PRINT RESET

FOR DEPARTMENTAL USE ONLY	
District:	***ELMS Facility Number:***
Proposed name of facility/agency/clinic:	

Licensure & Certification Application

A. Application Information

1. 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 (see #2 below)
- ◯ e. Management Company (see Sections C1, E, G, and Attachment E-1)
- ◯ f. License Suspension Reinstatement
- ◯ g. Other Change (see Section A3)

2. Change of Ownership Only - for Certification Purposes:

We wish to make certain that our records correctly show the effective date of the ownership change for certification. This date should reflect the actual date on which you took charge of the financial management of the facility rather than the date of sale or date of state license change. **Effective date of change:** _____

3. Type of Change (Check all that apply):

- ☐ a. Change of Bed
- ☐ b. Change of Bed Classification _____
- ☐ c. Change of Capacity
- ☐ d. Change of Certification (Addition)
- ☐ e. Change of Facility Type _____
- ☐ f. Change of Geographical Service Area
- ☐ g. Change of Governing Board
- ☐ h. Change of Indirect Owner
- ☐ i. Change of Location
- ☐ j. Change of Mailing Address
- ☐ k. Change of Name
- ☐ l. Change of National Provider Identifier
- ☐ m. Change of Property Owner
- ☐ n. Change of Service _____
- ☐ o. Change of Stock Transfer
- ☐ p. Other: (Specify) _____

4. 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: (Specify) _____

5. Do you wish to apply for the Medicare program? ◯ Yes ◯ No

a. If "yes" enter Medicare Provider #: _____

b. If "yes" enter Fiscal Intermediary Choice: _____

c. If "yes" enter National Provider Identifier (NPI): _____

6. Do you wish to apply for the Medi-Cal (Medicaid) program? ◯ Yes ◯ No

a. If "yes" complete **Section F. Subcontractor Information and Significant Business Transactions.**

b. If "yes" enter NPI: _____

7. Bed capacity:

a. Current bed capacity: _____

b. Proposed bed capacity: _____

8. Age range of clients: _____

9. Days and hours of operation:

a. ☐ Check here if facility, agency, or clinic is in operation 24/7/365

b. Complete the table if not in operation 24/7/365:

Days	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Hours of operation							

c. List service hours in the space provided if different than the hours of operation:

10. Was construction required for the application type(s) selected? ◯ Yes ◯ No

a. If "yes", **submit** copy of approved constructions documents from facilities building authority.

b. If "yes", date construction began: _____

c. If "yes", date construction was completed: _____

B. Licensee Information

1. Licensee legal name as reported to the IRS: _____

Licensee legal name as filed with the CA Secretary of State, if different from that reported to the IRS: _____

a. Physical Address of Licensee:

Number & Street: _____

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

b. Mailing Address of Licensee:

Number & Street: _____

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

c. Phone: _____

d. Fax: _____

e. Email Address: _____

f. Alternate Email Address: _____

g. Website: _____

2. Federal Tax Identification Number/Employer Identification Number (EIN): _____

3. Type of Entity (Select one): Submit organizational chart for a, b, d, e, f, and g.

- ◯ a. For-profit Corporation
- ◯ b. General Partnership
- c. Governmental (*Select One*)
  - ◯ 1) City
  - ◯ 2) County
  - ◯ 3) State Agency
  - ◯ 4) Public Agency
  - ◯ 5) Other Agency: (Specify) _____
- ◯ d. Limited Liability Company (LLC)
- ◯ e. Limited Liability Partnership
- ◯ f. Limited Partnership
- g. Nonprofit (Select One)
  - ◯ 1) Corporation
  - ◯ 2) Unincorporated Association
  - ◯ 3) Charitable
  - ◯ 4) Religious
  - ◯ 5) Other: (Specify) _____
- ◯ h. Sole Proprietorship (Individual)
- ◯ i. Other: (Specify) _____

4. Licensure Information

a. Identify other facilities, agencies, or clinics the licensee is currently or has been licensed for, operated, managed, held a 5 percent or more (direct or indirect) ownership interest and/or control interest in, or served as a director or officer. Include facilities both in and outside of California. **Submit** an attachment for additional facilities that includes all the required information listed below.

1. Facility Name: _____
   Facility Type: _____
   Facility Address (Number & Street): _____
   City: _____ State: _____ Zip (9-digit): _____
   Is the above facility participating in the Medi-Cal program: ◯ Yes ◯ No

2. Facility Name: _____
   Facility Type: _____
   Facility Address (Number & Street): _____
   City: _____ State: _____ Zip (9-digit): _____
   Is the above facility participating in the Medi-Cal program: ◯ Yes ◯ No

3. Facility Name: _____
   Facility Type: _____
   Facility Address (Number & Street): _____
   City: _____ State: _____ Zip (9-digit): _____
   Is the above facility participating in the Medi-Cal program: ◯ Yes ◯ No

4. Facility Name: _____

Facility Type: _____

Facility Address (Number & Street): _____

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

Is the above facility participating in the Medi-Cal program: ◯ Yes ◯ No

b. If any facility, agency, or clinic identified in 4(a) has had a license revocation action filed, license placed on probation, suspended, revoked (whether stayed or not), been disciplined by any licensing authority, and/or, the agency or clinic resolved by settlement or receiver appointed; please **submit** additional information, including all ownership and facility information, date, and any final action.

☐ Check here if not applicable

5. Medicaid, Medi-Cal, and All Other Federal and State Health Care Programs Information

a. Does the Licensee, currently participate or has ever participated as a provider in the Medi-Cal program or in another state's Medicaid program?

