



APPLICATION REQUEST FOR A HOME HEALTH AGENCY

or Certification of a HOSPICE Under a HHA License

This letter is to assist you in preparing a home health agency (HHA) licensing and/or certification (for Medi-Cal Title 19 and/or Medicare Title 18 reimbursement) application package to the California Department of Public Health (CDPH), Licensing and Certification (L&C) Program for:

- Initial application for a HHA; or
- Initial Application for a “branch” HHA; or
- Change of ownership (CHOW) package for a HHA; or
- All “**other**” changes for a HHA; or
- Certification of a hospice that is licensed under the HHA license.

NOTE: A “certified” hospice needs to be separately licensed as a hospice (refer to the hospice letter on this website) or separately certified under a licensed HHA (**as a service**). **NOTE:** If a HHA is adding a HOSPICE service, refer to the CMS 1572 form. **Do NOT use this** checklist. Also, if a separately “licensed” HOSPICE wants to be certified for Medi-Cal and/or Medicare, **do NOT use this** checklist (use the HOSPICE letter/checklist).

A state license is required to operate a HHA in California, which is defined as:

HHA means “a private or public organization, including but not limited to, any partnership, corporation, political subdivision of the state, or other government agency within the state, which provides, or arranges for the provision of, skilled nursing services, to persons in their temporary or permanent place of residence.”

An application is required for: (1) a new (initial) HHA (whether it is a parent or a branch of a parent), (2) whenever a HOSPICE is requesting to be certified under a HHA license, and (3) within **10 working days** whenever a CHOW occurs.

1. HHA CHOW applications:

A CHOW is the only “change” requiring a new application. All HHA initial and CHOW application packages are to be submitted to L&C’s Centralized Applications Unit (CAU), pursuant to Section 74667(a) of Title 22 of the California Code of Regulations (CCR).



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2. HHA “OTHER” changes (besides a CHOW):

“Other” changes must be reported to the L&C DO in writing within **10 days** of the change. The appropriate DO will assist you on which HHA forms on the checklist that must be submitted for the specific change to the license. A list of DOs and appropriate contacts are located on the L&C website at:

<http://www.cdph.ca.gov/certlic/facilities/Pages/LCDistrictOffices.aspx>

For your convenience, the **attached checklist** has instructions to complete the forms required for licensing and certification of a HHA. The **checklist** provides specific item numbers that applicants typically have encountered problems in submitting incorrect or missing information. Please make sure that all item numbers in each form are completely filled out. For example: (1) the applicant’s formal name must be consistently the same throughout all the documents in the application package; or (2) in some instances, a specific attachment may need to be submitted with a specific form. **All forms are required to be signed by the “licensee”, owners or officers, unless otherwise stated.**

Please read each required application package form carefully and provide all requested supplemental documents. **DO NOT LEAVE ANY ITEMS BLANK. NOTE:** If a question does not apply, please respond with “Not Applicable” or “N.A.”. **Do not make changes to these forms. USE “BLUE” INK TO SIGN ALL FORMS.** Do not use white out/correction fluid to make corrections. To correct an error, place a single line through the entry and enter the correct information. The individual responsible for making the correction must **initial and date** the correction. You should retain a photocopy of the completed documents for your files. We may need to contact you in the future and we will be referring to the information in the documents you provided.

In addition, a check or money order, made payable to the “**California Department of Public Health**”, for the licensing fee, determined pursuant to Section 1266 of the Health and Safety Code (H&S), must accompany the required forms before your application will be processed. The licensing fees change annually; therefore please check the current licensing fee for a HHA which is posted on the L&C website at:

<http://www.cdph.ca.gov/pubsforms/forms/Pages/HealthFacilities.aspx>

The application fee will NOT be returned if the application is withdrawn or denied, pursuant to Section 1729 of the H&S Code.



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The application package review process will consider the applicant's and associates' (i.e., board members, LLC members, managers, etc.) past compliance history. This will be based on a review of all facilities and agencies operated by those individuals in California and nationally. The applicant and associates must demonstrate substantial compliance with state and federal requirements for all facilities that they operate.

