STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF LEGAL AND REGULATORY SERVICES
HEALTH FACILITIES ADMINISTRATION
129 Pleasant Street, Concord, NH 03301
TDD Access: Relay NH 1-800-735-2964
Agency Phone: 603-271-9039

APPLICATION FOR RESIDENTIAL, HEALTH CARE LICENSE OR SPECIAL HEALTH CARE SERVICES

EXISTING FACILITY LICENSE #: —
CURRENT FACILITY LICENSE EXPIRATION DATE, IF APPLICABLE: —

THIS APPLICATION SHALL BE FILLED OUT IN ACCORDANCE WITH RSA 151:4. A SEPARATE APPLICATION MUST BE SUBMITTED FOR EACH LICENSURE CATEGORY. **PLEASE BE SURE TO COMPLETE THE ENTIRE APPLICATION**. IF A SECTION DOES NOT APPLY TO YOUR FACILITY, MARK NOT APPLICABLE (N/A). FAILURE TO COMPLETE THE APPLICATION WILL RESULT IN A DELAY IN THE LICENSURE PROCESS. SEND THE ENTIRE COMPLETED FORM TO THE ADDRESS ABOVE. IF YOU NEED TO REVIEW YOUR LICENSING RULES, THEY CAN BE FOUND ONLINE AT: https://www.dhhs.nh.gov/administrative-rules-health-facilities

Check all applicable items:

- ☐ License renewal:
- ☐ *New owner:
- ☐ **Change in address:
- ☑ *New facility:
- ☐ **Change in # of beds:
- ☐ Other (please explain):
- ☐ ***Change in classification:

* Requires processing as a new application.
** Requires Local Approval Forms
***Requires both

LICENSEE (Legal Owner of Facility): BENJAMIN VELEZ TELEPHONE #: (603) 866-6653

NAME OF FACILITY (DBA): HOMECARE BY BTS LLC TELEPHONE #: (603) 866-6658

FAX #: (___)_____

STREET ADDRESS: 2 PINNACLE ST CITY: HOOKSETT STATE: NH ZIP: 03106

MAILING ADDRESS: 2 PINNACLE ST CITY: HOOKSETT STATE: NH ZIP: 03106

ADMINISTRATOR: MONIQUE MISEIRVITCH, ADMINISTRATOR - STEFANIE SANTOMASSINO, CO-ADMINISTRATOR

MEDICAL DIRECTOR (IF APPLICABLE): N/A

FACILITY E-MAIL ADDRESS (REQUIRED): HOMECAREBYBTSLLC@OUTLOOK.COM

IF APPLICABLE:
NUMBER OF BEDS: PRESENTLY LICENSED: Ø TOTAL # TO BE LICENSED: Ø

NUMBER OF HCBC CFI OR STATE PLACED INDIVIDUALS IN HOME (Complete for He-P 804, He-P 805 and He-P 814): Ø

NUMBER OF ESRD STATIONS (Completed for He-P 811 licensees only):_____

BRANCH OFFICE LOCATIONS (Complete if applies under He-P 809.07, 819.07, 822.07 & 823.07 only):

OWNERSHIP

a. Type of ownership: ☐ Association ☐ Partnership ☐ Corporation ☒ LLC ☐ Individual ☐ Other (explain

b. List name and address of each person having an ownership interest (directly or indirectly) of greater than 5% in the facility.

c. If the licensee is organized as an association or corporation, list the name of the association or corporation and the name, address, and title of each officer.

d. If the licensee is a partnership, list the name and address of each partner.

e. Is this a certified facility? **(Facilities with deem status under RSA 151)** ☐ YES ☒ NO
Only applies to He-P 802, 803, 809, 811, 812, 815, & 823

If you are already a certified facility, is this an increase in services? If YES, please call 1-800-852-3345 ext. 9049

f. Are you planning on being a certified facility? If YES, please call 1-800-852-3345 ext. 9049

FEES:

Hospitals (General, CAH, Psychiatric, Rehabilitation) (802)	$25 per licensed bed
Free Standing Emergency Rooms (802)	$500
Nursing Homes (803)	$25 per licensed bed
Residential and Supported Residential Care Homes (804 & 805)	$15 per licensed bed (NO CHARGE FOR HCBC OR NH STATE PLACED RESIDENTS)
Non-Emergency Walk-In Care Centers (806)	$500
Residential Treatment and Rehabilitation Facilities (807)	$25 per licensed bed
Home Health Care Providers (809)	$250
Birthing Centers (810)	$150
End Stage Renal Disease Dialysis Centers (811)	$500
Ambulatory Surgical Centers (812)	$500
Intermediate Care Facilities for Individuals with Intellectual Disabilities(ICF/IID)(815)	$25 per licensed bed
Educational Health Centers (816)	$500
Adult Day Care Centers (818)	$200
Case Management Agencies (819)	$150
Home Care Service Provider Agencies (822)	Less than ten clients $25; Ten or more clients $250
Home Hospice Care Providers (823)	$250
Hospice Houses (824)	$25 per licensed bed
Substance Use Disorder Residential Treatment Facilities (826)	$25 per licensed bed
Freestanding Megavoltage Radiation Therapy Facility (827)	$500
Psychiatric Residential Treatment Programs (830)	$25 per licensed bed

