/2014	
SI-COMPLETE	06/09/2014	
REGISTRATION	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 **Information Requests**.
- 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 **Information Requests**.
- For help with searching an entity name, refer to **Search Tips**.

Insert

Articles of Organization or Articles of Incorporation

Here

Insert
Copy of Signed Resolution
Here

Insert

Copy of Signed Partnership Agreement

Here

CDPH 325

CRIMINAL RECORD CLEARANCE SUBMISSIONS

CLEAR

Licensee name	Date	Facility name
ABC Home Healthcare, Inc.	3/15/2019	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		
Doe	John	01/09/1971	XXX-XX-XXXX	Owner	03/11/2019			
				HAL Verification:				

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. 4/2001; rev. 01/2011)

DEPARTMENT OF JUSTICE

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, PO BOX 997416
Street Address or P.O. Box

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

Sacramento
City

CA
State

95899-7416
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 ☐ Male ☐ Female

California Driver's License Number
Driver's License Number

Height
Height

Weight
Weight

Color
Eye Color

Color
Hair Color

Billing Number
Not Applicable
(Agency Billing Number)

Place of Birth
Place of Birth (State or Country)

SSN (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: *SSN (Requred 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

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

DHCS 9098

INSTRUCTIONS FOR THE COMPLETION OF THE MEDI-CAL PROVIDER AGREEMENT
(Institutional Provider)

- **Type or print clearly.**
- **Return original and maintain a copy for your records.**
- **The Legal name and Business name must be consistent throughout the Medi-Cal Provider Agreement and any of its attachments.**
- **DO NOT LEAVE any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you. If this document is incomplete, it will be returned to you.**

Page 2 (Please enter the date)

Legal name is the name listed with the Internal Revenue Service (IRS).

Business name is the facility, hospital, agency, or clinic name (name of business/DBA)

Provider Number (NPI) is the ten-digit National Provider Identifier for the business address, as registered with the National Plan and Provider Enumeration System (NPPES).

Business telephone number is the primary business telephone number used at the business address.

Business address is the actual business location including the street name and number, room or suite number or letter, city, state, and nine-digit ZIP code. A post office box or commercial box is not acceptable.

Mailing address is the location at which the applicant or provider wishes to receive general Medi-Cal correspondence. General Medi-Cal correspondence includes bulletin updates and Provider Manual updates.

Pay-to address is the address at which the applicant or provider wishes to receive payment.

Previous business address is the address where the applicant or provider was previously enrolled. If the applicant or provider is not submitting an application for a change of location, enter N/A.

Taxpayer Identification Number is the Taxpayer Identification Number (TIN) issued by the IRS under the name of the applicant or provider.

Page 12

1. **Legal name** is the name listed with the IRS.
2. **Printed name** of the person signing this agreement.
3. **Original signature** of the person signing this agreement.
4. **Title** of the person signing this agreement.
5. **Notary Public** box is for Certificate of Acknowledgment, signature and seal of Notary Public. (See California Civil Code Section 1189).

MEDI-CAL PROVIDER AGREEMENT
(Institutional Provider)
(To Accompany Applications for Enrollment)*

Do not use staples on this form or any attachments.

Type or print clearly in ink. If you must make corrections, please line through, date, and initial in ink.

Do not leave any questions, lines, etc. blank. Enter N/A if not applicable to you.

For State Use Only

Date: 3/11/2019

Legal name of applicant or provider (as listed with the IRS)	Business name (if different than legal name)		
ABC Medical Hospice, LLC	same		
Provider number (NPI)		Business Telephone Number	
6666666666		(999) 555-2626	
Business address (number, street)	City	State	ZIP code (9-digit)
999 Beach Side Court	Sacramento	CA	95814-9999
Mailing address (number, street, P.O. Box number)	City	State	ZIP code (9-digit)
999 Beach Side Court	Sacramento	CA	95814-9999
Pay-to address (number, street, P.O. Box number)	City	State	ZIP code (9-digit)
999 Beach Side Court	Sacramento	CA	95814-9999
Previous business address (number, street)	City	State	ZIP code (9-digit)
1235 Hospice Road	Fair Oaks	CA	95628-9999
Taxpayer Identification Number (TIN)**			
55-5555555			