Failure to demonstrate substantial compliance history may result in the denial of your application package. You will be notified in writing of L&C's intent to deny the application.

All completed HHA **application packages must be submitted to the L&C, CAU address** (regular **or** overnight mail), listed below. Please note that "overnight" mail may actually take longer for the CAU to receive because of our CDPH in-house mail services.

For regular mail:

California Department of Public Health
Licensing and Certification Program
Centralized Applications Unit
P.O. Box 997377, MS 3402
Sacramento, CA 95899-7377

For overnight (FedEx-UPS)

California Department of Public Health
Licensing and Certification Program
Centralized Applications Unit
1615 Capitol Avenue, MS 3402
Sacramento, CA 95814

The CAU will review the **HHA** application package for completion and forward it to the appropriate DO once the application package has been given a recommendation of "approved". The DO will review the application package for completion. A list of DOs and appropriate contacts are located on the L&C website listed above.

Choice of Fiscal Intermediary.

The fiscal intermediaries are available from the Federal Department of Health and Human Services at the following website:

www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf

To apply for National Provider Identifier (NPI), go to the following website:

<https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.instructions>

Please NOTE the following:

1. There are some differences between documents required for a CHOW, and "initial" applications that are noted on the attached **checklist**.



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2. An initial **licensing survey** is part of the application process for “new” HHA applications.
3. The initial **licensing survey** is a scheduled survey conducted by L&C DOs.
4. **Certification:**
Certification status will allow the HHA to provide services to **Medicare beneficiaries** (under Title 18). Once the HHA has become **Medicare** certified, they may also provide services to **Medi-Cal beneficiaries** (Title 19), if requested. The HHA is **required** to be licensed prior to seeking **certification status**.

Many applicants, including HHA, have the option of becoming **certified** on the basis of accreditation by the Centers for Medicare & Medicaid Services’ (CMS) approved accreditation organizations (listed below) instead of a survey by L&C.

- Joint Commission (JC)
630-792-5000, (www.jointcommission.org)
- Community Health Accreditation Programs (CHAP)
800-656-9656, (www.chapinc.org)
- Accreditation Commission for Health Care, Inc. (ACHC)
919-785-1214, (www.achc.org)

Once approved by the accreditation organization, submit the approval letter from the accreditation organization to the appropriate DO. Since the Medicare certification forms listed on the attached **checklist** are submitted with your “initial” application package, if there are any changes to the forms, the DO will request amended forms after they receive the approval letter from the accreditation organization.

If you **DO NOT** choose to go through one of these accreditation organizations it will be several **YEARS** before L&C will be able to perform a certification survey since “initial” certification surveys for HHAs have been categorized as a **LOW priority**. However, if you still want the L&C DO to consider conducting the “initial” certification survey, you will need to submit justification to the DO for CMS approval. The burden will be on the HHA to provide data and other evidence that effectively establishes the probability of serious, adverse beneficiary health care access consequences if the HHA is **NOT** enrolled to participate in Medicare.

5. In addition you must be in compliance with state licensing laws and federal conditions of participation. The HHA Provider Manual can be viewed online at:

www.cms.hhs.gov



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It is the applicant's responsibility to obtain the Code of Federal Regulations and to understand the HHA Conditions of Participation, which are located on the following website:

http://www.access.gpo.gov/nara/cfr/waisidx_99/42cfr484_99.html

The DO will notify you when the application has been approved and will schedule an initial licensing survey. NOTE: YOU MUST BE READY FOR THE INITIAL LICENSING SURVEY UPON NOTIFICATION. It is L&C's policy that, except for very unusual circumstances, only one inspection visit will be made. Failure of the agency to be in substantial compliance, at the time of the visit, will result in the "denial" of the application. Any further activity regarding your request, after such denial, will require a new application, and license fee.

PLEASE NOTE: A license will not be issued until the application is approved and, if required, a successful licensing survey is conducted.

If you have any questions, please contact one of the following:

1. If the HHA is requesting an initial or CHOW, contact the CAU, at (916) 552-8630 or by e-mail at CAU@cdph.ca.gov.
2. If the HHA is requesting an "other" change (not including CHOWs) contact your local DO administrator located on the L&C website listed on page two.



