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

1 r 9

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:

New Home Health Care Provider

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

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

LICENSEE (Legal Owner of Facility): Quality Care Services LLC TELEPHONE #: (603) 707-9655

NAME OF FACILITY (DBA): Quality Care Services LLC TELEPHONE #: (603) 707-9655

FAX #: (___) _____

STREET ADDRESS: 32 C Whittier Highway, Suite 203C CITY: Moultonborough STATE: NH ZIP: 03254

MAILING ADDRESS: 32 C Whittier Highway, Suite 203C CITY: Moultonborough STATE: NH ZIP: 03254

ADMINISTRATOR: Kristen Griffin

MEDICAL DIRECTOR (IF APPLICABLE): Julie Furlan DO

FACILITY E-MAIL ADDRESS (REQUIRED): info@qualitycarehh.com

IF APPLICABLE: N/A
NUMBER OF BEDS: PRESENTLY LICENSED: N/A TOTAL # TO BE LICENSED: N/A

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

NUMBER OF ESRD STATIONS (Completed for He-P 811 licensees only): N/A

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. See attached

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.
N/A

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

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
N/A

f. Are you planning on being a certified facility? If YES, please call 1-800-852-3345 ext. 9049
No.

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)**
   N/A
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)**
   See attached.
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)**
   N/A
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)**
   N/A
5. Include NH Secretary of State Authority to do business in the State of NH and/or tradename registration **(Initial Application Only)**
   See attached letter rejecting name pending letter from DHHS.
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)**
   See attached.
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)**
   N/A
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)**
   N/A
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)**
   N/A
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)**
    See attached.

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.
   See attached.

*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: 03/11/24 SIGNED: Kristen Griffin, Administrator
(NAME AND TITLE)

DATE: 03/14/2024 SIGNED: Peter Kelly
(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: 239 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:

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

☒ 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: Quality Care Services LLC
STREET ADDRESS: 32 C Whittier Highway Suite 203C, Moultonborough, NH 03245
OWNERS'S NAME: Quality Care Services LLC
ADMINISTRATOR NAME: Kristen Griffin
TELEPHONE NUMBER: 603 707-9655
PROPOSED TYPE OF FACILITY: Office for Home Health Agency & Hospice

Local authorities please complete and sign each section:

HEALTH OFFICER

I HEREBY CERTIFY THAT THE ENTITY 32 C Whittier Hwy Suite 203C COMPLIES WITH ALL APPLICABLE HEALTH, SEWAGE AND WATER REGULATIONS FOR THE CITY/~~TOWN~~ OF Moultonborough

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

NUMBER OF BEDS/CLIENTS: N/A

FINAL INSPECTION: DATE: 3-1-24 SIGNATURE: _____
(NAME AND TITLE OF HEALTH OFFICIAL)

BUILDING REGULATIONS

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

PLAN REVIEW: DATE: _____ SIGNATURE: _____
(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 Moultonborough BUILDING DEPARTMENT HAS INSPECTED 326 Whittier Hwy Suite 203C ON 3-1-24 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: _____

FINAL INSPECTION: DATE: 3-1-24 SIGNATURE: _____
(NAME AND TITLE OF BUILDING OFFICIAL)

ZONING REGULATIONS

I HEREBY CERTIFY THAT THE ENTITY 326 WHITTIER HIGHWAY SUITE 203C COMPLIES WITH ALL APPLICABLE ZONING REGULATIONS FOR THE CITY/TOWN OF ~~MOULTONBOROUGH, NH~~

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

NUMBER OF BEDS/CLIENTS: NO CLIENTS ON SITE

FINAL INSPECTION: DATE: 3/1/24 SIGNATURE: _____
(NAME AND TITLE OF ZONING OFFICIAL)

FIRE REGULATIONS

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

_____

_____

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 _____ FD HAS INSPECTED _____ ON _____ AND FOUND NO VIOLATIONS OF THE STATE AND/OR LOCAL MUNICIPAL FIRE CODE.

