APPLICANT INDIVIDUAL INFORMATION

Department Use Only

Facility Name:

(If Initial, CHON, or CHOW, use proposed name)

District Office:

Facility ID: **Application ID:**

The Applicant Individual Information (HS 215A) form is intended for any individual with five (5) percent or more (direct or indirect) ownership interest and/or control interest in the applicant facility or any individual involved (now or in the past) with any health care facility, agency, clinic, or community care facility. **Refer to the Instructions for assistance.**

The HS 215A form is required as part of a health care facility, agency, or clinic's application packet for state licensing and/or federal certification, including when changes are reported regarding officers, directors, purchase of stock, etc., **even though no change in legal ownership has or is occurring.**

A. Applicant Facility Information

1. **Facility Name**:
2. **Facility Business Address (Number & Street)**:

   City: **State:** **Zip Code**:
3. **Type of facility, agency, or clinic (Select one)**:

   a. Acute Psychiatric Hospital (APH)
   b. Adult Day Health Center (ADHC)
   c. Alternative Birth Center (ABC)
   d. Ambulatory Surgery Center (ASC)
   e. Chemical Dependency Recovery Hospital (CDRH)
   f. Chronic Dialysis Clinic (CDC)
   g. Chronic Dialysis Clinic/End Stage Renal Dialysis (CDC/ESRD)
   h. Community Clinic (COMTYC)
   i. Community Clinic/Rural Health Clinic (COMTYC/RHC)
   j. Community Mental Health Center (CMHC)
   k. Comprehensive Outpatient Rehabilitation Facility (CORF)
   l. Congregate Living Health Facility (CLHF)
   m. Correctional Treatment Center (CTC)
   n. End Stage Renal Dialysis (ESRD)
   o. Free Clinic (FREEC)
   p. Free Clinic/Rural Health Clinic (FREEC/RHC)
   q. General Acute Care Hospital (GACH)
   r. Home Health Agency (HHA)
   s. Hospice Agency
   t. Hospice Facility (HOFA)
   u. Intermediate Care Facility (ICF)
   v. Intermediate Care Facility/Developmentally Disabled (ICF/DD)
   w. Intermediate Care Facility/Developmentally Disabled-Habilitative (ICF/DD-H)

x. Intermediate Care Facility/Developmentally Disabled-Nursing (ICF/DD-N)
y. Outpatient Physical Therapy/Speech-Language Pathology Provider (OPT/SP)
z. Pediatric Day Health & Respite Care (PDHRC)
aa. Psychology Clinic (PSYCHC)
bb. Referral Agency (REFRLAG)
cc. Rehabilitation Clinic (REHABC)
dd. Rehabilitation Clinic/Comprehensive Outpatient Rehabilitation Facility (REHABC/CORF)
ee. Rural Health Clinic (RHC)
ff. Skilled Nursing Facility (SNF)
gg. Surgical Clinic (SURGC)
hh. Surgical Clinic/Ambulatory Surgery Center (SURGC/ASC)
ii. Other:

4. **Type of Application (Check one):**

a. Initial
b. Initial – Home Health Agency Add Branch
c. Initial – Hospice Agency Add Multiple Location
d. Change of Ownership
e. Management Company
f. License Suspension Reinstatement
g. Other:

B. Applicant Individual Information

1. **Individual Legal Name (First, Middle Initial, Last Name):**
2. **Nature of involvement to the Applicant Facility:**
3. **Date of Birth (MM/DD/YYYY):**
4. **Provide your Driver's License Number. If not available, provide a State-Issued Identification Card Number.** (Attach a copy of the Driver's License or State - Issued Identification Card. Driver's License or State – Issued Identification Card must not be expired. Title the attachment "Section B.4 - Driver's License or State-Issued Identification Card".)

   Driver's License Number or State-Issued Identification Number:

   Expiration Date:
5. **Social Security Number:**
6. **Have you applied for ANY license for a health care facility, agency, clinic, or community care facility using any name other than your legal name?** Yes No

   If "yes", list all other names:

7. **Administrator**: If you have an Administrator role at the applicant facility, agency or clinic named in Section A, list the number of hours that you will spend at the facility each week. If you are an Administrator at more than one licensed and/or certified facility list **the name of each facility** and the number of hours spent in each facility per week. (Attach additional pages if necessary. Title pages: “Section B.7 – Administrator Schedule of Multiple Facilities”.)

