LICENSURE & CERTIFICATION APPLICATION

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

A. APPLICATION INFORMATION

1. Type of application (check one):
   - ◯ **a.** Initial
   - ◯ **b.** Change of Ownership (see #2 below)
   - ◯ **c.** Management company (see Sections C1-5, F, and Attachment E-1)
   - ◯ **d.** Other change (see Section A4): _____

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. Amount of fee enclosed: $ _____

4. Type of Change (check all that apply):
   - ◯ **a.** Not applicable
   - ◯ **b.** Change of capacity (see # 8 below)
   - ◯ **c.** Change of location
   - ◯ **d.** Change of services _____
   - ◯ **e.** Change of facility type _____
   - ◯ **f.** Change of bed classification _____
   - ◯ **g.** Change of name
   - ◯ **h.** Construction of new or replacement facility
   - ◯ **i.** Stock transfer
   - ◯ **j.** Other (specify) _____

5. Type of facility, agency, or clinic (check one)
   - ◯ **a.** Skilled Nursing Facility (SNF)
   - ◯ **b.** Intermediate Care Facility (ICF)
   - ◯ **c.** ICF/Developmentally Disabled (ICF/DD)
   - ◯ **d.** ICF/DD-Habilitative (ICF/DD-H)
   - ◯ **e.** ICF/DD-Nursing (ICF/DD-N)
   - ◯ **f.** Primary care clinic – Free
   - ◯ **g.** Primary care clinic – Community
   - ◯ **h.** Surgical clinic
   - ◯ **i.** Rural health clinic (for Certification "only")
   - ◯ **j.** General acute care hospital
   - ◯ **k.** Adult day health care center
   - ◯ **l.** Home Health Agency (HHA)
   - ◯ **m.** Hospice
   - ◯ **n.** Chronic dialysis clinic
   - ◯ **o.** Other (specify) _____

6. **a.** Do you wish to apply for the Medicare program? ◯ Yes ◯ No Medicare Provider #: _____
   b. Fiscal Intermediary choice: _____

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

8. **a.** Current facility bed capacity: _____
   b. Proposed facility bed capacity: _____

9. Age range of clients: _____

10. Days and hours of operation: _____

11. Is construction required? ◯ Yes ◯ No
    If "yes", submit copy of "OSHPD" form (see instructions on page 6)
    If "yes", date construction to begin: _____
    If "yes", date construction to be completed: _____

B. LICENSEE INFORMATION

1. Licensee name:

2. Federal employer's tax ID number:

3. Owner type (check one): ***Submit*** organizational chart for b, c, d, and e.

- ◯ **a.** Sole proprietorship (Individual)
- ◯ **b.** Profit corporation
- ◯ **c.** Nonprofit corporation
- ◯ **d.** Limited Liability Company (LLC)
- ◯ **e.** Partnership – General
- ◯ **f.** Partnership – Limited
- ◯ **g.** City
- ◯ **h.** County
- ◯ **i.** State agency
- ◯ **j.** Other agency (specify)
- ◯ **k.** Public agency (specify)

4. Licensee address (number & street): Telephone number:

City, State, & Zip: E-Mail: Fax number:

5. **a.** Identify other facilities, agencies, or clinics the licensee has been licensed for, operated, managed, held a **5%** or more 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 of the required information listed below.

(1) Facility Name: Facility Type:

Facility address (number & street): City, State, & Zip:

(2) Facility Name: Facility Type:

Facility address (number & street): City, State, & Zip:

(3) Facility Name: Facility Type:

Facility address (number & street): City, State, & Zip:

(4) Facility Name: Facility Type:

Facility address (number & street): City, State, & Zip:

b. If any facility, agency, or clinic identified in 5.a. has had a license revocation action filed, license placed on probation, suspended, or revoked (whether stayed or not) or, for agency or clinic resolved by settlement, receiver appointed, or had a final Medi-Cal decertification action taken, please ***submit*** additional information, including all ownership and facility information, date and any final action.