EXECUTION OF THIS PROVIDER AGREEMENT BETWEEN AN APPLICANT OR PROVIDER (HEREINAFTER JOINTLY REFERRED TO AS "PROVIDER") AND THE DEPARTMENT OF HEALTH CARE SERVICES (HEREINAFTER "DHCS"), IS MANDATORY FOR PARTICIPATION OR CONTINUED PARTICIPATION AS A PROVIDER IN THE MEDI-CAL PROGRAM PURSUANT TO 42 UNITED STATES CODE, SECTION 1396a(a)(27), TITLE 42, CODE OF FEDERAL REGULATIONS, SECTION 431.107, WELFARE AND INSTITUTIONS CODE, SECTION 14043.2, AND TITLE 22, CALIFORNIA CODE OF REGULATIONS, SECTION 51000.30(a)(2).

AS A CONDITION FOR PARTICIPATION OR CONTINUED PARTICIPATION AS A PROVIDER IN THE MEDI-CAL PROGRAM, PROVIDER AGREES TO COMPLY WITH ALL OF THE FOLLOWING TERMS AND CONDITIONS, AND WITH ALL OF THE TERMS AND CONDITIONS INCLUDED ON ANY ATTACHMENT(S) HERETO, WHICH IS/ARE INCORPORATED HEREIN BY REFERENCE:

* Every applicant and provider must execute this Provider Agreement.
** The taxpayer identification number may be a Taxpayer Identification Number (TIN) or a social security number for sole proprietors.

1. **Term and Termination.** This Agreement will be effective from the date applicant is enrolled as a provider by DHCS, or, from the date provider is approved for continued enrollment. Provider may terminate this Agreement by providing DHCS with written notice of intent to terminate, which termination shall result in Provider's immediate disenrollment and exclusion (without formal hearing under the Administrative Procedure Act) from further participation in the Medi-Cal program, including deactivation of any provider agreement, unless and until such time as Provider is re-enrolled by DHCS in the Medi-Cal Program. DHCS may immediately terminate this Agreement for cause if Provider is suspended/excluded for any of the reasons set forth in Paragraph 25(a) below, which termination will result in Provider's immediate disenrollment and exclusion (without formal hearing under the Administrative Procedures Act) from further participation in the Medi-Cal program.
2. **Compliance With Laws and Regulations.** Provider agrees to comply with all applicable provisions of Chapters 7 and 8 of the Welfare and Institutions Code (commencing with Sections 14000 and 14200), and any applicable rules or regulations promulgated by DHCS pursuant to these Chapters. Provider further agrees that if it violates any of the provisions of Chapters 7 and 8 of the Welfare and Institutions Code, or any other regulations promulgated by DHCS pursuant to these Chapters, it may be subject to all sanctions or other remedies available to DHCS. Provider further agrees to comply with all federal laws and regulations governing and regulating Medicaid providers.
3. **National Provider Identifier (NPI).** Provider agrees not to submit any treatment authorization requests (TARs) or claims to DHCS using an NPI unless that NPI is appropriately registered for this provider with the Centers for Medicare and Medicaid Services (CMS) and is in compliance with all NPI requirements established by CMS as of the date the claim is submitted. Provider agrees that submission of an NPI to DHCS as part of an application to use that NPI to obtain payment constitutes an implied representation that the NPI submitted is appropriately registered and in compliance with all CMS requirements at the time of submission. Provider also agrees that any subsequent defect in registration or compliance of the NPI constitutes an "addition or change in the information previously submitted" which must be reported to DHCS under the requirements of Title 22, California Code of Regulations, Section 51000.40 and 51000.52(b).
4. **Forbidden Conduct.** Provider agrees that it shall not engage in conduct inimical to the public health, morals, welfare and safety of any Medi-Cal beneficiary, or the fiscal integrity of the Medi-Cal program.
5. **Nondiscrimination.** Provider agrees that it shall not exclude or deny aid, care, service or other benefits available under Medi-Cal or in any other way discriminate against any Medi-Cal patient because of that person's race, color, ancestry, marital status, national origin, gender, age, economic status, physical or mental disability, political or religious affiliation or beliefs in accordance with California and federal laws. In addition, Provider shall not discriminate against Medi-Cal beneficiaries in any manner, including, but not limited to, admission practices, room selection and placement, meals provision and waiting time for surgical procedures. Without exception, Provider shall provide to Medi-Cal patients their specific Medi-Cal benefit Inpatient Services in the same manner as Provider also directly, or indirectly, renders those same services to non-Medi-Cal patients, regardless of payor source.
6. **Scope of Health and Medical Care.** Provider agrees that the health care services it provides may include diagnostic, preventive, corrective, and curative services, goods, supplies, and merchandise essential thereto, provided by qualified personnel for conditions that cause suffering, endanger life, result in illness or infirmity, interfere with capacity for normal activity, including employment, or for conditions which may develop into some significant handicap or disability. Provider further agrees such health care services may be subject to prior authorization to determine medical necessity.