Days of the Week	Applicant Facility	Facility Name 2	Facility Name 3
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

C. Criminal Record

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

2. **Has there been a judgment against you for Medicare or Medicaid (Medi-Cal) fraud**? Yes No

3. **Has there been a judgment against you by a health care professional/technical licensing entity?** Yes No

If "yes" to any of the questions above, provide conviction information, dates of misdemeanor and/or felony, and any supporting documents (Attach additional pages if necessary. Title pages: "Section C – Criminal Record".)

D. Professional Licenses/Certificates – If a professional license or certificate is required for your role in association with the applicant facility, agency, or clinic (as identified in Section B.2.), provide the information in the table below:

Type of License/Certificate	License or Certificate Number	Period Held (MM/DD/YY-MM/DD/YY)	Issuing Agency

E. Employment History. Please list your complete employment history for the past 10 years. In addition, any additional experience that qualifies you for the nature of your involvement in this facility, agency, or clinic. Begin with your most recent job. (Attach additional pages if necessary. Title pages: "Section E–Employment History".) You may submit a resume in lieu of completing this section, include all pertinent information as requested below.

1. Employer Name: From – To:
   Address (Number & Street):
   City: State: Zip (9-digit):
   Job Title:

   If the employer is a licensed health care facility, agency, or clinic, provide the following information:
   Facility Name:
   Facility Type:
   Did you own, operate, or manage this facility, agency, or clinic? Yes No
   If yes, individual's nature of involvement:

2. Employer Name: From – To:
   Address (Number & Street):
   City: State: Zip (9-digit):
   Job Title:

   If the employer is a licensed health care facility, agency, or clinic, provide the following information:
   Facility Name:
   Facility Type:
   Did you own, operate, or manage this facility, agency, or clinic? Yes No
   If yes, individual's nature of involvement:

3. Employer Name: From – To:
   Address (Number & Street):
   City: State: Zip (9-digit):
   Job Title:

   If the employer is a licensed health care facility, agency, or clinic, provide the following information:
   Facility Name:
   Facility Type:
   Did you own, operate, or manage this facility, agency, or clinic? Yes No
   If yes, individual's nature of involvement:

4. Employer Name: From – To:
   Address (Number & Street):
   City: State: Zip (9-digit):
   Job Title:

   If the employer is a licensed health care facility, agency, or clinic, provide the following information:
   Facility Name:
   Facility Type:
   Did you own, operate, or manage this facility, agency, or clinic? Yes No
   If yes, individual's nature of involvement:

F. Facility, Agency, Clinic Involvement (In or out of California)

1. **Have you ever been involved with a business entity that owned, operated, or managed a health care facility, agency, or clinic?**

   Yes No

2. **Have you ever held a <u>five (5) percent</u> or more beneficial (direct or indirect) ownership interest and/or control interest in any health care facility, agency, or clinic?** Yes No

If "yes" to any of the questions above, complete Section H, Facility Information Sheet.

G. Adverse Actions

1. **Have you ever been affiliated with any facility, either past or present, that has been identified as having one or more of the following adverse actions or other adverse actions not listed?** Yes No

If "yes", check **ALL** applicable: include facility name/address, provide dates, and findings. (Attach additional pages. Title pages: "Section G - Adverse Action".)

a. Action Resolved by settlement
b. Bankruptcy
c. Foreclosures
d. Judgments
e. License Revocation action filed
f. License Revoked (Whether stayed or not)
g. License Involuntarily Suspended
h. Medicaid (Medi-Cal) decertification
i. Medicare decertification
j. Placed on any form of probation
k. Receiver Appointed
l. Temporary Manager appointed
m. Other:

H. 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 5 years for SNFs and 3 years for all other facility types). Please see instructions for guidance to complete this section. (Attach additional pages if necessary, include the same required content with the same formatting Title pages: “Section H - Facility Information Sheet”.)