NUMBER OF BEDS/CLIENTS: _____

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

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: _____

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

ZONING REGULATIONS

I HEREBY CERTIFY THAT THE ENTITY _____ COMPLIES WITH ALL APPLICABLE ZONING REGULATIONS FOR THE CITY/TOWN OF _____

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

NUMBER OF BEDS/CLIENTS: _____

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

FIRE REGULATIONS

THIS CITY/TOWN USES THE FOLLOWING FIRE CODES: (EXAMPLE NFPA 101 CHAPTER 2016.)

_____

_____

I HEREBY CERTIFY THAT THE CITY/TOWN OF Maryland borough FD HAS REVIEWED THE PLANS FOR Quality Care Services LLC ON 3/1/24 APPROVED ✓ DENIED ____

PLAN REVIEW: DATE: 3/1/24 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 _____ FD HAS INSPECTED _____ ON _____ AND FOUND NO VIOLATIONS OF THE STATE AND/OR LOCAL MUNICIPAL FIRE CODE.

NUMBER OF BEDS/CLIENTS: _____

FINAL INSPECTION: DATE: 3/1/24 SIGNATURE: ✓ _____
(FIRE CHIEF OR DESIGNEE)

Supplemental Materials for Application for Home Health Care Provider License
Quality Care Services LLC

OWNERSHIP

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

Matt Ritz, [redacted]

Peter Kelly, [redacted]

FACILITY SERVICE DESCRIPTION

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

Quality Care Services LLC will provide, directly or through contract arrangement, one or more of the following services: nursing services; home health aide services; and other therapeutic and related services, which can include, but are not limited to; physical and occupational therapy; speech pathology; nutritional services; medical social services; and personal care services.

State of New Hampshire

Department of State

QUALITY CARE SERVICES LLC
Paul Joseph Phillips
900 Elm Street, 19th Floor
P.O. Box 3600
Manchester, NH 03105

State of New Hampshire
Department of State

Date Submitted: 3/5/2024
David M. Scanlan
Secretary of State

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:

QUALITY CARE SERVICES LLC

Principal Business Information:

Principal Office Address:

32C Whittier Highway #203C	**Moultonborough**	**NH**	**03254**
(no. & street)	(city/town)	(state)	(zip code)

Principal Mailing Address (if different):

32C Whittier Highway #203C	**Moultonborough**	**NH**	**03254**
(no. & street)	(city/town)	(state)	(zip code)

Business Phone: **6037079655**

Business Email: **info@qualitycarehh.com**

Notification Email: **info@qualitycarehh.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):

62-Health Care and Social Assistance - 610-Home Health Care Services

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

Primmer Piper Eggleston & Cramer PC (598874)

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

900 Elm Street 19Fl	**Manchester**	**NH**	**03101**
(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
Net45 LLC	Manager	251 Little Falls Drive, Wilmington, DE, 19808, USA

Title: **Attorney-in-Fact**
Signature: **Paul Joseph Phillips**
Name of Signer: **Paul Joseph Phillips**
Date signed: **03/05/2024**
Effective Date: **03/05/2024 04:04:00 PM**

Note: The sale or offer for sale of membership interests of the limited liability company will comply with the requirements of the New Hampshire Uniform Securities Act (RSA 421-B). The membership interests of the limited liability company: 1) have been registered or when offered will be registered under RSA 421-B; 2) are exempted or when offered will be exempted under RSA 421-B; 3) are or will be offered in a transaction exempted from registration under RSA 421-B; 4) are not securities under RSA 421-B; OR 5) are federal covered securities under RSA 421-B. The statement above shall not by itself constitute a registration or a notice of exemption from registration of securities within the meaning of sections 448 and 461(i)(3) of the United States Internal Revenue Code and the regulation promulgated thereunder.

* Must be signed by a **manager**; if no manager, must be signed by a **member**.

DISCLAIMER: All documents filed with the Corporation Division become public records and will be available for public inspection in either tangible or electronic form.