◯ Yes ◯ No If "yes", complete items b, c, and d.

b. If any facility, agency, or clinic identified in 4a, has had a final Medi-Cal decertification action taken, please **submit** additional information, including all ownership and facility information, date, and any final action.

☐ Check here if not applicable

c. List in the table below fines/debts due and owing by Licensee to any federal, state, or local government that relate to Medicare, Medicaid and all other federal and state health care programs that have not been paid and what arrangements have been made to fulfill the obligation(s). **Submit** copies of all documents pertaining to the arrangements including terms and conditions. (*See* California Code of Regulations (CCR), Title 22, Section 51000.50(a)(6).)

☐ Check here if not applicable

Fine/Debt	Agency	Date Issued	Date to be Paid in Full

d. Has the Licensee ever been suspended from a Medicare, Medicaid, or Medi-Cal program?

◯ Yes ◯ No

If "yes", attach the verification of reinstatement and provide the following information:

Check Applicable Program: ☐ Medi-Cal ☐ Medicaid ☐ Medicare

NPI and/or Provider Number(s): _____

Effective Date(s) of Suspension: _____

Date(s) of Reinstatement(s) as applicable: _____

Check Applicable Program: ☐ Medi-Cal ☐ Medicaid ☐ Medicare

NPI and/or Provider Number(s): _____

Effective Date(s) of Suspension: _____

Date(s) of Reinstatement(s) as applicable: _____

6. Is the licensee a subsidiary of another organization? ◯ Yes ◯ No

If "yes", complete the information below for all corporations, unincorporated associations, partnerships, or similar entities having 5 percent or more (direct or indirect) ownership interest and/or control interest, or any partnership interest, in the Licensee identified in **Section B.1** and **submit** an organizational chart. If there is more than two, please **submit** an attachment for additional entities that includes all the required information listed below.

a. Organization name: _____

Federal tax ID number: _____

Number & Street: _____

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

b. Organization name: _____

Federal tax ID number: _____

Number & Street: _____

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

C. Facility, Agency, or Clinic Information

1. Management Agreements:

a. Is the facility going to be operated under a management contract/agreement between the current or proposed owner and a management company (this only applies to an APH, GACH, ICF, and SNF)?

◯ Yes ◯ No

If "yes" complete **Section E. Management Company**.

b. Is there an "interim" management agreement, between the proposed owner and the current owner, to run the facility until the change of ownership is completed?

◯ Yes ◯ No

If "yes", **submit** a copy of the "interim" management agreement.

2. Name and address of "current" facility, agency, or clinic:

a. Current facility, agency, or clinic name: _____

b. Current physical address of facility, agency, or clinic where services are rendered or provided:

1) Number & Street: _____

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

2) Telephone Number: _____

3) Email address: _____

4) Fax number: _____

c. Current mailing address of facility, agency, or clinic if different from physical address above:

1) Number & Street: _____

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

2) Telephone number: _____

d. Facility License Number: _____

3. Name and address of "proposed" facility, agency, or clinic (if change of ownership, change of location, change of mailing address, or change of name)**:**

a. Proposed facility, agency, or clinic name: _____

b. Proposed physical address of facility, agency, or clinic where services are rendered or provided:

1) Number & Street: _____

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

2) Telephone Number: _____

3) Email address: _____

4) Fax Number: _____

c. Proposed mailing address of facility, agency, or clinic if different from physical address above:

1) Number & Street: _____

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

2) Telephone number: _____

4. Managing Positions (complete all that are applicable):

a. Name of Administrator: _____

Professional License Number: _____ Expiration date: _____

Date of hire: _____

b. Name of Agency Manager: _____

Professional License Number: _____ Expiration date: _____

Date of hire: _____

c. Name of Director of Nursing: _____

Professional License Number: _____ Expiration date: _____

Date of hire: _____

d. Name of Director of Patient Care Services: _____

Professional License Number: _____ Expiration date: _____

Date of hire: _____

e. Name of Program Director: _____

Professional License Number: _____ Expiration date: _____

Date of hire: _____

f. Name of Medical Director: _____

Professional License Number: _____ Expiration date: _____

Date of hire: _____

5. List persons having <u>5 percent</u> or more (direct or indirect) ownership interest and/or control interest in this facility, agency, or clinic (42 Code of Federal Regulations, Sections 455.100, 455.101, & 455.102). Are any of these persons (listed below) related to one another as spouse, parent, child, or sibling? **<u>Submit</u>** an attachment for additional names that includes all the required information listed below.

a. Name of Individual: _____

Ownership Percentage: _____

Are they related to one another as a spouse, parent, child, or sibling? ◯ Yes ◯ No

What is the relationship: _____

b. Name of Individual: _____

Ownership Percentage: _____

Are they related to one another as a spouse, parent, child, or sibling? ◯ Yes ◯ No

What is the relationship: _____

c. Name of Individual: _____

Ownership Percentage: _____

Are they related to one another as a spouse, parent, child, or sibling? ◯ Yes ◯ No

What is the relationship: _____

d. Name of Individual: _____

Ownership Percentage: _____

Are they related to one another as a spouse, parent, child, or sibling? ◯ Yes ◯ No

What is the relationship: _____

6. Financial Resources (Only applies to SNF and ICF)

(Health and Safety Code (HSC) section 1265(g))

Submit evidence, i.e., bank statements, line of credit, certificate(s) of deposit, satisfactory to the department(s) that the licensee possesses financial resources sufficient to operate the facility for a period of at least 90 days. (The amount is determined by multiplying 90 (days) X [number of beds] X [facility rate]).