7. **Licensing.** Provider agrees to possess at the time this Agreement becomes effective, and to maintain in good standing throughout the term of this Agreement, valid and unexpired license(s), certificate(s), or other approval(s) to provide health care services, which is appropriate to the services, goods, supplies, and merchandise being provided, if required by the state or locality in which Provider is located, or by the Federal Government. Provider further agrees it shall be automatically suspended as a provider in the Medi-Cal program pursuant to Welfare and Institutions Code, Section 14043.6, if Provider has license(s), certificate(s), or other approval(s) to provide health care services, which are revoked or suspended by a federal, California, or another state's licensing, certification, or approval authority, has otherwise lost that/those license(s), certificate(s), or approval(s), or has surrendered that/those license(s), certificate(s), or approval(s) while a disciplinary hearing on that/those license(s), certificate(s), or approval(s) was pending. Such suspension shall be effective on the date that Provider's license, certificate, or approval was revoked, suspended, lost, or surrendered. Provider further agrees to notify DHCS within ten business days of learning that any restriction has been placed on, or of a suspension of Provider's license, certificate, or other approval to provide health care. Provider further agrees to provide DHCS complete information related to any restriction to, or revocation or loss of, Provider's license, certificate, or other approval to provide health care services.
8. **Record Keeping and Retention.** Provider agrees to make, keep and maintain in a systematic and orderly manner, and have readily retrievable, such records as are necessary to fully disclose the type and extent of all services, goods, supplies, and merchandise provided to Medi-Cal beneficiaries, including, but not limited to, the records described in Section 51476 of Title 22, California Code of Regulations, and the records described in Section 431.107 of Title 42 of the Code of Federal Regulations. Provider further agrees that such records shall be made at or near the time at which the services, goods, supplies, and merchandise are delivered or rendered, and that such records shall be retained by Provider in the form in which they are regularly kept for a period of three years from the date the goods, supplies, or merchandise were delivered or the services rendered or a claim was submitted. Providers using billing agents shall assure that the billing agents maintain and submit documents required.
9. **DHCS, CDPH, AG and Secretary Access to Records; Copies of Records.** Provider agrees to make available, during regular business hours, all pertinent financial records, all records of the requisite insurance coverage, and all records concerning the provision of health care services to Medi-Cal beneficiaries to any duly authorized representative of DHCS, CDPH, the California Attorney General's Medi-Cal Fraud Unit ("AG") or the Health, Education and Welfare Unit, and the Secretary of the United States Centers for Medicare and Medicaid Services (Secretary). Provider further agrees to provide, if requested by any of the above, copies of the records and documentation, and that failure to comply with any request to examine or receive copies of such records shall be grounds for immediate suspension of Provider or its billing agent from participation in the Medi-Cal program. Provider will be reimbursed for reasonable copy costs as determined by DHCS, CDPH, AG or Secretary.
10. **Confidentiality of Beneficiary Information.** Provider agrees that all documents, whether paper, electronic or in any media, that contain protected health information as defined under the Health Information Portability and Accountability Act or personal, confidential information of beneficiaries made or acquired by Provider, shall be confidential and shall not be released without the written consent of the beneficiary or his/her personal representative, or as otherwise authorized by law. Provider agrees to enter into a business associate agreement with any billing agents to assure that they comply with these requirements.

11. **Disclosure of Information to DHCS.** Provider agrees to disclose all information as required in Federal Medicaid laws and regulations and any other information required by DHCS, and to respond to all requests from DHCS for information. Provider further agrees that the failure of Provider to disclose the required information, or the disclosure of false information shall, prior to any hearing, result in the denial of the application for enrollment or shall be grounds for termination of enrollment status or suspension from the Medi-Cal program, which shall include deactivation of all provider numbers used by Provider to obtain reimbursement from the Medi-Cal program. Provider further agrees that all bills or claims for payment to DHCS by Provider shall not be due and owing to Provider for any period(s) for which information was not reported or was reported falsely to DHCS. Provider further agrees to reimburse those Medi-Cal funds received during any period for which information was not reported, or reported falsely, to DHCS.