State of New Hampshire

Department of State

Work Order #: 20249980872436

Receipt Date/Time: 03/13/2024 01:52:15 PM

Payer Information:

Paul Joseph Phillips
900 Elm Street, 19th Floor, P.O. Box 3600
Manchester, NH, 03105, USA

Payer Customer ID: 297182

Filer Information:

Paul Joseph Phillips
900 Elm Street, 19th Floor, P.O. Box 3600
Manchester, NH, 03105, USA

Filer Customer ID: 297182

Payment Information:

Date	Payment Type	Payment Reference	Authorization #	Payment Status	Payment Amount
03/05/2024 04:06:25 PM	Credit Card	CC#: XXXXXXXXXXXX1175	Auth#: 044861	Paid	$107.00
				Total Payment Received:	**$107.00**

Transaction Description:

Transaction #	Description	Reference Information
20249980872436-000	Handling Charge	N/A
20249980872436-001	Business Formation - Domestic Limited Liability Company	QUALITY CARE SERVICES LLC

Transaction Information:

Date Received	Transaction #	Processing Status	Invoice Status	Amount
03/05/2024 04:04:00 PM	20249980872436-000	Accepted	Paid	$2.00
03/05/2024 04:04:00 PM	20249980872436-001	Rejected	Paid	$105.00
			Total	**$107.00**

Drawdown Account Balance:	$0.00	**Total Due:**	$0.00
Credit Account Balance:	$0.00	**Total Refunded:**	$0.00
		Total Change To Credit Account Balance:	$0.00

Laconia, NH 03246 | info@qualitycarehh.com | **WWW:** Bold Profile

KRISTEN GRIFFIN

PROFESSIONAL SUMMARY

Dedicated Social Worker provides exceptional professional care and implements appropriate interventions. Utilizes variety of resources to identify unique needs and assist vulnerable populations. Adept at establishing strong rapport with individuals from diverse backgrounds.

SKILLS

- Multidisciplinary Collaboration
- Medical Social Work
- Community Outreach
- Case Management
- Team Leadership
- Resource Coordination
- Program Development
- Case Documentation
- Staff Development

WORK HISTORY

LEAD SOCIAL WORKER 12/2017 to 08/2023
LRVNA , Meredith

- Developed, led, and supervised a team of BSW staff while ensuring the delivery of high-quality home care and hospice services.
- Provided support, assistance, and education to patients, families, caregivers, and staff on end of life, social support, and death planning.
- Actively participated and interdisciplinary team meetings (IDT) per hospice conditions of participation.
- Created and maintain personalized, patient care plans, ensuring individualized and comprehensive support.
- Organized and lead staff and volunteer education series, enhancing the skills and knowledge of the team.
- Worked with physicians, providers, community agencies, and staff to provide the highest level, home care and hospice services possible.

SOCIAL WORK CONSULTANT 07/2006 to 09/2016
New Hampshire Veterans Home, Laconia, NH

- Improved client outcomes by implementing evidence-based practices in social work consultation.
- Developed comprehensive care plans for clients, resulting in enhanced quality of life and well-being.
- Collaborated with interdisciplinary teams to provide holistic support for clients and their families.
- Identified gaps in service provision and advocated for necessary resources, ensuring client needs were met effectively.
- Conducted assessments of mental health status for residents and collaborated with psychiatrist and psychiatric APRN to develop comprehensive care plans.

- Actively participated as a member of the palliative care committee, contributing insight and expertise to enhance the quality of care provided.
- Facilitated a 12-hour abuse and neglect prevention training program. Ensuring staff members were well-equipped to address critical issues.
- Promoted and maintained the psychosocial, well-being, and quality of life for residents through individual care and ongoing support.