1. Facility Name:

a. **Address (Number & Street):**

City: **State:** **Zip (9-digit):**

b. **Facility Type:**

c. **Individual’s Nature of Involvement:**

d. **Dates of Involvement** (From and To): xx/xx/xxxx – xx/xx/xxxx

e. **Entity Name:**

f. **Type of Business Entity: (Select One)**

1) For-profit Corporation
2) General Partnership
3) Governmental (Select One)
   a) City
   b) County
   c) State Agency
   d) Public Agency
   e) Other Agency:
4) Limited Liability Company (LLC)
5) Limited Liability Partnership
6) Limited Partnership
7) Nonprofit (Select One)
   a) Corporation
   b) Unincorporated Association
   c) Charitable
   d) Religious
   e) Other:
8) Sole Proprietorship (Individual)
9) Other:

g. **Business Entity Employer Identification Number (EIN):**

h. **Are any of the above Business Entities a “PARENT” organization to the applicant facility in Section A?** Yes No

If “yes”, explain:

2. Facility Name:

a. **Address (Number & Street):**

City: **State:** **Zip (9-digit):**

b. **Facility Type:**

c. **Individual's Nature of Involvement:**

d. **Dates of Involvement** (From and To): xx/xx/xxxx – xx/xx/xxxx

e. **Entity Name:**

f. **Type of Business Entity: (Select One)**

1) For-profit Corporation
2) General Partnership
3) Governmental (Select One)
   a) City
   b) County
   c) State Agency
   d) Public Agency
   e) Other Agency:
4) Limited Liability Company (LLC)
5) Limited Liability Partnership
6) Limited Partnership
7) Nonprofit (Select One)
   a) Corporation
   b) Unincorporated Association
   c) Charitable
   d) Religious
   e) Other:
8) Sole Proprietorship (Individual)
9) Other:

g. **Business Entity Employer Identification Number (EIN):**

h. **Are any of the above Business Entities a "PARENT" organization to the applicant facility in Section A?** Yes No

If "yes", explain:

3. Facility Name:

a. **Address (Number & Street):**

City: **State:** **Zip (9-digit):**

b. **Facility Type:**

c. **Individual's Nature of Involvement:**

d. **Dates of Involvement** (From and To): xx/xx/xxxx – xx/xx/xxxx

e. **Entity Name:**

f. **Type of Business Entity: (Select One)**

1) For-profit Corporation
2) General Partnership
3) Governmental (Select One)
   a) City
   b) County
   c) State Agency
   d) Public Agency
   e) Other Agency:
4) Limited Liability Company (LLC)
5) Limited Liability Partnership
6) Limited Partnership
7) Nonprofit (Select One)
   a) Corporation
   b) Unincorporated Association
   c) Charitable
   d) Religious
   e) Other:
8) Sole Proprietorship (Individual)
9) Other:

g. **Business Entity Employer Identification Number (EIN):**

h. **Are any of the above Business Entities a "PARENT" organization to the applicant facility in Section A?** Yes No

If "yes", explain:

4. Facility Name:

a. Address (Number & Street):

City: **State:** **Zip (9-digit):**

b. Facility Type:

c. Individual's Nature of Involvement:

d. Dates of Involvement (From and To): xx/xx/xxxx – xx/xx/xxxx

e. Entity Name:

f. Type of Business Entity: (Select One)

1) For-profit Corporation
2) General Partnership
3) Governmental (Select One)
   a) City
   b) County
   c) State Agency
   d) Public Agency
   e) Other Agency:
4) Limited Liability Company (LLC)
5) Limited Liability Partnership
6) Limited Partnership
7) Nonprofit (Select One)
   a) Corporation
   b) Unincorporated Association
   c) Charitable
   d) Religious
   e) Other:
8) Sole Proprietorship (Individual)
9) Other:

g. Business Entity Employer Identification Number (EIN):

h. Are any of the above Business Entities a "PARENT" organization to the applicant facility in Section A? Yes No

If "yes", explain:

Applicant Release

I declare under penalty of perjury under the laws of the State of California that the statements on this application and on the accompanying attachments are correct to the best of my knowledge.