6. Is the licensee a **subsidiary** of another organization? ◯ Yes ◯ No
If "yes", complete the information below and ***submit*** an organizational chart:

Parent organization name:

Parent federal tax ID Number:

P.O. Box or number & street:

City, State, & Zip:

C. FACILITY, AGENCY OR CLINIC INFORMATION

Management Agreement (this only applies to SNF's & ICF's):

1. **a.** Is the facility, agency, or clinic going to be operated under a management contract/agreement between the proposed owner and a management company? ◯ Yes
   If "yes", proceed to **Section E** (below). ◯ No

   b. Is there an "interim" management agreement, between the proposed owner and the current owner, to run the facility, agency, or clinic until the change of ownership is completed? ◯ Yes
   If "yes", ***submit*** a copy of the "interim" management agreement. ◯ No

2. Name of **"proposed" facility**, agency, or clinic: _____
   Current facility, agency, or clinic name (if change of ownership): _____ Facility license number: _____

3. Address (number & street) of "proposed" facility, agency, or clinic: _____ Telephone number: _____
   City, State, & Zip: _____

4. Mailing address, if different from above: Telephone number:
   Number & Street: _____ _____
   Fax number: E-mail address:
   City, State, & Zip: _____ _____ _____

5. **Name of person to be in charge of facility, agency, or clinic:** _____
   Title: _____ Professional License number: _____

6. **a.** Name of administrator: _____ Date of hire: _____
   Professional License number: _____ Expiration date: _____
   b. Name of director of nursing: _____ Date of hire: _____
   Professional License number: _____ Expiration date: _____

7. List persons having **5 percent** or more direct or indirect (42 CFR, Section 455.102) interest in the ownership of this facility if applying for skilled nursing or intermediate care licensure, and **10 percent** for all other facilities, agencies, or clinics. Provide federal employer's tax ID number. Are any of these persons (listed below) related to one another as spouse, parent, child or sibling? ***Submit*** an attachment for additional names that includes all of the required information listed below.

	Name of individual	% Owned	EIN Number	Are they related to one another as a spouse, parent, child or sibling?		Relationship
(1)				◯ Yes	◯ No	
(2)				◯ Yes	◯ No	
(3)				◯ Yes	◯ No	
(4)				◯ Yes	◯ No	
(5)				◯ Yes	◯ No	

8. **Financial resources -- Only applies to SNF and ICF:**
   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 45 days. (The amount is determined by multiplying 45 days X number of beds X rate).

9. **Over-concentration -- Only applies to ICF/DD, ICF/DD-H and ICF/DD-N:**
   a. Are there any ICF/DD, ICF/DD-H, ICF/DD-N, RCF (residential care facility), or pediatric day health or respite care facilities within 300 feet of this facility? (H&S Code, Section 1267.9) ◯ Yes ◯ No ◯ Don't know
   b. Are there any congregate living health facilities within 1,000 feet of this facility? ◯ Yes ◯ No ◯ Don't know

10. **Program Plan -- Only applies to ICF/DD, ICF/DD-H and ICF/DD-N (H&S Code, Section 1275.3(b)(3))**
    Has the program plan been approved by the Department of Developmental Services? ◯ 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 CDHS. If "no", the application package will be delayed until a copy of the approved program letter is recieved

D. PROPERTY INFORMATION

1. Property ownership: Check one and ***submit*** evidence of control of property: ◯ Own ◯ Rent ◯ Lease ◯ Sublease ◯ Other (specify): _____

2. **Owner of Record** name in the real estate: _____
   Address (number & street): _____
   City, State, & Zip: _____

   Lessee name: _____
   Address (number & street): _____
   City, State, & Zip: _____

   Sub-Lessee name: _____
   Address (number & street): _____
   City, State, & Zip: _____

E. MANAGEMENT COMPANY

If the proposed facility, agency, or clinic will be operated by a management company, under a management contract between the proposed owner and a management company, complete Attachment E-1 (next page). NOTE: if the facility is a SNF or ICF, the management company will have to SUBMIT a separate application to the Department, unless previously approved.

F. 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 statements on this application and on the accompanying attachments are correct to my (our) knowledge.

Signature	Title	Date
Signature	**Title**	**Date**
Signature	**Title**	**Date**
Signature	**Title**	**Date**

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 Health Services, 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 may result in nonissuance 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 Licensing and Certification district offices.