A check or money order (payable to: TREASURER, **STATE OF NEW HAMPSHIRE**) must be attached to this application.

Applications submitted by those facilities exempt under RSA 151:4 I (a), (b) & (c) are not required to pay the license fee.

ADDITIONAL APPLICATION REQUIREMENTS: NOTE THAT NOT ALL APPLICATION REQUIREMENTS ARE LISTED HERE PLEASE REFER TO THE APPROPRIATE RULE TO DETERMINE OTHER ITEMS THAT NEED TO BE SUBMITTED.

1. Renewal applications must be submitted at least 120 days prior to expiration of the current license. **(Yearly)**

2. Include qualifications, including a resume with education and experience, and copies of all applicable licenses and certifications, for the administrator and medical director **(if applicable)**. **(Initial Application Only, unless changing Administrator or Medical Director)**

3. Include information relative to whether the facility has been granted any waivers, exemptions, or variances to the rules by the Department of Health and Human Services and/or the State Fire Marshal. **(Yearly)**

4. Include a floor plan indicating the location of all rooms, # of beds in each bedroom, and fire exits. **(Initial Application Only – NOT FOR He-P 809, 819, 820 & 823)**

5. Include NH Secretary of State Authority to do business in the State of NH and/or tradename registration **(Initial Application Only)**

6. Include written local approvals from the health officer, the building official, the zoning officer, and the fire chief. For a building under construction, the written approvals required shall be submitted at the time of the application based on the local official's review of the building plans and again upon completion of the construction project. **(Initial Application Only for ALL categories)**

7 Include documentation that the water supply has been tested in accordance with RSA 485 and Env-Dw 702.02 and 704.02 (formerly Env-Ws 313.01 and 314.01). **(Initial Application Only – NOT FOR He-P 809. 819, 820 & 823)**

8. Include documentation that **every 3 years** the water supply has been tested for bacteria and nitrates and determined to be at acceptable levels, in accordance with Env-Dw 702.02 (formerly Env-Ws 313.01) for bacteria and Env-Dw 704.02 (formerly Env-Ws 314.01) for nitrates. **(NOT FOR He-P809. 819, 820 & 823)**

9. Include a list of all employees who have previously been granted waivers for criminal background check results from the Department of Health and Human Services. **(Yearly and on initial application if change of ownership or category)**

10 Include the results of a criminal records check to include results for the state of New Hampshire for the applicant(s), the licensee (owner even if entity) if different than the applicant, the administrator, medical director and, if applicable, each household member 17 years of age or older who resides at the facility. **(Initial Application Only)**

FACILITY SERVICE DESCRIPTION: Complete even on renewal

The following information will be used to determine which licensure category your facility will be placed in.

I. Provide a detailed description of the services and programs you wish to provide.

*II. Describe the facility's health care you wish to provide to residents.

*III. Identify who will provide the health care listed in II.

*To be completed if applying for beds

SIGNATURES: This application must be signed by:

1. The owner if a private facility;
2. Two officers if a corporation;
3. Two authorized individuals if an association or partnership; or
4. The head of the government agency if a government unit.

I affirm that I am familiar with the requirements of RSA 151 and the rules adopted thereunder and that the premises are in full compliance. I understand that providing false information shall be grounds for denial, suspension, or revocation of the license and the imposition of a fine.

DATE: 2-13-24 SIGNED: [signature] Owner, Licensee
(NAME AND TITLE)

DATE: _____ SIGNED: _____
(NAME AND TITLE)

For all facilities to be newly licensed as an ambulatory surgical center (He-P 812), hospital (He-P 802), birthing center (He-P 810), walk in care center (He-P 806), dialysis center (He-P 811), or special health care service (He-P 802 and He-P 827) located within a 15 mile radius of a hospital certified as a critical access hospital, pursuant to 42 C.F.R. section 485.610 (b) and (c):

I affirm that I have complied with 151:4-a and a determination is on file with the department that finds the proposed health care facility shall be allowed to apply for licensure.