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		The following is a quick reference of SOME of the questions found on the required forms. It includes the form number, name of form, and an explanation of SPECIFIC requirements and/or attachments needed for specific forms. This is NOT an all-inclusive list of the questions that need to be answered so read the questions and instructions on each form.	LICENSING and / or Certification	TECHNICAL CHOW	BRANCH OFFICE
LICENSURE HOME HEALTH AGENCIES Includes the forms and information required to be “licensed”					
BRANCH OFFICE		• BRANCH Office means a HHA established and administered by a PARENT HHA, providing services within a portion of the total service area served by the PARENT agency.	N/A	N/A	FYI
		• A BRANCH Office is located at a separate location from the PARENT and must offer the same services as the parent.	N/A	N/A	FYI
		• A BRANCH Office is listed on the PARENT license. (Title 22, Section 74675)	N/A	N/A	FYI
		• BRANCH Offices are required to SUBMIT a separate application package consisting of the forms identified on this checklist.	N/A	N/A	FYI
HOSPICE		• If a HHA is adding HOSPICE as a “ <u>service</u> ”, refer to the instructions on the <u>CMS 1572</u> form on the following pages.	FYI	N/A	N/A
		• If a “LICENSED” HHA already has a HOSPICE and that HOSPICE wants to be “CERTIFIED” for MEDI-CAL and/or MEDICARE , you need to complete the forms indicated under the Medi-Cal and MEDICARE Certification instructions.	FYI	N/A	N/A
		• If a separately “licensed” HOSPICE wants to be certified for MEDI-CAL and/or MEDICARE , refer to the HOSPICE application letter and checklist located on the L&C website. Do NOT use this Checklist.	N/A	N/A	N/A
TECHNICAL CHOW		• CMS does not differentiate a TECHNICAL CHOW from a CHOW – they view it as being an actual CHOW.	N/A	FYI	N/A
		• TECHNICAL CHOWs are “only” a LICENSURE Requirement.	N/A	FYI	N/A
		• SUBMIT a separate application package consisting of the TECHNICAL CHOW forms identified on this checklist in the column to the right.	N/A	FYI	N/A
		• TECHNICAL CHOWs will NOT become effective until approved by CAU.	N/A	FYI	N/A
HS 200	Licensing & Certification Application (Title 22, Sections 74661 & 74665)				
	NOTE: Please read the instructions on the HS 200 form prior to completion of the form. Also, pay close attention to the following:				
	A.3.	Amount of Fee Enclosed. [Title 22, Section 74669(a) and H&S Code, Section 1266]			
	A.8.	Bed capacity does NOT apply to HHAs.	N/A	N/A	N/A
	A.9.	Age range of clients.			
A.10.	Days and hours of operation.				



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		<p>The following is a quick reference of SOME of the questions found on the required forms. It includes the form number, name of form, and an explanation of SPECIFIC requirements and/or attachments needed for specific forms. This is NOT an all-inclusive list of the questions that need to be answered so read the questions and instructions on each form.</p>		
A.11.	Construction. This does NOT apply to HHAs since there are no patients in the building.	N/A	N/A	N/A
B.1.	Licensee's name. The licensee's formal organization name must be consistent throughout all documents.			
B.3.	Owner type. [Title 22, Section 74603(a)(b) and 74661(a)(7)] SUBMIT an organization chart/flow chart if the owner is a profit or nonprofit corporation, limited liability company (LLC), or general partnership. The organization chart needs to display the following: <ul style="list-style-type: none"> • Applicant's owners and their ownership percentages, directors, board members, corporate officers, LLC members/managers, and partners. • PARENT company of applicant, if applicable, and all the licensed agencies/facilities they are operating – See Item "B.6." below. 			
B.5.a.	Licensee's "other" Facility Involvement. Answer all aspects of the question.		N/A	
B.5.b.	Revocation, suspension, etc. action. If applicable to the licensee, SUBMIT the information requested.			
B.6.	Subsidiary (PARENT company) information. If there is a "subsidiary" (PARENT company) SUBMIT : <ul style="list-style-type: none"> • An organization chart with the PARENT company name. • A listing of all owners (of the PARENT company) and their ownership percentages, directors, board members, corporate officers, LLC members/managers, and partners of the PARENT company. • A listing of all facilities the PARENT company is operating. 		N/A	
C.1.a.	Management Company. This question does not apply to home health agencies.	N/A	N/A	N/A
C.1.b.	"Interim" Management Company Agreement. NOTE if CHOW: If there is an "interim" Management Company Agreement, between the current and the prospective licensee, SUBMIT a signed and dated copy of Agreement.		N/A	
C.2.	Item C.2. Name of "proposed" & "current" facility, agency or clinic. Enter BOTH agency names if this is a CHOW . If this agency does NOT have a separate facility name, they may insert the corporate name			
C.3.	Address of "proposed" facility, agency or clinic: The BRANCH OFFICE address must be listed on the PARENT license. [Title 22, Section 74661(a)(3)] Indicate the address of "proposed" facility, agency or clinic:	N/A	N/A	