EDUCATION

Plymouth State University, Plymouth, NH
Bachelor Of Social Work

University of New Hampshire, Durham, NH
Master Of Social Work

Curran, Marilee

From: Curran, Marilee
Sent: Wednesday, April 3, 2024 3:40 PM
To: Shireen Hart; Info QCHH
Cc: Beyer, Paulette
Subject: Applications for Home Health and Hospice Quality Care Services LLC

Good afternoon:

In accordance with RSA 151-A:14, the Office of Legal and Regulatory Services hereby acknowledges receipt of your applications and fees in the amount of $ 500.00 for a Home Health Agency Hospice and Home Health Care Provider.

Review of your applications indicate that it has been completed in accordance with RSA 151:4, and He-P 823 and 809, the rules of the Office of Legal and Regulatory Services for a Home Health Agency Hospice and Home Health Care Provider.

Staff from this office are available for consultation visits to assist you in achieving compliance. In order to receive a licenses, 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 823 and 809. 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 Health Agency Hospice and Home Health Care 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.

Take Care

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

State of New Hampshire

Department of State

Filed
Date Filed : 03/25/2024 04:30:00 PM
Effective Date : 03/25/2024 04:30:00 PM
Filing # : 6655814 Pages : 3
Business ID : 958605
David M. Scanlan
Secretary of State
State of New Hampshire

Form LLC-1
RSA 304-C:31

CERTIFICATE OF FORMATION
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QUALITY CARE SERVICES LLC

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Principal Office Address:

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(no. & street)	(city/town)	(state)	(zip code)

Principal Mailing Address (if different):

32C Whittier Highway #203C	Moultonborough	NH	03254
(no. & street)	(city/town)	(state)	(zip code)

Business Phone: 6037079655

Business Email: info@qualitycarehh.com

Notification Email: info@qualitycarehh.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):

62-Health Care and Social Assistance - 610-Home Health Care Services

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

Primmer Piper Eggleston & Cramer PC (598874)

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

900 Elm Street 19Fl	Manchester	NH	03101
(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
Net45 LLC	Manager	251 Little Falls Drive, Wilmington, DE, 19808, USA

Title: Attorney-In-Fact

Signature: Paul Joseph Phillips

Name of Signer: Paul Joseph Phillips

Date signed: 03/05/2024

Note: The sale or offer for sale of membership interests of the limited liability company will comply with the requirements of the New Hampshire Uniform Securities Act (RSA 421-B). The membership interests of the limited liability company: 1) have been registered or when offered will be registered under RSA 421-B; 2) are exempted or when offered will be exempted under RSA 421-B; 3) are or will be offered in a transaction exempted from registration under RSA 421-B; 4) are not securities under RSA 421-B; OR 5) are federal covered securities under RSA 421-B. The statement above shall not by itself constitute a registration or a notice of exemption from registration of securities within the meaning of sections 448 and 461(i)(3) of the United States Internal Revenue Code and the regulation promulgated thereunder.

* Must be signed by a manager; if no manager, must be signed by a member.

DISCLAIMER: All documents filed with the Corporation Division become public records and will be available for public inspection in either tangible or electronic form.

Lori A. Weaver
Commissioner

Melissa A. St. Cyr, Esq.
Chief Legal Officer

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

LEGAL AND REGULATORY SERVICES

HEALTH FACILITIES LICENSING AND CERTIFICATION

129 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-9499 1-800-852-3345 Ext. 9499
Fax: 603-271-4968 TDD Access: 1-800-735-2964
www.dhhs.nh.gov

March 20, 2024

Mr. David M. Scanlan
Secretary of State
State House, Room 204
Concord, New Hampshire 03301

Dear Secretary Scanlan:

This is to certify that Quality Care Services, LLC located at 32 C Whittier Highway, Ste 203C, has submitted applications for licensure as a Home Health Care Provider and a Home Health Hospice Agency under RSA 151. This certification is sent to you in conformance with RSA 151:2-C, I. Your early attention to this matter shall be greatly appreciated.

Sincerely,

Melissa St. Cyr – Chief Legal Officer
Office of Licensing & Regulation Srvs.