7. Over – Concentration (Only applies to ICF/DD, ICF/DD-H, ICF/DD-N, PDHRC, and CLHF)

(HSC section 1267.9)

a. **Are there any ICF/DD, ICF/DD-H, ICF/DD-N, Residential Care Facility (RCF), or Pediatric Day Health & Respite Care (PDHRC) facilities within 300 feet of this facility?**

◯ Yes ◯ No ◯ Don't know

b. **Are there any Congregate Living Health Facilities (CLHF) within 1,000 feet of this facility?**

◯ Yes ◯ No ◯ Don't know

8. Program Plan (Only applies to ICF/DD, ICF/DD-H and ICF/DD-N):

(HSC section 1275.3 (b)(3))

a. **Has the Program Plan been approved by the California Department of Developmental Services (DDS)?**

◯ Yes ◯ No

If "yes", **submit** a copy of the approval letter. The "current licensee" can grant permission for their Program Plan to be used for 6 months if they submit a letter to CDPH.

If "no", the application package will be delayed until a copy of the approved program letter is received.

9. Type of Service – (Only applies to CLHF):

(HSC section 1250(i)(2)

a. **Check all services identified under the statute listed above provided by the facility:**

☐ **A** ☐ **B** ☐ **C**

D. Property Information

1. **Property Ownership**: Select one and **submit** evidence of control of property:

   ◯ Own ◯ Rent ◯ Lease ◯ Sublease ◯ Other: (Specify) _____

2. **If the Licensee owns the property, complete the following information regarding the property owner:**

   a. Owner of Record name in the real estate: _____

   b. Address (Number & Street): _____

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

If the Licensee leases the property, complete the following information regarding the Lessor (party that receives payments in exchange for the usage of its asset or property) and enclose a copy of the current signed Lease Agreement, including any sublease agreements entered into by the Licensee at the business address on the Application.

c. **Lessor Information:**

   1) Lessor Name: _____

   2) Lessor address (Number & Street): _____

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

   3) Lessor email address: _____

   4) Term of lease: _____

d. **Lessee Information (party that pays the lessor for the use of the property):**

   1) Lessee Name: _____

   2) Lessee Address (Number & Street): _____

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

e. **Sub-Lessee Information (person who holds a sub-lease):**

   1) Sub-Lessee Name: _____

   2) Sub-Lessee Address (Number & Street): _____

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

E. Management Company

If the current or proposed APH, GACH, ICF, or SNF will be operated by a management company, under a management contract between the current or proposed owner and a management company, complete Attachment E-1: Management Company Information for APH, GACH, ICF, and SNF.

NOTE: The management company is required to **submit** a separate application to the Department for each facility it proposes to manage.

F. Subcontractor Information and Significant Business Transactions

If the current or proposed facility, agency, or clinic is applying for Medi-Cal certification, complete Attachment F-1: Subcontractor Information and Significant Business Transactions.

G. I (We) Accept Responsibility to

a. Comply with local ordinances concerning zoning, sanitation, building, and other appropriate ordinances.
b. Comply with the Labor Code on employment practices concerning nondiscrimination, liability insurance, wages, hour and working conditions.
c. Comply with Health and Safety Code and regulations concerning licensing and fire safety.

I (We) declare under penalty of perjury that the statement on this application and on the accompanying attachments are correct to my (our) knowledge.

I (We) declare under penalty of perjury under the laws of the State of California that the foregoing information in this document and any attachments is true, accurate, and complete to the best of my (our) knowledge and belief.

I (We) declare that I (we) have the authority to legally bind the applicant or provider pursuant to Title 22, CCR Section 51000.30(a)(2)(B).

Signature and printed name of person(s) signing this declaration with authority to legally bind the Licensee:

Signature	Printed Name	Title	Date
1.			
2.			
3.			
4.			

Contact Person's Information (Person Completing Application):

a. Contact person's name (last, first, middle): _____
b. Title/Position: _____
c. Email address: _____
d. Telephone number: _____

Release of Information Statement

This information shall be provided to the state department upon initial licensure. **Any changes must be provided to the state department within 10 days of the change.** The information shall be made available to the public upon request and shall be included in the public file of the facility.

The information provided on this form is mandatory and is necessary for licensure approval. It will be used to determine individual applicants or applicant facility's ability to provide health services. The information is requested by the California Department of Public Health, Licensing and Certification, in accordance with Health and Safety Code, Sections 1212, 1253, 1265, 1267.5, and 1728, and California Code of Regulations (CCR), Title 22, Sections 70107, 71107, 73205, 74105, 75022, 76205, and 78205.

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

The information is considered public information and will be made available to the public upon request. The information shall be included and maintained in the individual facility's public files located in California Department of Public Health, Licensing and Certification, district offices.

ATTACHMENT E–1
Management Company information for APH, GACH, ICF, and SNF

1. **Submit** a copy of the Management Agreement with this application.