DATE: _____ SIGNED: _____
(NAME AND TITLE)

DATE: _____ SIGNED: _____
(NAME AND TITLE)

HFA OFFICE USE ONLY

CHECK NUMBER: 1018 AMOUNT: 250.00

APPLICATION COMPLETE: _____ NOT COMPLETE: _____ (Describe in comments)

NEW ☑ RENEWAL ☐ CHANGE ☐

QUALIFICATIONS OF ADMINISTRATOR	Required	☐	Not Required	☐	Received	☐
COPY OF ADMINISTRATOR LICENSE	Required	☐	Not Required	☐	Received	☐
LIST OF EMPLOYEES WITH WAIVERS	Required	☐	Not Required	☐	Received	☐
WATER TEST (INITIAL OR 3YR)	Required	☐	Not Required	☐	Received	☐
FLOOR PLAN*	Required	☐	Not Required	☐	Received	☐
SECRETARY OF STATE INFORMATION	Required	☐	Not Required	☐	Received	☐
LOCAL APPROVAL	Required	☐	Not Required	☐	Received	☐
LSC INSPECTION	Required	☐	Not Required	☐	Received	☐
LSC PLAN OF CORRECTION	Required	☐	Not Required	☐	Received	☐
LICENSURE INSPECTION	Required	☐	Not Required	☐	Received	☐
PLAN OF CORRECTION	Required	☐	Not Required	☐	Received	☐
COMPLIED WITH RSA 151:4-a	Required	☐	Not Required	☐	Received	☐

FEDERAL FACILITY (EXEMPT FROM INSPECTION) YES ☐ NO ☐

LICENSURE CATEGORY:

- ☐ 02 Hospitals (General, CAH, Psychiatric, Rehabilitation)
- ☐ 03 Nursing Homes
- ☐ 04 Residential Care Home Facility
- ☐ 05 Supported Residential Health Care Facility
- ☐ 06 Non-Emergency Walk-in Care
- ☐ 07 Residential Treatment & Rehabilitation Facility
- ☐ 09 Home Health Care Provider
- ☐ 10 Birthing Center
- ☐ 11 End Stage Renal Disease Dialysis
- ☐ 12 Ambulatory Surgical Center
- ☐ 14 Community Residence
- ☐ 15 ICF/IID
- ☐ 16 Educational Health Services
- ☐ 18 Adult Day Care
- ☐ 19 Case Management
- ☐ 22 Home Care Service Provider
- ☐ 23 Home Hospice Care Provider
- ☐ 24 Hospice House
- ☐ 26 Substance Use Disorder Res Treatment Facility
- ☐ 27 Freestanding Megavoltage Radiation Therapy
- ☐ 30 Psychiatric Residential Treatment

REVIEWED BY: _____
(NAME & TITLE) (DATE)

ISSUE ANNUAL LICENSE: YES ____ NO ____

LICENSE CERTIFICATE DATES: FROM _____ TO _____

NUMBER OF PATIENTS/STATIONS/BEDS: _____

NOTES:

COMMENTS ON CERTIFICATE:

BTS Home Care

BTSHOMECARE.COM BTSLLCHOMECARE2023@OUTLOOK.COM 603 866 6658

Home Care by BTS LLC Description of Services

The company Home Care by BTS LLC will be offering the public the following Personal Home Care Services.

1-Personal Appearance including: personal grooming and personal hygiene.

2-Shopping and Meal Preparation including: shop for food and prepare meals according to their diet.

3-Mobility Assistance including: walking, exercising and transferring.

4-Transportation via (BTS LLC Non-Emergency Medical Transport Services) including: Ambulatory, Wheelchair & Stretcher transport.

5-Housekeeping includes: light housekeeping, vacuuming, dusting and trash emptying.

6-Companionship.

-We will employ nursing staff for initial client assessments and continuous follow-ups, caregivers in house training.

-Also, we will employ LNA's, and unexperienced caregiver staff (to be trained and qualified inhouse) We will NOT practice any Health-Related activities whatsoever.

-All our clients will be in their own residences, and we will travel on a scheduled weekly basis or as agreed by all parties.

-Our projected area of service will consist of the southern NH area including areas of the Merrimack and Hillsborough counties.

-Our clientele will consist of government assisted and private pay.

State of New Hampshire

Department of State

Accepted Date:	**06/02/2023**
Business Name:	**HOME CARE BY BTS LLC**
Principal Office Address:	**2 Pinnacle St, Hooksett, NH, 03106, USA**

RE: Acceptance of Business Formation

This letter is to confirm the acceptance of the following business formation:

Business ID:	**932273**
Filing #:	**6233064**
Expiration Date:	**Perpetual**
Effective Date:	**05/17/2023**
Payment Transaction #:	**20239980776369001**

To maintain your business registration in good standing, you must maintain a Registered Agent at all times. You must also file an annual report no later than April 1st of each year. To file your annual report please go to https://quickstart.sos.nh.gov/online/Account.