12. **Background Check.** Provider agrees that DHCS may conduct a background check on Provider for the purpose of verifying the accuracy of the information provided in the application and in order to prevent fraud or abuse. The background check may include, but not be limited to, the following: (1) on-site inspection prior to enrollment; (2) review of medical and business records; and, (3) data searches.

13. **Unannounced Visits By DHCS, AG and Secretary.** Provider agrees that DHCS, AG and/or Secretary may make unannounced visits to Provider, at any of Provider's business locations, before, during or after enrollment, for the purpose of determining whether enrollment, continued enrollment, or certification is warranted, to investigate and prosecute fraud against the Medi-Cal program, to investigate complaints of abuse and neglect of patients in health care facilities receiving payment under the Medi-Cal program, and/or as necessary for the administration of the Medi-Cal program and/or the fulfillment of the AG's powers and duties under Government Code Section 12528. Premises subject to inspection include billing agents, as defined in Welfare and Institutions Code Section 14040.1. Pursuant to Welfare and Institutions Code Section 14043.7(b), such unannounced visits are authorized should the department have reason to believe that the provider will defraud or abuse the Medi-Cal program or lacks the organizational or administrative capacity to provide services under the program. Failure to permit inspection by DHCS, AG or Secretary or any agent, investigator or auditor thereof, shall be grounds for immediate suspension of provider from participation in the Medi-Cal program.

14. **Provider Fraud and Abuse.** Provider agrees that it shall not engage in or commit fraud or abuse. "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law. "Abuse" means either: (1) practices that are inconsistent with sound fiscal or business practices and result in unnecessary cost to the Medicare program, the Medi-Cal program, another state's Medicaid program, or other health care programs operated, or financed in whole or in part, by the Federal Government or any state or local agency in this state or any other state; (2) practices that are inconsistent with sound medical practices and result in reimbursement by the Medi-Cal program or other health care programs operated, or financed in whole or in part, by the Federal Government or any state or local agency in this state or any other state, for services that are unnecessary or for substandard items or services that fail to meet professionally recognized standards for health care.

15. **Investigations of Provider for Fraud or Abuse.** Provider certifies that, at the time this Agreement was signed, it was not under investigation for fraud or abuse pursuant to Subpart A (commencing with Section 455.12) of Part 455 of Title 42 of the Code of Federal Regulations or under investigation for fraud or abuse by any Federal, state or local law enforcement agency, including the Medicaid investigation units of DHCS and the Office of the Inspector General for the Federal Department of Health and Human Services. Provider further agrees to notify DHCS within ten business days of learning that it is under

investigation for fraud or abuse by any such entity. Provider further agrees that it may be subject to temporary suspension pursuant to Welfare and Institutions Code, Section 14043.36(a), which may include temporary deactivation of all provider numbers used by Provider to obtain reimbursement from the Medi-Cal program, if it is discovered that Provider is under investigation as described in that section. Provider further agrees to cooperate with and assist DHCS and any state or federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected fraud and abuse, although Provider does not waive any timely and properly asserted rights it may have under the 5th Amendment privilege against self-incrimination.

16. **Provider Fraud or Abuse Convictions and/or Civil Fraud or Abuse Liability.** Provider certifies that it and its owners, officers, directors, employees, and agents, have not: (1) been convicted of any felony or misdemeanor involving fraud or abuse in any government program, within the last ten years; or (2) been convicted of any felony or misdemeanor involving the abuse of any patient; or (3) been convicted of any felony or misdemeanor substantially related to the qualifications, functions, or duties of a provider; or (4) entered into a settlement in lieu of conviction for fraud or abuse, within the last ten years; or, (5) been found liable for fraud or abuse in any civil proceeding, within the last ten years. Provider further agrees that DHCS shall not enroll Provider if within the last ten years, Provider has been convicted of any felony, or any misdemeanor involving fraud or abuse in any government program, has entered into a settlement in lieu of conviction for fraud or abuse, or has been found liable for fraud or abuse in any civil proceeding.

17. **Changes to Provider Information.** Provider agrees to keep its application for enrollment in the Medi-Cal program current by informing the California Department of Public Health (CDPH), District Office, in writing on a form or forms to be specified by DHCS, within 35 days of any changes to the information contained in its application for enrollment, its disclosure statement, this Agreement, and/or any attachments to these documents.