   Name of management company: _____

   EIN: _____

   Address (Number & Street): _____

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

   Name of facility to be managed: _____

   EIN: _____

   Address (Number & Street): _____

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

2. Provide the following information for each individual having a 5 percent or more (direct or indirect) ownership interest and/or control interest in the management company. **Submit** an attachment for additional names that includes all of the required information listed below.

   a. Individual's Name: _____

      Ownership Percentage: _____

      Address (Number & Street): _____

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

   b. Individual's Name: _____

      Ownership Percentage: _____

      Address (Number & Street): _____

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

   c. Individual's name: _____

      Ownership Percentage: _____

      Address (Number & Street): _____

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

d. Individual's name: _____

Ownership Percentage: _____

Address (Number & Street): _____

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

3. Provide a list of all facilities, agencies, or clinics with which you have entered into a management agreement. **Submit** an attachment for additional facility, agency, or clinic names that includes all of the required information listed below. If there are more than four, please provide and attach a separate sheet with all required information.

a. Facility, Agency, or Clinic Name: _____

Address (Number & Street): _____

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

Dates of involvement: _____

b. Facility, Agency, or Clinic Name: _____

Address (Number & Street): _____

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

Dates of involvement: _____

c. Facility, Agency, or Clinic Name: _____

Address (Number & Street): _____

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

Dates of involvement: _____

d. Facility, Agency, or Clinic Name: _____

Address (Number & Street): _____

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

Dates of involvement: _____

ATTACHMENT F–1
Subcontractor Information and Significant Business Transactions

"Subcontractor" means an individual, agency, or organization: (a) To which the Licensee has contracted or delegated some of its management functions or responsibilities of providing healthcare services, equipment or supplies to its patients. (b) With whom the Licensee has entered into a contract, agreement, purchase order, lease, or leases of real property, to obtain space, supplies, equipment, or services provided under the Medi-Cal Program.

"Significant business transaction" means any business transaction or series of transactions that involve health care services, goods, supplies, or merchandise related to the provision of services to Medi-Cal beneficiaries that, during any one fiscal year, exceed the lessor of $25,000 or 5 percent of an applicant's or provider's total operating expenses.

Part A.

Does the Licensee (as named in **Section B.1** of the HS200) have 5 percent or more (direct or indirect) ownership interest and/or control interest in any of its subcontractors that provide healthcare services or goods?

◯ Yes ◯ No

Do any of the entities (as named in **Section B.6** of the HS200) have 5 percent or more (direct or indirect) ownership interest and/or control interest in any of the Licensee's subcontractors that provide healthcare services or goods?

◯ Yes ◯ No

Do any of the individuals (as named in **Section C.5** of the HS200) have 5 percent or more (direct or indirect) ownership interest and/or control interest in any of the Licensee's subcontractors that provide healthcare services or goods?

◯ Yes ◯ No

If you answered "no" to ALL of the above, please proceed to Part C.

If you answered "yes" to ANY of the above, please proceed to Part B and provide the following information about the subcontractor and attach a copy of any written agreement(s) that you have with the subcontractor that relate to its functions/responsibilities.

1. Subcontractor's full legal name: _____
2. Subcontractor's phone number: _____
3. Subcontractor's address (Number & Street): _____

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

4. Subcontractor's federal employer identification number (if applicable): _____

5. Subcontractor's corporation number (if applicable): _____

If there is more than one subcontractor, **submit** a separate sheet with all required information. (Label separate sheet "Additional Attachment F-1: Subcontractor Information and Significant Business Transactions, Part A")

☐ Check here if additional sheet(s) is attached. Number of pages attached: _____

Part B.

List the following information for any person or entity, other than the Licensee, with 5 percent or more (direct or indirect) ownership interest and/or control interest in any **subcontractor** listed in Part A of the F-1 attachment.

If there is more than one subcontractor, **submit** a separate sheet with all required information. (Label separate sheet "Additional Attachment F-1: Subcontractor Information and Significant Business Transactions, Part B")

☐ Check here if additional sheet(s) is attached. Number of pages attached: _____

Name of Subcontractor in Part A of the F-1 attachment:

1. Full legal name of person or entity with 5 percent or more (direct or indirect) ownership interest and/or control interest in the subcontractor:

_____

Phone Number: _____

Address (Number & Street): _____

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

What is this individual's role with the subcontractor reported in Part A of the F-1 attachment? (Check all that apply)

☐ 5 percent or greater owner – Ownership Percentage: _____

☐ Partner ☐ Managing Employee

☐ Director/Officer, Title: _____ ☐ Other: (Specify) _____

Is the above individual related to any individual identified in Section C.5 that has 5 percent or more (direct or indirect) ownership interest and/or control interest or ***any*** partnership interest, in the Licensee identified in Section B.1?

◯ Yes ◯ No

If "yes", check the appropriate box and list the name of the related individual.

◯ Spouse ◯ Parent ◯ Child ◯ Sibling

◯ Other: (Specify) _____

Name of related individual: _____

2. Full legal name of person or entity with 5 percent or more (direct or indirect) ownership interest and/or control interest in the subcontractor:

_____

Phone Number: _____

Address (Number & Street): _____

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

What is this individual's role with the subcontractor reported in Part A of the F-1 attachment? (Check all that apply)

☐ 5 percent or greater owner – Ownership Percentage: _____

☐ Partner ☐ Managing Employee

☐ Director/Officer, Title: _____ ☐ Other: (Specify) _____

Is the above individual related to any individual identified in Section C.5 that has 5 percent or more (direct or indirect) ownership interest and/or control interest or ***any*** partnership interest, in the Licensee identified in Section B.1?

◯ Yes ◯ No

If "yes", check the appropriate box and list the name of the related individual.