It is incumbent upon you to keep this office informed of address or email changes to ensure that all communications from our office reaches you. There is no charge for address changes.

Please visit our website for helpful information regarding all your business needs. If you require assistance or should you have any questions, you may contact the Corporation Division using the information provided below.

Please reference your Business ID in your communication.

Thank you,

New Hampshire Department of State
Corporation Division

State of New Hampshire
Department of State

Filed
Date Filed : 05/17/2023 04:32:00 PM
Effective Date : 05/17/2023 04:32:00 PM
Filing # : 6233064 Pages : 2
Business ID : 932273
David M. Scanlan
Secretary of State
State of New Hampshire

Form LLC-1
RSA 304-C:31

CERTIFICATE OF FORMATION
NEW HAMPSHIRE LIMITED LIABILITY COMPANY

THE UNDERSIGNED, under the New Hampshire Limited Liability Company Laws submits the following certificate of formation:

FIRST: The name of the limited liability company is:

HOME CARE BY BTS LLC

Principal Business Information:

Principal Office Address:

2 Pinnacle St	**Hooksett**	**NH**	**03106**
(no. & street)	(city/town)	(state)	(zip code)

Principal Mailing Address (if different):

2 Pinnacle St	**Hooksett**	**NH**	**03106**
(no. & street)	(city/town)	(state)	(zip code)

Business Phone: **6038666653**

Business Email: **HCBYBTSLLC2023@HOTMAIL.COM**

Notification Email: **HCBYBTSLLC2023@HOTMAIL.COM**

_____ Please check if you would prefer to receive the Annual Report Reminder Notice by email.

SECOND: Describe the nature of the primary business or purposes (and if known, list the NAICS Code and Sub Code):

Other / NON MEDICAL HOME CARE AGENCY

THIRD: The name of the limited liability company's initial registered agent is:

Benjamin Velez

The complete address of its registered office (agent's business address) is:

2 Pinnacle St	**Hooksett**	**NH**	**03106**
(no. & street)	(city/town)	(state)	(zip code)

FOURTH: The management of the limited liability company **is** vested in a manager or managers.

The period of its duration is: **Perpetual**

Manager/Member Information:

Name	Title	Address
Benjamin Velez	Manager	2 Pinnacle St, Hooksett, NH, 03106, USA

State of New Hampshire
Department of State
2024 ANNUAL REPORT

Filed
Date Filed: 1/23/2024
Effective Date: 1/23/2024
Business ID: 932273
David M. Scanlan
Secretary of State

BUSINESS NAME:	**HOME CARE BY BTS LLC**
BUSINESS TYPE:	**Domestic Limited Liability Company**
BUSINESS ID:	**932273**
STATE OF FORMATION:	**New Hampshire**

CURRENT PRINCIPAL OFFICE ADDRESS	CURRENT MAILING ADDRESS
2 Pinnacle St Hooksett, NH, 03106, USA	**2 Pinnacle St Hooksett, NH, 03106, USA**

REGISTERED AGENT AND OFFICE	
REGISTERED AGENT:	**Benjamin Velez**
REGISTERED AGENT OFFICE ADDRESS:	**2 Pinnacle St Hooksett, NH, 03106, USA**

PRINCIPAL PURPOSE(S)	
NAICS CODE	NAICS SUB CODE
OTHER / NON MEDICAL HOME CARE AGENCY	

MANAGER / MEMBER INFORMATION		
NAME	BUSINESS ADDRESS	TITLE
Benjamin Velez	**2 Pinnacle St, Hooksett, NH, 03106, USA**	**Manager**

I, the undersigned, do hereby certify that the statements on this report are true to the best of my information, knowledge and belief.

Title: **Manager**

Signature: **benjamin velez**

Name of Signer: **benjamin velez**

State of New Hampshire

Department of State

CERTIFICATE OF EXISTENCE

OF

HOME CARE BY BTS LLC

This is to certify that **HOME CARE BY BTS LLC** is registered in this office as a **New Hampshire Limited Liability Company** to transact business in New Hampshire on 5/17/2023 4:32:00 PM.