Applicant Signature:____ Date:

(Please type your full legal name)

Applicant Printed Name **Title**

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 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, Center for Health Care Quality 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.

The information is considered public information and will be made available to the public upon request. However, legally protected information shall be redacted before any release in accordance with applicable law. The information shall be included and maintained in the individual facility's files located in California Department of Public Health, Center for Health Care Quality, district offices.

Failure to provide the information as requested or misrepresentation of a material fact may result in denial of an application, non-issuance of a license, or license revocation.

Instructions for HS 215A

Type or print clearly. Complete all applicable questions. Do not leave items blank. Mark N/A, if not applicable. **Submit** all supplemental paperwork and supporting documents to complete the Applicant Individual Information (HS 215A) Form. **The signature and date of this form should be within the last three months and must contain the signature of the individual whom this form is regarding.**

This form is intended to be completed by the following individuals:

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, each manager of a parent organization of a licensee applicant, each member of a limited liability company.
3. Administrators, Administrator Designee, Agency Manager, Director of Nursing, Director of Patient Care Services, Director of Patient Care Services Designee, Medical Director, Program Director.
4. Each person having five (5) percent or more (direct or indirect) ownership interest and/or control interest in the applicant corporation, applicant limited liability company, applicant partnership, applicant management company, applicant facility or private agency.
5. Each officer and each director of the parent of the management company.

Refer to the following Health Safety Code (HSC) Sections for the definitions below.

Owned: “Beneficial ownership interest” means any of the following:

(1) The possession by a person, as defined in Section 19, of an ownership interest, including a combination of direct and indirect ownership interests, totaling 5 percent or more in any licensed health facility.
(2) An ownership interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by a licensee of or applicant for licensure of a health facility if that interest equals at least 5 percent of the value of the property or assets of the applicant or licensed health facility.
(3) Is an officer or director of a licensed health facility or applicant for licensure of a health facility that is organized as a corporation.
(4) Is a partner in a licensed health facility or applicant for licensure of a health facility that is organized as a partnership.
(5) Is a member of a licensed health facility or applicant for licensure of a health facility that is organized as a limited liability company.
(HSC 1253.2© 1-5)
“Ownership interest” means the possession of equity in the capital, the stock, the principal property and assets, or the profits of the licensed health facility. An ownership interest may be either direct or indirect.
(1) A direct ownership interest is an interest in the licensed health facility or applicant for licensure of a health facility.
(2) An indirect ownership interest is an ownership interest in an entity that itself has an ownership interest in a licensed health facility or of an applicant for licensure of a health facility.
(HSC 1253.2(j) 1-2)

Operated: “Operate” means to own, lease, sublease, establish, maintain, conduct the affairs of, or manage a skilled nursing facility.
(HSC 1253.2(k))

Managed: “Manage” means to assume operational control over a facility, to make financial decisions for the facility, to direct or control aspects of patient care and quality within the facility, or to be involved in the hiring, firing, supervision, and direction of direct care staff when these actions are completed by a management company hired, retained, or authorized to act on behalf of a licensee. Manage does not include financing exchanged between multifacility organizations.
(HSC 1253.2(g))

Involved or Nature of Involvement: A relationship in which the applicant owns, manages, or holds some form of management over the facility. Individuals with five (5) percent or more (direct or indirect) ownership interest and/or control interest.

Section A. Applicant Facility Information

1. Facility Name: Enter the name of the facility, agency, or clinic.
2. Facility Business Address: Enter the address where the facility, agency, or clinic provides services.
3. Type of Facility: Select the type of facility, agency, or clinic you are **involved** with identified in Section A.1 and A.2.
4. Type of Application: Select the type of application you are submitting.