◯ Spouse ◯ Parent ◯ Child ◯ Sibling

◯ Other: (Specify) _____

Name of related individual: _____

3. Full legal name of person or entity with 5 percent or more (direct or indirect) ownership interest and/or control interest in the subcontractor:

_____

Phone Number: _____

Address (Number & Street): _____

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

What is this individual's role with the subcontractor reported in Part A of the F-1 attachment? (Check all that apply)

☐ 5 percent or greater owner – Ownership Percentage: _____

☐ Partner ☐ Managing Employee

☐ Director/Officer, Title: _____ ☐ Other: (Specify) _____

Is the above individual related to any individual identified in Section C.5 that has 5 percent or more (direct or indirect) ownership interest and/or control interest or ***any*** partnership interest, in the Licensee identified in Section B.1?

○ Yes ○ No

If "yes", check the appropriate box and list the name of the related individual.

○ Spouse ○ Parent ○ Child ○ Sibling

○ Other: (Specify) _____

Name of related individual: _____

4. Full legal name of person or entity with 5 percent or more (direct or indirect) ownership interest and/or control interest in the subcontractor:

_____

Phone Number: _____

Address (Number & Street): _____

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

What is this individual's role with the subcontractor reported in Part A of the F-1 attachment? (Check all that apply)

☐ 5 percent or greater owner – Ownership Percentage: _____

☐ Partner ☐ Managing Employee

☐ Director/Officer, Title: _____ ☐ Other: (Specify) _____

Is the above individual related to any individual identified in Section C.5 that has 5 percent or more (direct or indirect) ownership interest and/or control interest or ***any*** partnership interest, in the Licensee identified in Section B.1?

○ Yes ○ No

If "yes", check the appropriate box and list the name of the related individual.

○ Spouse ○ Parent ○ Child ○ Sibling

○ Other: (Specify) _____

Name of related individual: _____

Part C.

Has the Licensee had any significant business transaction with any wholly owned supplier or with any subcontractor (not listed on Part A of the F-1 attachment) during the 5-year period immediately preceding the date of this Application?

○ Yes ○ No

"**Wholly owned supplier**" means a supplier whose total ownership interest is held by the Licensee or by a person, persons, or other entity with an ownership or control interest in the Licensee.

If no, please proceed to Part D.

If yes, complete the following information about the supplier or subcontractor:

1. Subcontractor's or supplier's full legal name: _____
2. Subcontractor's or supplier's phone number: _____
3. Subcontractor's or supplier's address (Number & Street): _____

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

4. Describe the transaction(s): _____

If there is more than one subcontractor or supplier, **submit** a separate sheet with all required information. (Label separate sheet "Additional Attachment F-1: Subcontractor Information and Significant Business Transactions, Part C")

☐ Check here if additional sheet(s) is attached. Number of pages attached: _____

Part D.

List the name and address of each person(s) with 5 percent or more (direct or indirect) **ownership interest and/or control interest** in any subcontractor (listed in Part C of the F-1 attachment) with whom the Licensee has had business transactions involving health care services, goods, supplies or merchandise related to the provision of services to a Medi-Cal beneficiary that total more than $25,000 during the 12-month period immediately preceding the date of the application, or immediately preceding the date on the Department's request for such information. If there is more than one subcontractor, **submit** a separate sheet with all required information. (Label separate sheet "Additional Attachment F-1: Subcontractor Information and Significant Business Transactions, Part D")

☐ Check here if no subcontractors listed in Part C of the F-1 attachment or the Licensee has had no business transactions with subcontractors involving health care services, goods, supplies, or merchandise related to the provision of services to a Medi-Cal beneficiary that total more than $25,000 during the 12-month period immediately preceding the date of the application, or immediately preceding the date on the Department's request for such information.

☐ Check here if additional sheet(s) is attached. Number of pages attached: _____

Name of Subcontractor in Part C of the F-1 attachment:

1. Full legal name of person or entity with 5 percent or more (direct or indirect) ownership interest and/or control interest in the subcontractor:

   _____

   Phone Number: _____

   Address (Number & Street): _____

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

2. Full legal name of person or entity with 5 percent or more (direct or indirect) ownership interest and/or control interest in the subcontractor:

   _____

   Phone Number: _____

   Address (Number & Street): _____

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

3. Full legal name of person or entity with 5 percent or more (direct or indirect) ownership interest and/or control interest in the subcontractor:

   _____

   Phone Number: _____

   Address (Number & Street): _____

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

4. Full legal name of person or entity with 5 percent or more (direct or indirect) ownership interest and/or control interest in the subcontractor:

   _____

   Phone Number: _____

   Address (Number & Street): _____

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

5. Full legal name of person or entity with 5 percent or more (direct or indirect) ownership interest and/or control interest in the subcontractor:

   _____

   Phone Number: _____

   Address (Number & Street): _____

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

Instructions

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 Licensure & Certification Application (HS200). Return original and maintain a copy for your records.

A. APPLICATION INFORMATION

1. Type of application: Select item a, b, c, d, e, f, or g
   Select a. for applicants seeking an initial "new" license.
   Select b. to add a branch to an existing home health agency license.
   Select c. to add multiple locations to an existing hospice agency license.
   Select d. to report a Change of Ownership (see #2 below).
   Select e. to apply as a Management Company (only for APH, GACH, ICF, and SNF).
   Select f. to reinstate a license that is currently suspended.
   Select g. to report another type of change (You must select an option in A3).

2. Change of Ownership only.
   Provide actual date applicant took charge of the financial management of the facility.
   This date is used to show effective date of the ownership change for certification purposes only.

3. Type of change: Check all that apply.
   Any changes must be provided to the state department within 10 days of the change.