18. **Prohibition of Rebate, Refund, or Discount.** Provider agrees that it shall not offer, give, furnish, or deliver any rebate, refund, commission, preference, patronage, dividend, discount, or any other gratuitous consideration, in connection with the rendering of health care services to any Medi-Cal beneficiary. Provider further agrees that it shall not solicit, request, accept, or receive, any rebate, refund, commission, preference, patronage, dividend, discount, or any other gratuitous consideration, in connection with the rendering of health care services to any Medi-Cal beneficiary. Provider further agrees that it will not take any other action or receive any other benefit prohibited by state or federal law.

19. **Payment From Other Health Coverage Prerequisite to Claim Submission.** Provider agrees that it shall first seek to obtain payment for services provided to Medi-Cal beneficiaries from any private or public health insurance coverage to which the beneficiary is entitled, where Provider is aware of this coverage and to the extent the coverage extends to these services, prior to submitting a claim to DHCS for the payment of any unpaid balance for these services. In the event that a claim submitted to a private or public health insurer has not been paid within 180 days of billing by Provider, Provider may submit a claim to DHCS but must provide documentation of denial when requested to do so by DHCS. Providers billing for services to beneficiaries who are dual eligible Medicare-Medi-Cal must submit payment denial from Medicare Part A&B with all claims.

20. **Beneficiary Billing.** Provider agrees that it shall not submit claims to or demand or otherwise collect reimbursement from a Medi-Cal beneficiary, or from other persons on behalf of the beneficiary, for any service included in the Medi-Cal program's scope of benefits in addition to a claim submitted to the Medi-Cal program for that service, except to: (1) collect payments due under a contractual or legal entitlement pursuant to Welfare and Institutions Code, Section 14000(b); (2) bill a long-term care patient for the amount of his/her liability; and, (3) collect a co-payment pursuant to Welfare and Institutions Code,

Sections 14134 and 14134.1. Provider further agrees that, in the event that a beneficiary willfully refuses to provide current other health care coverage billing information as described in Section 50763(a)(5) of Title 22, California Code of Regulations, Provider may, upon giving the beneficiary written notice of intent, bill the beneficiary as a private pay patient.

21. **Payment From Medi-Cal Program Shall Constitute Full Payment.** Provider agrees that payment received from DHCS in accordance with Medi-Cal fee structures shall constitute payment in full, except that Provider, after making a full refund to DHCS of any Medi-Cal payments received for services, goods, supplies, or merchandise, may recover all of Provider's fees to the extent that any other contractual entitlement, including, but not limited to, a private group or indemnification insurance program, is obligated to pay the charges for the services, goods, supplies, or merchandise provided to the beneficiary. Providers agree to submit all claims within 60 days of the dates of service but no later than six months to receive full payment. Providers agree to comply with Welfare and Institutions Code Section 14115 and California Code of Regulations, Title 22, Section 51008 and 51008.5.

22. **Return of Payment for Services Otherwise Covered by the Medi-Cal Program.** Provider agrees that any beneficiary who has paid Provider for health care services, goods, supplies, or merchandise otherwise covered by the Medi-Cal program received by the beneficiary shall be entitled to a prompt return from Provider of any part of the payment which meets any of the following: (1) was rendered during any period prior to the receipt of the beneficiary's Medi-Cal card, for which the card authorizes payment under Welfare and Institutions Code, Sections 14018 or 14019; (2) was reimbursed to Provider by the Medi-Cal program, following audits and appeals to which Provider is entitled; (3) is not payable by a third party under contractual or other legal entitlement; (4) was not used by the beneficiary to satisfy his/her paid or obligated liability for health care services, goods, supplies, or merchandise, or to establish eligibility.

23. **Compliance With Requirements.** Provider and any billing agent agree that it shall comply with all of the requirements set forth in the Welfare and Institutions Code and its implementing regulations, and the Medi-Cal Provider Manuals, including applicable changes to the Medi-Cal Provider Manuals published by DHCS subsequent to the effective date of this Agreement. Providers and their billing agents agree to comply with Welfare and Institutions Code Section 14115 and California Code of Regulations, Title 22, Section 51008 and 51008.5. Providers agree to submit all claims within 60 days of the dates of service but no later than six months to receive full payment. Provider and its billing agent also agree to exhaust all administrative remedies with the fiscal intermediary prior to filing a writ of mandate pursuant to Welfare and Institutions Code Section 14104.5. In the event DHCS determines a reimbursement overpayment has been made to Provider or monies are otherwise owed pursuant to this Agreement, Provider agrees to promptly repay the amounts owed in accordance with applicable federal and California statutes and regulations, and rules and policies of DHCS. DHCS may recoup any overpayment from monies otherwise payable to Provider under this Agreement under any provider number of Provider.