   If selecting “Other” please specify the type of application, you are intending to submit using the options listed below.

   a. Change of Administrator (CHOA)
   b. Change of Administrator Designee (CHAD)
   c. Change of Agency Manager (CHAM)
   d. Change of Director of Nursing (DON)
   e. Change of Director of Patient Care Services (DPCS)
   f. Change of Director of Patient Care Services of Designee (DPCSD)
   g. Change of Governing Board (CHGB)
   h. Change of Indirect Ownership (CHIO)
   i. Change of Medical Director (CHMD)
   j. Change of Program Director (CHPD)
   k. Change of Stock Transfer (CHST)

Section B. Individual Information

1. Applicant Name: Enter the name of the individual filling out this form.

2. Nature of involvement to this Facility: Enter the title of the relationship the individual has with this facility.
   a. Administrator
   b. Administrator Designee
   c. Agent
   d. Board Member
   e. Director
   f. Director of Nursing
   g. Director of Patient Care Services
   h. Director of Patient Care Services Designee
   i. Licensee
   j. Manager of "Parent" organization
   k. Managing Employee of an HHA
   l. Medical Director
   m. Member
   n. Officer of corporation
   o. Owner
   p. Partner
   q. Program Director
   r. Property Owner
   s. Sole Proprietorship
   t. Stockholder – Ownership %
   u. Trustee
   v. Other (Specify)

3. Date of Birth: Enter the individual's date of birth in numerical format with two digits for the month, two digits for the date, and four digits for the year. (Ex. XX/XX/XXXX) Applicant must provide this information as required per Title 42 Code of Federal Regulations (CFR) section 455.104(b)(1).

4. Driver's License Number or State-Issued Identification Number: Enter driver's license number or state-issued identification number. Applicant must provide this information as required per Title 22 section 51000.35(c)(6).

   Submit a copy of the individual's driver's license or state- issued identification card and title as: "Section B.4 - Driver's License or State-Issued Identification Card".

5. Social Security Number: Applicant must provide this information as required per Title 42 Code of Federal Regulations (CFR) Section 455.104(b)(1).

   Pursuant to 42 Code of Federal Regulations (CFR) Section 455.104(b), Welfare and Institutions Code (W&I) section 14043.2,and the regulatory provider bulletin entitled, "Mandatory SSN Requirement for Medi-Cal Provider Applicants" applicants and individuals with a 5% or more ownership (direct or indirect) or control interest in an applicant are required to provide a social security number and date of birth when they submit an application for enrollment as a provider in the Medi-Cal program. These sections further state that an entity with a 5% or more ownership interest in the applicant must provide a tax identification number.

6. Select "yes" or "no" if you applied for any license for health care facility or community care facility using any other name than your legal name:
   If "yes" is selected, list the names used in the space provided.

7. If the applicant individual is the Administrator at the applicant facility, agency, or clinic in the diagram list the name and hours spent at the facility each week.
   If the applicant individual is the Administrator at more than one licensed and/or certified facility, in the diagram list the name of each facility and the number of hours spent at each during the week.

Section C. Criminal Record

1. Select “yes” or “no” if you have ever been convicted of an offense that is still on your record, whether misdemeanor or felony.

2. Select “yes” or “no” If there has been a judgment against you for Medicare, or Medicaid (Medi-Cal).

3. Select “yes” or “no” if there has been a judgment against you by a health care professional/technical licensing entity.

   If “yes” is selected for any questions, provide a written explanation, dates of misdemeanor or felony, and supporting documents. (Additional pages should be titled: “Section C – Criminal Record).

Section D. Professional Licenses / Certificates

If the qualifications for your role at the applicant facility requires a professional license and/or certificate, enter all relevant information:

Type of License/Certificate
Licensure or Certificate Number
Period Held
Issuing Agency

Section E. Employment/Business Summary (for the last 10 years)

Enter the following information for all employment experience from the last 10 years. If additional pages are required, title page “Section E - Employment/Business Summary” and provide the requested information for all additional employment experience.

- Employer Name
- From – To: Enter dates as two-digit month, two-digit day, and four-digit year. (Example. xx/xx/xxxx – xx/xx/xxxx)
- Address (Street & Number)
- City, State, Zip
- Job Title

If the employer is a licensed health care facility, agency, or clinic, provide the following information:

- Facility Name:
- Facility Type:
- Did you own, operate, or manage this facility, agency, or clinic? Yes No
- If yes, individual’s nature of involvement:

Section F. Facility, Agency, Clinic Involvement (In or out of California)

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

1. Select "yes" or "no" if the applicant has ever been **involved** with a business entity that operated a health care facility.
   If "yes" is selected, complete Section H (Facility Information Sheet).

