RECEIVED
APR 10 2013
HEALTH STANDARDS

(INITIAL) RENEWAL OTHER (Specify)_____

LICENSE NUMBER_____ EXPIRATION DATE _____

*Check & Payment Transmittal Form must be submitted to DHH Licensing Fee, PO Box 62949, New Orleans, LA 70162-2949

CHECK / MONEY ORDER # 101

check if any change has occurred since last application STATE ID# AB _____

I. FACILITY (DBA) NAME Deanz Health Care for Women

PHYSICAL ADDRESS 5437 Crowder Boulevard

CITY / STATE / ZIP New Orleans La 70127

TELEPHONE NUMBER (504) 252-9292 FAX NUMBER 504 252-9902

II. MAILING ADDRESS (IF DIFFERENT FROM ABOVE) _____

CITY / STATE / ZIP _____

III. ADMINISTRATOR Jackie Bayonne MEDICAL DIRECTOR: Rashonda Dean, M.D.

REGISTERED NURSE: Lornell Dean

***If HSS not notified, you must submit a Change of Key Personnel form if these positions have changed in the last year - http://www.dhh.la.gov/index.cfm/directory/detail/703

IV. TYPE OF OWNERSHIP:

NON- PROFIT	(FOR - PROFIT)
INDIVIDUAL / SOLE PROPRIETOR	INDIVIDUAL / SOLE PROPRIETOR
CORPORATION	(CORPORATION)
PARTNERSHIP	PARTNERSHIP
RELIGIOUS AFFILIATION	GROUP PRACTICE
UNINCORPORATED ASSOCIATION	OTHER (Specify) L.L.C.
OTHER (Specify): _____	

V. ENTITY / CORPORATION NAME Deanz Health Care for Women

MAILING ADDRESS (IF DIFFERENT) 1275 Bonaire Trace

CITY / STATE / ZIP Alexandria La 71303

TELEPHONE NUMBER (337) 308-2829 FAX NUMBER 504 252-9902 EIN# 46-2590337

VI. List name, address, and telephone numbers for persons or group of persons having direct or indirect ownership or a controlling interest (≥5%) of the corporate stock or partnership interest or any person or business entity which has a direct business interest, including, but not limited to, a wholly owned subsidiary, the details of any conversion rights which may exist for the benefit of any party and whether such stock, partnership interest, or ownership being held by the disclosed person or business entity is, in fact, owned by another person or business entity (ATTACH ADDITIONAL SHEETS IF ADDITIONAL SPACE IS NEEDED).

OWNER NAME	ADDRESS	TELEPHONE #
Rashonda Dean, M.D.	1275 Bonaire Trace	(337)308-2829

VII. If the disclosing entity is a corporation, list name, address and telephone number of the President.		
NAME	*ADDRESS*	*TELEPHONE NUMBER*
Rashonda Dean, M.D.	1275 Bonaire Trace Alexandria La 71303	(337)308-2829

VIII. Are any owners of the disclosing entity also owners of other licensed health care facilities? YES (NO) (Proprietorship, Partnership or Board Member). If yes, list names, addresses of individuals and Facility provider numbers.		
NAME	*ADDRESS*	*PROVIDER NUMBER*

IX. Has there been a change of ownership or control within the last year? YES (NO)

If yes, give date. _____

X. PROGRAM OPERATIONAL INFORMATION:

DAYS OF OPERATION Monday - Friday *HOURS OF OPERATION* 8:30 AM - 4:00 PM

Is this a change since last application? YES (NO)

***ATTESTATION:** I understand that if the agency license is granted, it is granted for one year and shall become void upon change of ownership. It is my responsibility to notify the Department of Health and Hospitals, Health Standards Section in writing of any changes in the information provided in this application. I certify that the information herein is true, correct and supportable by documentation to the best of my knowledge. Documentation of the information above is available upon request by the Department of Health and Hospitals.*

Jackie Bayonne
AUTHORIZED REPRESENTATIVE NAME (TYPED OR PRINTED)

Jackie Bayonne
AUTHORIZED REPRESENTATIVE SIGNATURE

4/3/18
DATE