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	C.6.a.	Name of ADMINISTRATOR and date of hire. Insert the name of the Administrator and requested information. Administrator and Director of Patient Care Services can be the same individual. [Title 22, Section 74718(b)]			FYI	FYI	N/A
	C.6.b.	Name of DIRECTOR OF NURSING and date of hire. Insert the name of the Director of Nursing and requested information. Director of Patient Care Services and Administrator can be the same individual. [Title 22, Section 74718(b)]					N/A
	C.7.	Ownership. [Title 22, Section 74661(a)(5)] List all individuals having 5% or more ownership, unless "nonprofit".					
	C.8.	Item C.8. Financial Resources. The "specific" question on the HS 200 form DOES NOT apply to HHAs (only skilled nursing and intermediate care facilities). However, specific financial resources are required for a LICENSED "only" HHA (i.e., with no MEDI-CAL OR MEDICARE): Any HHA that is going to be LICENSED "only" will need to SUBMIT evidence that the licensee has sufficient financial resources to operate the HHA for the first three (3) months. [Title 22, Section 74661(a)(6)]				N/A	N/A
		This evidence should consist of the following: (1) Projected expenses for the first three (3) months (90 days) of operation broken down by rent, utilities, salaries, overhead, etc. (2) A copy of an "official" bank statement, certificate of deposit, etc. (in the name of the licensee) providing current balances.				N/A	N/A
	C.9. & 10.	Over-concentration and Program Plan does not apply to HHAs.			N/A	N/A	N/A
	D.1. & 2.	Property Ownership for a TECHNICAL CHOW: CAU to review the TECHNICAL CHOW leases, subleases, and etc., individually on a case-by-case basis. CAU to check that the current and/or new owner's signatures are reflected on any amended lease, sublease, etc.			N/A	FYI	N/A
		Property ownership. SUBMIT a copy of the Grant Deed, Bill of Sale, Lease, Sublease, or Rental Agreement between the owner of the property and the proposed licensee. Assignment & Assumption of Lease is acceptable as long as it states the Lease will become effective upon issuance of the license to the new licensee. [Title 22, Section 74661(a)(3)]					N/A
	E.1. & Attach E-1	Management Company Information does not apply to HHAs.			N/A	N/A	N/A