4. Type of facility, agency, or clinic: Only select one of the options in the appropriate category.

5. Medicare Program. **ICF/DD, ICF/DD-N, ICF/DD-H, and primary care clinics that are not certified as rural health clinics are not eligible for Medicare.**
   Select "yes" if requesting certification for Medicare.
   a. If "yes", enter the Medicare provider #.
   b. If "yes", enter the name of fiscal intermediary.
   c. If "yes" enter National Provider Identifier (NPI).

6. Medi-Cal (Medicaid) Program.
   Select "yes" if requesting participation in Medi-Cal (Medicaid).
   a. If "yes", complete Section F and Attachment F-1. Subcontractor Information and Significant Business Transactions.
   b. If "yes", enter the National Provider Identifier (NPI).

7. Bed Capacity.
   a. Current bed capacity: Enter the total number of persons for whom care can currently be provided in any 24-hour period. This figure must agree with the "Certificate of Occupancy".
   b. Proposed facility bed capacity: enter the proposed total number of persons for whom care will be provided in any 24-hour period.

8. Enter age range of persons to receive/receiving care.

9. Enter days and hours of facility operation.
    a. Check mark if the facility, agency, or clinic is in operation 24 hours, 7 days a week the full year.
    b. If the facility, agency, or clinic is not in operation 24 hours, 7 days a week the full year complete the table. Under each day write the time frame in which the facility, agency or clinic is in operation.
    c. List service hours in the space provided if different than hours of operation.

10. Was construction required? Select yes or no.
    a. If "yes", **submit** a copy of approved construction documents from facilities building authority.
    b. If "yes", enter the date construction started.
    c. If "yes", enter the date construction was completed.

B. LICENSEE INFORMATION

1. Licensee name: Enter the full legal organization name (LLC, partnership, and corporation) or individual(s) responsible for the facility/agency. If "Inc." is included in your legal name, it must appear in the name. Individuals enter first, middle, and last name. If joint applicants, all applicants must be listed. Enter the full legal organization name as filed with the CA Secretary of State, if different from that reported to the IRS.
    a. Enter physical address of legal organization (LLC, corporation, partnership) or individual(s) responsible for the facility, agency, or clinic.
    b. Enter the mailing address if different than the physical address.
    c. Enter phone number with area code.
    d. Enter the fax number.
    e. Enter the e-mail address.
    f. Enter the alternate email address.
    g. Enter the website

2. Enter the federal tax identification number/employer identification number (EIN).

3. Type of Entity: select one of the options.
    If "a" or "b" is selected, **submit** an organizational chart.
    If "c" is selected, choose options 1, 2, 3, 4, or 5.
    If "d", "e", or "f" is selected, **submit** an organizational chart.
    If "g" is selected, choose options 1, 2, 3, 4, or 5 and submit an organizational chart.
        If "g" item 1. (Corporation) is selected and the facility type is Primary Care Clinic, then **submit** a copy of the Internal Revenue Service and Franchise Tax Board letters of determination of nonprofit status.
    If "h" is selected, this is applicable to a single owner or individual.
    If "i" is selected, specify other type of entity.

4. Licensure Information.
    a. Identify all other facilities, agencies, or clinics the licensee has been involved in, both in and outside of California.
        Submit an attachment, if needed, for additional entities, which includes the facility, agency or clinic type (including "affiliate" clinics), name, address, nature of

involvement, dates of involvement, and if participating in Medi-Cal program. **This attachment must include all of the required information listed.**

b. If any facility, agency, or clinic identified in 4a has had a license revocation action filed, license placed on probation, suspended, revoked (whether stayed or not), been disciplined by any licensing authority, and/or, for agency or clinic resolved by settlement or receiver appointed, **submit** additional information, including all ownership and facility information, date, and any final action.

5. Medicaid, Medi-Cal, and all other Federal and State Health Care programs information.
   a. If the Licensee is currently or has ever participated as a provider in the Medi-Cal program or in another state's Medicaid program, select "yes" or "no."

   b. If "yes" was selected in 5a. complete 5b: If any facility, agency, or clinic identified in 4a, has had a final Medi-Cal decertification action taken, **submit** additional information, including all ownership and facility information, date, and any final action.

   c. If "yes" was selected in 5a. complete 5c: In the appropriate space list the fines/debts due and owing by the Licensee to any federal, state, or local government that relate to Medicare, Medicaid and all other federal and state health care programs. **Submit** copies of all documents pertaining to the arrangements including terms and conditions.(See California Code of Regulations (CCR), Title 22, Section 51000.50 (a)(6).

   d. If "yes" was selected in 5a. complete 5d: Select "yes" or "no" if the Licensee has ever been suspended from a Medicare, Medicaid, or Medi-Cal program.
      If "yes" is selected in 5d. attach verification of reinstatement and provide the information requested on page 5.

6. Subsidiary: Select "yes" if the licensee is a subsidiary of another organization and complete the information requested.
   Submit a detailed organizational chart that includes all the information required in 6.a

C. FACILITY, AGENCY, OR CLINIC INFORMATION

1. Management Agreement:
   a. Select "yes" if the facility is going to be operated under a management contract/agreement, between the proposed owner and a management company (this only applies to APH, GACH, ICF and SNF).
      If "yes", complete Section "E" (Management Company).

   b. Select "yes" if there is an "interim" management agreement, between the proposed owner and the current owner, to run the facility until the change of ownership is completed.
      If "yes", **submit** a copy of the "interim" management agreement.