Business ID: **932273**

IN TESTIMONY WHEREOF,
I hereto set my hand and cause to be affixed
the Seal of the State of New Hampshire,
this 17th day of May A.D. 2023

David M. Scanlan
Secretary of State

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH & HUMAN SERVICES
Bureau of Licensing and Certification
HEALTH FACILITIES ADMINISTRATION
129 Pleasant Street, Concord, New Hampshire 03301-3857
TDD Access: Relay NH 1-800-735-2964
Agency Phone Number: 603-271-9039

- [x] Initial Licensing – This includes a change in ownership or address other than a 911 change
- [ ] A change in current licensing category
- [ ] New Construction and/or Renovation of Existing Building
- [ ] An increase in occupancy (ie: Beds, ESRD Stations or Clients)

Please note: All applicants must have each final inspection signed by local officials, even if they do not see clients at their place of business. This is to confirm that the local authorities are aware that a business is operating at the identified location and that the business complies with all local ordinances pursuant to RSA 151:4,III(3).

Please note: Applicants that are planning new construction, modifying/renovating or requesting a bed increase that involves modifications to the building must have both the plan review sections as well as the final inspection sections of the form completed and signed by building and fire officials.

FACILITY NAME: HOME CARE BY BTS LLC
STREET ADDRESS: 2 PINNACLE ST HOOKSETT N.H. 03106
OWNERS'S NAME: BENJAMIN VELEZ
ADMINISTRATOR NAME: MONIQUE MISIERVITCH
TELEPHONE NUMBER: 603 866-6653
PROPOSED TYPE OF FACILITY: NON-MEDICAL HOME CARE AGENCY (HOME OFFICE)
Local authorities please complete and sign each section:
NOTE: NO PHYSICAL BUSINESS WILL BE CONDUCTED OUT OF LOCATION ALL WORK WILL BE REMOTE

HEALTH OFFICER

I HEREBY CERTIFY THAT THE ENTITY X HOME CARE BY BTS LLC COMPLIES WITH ALL APPLICABLE HEALTH, SEWAGE AND WATER REGULATIONS FOR THE CITY/TOWN OF Hooksett

I HEREBY CERTIFY THAT THE CITY/TOWN OF Hooksett DOES NOT REQUIRE HEALTH, SEWAGE AND WATER APPROVAL OF THIS FACILITY/ESTABLISHMENT.

NUMBER OF BEDS/CLIENTS: 0

FINAL INSPECTION: DATE: 1/24/2024 SIGNATURE: Dan
(NAME AND TITLE OF HEALTH OFFICIAL)

BUILDING REGULATIONS

I HEREBY CERTIFY THAT THE CITY/TOWN OF Hooksett BUILDING DEPARTMENT HAS REVIEWED THE PLANS FOR HOME CARE BY BTS LLC ON 1/24/2024 APPROVED X DENIED ___

PLAN REVIEW: DATE: 1/24 SIGNATURE: Dan
(NAME AND TITLE OF BUILDING OFFICIAL)

I HEREBY CERTIFY THAT THE CITY/TOWN OF _____ BUILDING DEPARTMENT HAS INSPECTED _____ ON _____ AND OBSERVED THE FOLLOWING VIOLATIONS:

_____

_____

I HEREBY CERTIFY THAT THE CITY/TOWN OF _____ BUILDING DEPARTMENT HAS INSPECTED _____ ON _____ AND ALL PREVIOUS VIOLATIONS HAVE BEEN CORRECTED.

I HEREBY CERTIFY THAT THE CITY/TOWN OF _____ BUILDING DEPARTMENT HAS INSPECTED _____ ON _____ AND FOUND NO VIOLATIONS OF THE BUILDING CODE.

I HEREBY CERTIFY THAT THE CITY/TOWN OF _____ DOES NOT HAVE LOCAL BUILDING CODES OR REGULATIONS.

NUMBER OF BEDS/CLIENTS: 0

FINAL INSPECTION: DATE: _____ SIGNATURE: _____
(NAME AND TITLE OF BUILDING OFFICIAL)

ZONING REGULATIONS

I HEREBY CERTIFY THAT THE ENTITY Howe Cave by BTS LLC COMPLIES WITH ALL APPLICABLE ZONING REGULATIONS FOR THE CITY/TOWN OF Hooksett

I HEREBY CERTIFY THAT THE CITY/TOWN OF _____ DOES NOT HAVE LOCAL ZONING REGULATIONS.

NUMBER OF BEDS/CLIENTS: 0

FINAL INSPECTION: DATE: 1/24/2024 SIGNATURE: _____
(NAME AND TITLE OF ZONING OFFICIAL)

FIRE REGULATIONS

THIS CITY/TOWN USES THE FOLLOWING FIRE CODES: (EXAMPLE NFPA 101 CHAPTER _____.)