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	F.1.	Signature. Original "signature" is required and MUST be signed by the APPLICANT (not the Administrator unless the owner is the Administrator).					
HS 215A	Applicant Individual Information (Title 22, Sections 74661(a)(5) & 74665)						
	NOTE: Please read the instructions on the HS 215A form prior to completion of the form. This form must be completed for the following individuals with ORIGINAL signatures:						
	<u>TECHNICAL CHOW</u>				N/A	FYI	N/A
	The HS 215A form required only if there is a "NEW" administrator, stock holder, officer, member, partner, etc.						
	SUBMIT the HS 215A form plus any other required documents (which will be listed below) for the following individuals:						
	APPLICANT Organization [Title 22, Section 74661(a)(5)]						
	HS 215A form for each individual having a beneficial interest of 5% or more in the APPLICANT organization (list their ownership percentages).						
	HS 215A form for directors, board members, corporate officers, LLC members/managers, and partners of the APPLICANT organization.						
	PARENT Company [Title 22, Section 74661(a)(5)]						
	HS 215A form for each individual having a beneficial interest of 5% or more in the PARENT company (list their ownership percentages).					N/A	
	HS 215A form for directors, board members, corporate officers, LLC members/managers, and partners of the PARENT company.					N/A	
	MANAGEMENT Company HS 215A form				N/A	N/A	N/A
	ADMINISTRATOR of the Facility [Title 22, Section 78415(b)]						
	HS 215A form for Administrator.						N/A
	"RESUME" for the Administrator. Compare with qualifications contained in Title 22, Section 74718 .						N/A
Copy of Administrator's professional license, if applicable.						N/A	
Copy of Governing Body signed written statement verifying their appointment. (Title 22, Section 74613)						N/A	
ADMINISTRATOR'S DESIGNEE							
HS 215A form for Administrator's DESIGNEE.						N/A	
"Administrative DESIGNEE RESUME."						N/A	
Copy of Administrator DESIGNEE'S professional license, if applicable.						N/A	
DIRECTOR OF PATIENT CARE SERVICES (DON)							
HS 215A form for DON.				N/A	N/A	N/A	
DON's "RESUME."						N/A	
Copy of DON's RN license.						N/A	



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	Section D	Employment/Business Summary. A resume or attachment will be acceptable in lieu of Section "D" being filled out.				N/A	
	Signature	Original "signature" is required on all the HS 215A forms.				N/A	
	Facility Information Sheet	If applicable, each individual must complete and SUBMIT the "Facility Information Sheet" for each facility and/or agency with which they have a <u>current</u> or <u>past</u> relationship within the last 3 years. The following <u>MUST</u> be completed for each facility and/or agency: <ul style="list-style-type: none"> • Facility name and address • Type of facility • Type of business entity (include EIN Number) • Individual's <u>nature</u> and <u>dates</u> of involvement • This Sheet must also include any facilities licensed by the California Department of Social Services. [Title 22, Section 74665(d)] 				N/A	
HS 309 1 st page	Administrative Organization (Title 22, Section 74665)						
		TECHNICAL CHOW The HS 309 form required for TECHNICAL CHOWS only if there are "NEW" officers, members, managers, holders, partners, etc.		N/A	FYI	N/A	
	2.	This form is N/A for sole proprietor. Administrator of Corporation or LLC – This name is usually the CEO/President.				N/A	
	3-7	Corporations need to SUBMIT: <ul style="list-style-type: none"> • Copy of Filing Statement from CA Secretary of State (only required if Articles of Incorporation are NOT endorsed by the CA Secretary of State). 		Limited Liability Companies need to SUBMIT: <ul style="list-style-type: none"> • Copy of Filing Statement from CA Secretary of State (only required if Articles of Organization are NOT endorsed by the CA Secretary of State). 			N/A
		<ul style="list-style-type: none"> • Copy of "all" Articles of Incorporation (endorsed by CA Secretary of State). 		<ul style="list-style-type: none"> • Copy of Articles of Organization (endorsed by CA Secretary of State). 			N/A
		<ul style="list-style-type: none"> • Copy of By-Laws. 		<ul style="list-style-type: none"> • Copy of Operating Agreement. 			N/A
	9.	Governing Board of Directors. <ul style="list-style-type: none"> • Enter the number of board members or LLC members/holders. 					N/A
		<ul style="list-style-type: none"> • SUBMIT a list of the board of directors or the LLC members/holders. 					N/A
	10.	Enter the names of the board officers or the LLC officers/managers.					N/A



