

### APPLICATION FOR HEALTH FACILITY CHANGE OF LOCATION

*This form is for Change of Location information only and is not to be used for any other purpose. To report any other required changes, please contact your local district office to obtain the appropriate forms.*

**Home Health Agencies and Hospices must submit documentation that CMS has approved the relocation.**

#### A. CURRENT FACILITY INFORMATION

1. Facility Name:

2. Type of Facility:

3. Current Street Address:

City/State/Zip:

4. Days and Hours of Operation:

#### B. LICENSEE INFORMATION

1. Licensee Name:

License Number:

2. Federal Employer's Tax ID Number:

3. Licensee Street Address:

City/State/Zip:

4. Telephone Number:

5. Fax Number:

6. E-mail Address:

#### C. FACILITY, AGENCY OR CLINIC NEW LOCATION INFORMATION

1. New Street Address:

City/State/Zip:

2. Telephone Number:

3. Fax Number:

4. E-mail Address:

5. Pay to address if different from what is stated in Section B:

Street Address:

City/State/Zip:

6. Is construction required?  Yes  No

If yes, submit documentation with this application that the physical plant meets minimal building requirements (see instructions).

Date construction to begin:

Date construction to be completed:

7. Submit documentation with this application that the physical plant meets minimal building requirements (see instructions)

8. Submit form STD 850 (Fire Safety Inspection Request) with this application (only applies to clinics).

9. Name of Person to be in charge of facility, agency or clinic:

**D. PROPERTY INFORMATION**

1. Owner of Record:

Street Address:

City/State/Zip:

2. Lessee Name:

Street Address:

City/State/Zip:

3. Sub-lessee Name:

Street Address:

City/State/Zip:

**I (WE) ACCEPT RESPONSIBILITY TO:**

- a. Comply with local ordinances concerning zoning, sanitation, building, and other appropriate ordinances.
- b. Comply with Labor Code on employment practices concerning nondiscrimination, liability insurance, wages, hours 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 \_\_\_\_\_

## APPLICATION FOR HEALTH FACILITY CHANGE OF LOCATION INSTRUCTIONS

### **A. CURRENT FACILITY INFORMATION**

1. Enter the name used to designate the single facility, agency or clinic under the license being requested.
2. Enter the type of facility, agency or clinic.
3. Enter the current facility, agency or clinic street address, city, state and zip.
4. Enter the days and hours of facility, agency or clinic operation.

### **B. LICENSEE INFORMATION**

1. Enter the licensee's full legal organization name (corporation, LLC, partnership) or sole proprietorship (include the first, middle and last name) responsible for the facility, agency or clinic. Husband and wife, enter both names.  
Enter the license number.
2. Enter the Federal Employer's Tax ID Number.
3. Enter the licensee street address, city, state and zip.
4. Enter the licensee telephone number including area code.
5. Enter the licensee fax number including area code.
6. Enter the licensee e-mail address (do not include the administrator's; it should be either an owner or officer of the licensee).

### **C. FACILITY, AGENCY OR CLINIC NEW LOCATION INFORMATION**

1. Enter the new street address, city, state and zip of the facility, agency or clinic.
2. Enter the facility, agency or clinic telephone number including area code.
3. Enter the facility, agency or clinic fax number including area code.
4. Enter the facility, agency or clinic e-mail address.
5. If the pay to address remains the same as entered in Section B, please enter **N/A**. If different from the address listed in Section B, enter the street address, city, state and zip where you would like the reimbursement to be mailed.
6. If construction is required, submit certification from a licensed architect or local building authority stating building is in compliance with Title 24, California Code of Regulations and the California Building Code. A certificate of occupancy is also required.
7. Submit certification from a licensed architect or local building authority stating building is in compliance with Title 24, California Code of Regulations and the California Building Code. A certificate of occupancy is also required.
8. Clinics Only: Submit form STD 850 (Fire Safety Inspection Request) with this application.
9. Enter name of person to be in charge of facility, agency or clinic.

**D. PROPERTY INFORMATION**

Provide name and address of the owner of record, lessee and sub-lessee as applicable. Submit copy of grant deed, lease, rental agreement, sublease, or bill of sale with this application. The lease must be between the landlord and/or lessee and the licensee.

**The application must be signed by the licensee or an authorized representative.  
Mail the completed application and attachments to the appropriate district office.**