24. **Deficit Reduction Act of 2005, Section 6032 Implementation.** To the extent applicable, as a condition of payment for services, goods, supplies and merchandise provided to beneficiaries in the Medical Assistance Program ("Medi-Cal"), providers must comply with the False Claims Act employee training and policy requirements in 1902(a) of the Social Security Act (42 USC 1396a(a)(68)), set forth in that subsection and as the federal Secretary of Health and Human Services may specify.

25. **Provider Suspension; Appeal Rights; Reinstatement.** Provider agrees that it is to be subject to the following suspension actions. Provider further agrees that the suspension of Provider shall include deactivation of all of Provider's provider numbers and shall preclude Provider from submitting claims for payment, either personally or through claims submitted by any individual, clinic, group, corporation, or other association to the Medi-Cal program for any services, supplies, goods, or merchandise that

provider has provided directly or indirectly to a Medi-Cal beneficiary, except for services, supplies, goods, or merchandise provided prior to the suspension.

a. **Automatic Suspensions/Mandatory Exclusions.** The provider shall be automatically suspended under the following circumstances:

(1) Upon notice from the Secretary of the United States Department of Health and Human Services that Provider has been excluded from participation in the Medicare or Medicaid programs. No administrative appeal of a suspension on this ground shall be available to Provider. (Welfare and Institutions Code, Section 14123(b),(c)).

(2) If Provider has license(s), certificate(s), or other approval(s) to provide health care services, revoked or suspended by a federal, California, or another state's licensing, certification, or approval authority, has otherwise lost that/those license(s), certificate(s), or approval(s), or has surrendered that/those license(s), certificate(s), or approval(s) while a disciplinary hearing on that license, certificate, or approval was pending. (Welfare and Institutions Code, Section 14043.6).

(3) If Provider is convicted of any felony or any misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of service. Suspension following conviction is not subject to the proceedings under Welfare and Institutions Code Section 14123(c). However, the director may grant an informal hearing at the request of the provider to determine in the director's sole discretion if the circumstances surrounding the conviction justify rescinding or otherwise modifying the suspension.

b. **Permissive Suspensions/Permissive Exclusions.** The provider may be suspended under the following circumstances:

(1) Provider violates any of the provisions of Chapter 7 of the Welfare and Institutions Code (commencing with Section 14000 except for Sections 14043-14044), or Chapter 8 (commencing with Section 14200) or any rule or regulations promulgated by DHCS pursuant to those provisions. Administrative appeal pursuant to Health and Safety Code, Section 100171. (Welfare and Institutions Code, Section 14123(a),(c)).

(2) Provider fails to comply with DHCS's request to examine or receive copies of the books and records pertaining to services rendered to Medi-Cal beneficiaries. Administrative appeal pursuant to Health and Safety Code, Section 100171. (Welfare and Institutions Code, Section 14124.2).

(3) Provider participating in the Medi-Cal dental program provides services, goods, supplies, or merchandise that are below or less than the standard of acceptable quality, as established by the California Dental Association Guidelines for the Assessment of Clinical Quality and Professional Performance, Copyright 1995, Third Edition, as periodically amended. (Welfare and Institutions Code, Section 14123(f)).

c. **Temporary Suspension.** The provider may be temporarily suspended under the following circumstances:

(1) Provider fails to disclose all information as required in federal Medicaid regulations or any other information required by DHCS, or discloses false information. Administrative appeal pursuant to Welfare and Institutions Code, Section 14043.65. (Welfare and Institutions Code, Section 14043.2(a)).

(2) If it is discovered that Provider is under investigation for fraud or abuse. Administrative appeal pursuant to Welfare and Institutions Code, Section 14043.65. (Welfare and Institutions Code, Section 14043.36(a)).

(3) Provider fails to remediate discrepancies discovered as a result of an unannounced visit to Provider. Administrative appeal pursuant to Welfare and Institutions Code, Section 14043.65. (Welfare and Institutions Code, Section 14043.7(c)).