ATTACHMENT E-1

MANAGEMENT COMPANY INFORMATION ONLY FOR SNF's or ICF's

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

Name of management company: _____ EIN: _____
Address (number & street): _____
City, State, & Zip: _____

Name of facility to be managed: _____ EIN: _____
Address (number & street): _____
City, State, & Zip: _____

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

(1) Individual's name: _____ % Owner: _____
Address (number & street): _____
City, State, & Zip: _____

(2) Individual's name: _____ % Owner: _____
Address (number & street): _____
City, State, & Zip: _____

(3) Individual's name: _____ % Owner: _____
Address (number & street): _____
City, State, & Zip: _____

(4) Individual's name: _____ % Owner: _____
Address (number & street): _____
City, State, & Zip: _____

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.

(1) Facility, agency, or clinic name: _____
Address (number & street): _____
City, State, & Zip: _____ Dates of involvement: _____

(2) Facility, agency, or clinic name: _____
Address (number & street): _____
City, State, & Zip: _____ Dates of involvement: _____

(3) Facility, agency, or clinic name: _____
Address (number & street): _____
City, State, & Zip: _____ Dates of involvement: _____

(4) Facility, agency, or clinic name: _____
Address (number & street): _____
City, State, & Zip: _____ Dates of involvement: _____

INSTRUCTIONS

SNF or ICF Management Company Application: See Attachment E-1 below.

Type or print clearly. Return original and maintain a copy for your records. The Licensee's name must be consistent throughout all documents submitted. ***Submit*** all supplemental paperwork requested to complete your application. **Do not leave items blank. If not applicable, mark N/A.**

A. APPLICATION INFORMATION

1. Type of application: select items a, b, c, or d.
   If b is selected, provide effective date of change in number 2.
   If c is selected, complete Sections C1-5; F, and Attachment E-1.
   If d is selected you must select an option in number 4 -- "Type of Change."
2. Provide actual date applicant took charge of the financial management of facility.
   This date is used to show effective date of the ownership change for certification purposes only.
3. Amount of fee enclosed: enter the amount of money enclosed with this application.
   If no fee is required, enter "N/A". (Refer to fee schedule for appropriate fee requirements.)
4. Type of change: check all that apply.
5. Type of facility, agency, or clinic: select the appropriate category.
6. (a) Check "yes" if requesting certification for Medicare. ICF/DD, ICF/DD-N, ICF/DD-H facilities and primary care clinics that are not certified as rural health clinics are not eligible for Medicare.
   (b) If "yes" to item 6(a), provide name of fiscal intermediary under item 6(b).
7. Check "yes" if requesting participation in Medi-Cal (Medicaid).
8. (a) Current facility 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.
9. Enter age range of persons to receive/receiving care.
10. Enter days and hours of facility operation.
11. Enter date construction is to begin, and date construction is to be completed (not applicable for ICF/DD, ICF/DD-N, ICF/DD-H facilities).
    - ☐ ***Submit*** a copy of the form *"Construction Advisory Board"* (form OSH-FDD 377(11/97)) if OSHPD has approved construction.
    - ☐ ***Submit*** a copy of the above form to the local district office *prior* to the survey if OSHPD has not yet approved construction.

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. Husband and wife, if joint applicants, must both be listed.

   NOTE: All individuals including owners, partners, principal officers of corporations/LLCs, members, managers, and administrators (clinics only) must complete "Applicant Individual Information" (HS 215A).

2. Enter the federal employer's tax ID number.
3. Owner Type: select one of the options and then:
   - ☐ ***Submit*** an organizational chart, for items b, c, d, or e showing entity, persons, facilities, and tax EIN numbers.
   - ☐ ***Submit*** a copy of the Internal Revenue Service and Franchise Tax Board letters of determination of nonprofit status, if item c, "nonprofit corporation" is selected, and the facility is a primary care Clinic.

4. Licensee address: enter address of legal organization (LLC, corporation, partnership) or individual(s) responsible for the facility, agency, or clinic. Provide phone number with area code, fax number, and e-mail address.

5. Other Facilities:
   (a) Identify all other facilities, agencies, or clinics the licensee (LLC, corporation, partnership, individual) 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, and dates of involvement. This attachment must include all of the required information listed.
   - ☐ ***Submit*** an attachment, if needed, for any entity identified in number 5a, which has had a license revocation action filed, license placed on probation, suspended, or revoked (whether stayed or not) or, for SNFs and ICFs, resolved by settlement, receiver appointed, or has a final Medi-Cal decertification action taken. Include all ownership and facility information, dates, and any final action.