2018 NFPA 101 + 2018 NFPA 1

I HEREBY CERTIFY THAT THE CITY/TOWN OF _____ FD HAS REVIEWED THE PLANS FOR _____ ON _____ APPROVED ___ DENIED ___

PLAN REVIEW: DATE: _____ SIGNATURE: _____
(FIRE CHIEF OR DESIGNEE)

I HEREBY CERTIFY THAT THE CITY/TOWN OF _____ FD HAS INSPECTED _____ ON _____ AND OBSERVED THE FOLLOWING VIOLATIONS:

I HEREBY CERTIFY THAT THE CITY/TOWN OF # _____ FD HAS INSPECTED _____ ON _____ AND ALL PREVIOUS VIOLATIONS HAVE BEEN CORRECTED.

I HEREBY CERTIFY THAT THE CITY/TOWN OF Hooksett FD HAS INSPECTED 2 Pinnacle Street ON 1/22/24 AND FOUND NO VIOLATIONS OF THE STATE AND/OR LOCAL MUNICIPAL FIRE CODE.

NUMBER OF BEDS/CLIENTS: N/A

FINAL INSPECTION: DATE: _____ SIGNATURE: _____ - Captain
(FIRE CHIEF OR DESIGNEE)

Monique Miseirvitch

[redacted]

PROFESSIONAL SUMMARY

Fully credentialed RN with over 21 years of experience as an LPN in the healthcare industry. Graduated from the ASN program April, 2016. Comprehensive nursing career encompassing multiple disciplines including med surg, IPCU, rehab, CLC, ICU, Hospice, Homecare, Nurse manager, Operations manager and Certified Dementia Practitioner

SKILL HIGHLIGHTS

Acute and rehabilitative care
Health and wellness expertise
Telemetry
ELNEC trainir
Geriatric trea
Acute and rel
Therapy m
Mobility assis
Colostomy ca
Phlebotomy
Obtain EKGs
IV/PICCS

Psych and mental health care proficiency
Broad medical terminology knowledge
Diagnostic tools experience
urally sensitive
ng medical ethic
puterized charting specialist
etes, Hospice and Stroke Patient
re
nd cleaning/care expertise
tion control standards expert
cation Administration
h care

ADMINISTRATOR

RIENCE

W 03/07/2021 to current

RN Operations Manager 01/2017 to 02/2021
Nurse Manager 10/2016 to 01/2017
Right At Home Homecare-Londonderry, NH

- Started out as the Nurse Manager, and 3 months later promoted to the Operations Manager.
- Responsibilities include recruiting, hiring and training all new hires, both internal and field staff. Perform all the on-boarding, background checks and e-verifies. HR
- Oversee approx. 110 caregivers, 4 office staff employees, and 95 homecare clients.
- Provide continuing education for the caregivers throughout the year, including CPR certification classes.
- Provide the field client intakes and oversee the cases along with creating and updating of care plans pursuant to our state regulations.
- Manage and oversee the Safety Committee, QA, and emergency contingency plans.

- Assisted patients with multiple chronic diagnoses including COPD and asthma
- Evaluated patient care needs, prioritized treatment and maintained patient flow
- Accurately documented all elements of nursing assessment, treatments, medications, discharge instructions and follow-up care
- Utilized strong assessment skills to determine necessary patient care
- Provided quality nursing care in accordance with resident care policies and procedures
- Worked as part of team to ensure proper care of body mechanics and safety of patient
- Partnered with team of Registered Nurses to ensure over all well-being of all patients
- Tested glucose and administered injections. Maintained patient charts and confidential files
- Assessed patients in active withdrawal and provided interventions to manage physical and psychological withdrawal symptoms. Recorded patients' medical history, vital statistics and test results in medical records
- Actively participated in unit-based Quality Assurance Program
- Implemented new floor assignments based on evaluation of staffing requirements
- Assisted patients with healing and recovery after surgery
- Provided necessary health education training for patients
- Was an active member of the LPN board at the VA and involved in the hiring process and GS ratings
- Was a BCMA super user and educated staff on the proper usage of the facilities barcode administration. I provided coverage for when the lead, Debbie Sullivan was on vacations.
- Was ACLS certified, but let it expire after ICU floor closed
- Assessing learning needs, developing plan for providing education with family/significant others and providing/supervising education to patient and significant others

EDUCATION AND TRAINING

ASN: RN, 2016 **St. Joseph's School of Nursing** - Nashua, NH, USA
Class adviser; Graduated with Honors

LPN: Nursing, 1995 **St. Joseph's School of Nursing** - Nashua, NH, USA
Graduated with Honors

PROFESSIONAL MEMBERSHIPS

National Student Nurses Association

LICENSES AND CERTIFICATIONS

RN license in NH
Red Cross certified CPR Instructor
CPR certified through American Heart Association
Certified Dementia Practitioner
SAVVY caregiver Practitioner
Loss control coordinator from the Lawson Group