(4) When necessary to protect the public welfare or the interests of the Medi-Cal program. Administrative appeal pursuant to Health and Safety Code, Section 100171. (Welfare and Institutions Code, Section 14123(c)).

(5) Provider submits claims for payment under any provider number from an individual or entity that is suspended, excluded or otherwise ineligible. This includes a provider on the Suspended and Ineligible Provider List or any list published by the Office of the Inspector General or the Department of Health and Human Services. Appeal pursuant to Welfare and Institutions Code, Section 14043.65. (Welfare and Institutions Code, Section 14043.61).

26. **Provider Grievances and Complaints.** A provider who has a grievance or complaint concerning the processing or payment of money alleged to be payable for services provided to eligible Medi-Cal beneficiaries shall comply with and exhaust all administrative remedies and procedures outlined in statute, regulation or the Provider Manual, including the following:

a. The provider and its billing agent shall comply with and exhaust all administrative remedies provided by the Fiscal Intermediary or Contractor prior to filing a court action.

b. The provider and its billing agent shall comply with and exhaust all proceeding for claims processing outlined in the Provider Manual including all appeal procedures.

c. The provider and its billing agent shall submit to the Fiscal Intermediary or Contractor all source documentation to support its claim, including but not limited to the source documentation outlined in California Code of Regulations, Title 22, Section 51476.

d. The provider and its billing agent shall comply with all timeliness requirements including but not limited to those outlined in Welfare and Institutions Code Section 14115 and California Code of Regulations, Title 22, Section 51008 and 51008.5.

27. **Provider Termination, Imposition of Federal Sanctions, and Appeal Rights for Long Term Care Facilities.** Provider agrees that it is subject to any federal sanctions authorized under the state plan including termination of this provider agreement in accordance with federal law. Provider further agrees that the termination of this provider agreement or imposition of other federal sanctions authorized under the state plan shall include deactivation of all of Provider's provider numbers and shall preclude Provider from submitting claims for payment either personally or through claims submitted by any individual, clinic, group, corporation, or other association to the Medi-Cal program for any services, supplies, goods, or merchandise that provider has provided directly or indirectly to a Medi-Cal beneficiary, except for services, supplies, goods, or merchandise provided prior to the termination or imposition of sanctions.

a. Skilled Nursing Facility and Intermediate Care Facility Appeal Procedures. SNF and ICF Medi-Cal Providers shall have the appeal rights set forth in Article 1.6 of Chapter 3 of Division 3 of Title 22.

b. Intermediate Care Facilities-Mental Retardation Appeal Procedures. Intermediate Care Facilities Developmentally Disabled; Intermediate Care Facilities-Developmentally Disabled-Habilitative;

Intermediate Care Facilities- Developmentally Disabled-Nursing shall have the appeal rights set forth in 42 CFR 431.153 and 431.154.

28. **Liability of Group Providers.** Provider agrees that, if it is a provider group, the group, and each member of the group, are jointly and severally liable for any breach of this Agreement, and that action against any of the providers in the provider group may result in action against all of the members of the provider group.

29. **Legislative and Congressional Changes.** Provider agrees that this Agreement is subject to any future additional requirements, restrictions, limitations, or conditions enacted by the California Legislature or the United States Congress which may affect the provisions, terms, conditions, or funding of this Agreement.

30. **Provider Capacity.** Provider agrees that Provider, and the officers, directors, employees, and agents of Provider, in the performance of this Agreement, shall act in an independent capacity and not as officers or employees or agents of the State of California.

31. **Indemnification.** Provider agrees to indemnify, defend, and save harmless the State of California, its officers, agents, and employees, from any and all claims and losses accruing or resulting to any and all persons, firms, or corporations furnishing or supplying services, materials, or supplies in connection with Provider's performance of this Agreement, and from any and all claims and losses accruing or resulting to any Medi-Cal beneficiary, or to any other person, firm, or corporation who may be injured or damaged by Provider in the performance of this Agreement.

32. **Governing Law.** This Agreement shall be governed by and interpreted in accordance with the laws of the State of California.

33. **Venue.** Venue for all actions, including federal actions, concerning this Agreement, lies in Sacramento County, California, or in any other county in which the California Department of Justice maintains an office.

34. **Titles.** The titles of the provisions of this Agreement are for convenience and reference only and are not to be considered in interpreting this Agreement.