6. Subsidiary: check "yes" if the licensee is a subsidiary of another organization and complete the information requested.
   - ☐ ***Submit*** a detailed organizational chart, including parent and all subsidiary information, and federal tax ID numbers.

C. FACILITY, AGENCY, OR CLINIC INFORMATION

1. Management Agreement:
   (a) Check "yes" if the facility, agency, or clinic is going to be operated under a management contract/agreement, between the proposed owner and a management company. Proceed to Section "E" (below).
   (b) Check "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.
   - ☐ ***Submit*** a copy of the "interim" management agreement, if applicable.

2. Facility, agency, or clinic name: Enter the name used to designate the single facility, agency or clinic under the license being requested. Also, provide the current facility, agency, or clinic name, and current license number (if different). Change of ownership usually results in a name change.
3. Provide facility, agency, or clinic address, including phone number with area code, fax number, and e-mail.
4. Provide facility, agency, or clinic mailing address, if different from number 3 (above).
5. Provide the name and title of the individual to be in charge of the facility, agency, or clinic as well as any professional license number (if applicable).
6. Administrator:
   (a) Provide the name of the facility administrator, date of hire, license number, and license expiration date.
   (b) Provide the name of the director of nursing services (if applicable), date of hire, license number, and license expiration date.
7. Provide name(s) of all individuals having a **5 percent** or more interest in the ownership of this facility, if applying for SNF or ICF licensure. For all other facility, agency, or clinic types, provide the name(s) of those having **10 percent** or more interest in the ownership. Specify 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.
8. Financial Resources: Only applies to SNF, ICF, and ICF/DD:
   - ☐ ***Submit*** evidence, satisfactory to the Department, that the licensee has sufficient financial resources to operate the facility for at least 45 days (bank statement, certificate of deposit etc.). The amount is determined by multiplying 45 days X number of beds X rate.
9. 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, pediatric day health, or respite care facilities within 300 feet of this facility? Check "yes", "don't know" or "no".
   (b) Are there any congregate living health facilities within 1,000 feet of this facility? Check "yes", "don't know" or "no".

10. Program Plan -- Only applies to ICF/DD, ICF/DD-H and ICF/DD-N:
Indicate if the program plan has been approved by the Department of Developmental Services. The "current licensee" can grant permission for their Program Plan to be used for 6 months if a letter is submitted to CDHS. If "no" is checked, the application package will be held until a copy of the approved program plan letter is received.
   - ☐ ***Submit*** a letter to CDHS 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 applicable.
   - ☐ ***Submit*** a copy of the Program Plan approval letter, if "yes".

D. PROPERTY INFORMATION

1. Licensee must show evidence of control of property.
   - ☐ ***Submit*** **a** copy of the deed and/or bill of sale, if property is owned.
   - ☐ ***Submit*** a copy of the rental agreement, if property is rented.
   - ☐ ***Submit*** a copy of the lease agreement, if property is leased.
   - ☐ ***Submit*** a copy of the original lease plus a copy of the sublease, if property is subleased.
   - ☐ ***Submit*** appropriate evidence if "other" is checked.
2. Provide name and address of the Owner of Record, Lessee and Sub-lessee as applicable.

E. MANAGEMENT COMPANY INFORMATION
(Complete Sections A1, C1-5, F & ATTACHMENT E-1)

F. STATEMENT OF RESPONSIBILITIES
Application must be signed by licensee or authorized representative.

ATTACHMENT E-1

MANAGEMENT COMPANY INFORMATION ONLY FOR SNF's OR ICF's

1. If the proposed facility, agency, or clinic will be operated by a management company, under a management contract between the proposed owner and a management company, provide the name, address, and federal tax ID number of Management Company and name of facility to be managed.
   - ☐ ***Submit*** a copy of the Management Agreement.

2. Provide the name, address, and percent of ownership for each person having a **5 percent** or more interest in the Management Company.
   - ☐ ***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 that you have contracted to manage.
   - ☐ ***Submit*** an attachment for additional facilities, agencies, or clinics. This attachment must include all of the required information.