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HS 309 2 nd page	Organizational Structure					
		TECHNICAL CHOW -- The HS 309 form required only if there are any "NEW" officers, members, managers, holders, partners, etc.		N/A	FYI	N/A
	1.	California Out-of-State Corporations, LLC, etc. SUBMIT a copy of the Certificate of Qualification from the California Secretary of State.				N/A
	3. & 4.	Public Agency. SUBMIT a copy of the "signed" Resolution.				N/A
	5.	Corporations, LLCs and Partnerships need to complete Item 5. N/A for nonprofit.				N/A
	Bottom of page	Partnerships need to SUBMIT: <ul style="list-style-type: none"> • Copy of the Partnership Agreement. • Copy of the California Secretary of State filing, if applicable. 				N/A N/A
HS 322	Transmittal Application for Criminal Background Investigation					
		TECHNICAL CHOW – The HS 322 form is required only if there is a "NEW" administrator or new administrator's DESIGNEE.		N/A	FYI	N/A
		SUBMIT the HS 322 form for the following individuals: [H&S Code, Section 1728.1(a)(2)(A)]				N/A
		<ul style="list-style-type: none"> • Owners (having a 5% or more ownership) • Administrator • Administrator's DESIGNEE. 				N/A N/A
		Mail this form to the address indicated on the form.				N/A
CDPH 325	Criminal Record Clearance Submissions					
		TECHNICAL CHOW The HS 325 form is required only if there is a "NEW" administrator or new administrator's DESIGNEE.		N/A	FYI	N/A
		SUBMIT the HS 325 form with for the following individuals' names listed on the form: [H&S Code, Section 1728.1(a)(2)(A)] & Affordable Care Act				N/A
		<ul style="list-style-type: none"> • Owners (having a 5% or more ownership) • Administrator • Administrator's DESIGNEE. 				N/A N/A



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BCIA 8016	Request for Live Scan Service						
		<u>TECHNICAL CHOW</u> The BCIA 8016 form is required only if there is a "NEW" administrator or new administrator's DESIGNEE .			N/A	FYI	N/A
		For out-of-state fingerprint clearance, contact the Centralized Applications Unit at (916) 552-8630 or by e-mail at: CAU@cdph.ca.gov			FYI	FYI	N/A
		Instructions for completion of the BCIA 8016 form are available on the Attorney General's website at: http://ag.ca.gov/fingerprints/index.php			FYI	FYI	N/A
		Refer to the " SAMPLE " BCIA 8016 form on the L&C website "Applications for Licensing and/or Certification of a Home Health Agency" at: http://www.cdph.ca.gov/pubsforms/forms/Pages/HealthFacility-HomeHealthAgency.aspx			FYI	FYI	N/A
		The ORI# must be " A1226 ".			FYI	FYI	N/A
		SUBMIT the BCIA 8016 form for the following individuals: [H&S Code, Section 1728.1(a)(2)(A) & Affordable Care Act]					N/A
		<ul style="list-style-type: none"> • Owners (having a 5% or more ownership) • The administrator • Administrator's DESIGNEE. 					N/A
CMS 1572 Pages (a) & (b)	Home Health Agency Survey and Deficiency Report						
		• If this HHA is a LICENSED "only" , the only reason this form is being requested is for the listing of the types of services.			FYI	FYI	N/A
		• Complete pages (a) and (b), items 1-20, as indicated on the form.					N/A
	• If this HHA is adding HOSPICE as a "service", identify the HOSPICE service on page 2, Item 18, number 13 (under " OTHER "), of this form by writing in the word HOSPICE .				N/A		
Geographic Areas	Geographic Areas of HHA (Title 22, Sections 74607, 74663, and 74664)						
		<u>BRANCH OFFICE</u> Geographic Area of a BRANCH Office -- SUBMIT a copy of a web-based map reflecting the distance between the PARENT and BRANCH Office.			N/A	N/A	
		<ul style="list-style-type: none"> • The service area of a PARENT HHA may not extend beyond four (4) hours surface travel time from the agency unless the agency serves a rural, scarcely populated area. So we may verify this, SUBMIT the service area documented on page 23 of the CMS-855A application. [Title 22, Section 74607(a)] 				N/A	
	<ul style="list-style-type: none"> • Both licensed and certified HHAs (PARENT and BRANCH) must SUBMIT a list of geographical areas (including cities, counties & zip codes) to be served. This is required because a provider of HHA services cannot serve "ALL" of California. 				N/A		