2. Current facility, agency, or clinic name and address:
   a. Enter the **current** name of the facility, agency or clinic.
   b. Enter the **current** physical address of the facility, agency, or clinic where services rendered or provided.

Enter telephone number, email address and fax number of the facility on lines 3-5.

c. Enter the **current** mailing address of the facility, agency or clinic if different from physical address.
d. Enter the facility license number.

3. Proposed facility, agency, or clinic name and address:
   a. Enter the **proposed** name of the facility, agency or clinic.
   b. Enter the **proposed** physical address where services will be rendered.
      Enter telephone number, email address and fax number of the facility on lines 3-5.
   c. Enter the **proposed** mailing address of the facility, agency or clinic if different from the physical address.

4. Managing Positions. (Complete applicable fields)
   a. Enter the Administrator name, professional license number, expiration date and date of hire.
   b. Enter the Agency Manager name, professional license number, expiration date, and date of hire.
   c. Enter the Director of Nursing name, professional license number, expiration date and date of hire.
   d. Enter the Director of Patient Care Services' name, professional license number, expiration date and date of hire.
   e. Enter the Program Director name, professional license number, expiration date, and date of hire.
   f. Enter the Medical Director name, professional license number, expiration date and date of hire.

5. Provide name(s) of all individuals having a **5 percent** or more (direct or indirect) ownership interest and/or control interest in the facility, agency, or clinic.
   Specify if and how these persons are related to one another as spouse, parent, child or sibling.
   Submit an attachment for all additional names. This attachment must include all of the required information.

6. Financial Resources: **Only applies to SNF and ICF.**
   Submit evidence, (bank statement, certificate of deposit, etc.), satisfactory to the Department, that the licensee has sufficient financial resources to operate the facility for at least 90 days. The amount is determined by multiplying 90 (days) X [number of beds] X [facility rate].

7. Over-concentration: **Only applies to ICF/DD, ICF/DD-H and ICF/DD-N.**
   a. Are there other ICF/DD, ICF/DD-H, ICF/DD-N, Residential Care Facility (RCF), or Pediatric Day Health & Respite Care (PDHRC) facilities within 300 feet of this facility? Select "yes", "don't know" or "no".
   b. Are there any Congregate Living Health Facilities (CLHF) within 1,000 feet of this facility? Select "yes", "don't know" or "no".

8. Program Plan: **Only applies to ICF/DD, ICF/DD-H and ICF/DD-N.**
   a. Select "yes" or "no" if the program plan has been approved by the California Department of Developmental Services (DDS).

If "yes", **submit** a copy of the approval letter.
Submit a letter to CDPH from the "current" licensee that the "proposed" licensee has their permission to use the "current" licensee's Program Plan for up to 6 months.
If "no", the application package will be delayed until a copy of the approved Program Plan letter is received.

9. Type of Service: **Only applies to CLHF.**
   a. Select each type of service the facility will provide.
      HSC, section 1250(i)(2):

      Congregate living health facilities shall provide one or more of the following services:

      (A) Services for persons who are mentally alert, persons with physical disabilities, who may be ventilator dependent.

      (B) Services for persons who have a diagnosis of terminal illness, a diagnosis of a life-threatening illness, or both. Terminal illness means the individual has a life expectancy of six months or less as stated in writing by his or her attending physician and surgeon. A "life-threatening illness" means the individual has an illness that can lead to a possibility of a termination of life within five years or less as stated in writing by his or her attending physician and surgeon.

      (C) Services for persons who are catastrophically and severely disabled. A person who is catastrophically and severely disabled means a person whose origin of disability was acquired through trauma or nondegenerative neurologic illness, for whom it has been determined that active rehabilitation would be beneficial and to whom these services are being provided. Services offered by a congregate living health facility to a person who is catastrophically disabled shall include, but not be limited to, speech, physical, and occupational therapy.

D. PROPERTY INFORMATION

1. Property Ownership: Select one option. **Licensee must show evidence of control of property.**
   If "Own" is selected, **submit** a copy of the deed and/or bill of sale if property is owned.
   If "Rent" is selected, **submit** a copy of the rental agreement if property is rented.
   If "Lease" is selected, **submit** a copy of the lease agreement if property is leased.
   If "Sublease" is selected **submit** a copy of the original lease plus a copy of the sublease if property is subleased.
   If "Other" is selected, specify, and **submit** appropriate documentation as evidence.

2. If the Licensee owns the property, complete:
   a. Owner Information

3. If the Licensee leases the property, complete:
   a. Lessor information:
   b. Lessee information:
   c. Sub-Lessee information:

E. MANAGEMENT COMPANY INFORMATION

This only applies to APH, GACH, ICF, and SNF.

If you answered “yes” to C.1.a. that the facility will be operated under a management contract/agreement between the owner and a management company, you must complete Attachment E-1: Management Company Information for APH, GACH, ICF, and SNF.

NOTE: The management company is required to submit a separate application to the Department for each facility it proposes to manage.

F. SUBCONTRACTOR INFORMATION AND SIGNIFICANT BUSINESS TRANSACTIONS

If the current or proposed facility, agency, or clinic is applying for Medi-Cal certification, complete Attachment F-1: Subcontractor Information and Significant Business Transactions.

G. I (WE) ACCEPT RESPONSIBILITY TO.

Application must be signed by licensee or authorized representative.

Provide:

- Signature:
- Printed Name:
- Title:
- Date:

Contact information for the individual completing this application must be filled.