- Work with the Long-term Care insurance companies to ensure accuracy in billing and receiving.
- Administer employee benefits, both voluntary and employer paid.
- Creating and maintaining referral relationships with community recruitment resources
- Employee relations, including managing absence, disciplinaries, grievances and sickness
- Measuring employee satisfaction and identifying areas that require improvement
- Providing guidance on development for managers and their teams
- Monitor compliance for local and federal labor and safety laws including EOE, ADA, FMLA and OSHA
- Prepare for bi-annual state licensure audit from Health and human Services ensuring accuracy/completeness of all client and care staff files
- Sales support back-up
- Ensuring all company policies and procedures are up to date in line with current employment law.
- Work alongside bookkeeper with A/R

Nursing Field Supervisor, 08/2013 to 10/2016
MAS Homecare - Manchester, NH

- Started out at the agency as a part-time on-call specialist; later became full-time by becoming active in the field. Responsibilities include: assessing, planning, implementing, documenting and evaluating nursing care of homecare clients, often with multiple comorbidities
- Provide behavioral/emotional support and supervision for those with dementia and Alzheimer's
- Take and record patients' VS utilizing strong assessment skills to determine necessary care
- Work as part of team to ensure proper care of body mechanics and safety of patient
- Develop care plans and work closely with case managers, providers and others to make sure they have the necessary equipment needed to remain in the home setting
- Deliver high-quality and compassionate treatment to indigent and low-income patient community.
- Sound, ethical and independent decision-making ability consistent with medical protocols
- Disciplined, energetic employee who quickly establishes rapport with patients and colleagues
- Oversee approx. 45 caregivers in the patient's homes to assure they are providing appropriate care according to the developed care plans
- Taught PCSP classes to new employees for approx. 1 year, and did the mandatory review classes of current employees

Monique Miseirvitch

LPN, 04/1995 to 11/2014
VA Medical Center - Manchester, NH

- Managed caseload of 20 + clients, providing education, treatments, IV therapy, venipuncture and wound care
- Provided behavioral/emotional support and supervision for those with dementia and Alzheimer's
- Assisted patients with multiple chronic diagnoses including COPD and asthma
- Evaluated patient care needs, prioritized treatment and maintained patient flow

BTS Home Care

STATEMENT OF NON-CONVICTION; MONIQUE MISEIRVITCH (ADMINISTRATOR)

I UNDER PENALTY OF PURJURY I ATTEST THAT I HAVE NOT BEEN CONVICTED OF ANY FELONIES IN THIS AND ANY OTHER STATE.

I HAVE NOT BEEN CONVICTED OF SEXUAL ASSAULT, ANY VIOLENT CRIME, ASSAULT, FRAUD, THEFT, ABUSE NEGLECT OR EXPLOITATION OR POSE A THREAT TO THE HEALTH, SAFETY OR WELL-BEING OF A CLIENT.

I DO NOT HAVE A NEGATIVE FINDING BY THE DEPARTMENT OR ANY ADMINISTRATIVE AGENCY IN THIS OR ANY OTHER STATE FOR ASSAULT, FRAUD, THEFT, ABUSE, NEGLECT, OR EXPLOITATION OF ANY PERSON.

SIGNED: Monique Miseirvitch

DATED: 2-13-24

NEW HAMPSHIRE
Online Licensing

nh.gov Licensing Home

Person Information

Name: MONIQUE MISEIRVITCH
NH Multi-state license

License Information

License No:	073864-21
Profession:	Nursing
License Type:	Registered Nurse
License Status:	Active
Issue Date:	6/21/2016
Expiration Date:	10/31/2025

Discipline Information

No Discipline Information

Remarks

Board Action

No Related Documents

Disclaimer: The JCAHO and the NCQA consider on-line status information as fulfilling the primary source requirement for verification of licensure in compliance with their respective credentialing standards.

Stefanie Santomassino
[redacted]

Skills:

LNA(License nursing assistant), MNA (medication nursing assistant) , CPR certified, Alzheimer's training ,
Unit Coordinator the computer, booking transportation, fili

ALT ADMINISTRATOR
DIRECTOR OF SERVICES

Experience:

October 2015-to
Bedford Hills Ce
30 Colby Court,
Unit Coordinato

I am in charge of met. Which includes booking all necessary appoir eavily on the computer system and am responsil our inhouse specialty doctors, on a revolving ba and give residents all their medication inclu

April 2009- August 2015
Pine Hill Assisted Living
35 N Lowell Rd, Windham, NH 03087
Weekend Supervisor

I was the weekend supervisor of15 residents. I was to assist the residents with their medication, I would make lunch and supper for all residents and just oversee the weekend and attend to all of their needs.