35. **Severability.** If one or more of the provisions of this Agreement shall be invalid, illegal, void, or unenforceable, the validity, legality, and enforceability of the remaining provisions shall not in any way be affected or impaired. Either party having knowledge of such a provision shall promptly inform the other of the presumed non-applicability of such provision. Should the non-applicable provision go to the heart of this Agreement, the Agreement shall be terminated in a manner commensurate with the interests of both parties.

36. **Assignability.** Provider agrees that it has no property right in or to its status as a Provider in the Medi-Cal program or in or to the provider number(s) assigned to it, and that Provider may not assign its provider number for use as a Medi-Cal provider, or any rights and obligations it has under this Agreement except to the extent purchasing owner is joining this provider agreement with successor joint and several liability.

37. **Waiver.** Any action or inaction by DHCS or any failure of DHCS on any occasion, to enforce any right or provision of this Agreement, shall not be interpreted to be a waiver by DHCS of its rights hereunder and shall not prevent DHCS from enforcing such provision or right on any future occasion. The rights and remedies of DHCS herein are cumulative and are in addition to any other rights or remedies that DHCS may have at law or in equity.

38. **Complete Integration.** This Agreement, including any attachments or documents incorporated herein by express reference, is intended to be a complete integration and there are no prior or contemporaneous different or additional agreements pertaining to the subject matter of this Agreement, unless such additional agreement(s) is between DHCS and the Provider, expressly references or incorporates all or part of this Agreement, and is signed by the Provider.
39. **Amendment.** Any alteration or modification by the applicant or Provider of this Medi-Cal Provider Agreement (DHCS Form 9098) or to any of the terms in its exhibits or attachments, shall automatically and immediately void this agreement upon submission of the signed agreement to the State, unless such agreement is also signed by the State.
40. **Provider Attestation.** Provider agrees that all information it submits on the application form for enrollment, this Agreement, and all attachments or changes to either, is true, accurate, and complete to the best of Provider's knowledge and belief. Provider further agrees to sign the application form for enrollment, this Agreement, and all attachments or changes to either, under penalty of perjury under the laws of the State of California.

The parties agree that this agreement is a legal and binding document and is fully enforceable in a court of competent jurisdiction. The provider signing this agreement warrants that he/she has read this agreement and understands it.

I declare under penalty of perjury under the laws of the State of California that the foregoing information is true, accurate, and complete to the best of my knowledge and belief.

I declare I am the provider or I have the authority to legally bind the provider, which is an entity and not an individual person.

1. Printed legal name of provider
   ABC Medical Hospice, LLC
2. Printed name of person signing this declaration on behalf of provider (if an entity or business name is listed in item 1 above)
   Wain Jones
3. Original signature of provider or representative if this provider is an entity other than an individual person as sole proprietor
4. Title of person signing this declaration
   Owner
5. Notary Public (Affix notary seal or stamp in the space below)

Executed at: Sacramento (City), CA (State) on 3/11/2109 (Date)

Applicants and providers licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act ARE NOT REQUIRED to have this form notarized. If notarization is required, the Certificate of Acknowledgment signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.

6. **Contact Person's Information**

▣ Check here if you are the same person identified in item 2. If you checked the box, provide only the e-mail address and telephone number below.

Contact Person's Name (Last, First, Middle)		Gender □ Male □ Female
Title/Position	E-mail Address wainjones@abcmedLLC.org	Telephone Number (999) 555-2626

Privacy Statement
(Civil Code Section 1798 et seq.)

All information requested on the Application, the disclosure statement, and the provider agreement is mandatory. This information is required by the California Department of Health Care Services and any other California State Departments that are delegated responsibility to administer the Medi-Cal program, by the authority of the Welfare and Institutions Code, Sections 14043 – 14043.75, the California Code of Regulations, Title 22, Sections 51000 – 51451 and the Code of Federal Regulations, Title 42, Part 455. The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider or denial of continued enrollment as a provider and deactivation of all provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. Some or all of this information may also be provided to the California State Controller's Office, the California Department of Justice, the California Department of Consumer Affairs, the California Department of Corporations, the California Franchise Tax Board or other California state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Centers for Medicare and Medicaid Services, Office of the Inspector General, Medicaid, or as required or permitted by law. For more information or access to records containing your personal information maintained by this agency, contact the Provider Enrollment Division at (916) 323-1945.

Insert CMS 855A: Geographic Service Area Here