Provide:

- Contact person’s name (last, first, middle):
- Title/Position:
- E-mail address:
- Telephone number:

Attachment E-1: Management Company Information for APH, GACH, ICF, and SNF

1. If the current or proposed facility will be operated by a management company, under a management contract between the current or proposed owner and a management company, provide the Management Company name, federal tax identification number/Employer Identification Number (EIN), and address. Provide the name of facility to be managed, EIN, and address.
   Submit a copy of the Management Agreement.

2. For each individual having **5 percent** or more (direct or indirect) ownership interest and/or control interest in the Management Company, provide the individual's name, percent of ownership, and address.
   Submit an attachment for additional names. This attachment must include all of the required information.

3. Provide a list of all facilities, agencies, or clinics with which you have entered into a management agreement. Provide the Facility, Agency, or Clinic name, address, and dates of involvement.
   Submit an attachment for additional facilities, agencies, or clinics. This attachment must include all of the required information.

Complete Attachment F-1: Subcontractor Information and Significant Business Transactions if the current or proposed facility, agency or clinic is applying for Medi-Cal certification. If including additional pages for any section be sure to check the corresponding box and list the number of pages included.

Attachment F-1: Subcontractor Information and Significant Business Transactions

"**Subcontractor**" means an individual, agency, or organization: (a) To which the Licensee has contracted or delegated some of its management functions or responsibilities of providing healthcare services, equipment or supplies to its patients. (b) With whom the Licensee has entered into a contract, agreement, purchase order, lease, or leases of real property, to obtain space, supplies, equipment, or services provided under the Medi-Cal Program.

"Significant business transaction" means any business transaction or series of transactions that involve health care services, goods, supplies, or merchandise related to the provision of services to Medi-Cal beneficiaries that, during any one fiscal year, exceed the lesser of $25,000 or 5 percent of an applicant's or provider's total operating expenses.

"Wholly owned supplier" means a supplier whose total ownership interest is held by an applicant or provider or by a person, persons, or other entity with an ownership or control interest in an applicant or provider.

Part A

Select “yes” or “no” if the Licensee in Section B.1, of the HS200, has 5 percent or more (direct or indirect) ownership interest and/or control interest in any of its subcontractors that provide healthcare services.

Select “yes” or “no” if any of the entities named in Section B.6, of the HS200 has 5 percent or more (direct or indirect) ownership interest and/or control interest in any of the Licensee’s subcontractors that provide healthcare services or goods.

Select “yes” or “no” if any of the individuals named in Section C.5, of the HS200 has 5 percent or more (direct or indirect) ownership interest and/or control interest in any of the Licensee’s subcontractors that provide healthcare services or goods?

If you selected “no” to all questions in Part A proceed to Part C of the Attachment F-1.
If you selected “yes” to ANY of the questions in Part A, complete (questions 1-5) the subcontractor’s full legal name, phone number, address, EIN, corporation number and attach a copy of any written agreement(s) that you have with the subcontractor that relate to its functions/responsibilities.

If there is more than one subcontractor, submit a separate sheet with all required information. (Label the separate sheet “Additional Attachment F-1: Subcontractor Information and Significant Business Transactions, Part A”)

Part B.

List the following information for any person or entity, other than the Licensee, with 5 percent or more (direct or indirect) ownership interest and/or control interest in any subcontractor listed in Part A of the F-1 attachment. If there is more than one subcontractor, provide a separate sheet with all required information. (Label the separate sheet “Additional Attachment F-1: Subcontractor Information and Significant Business Transactions, Part B”)

1. Enter the full legal name, phone number, address of the person(s) or entity(ies) with ownership or control interest in the subcontractor.
   Check all options that apply to the role of this subcontractor.
   Select “yes” or “no” if the above individual is related to any individual identified in Section C.5 that has 5 percent or more (direct or indirect) ownership interest and/or control interest or any partnership interest, in the Licensee identified in section B.1.
      If “yes”, then select the appropriate relationship option and list the name of the related individual.

Part C

Select “yes” or “no” if the Licensee has had any significant business transaction with any wholly owned supplier or with any subcontractor during the 5-year period immediately preceding the date of this application.
   If “no”, Please proceed to Part D.
   If “yes”, complete (questions 1-4) the subcontractor’s or supplier’s full legal name, phone number, address, and describe the transaction.

If there is more than one subcontractor, provide a separate sheet with all required information. (Label the separate sheet “Additional Attachment F-1: Subcontractor Information and Significant Business Transactions, Part C”)

Part D

List the name and address of each person(s) with a 5 percent or more (direct or indirect) **ownership interest and/or control interest** in any subcontractor (listed in Part C of the F-1 attachment) with whom the Licensee has had business transaction involving health care services, goods, supplies or merchandise related to the provision of services to a Medi-Cal beneficiary that total more than $25,000 during the 12-month period immediately preceding the date of the Application, or immediately preceding the date on the Department’s request for such information. If there is more than one subcontractor, provide a separate sheet with all required information. (Label the separate sheet “Additional Attachment F-1: Subcontractor Information and Significant Business Transactions, Part D”)

Check mark the box if there are no subcontractors listed in Part C of the F-1 attachment or the Licensee has had no business transactions with subcontractors involving health care services, goods, suppliers, or merchandise related to the provision of services to a Medi-Cal beneficiary that total more than $25,000 during the 12-month period immediately preceding the date of the Application, or immediately preceding the date on the Department’s request for such information.

1. Enter the full legal name, phone number, and address of person(s) or entity(ies) with 5 percent or more (direct or indirect) ownership interest and/or control interest in the subcontractor named in Part C of the F-1 Attachment.