August 2004-April-2009
Home Instead Senior Home Care
100A Middle St, Manchester, NH 03101

Home Health Aide- I was assigned permanent clients where I would go into their home on a weekly basis sometimes more to help them with all their needs,(housework, shopping and showering and companionship)

March 2000-June2004
Macwac Mortgage
Rt 28 Derry, NH
Loan Processor

My job was to collect the mortgage applications and present them to the banks/ Lenders , they would then go over the application and inform me of what the clients need to be able to complete the mortgage process. I was also a loan officer assistant ,getting the clients ready and their needs to buy their home.

Education:

High School Graduate 1992
Lawrence High School
70-71 N Parish Rd,
Lawrence, MA 01843

Alzheimer's training
Dementia training
Licensed nursing assistant
Medication Nursing assistant
Loan officer Certified

BTS Home Care

STATEMENT OF NON-CONVICTION; STEFANIE SANTOMASSINO (ALT ADMIN, DIRECTOR OF SERVICES)

I UNDER PENALTY OF PURJURY I ATTEST THAT I HAVE NOT BEEN CONVICTED OF ANY FELONIES IN THIS AND ANY OTHER STATE.

I HAVE NOT BEEN CONVICTED OF SEXUAL ASSAULT, ANY VIOLENT CRIME, ASSAULT, FRAUD, THEFT, ABUSE NEGLECT OR EXPLOITATION OR POSE A THREAT TO THE HEALTH, SAFETY OR WELL-BEING OF A CLIENT.

I DO NOT HAVE A NEGATIVE FINDING BY THE DEPARTMENT OR ANY ADMINISTRATIVE AGENCY IN THIS OR ANY OTHER STATE FOR ASSAULT, FRAUD, THEFT, ABUSE, NEGLECT, OR EXPLOITATION OF ANY PERSON.

SIGNED: Stefanie E Santomassino

DATED: 2-13-24

NEW HAMPSHIRE Online Licensing

nh.gov Licensing Home

Person Information

Name: STEFANIE E SANTOMASSINO

License Information

License No:	055528-MNA
Profession:	Nursing Assistants
License Type:	Medication Nursing Assistant
License Status:	Active
Issue Date:	7/11/2018
Expiration Date:	9/30/2025

Discipline Information

No Discipline Information

Remarks

Board Action

No Related Documents

Disclaimer: The JCAHO and the NCQA consider on-line status information as fulfilling the primary source requirement for verification of licensure in compliance with their respective credentialing standards.

NEW HAMPSHIRE
Online Licensing

nh.gov Licensing Home

Person Information

Name: STEFANIE E SANTOMASSINO

License Information

License No:	055528-24
Profession:	Nursing Assistants
License Type:	Licensed Nursing Assistant
License Status:	Active
Issue Date:	9/25/2015
Expiration Date:	9/30/2025
Temporary Issue Date:	
Temporary Expiration Date:	

Discipline Information

No Discipline Information

Remarks

Board Action

No Related Documents

Disclaimer: The JCAHO and the NCQA consider on-line status information as fulfilling the primary source requirement for verification of licensure in compliance with their respective credentialing standards.

Curran, Marilee

From:	Curran, Marilee
Sent:	Thursday, February 22, 2024 3:03 PM
To:	benjamin velez
Cc:	Beyer, Paulette
Subject:	Application Home Care by BST LLC - Hooksett

Good afternoon Benjamin:

In accordance with RSA 151-A:14, the Office of Legal and Regulatory Services hereby acknowledges receipt of your application and fees in the amount of $ 250.00 for a Home Care Service Provider. (I have requested a refund for the overpayment)

Review of your application indicates that it has been completed in accordance with RSA 151:4, and He-P 822, the rules of the Office of Legal and Regulatory Services for a Home Care Service Provider.

Staff from this office are available for consultation visits to assist you in achieving compliance. In order to receive a license you must be in full compliance with all applicable laws and rules at the time of your inspection.

Accordingly, an inspection of your facility/agency will occur within the next 60 days to determine compliance with RSA 151, and He-P 822. After the inspection is complete, you will be notified as to the Office of Legal and Regulatory Services decision to approve or deny your application for licensure as a Home Care Service Provider under RSA 151.

If you have any questions regarding your application the application process or the provisions of RSA 151 and the rules of the Office of Legal and Regulatory Services which apply to your licensure request, Please do not hesitate to contact me

Marilee D. Curran, MS
Licensing Database Administrator
DHHS
Health Facilities Administration-Licensing
129 Pleasant St.
Concord, NH 03301
Phone (603) 271-9041
Fax (603) 271-4968