2. Select "yes" or "no" if the applicant has **ever held five (5) percent** or more (direct or indirect) ownership interest and/or control interest in any of the facility types above.
   If "yes" is selected, then complete Section H (Facility Information Sheet).

Section G. Adverse Actions

Select "yes" or "no" if the applicant has ever been affiliated with any facility, either past or present, that has been identified as having one or more of the listed adverse actions.

If "yes" is selected, check **all** adverse actions listed that apply and explain the adverse action including the facility name, address, and dates of adverse action. (Any additional pages should be titled: "Section F- Adverse Actions Continued".)

Section H. Facility Information Sheet

This must be completed for each facility (including all facilities in all business entities) that the applicant has a current relationship with or has had a past relationship with in the last 3 years.

1. Facility Name (questions 1 – 6): Enter the name of the facility.
   a. Address: Enter the physical location of the facility.
   b. Facility Type: Choose the corresponding facility type from the list below. If "other", then the applicant must provide the type of facility that they have a relationship with.

- Acute Psychiatric Hospital (APH)
- Adult Day Health Center (ADHC)
- Alternative Birth Center (ABC)
- Ambulatory Surgery Center (ASC)
- Chemical Dependency Recovery Hospital (CDRH)
- Chronic Dialysis Clinic (CDC)
- Chronic Dialysis Clinic/End Stage Renal Dialysis (CDC/ESRD)
- Community Clinic (COMTYC)
- Community Clinic/Rural Health Clinic (COMTYC/RHC)
- Community Mental Health Center (CMHC)
- Comprehensive Outpatient Rehabilitation Facility (CORF)
- Congregate Living Health Facility (CLHF)
- Correctional Treatment Center (CTC)
- End Stage Renal Dialysis (ESRD)
- Free Clinic (FREEC)
- Free Clinic/Rural Health Clinic (FREEC/RHC)
- General Acute Care Hospital (GACH)
- Home Health Agency (HHA)
- Hospice Agency
- Hospice Facility (HOFA)
- Intermediate Care Facility (ICF)
- Intermediate Care Facility/Developmentally Disabled (ICF/DD)
- Intermediate Care Facility/Developmentally Disabled-Habilitative (ICF/DD-H)
- Intermediate Care Facility/Developmentally Disabled-Nursing (ICF/DD-N)
- Outpatient Physical Therapy/Speech-Language Pathology Provider (OPT/SP)
- Pediatric Day Health & Respite Care (PDHRC)
- Psychology Clinic (PSYCHC)
- Referral Agency (REFRLAG)
- Rehabilitation Clinic (REHABC)
- Rehabilitation Clinic/Comprehensive Rehabilitation Facility (REHABC/CORF)
- Rural Health Clinic (RHC)
- Skilled Nursing Facility (SNF)
- Surgical Clinic (SURGC)
- Surgical Clinic/Ambulatory Surgery Center (SURGC/ASC)

c. Nature of Involvement: Choose an option provided from the list below:

- Administrator
- Administrator Designee
- Agent
- Board Member
- Director
- Director of Nursing
- Director of Patient Care Services
- Director of Patient Care Services Designee
- Licensee
- Manager of "Parent" organization
- Managing Employee of an HHA
- Medical Director
- Member
- Officer of corporation
- Owner
- Partner
- Program Director
- Property Owner
- Sole Proprietorship
- Stockholder – Ownership %
- Trustee
- Other (Specify)

If "Stockholder" is selected, then the applicant must enter the amount of ownership percentage held.
If "other" is selected, the applicant must list the type of involvement.

d. Dates of Involvement: Enter the start and finish date of involvement.
If this relationship is still ongoing indicate the start date to "Current".

e. Entity Name: Enter the entity's name.

f. Business Entity Type: Select an option provided.
If "other" is selected, the applicant must indicate the type of entity.

g. Business Entity Employment Identification Number (EIN): Enter the businesses EIN number.

h. If any of the above Business entities are a "Parent" organization to the applicant facility, then select "yes".
If "yes" is selected, then explain in the space provided.

Applicant Release

Application must be signed by the individual applicant whom it is about. Provide signature and date.