APPLICATION REQUEST FOR A HOME HEALTH AGENCY

or Certification of a HOSPICE Under a HHA License

Form Number	Item Number on Form	APPLICANT CHECKLIST For a HOME HEALTH AGENCY			Check List		
		The following is a quick reference of SOME of the questions found on the required forms. It includes the form number, name of form, and an explanation of SPECIFIC requirements and/or attachments needed for specific forms. This is NOT an all-inclusive list of the questions that need to be answered so read the questions and instructions on each form.			LICENSING and / or Certification	TECHNICAL CHOW	BRANCH OFFICE
CHOW	Change of Ownership (CHOW)						
	BRANCH OFFICE CHOW SUBMIT "only" the HS 200 form and the FEE .			N/A	N/A	N/A	
	If there has been a previous CHOW in the last <u>36 months</u> , you will need to apply for "INITIAL" licensure for MEDICARE certification purposes. Refer to the HHA MEDICARE forms identified on this checklist. [42 CFR, Section 424.550(b)] You must enroll as a "new" HHA. Undergo a State survey or obtain accreditation. Sign a new provider agreement.				N/A	N/A	
	• SUBMIT all of the forms required for an "initial" application plus:				N/A	N/A	
	• Copy of "Purchase Agreement" or "Operating Transfer Agreement".					N/A	
	• Need a letter from the prospective licensee to CDPH stating where the stored patient medical records will be maintained, and that the records will be made available to the previous licensee. [Title 22, Section 74731(g)]				N/A	N/A	
TECHNICAL CHOW	TECHNICAL CHOW						
	TECHNICAL CHOWs are "only" a LICENSURE Requirement . CMS does not differentiate a TECHNICAL CHOW from a CHOW – they view it as being an actual CHOW.			N/A	FYI	N/A	
	If there is a TOTAL purchase or transfer of 50% or more of the issued stock, assets, or partnership interest in the HHA, it is considered a TECHNICAL CHOW . [Title 22, Section 74667(a)]			N/A	FYI	N/A	
	• If there has been a previous change in majority ownership (more than 50%) in the last <u>36 months</u> , you will need to apply for "INITIAL" licensure for MEDICARE certification purposes. Refer to the HHA MEDICARE forms identified on this checklist. [42 CFR, Section 424.550(b)] • You must enroll as a "new" HHA. • Undergo a State survey or obtain accreditation. • Sign a new provider agreement.			N/A		N/A	
	• If there is a TOTAL purchase or transfer of stock of less than 50% , the district office will process these CHOWs. [Title 22, Section 74661(a)(5)]			N/A	FYI	N/A	
• SUBMIT copy of Stock Purchase Agreement.			N/A		N/A		



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Form Number	Item Number on Form	APPLICANT CHECKLIST For a HOME HEALTH AGENCY			Check List		
		The following is a quick reference of <u>SOME</u> of the questions found on the required forms. It includes the form number, name of form, and an explanation of <u>SPECIFIC</u> requirements and/or attachments needed for specific forms. This is <u>NOT</u> an all-inclusive list of the questions that need to be answered so read the questions and instructions on each form.			LICENSING and / or Certification	TECHNICAL CHOW	BRANCH OFFICE
<u>MEDI-CAL CERTIFICATION</u> HHA							
MEDI-CAL CERTIFICATION	MEDI-CAL Certification of a HHA						
		If you answered "YES" on Item A.7. of the HS 200 form (Do You Wish to Apply for the MEDI-CAL Program?) and your HHA wants to provide services to MEDI-CAL beneficiaries (under Title 19) SUBMIT the forms below, as indicated.			FYI	FYI	N/A
		<ul style="list-style-type: none"> The agency is required to be licensed prior to seeking certification status. 			FYI	FYI	N/A
		<ul style="list-style-type: none"> Once the HHA has become certified for MEDICARE, they may provide services to MEDI-CAL beneficiaries, if requested. 			FYI	FYI	N/A
TECHNICAL CHOW	TECHNICAL CHOW						
		<ul style="list-style-type: none"> CMS does not differentiate a TECHNICAL CHOW from a CHOW – they view it as being an actual CHOW. 			NA	FYI	N/A
		<ul style="list-style-type: none"> If this is a TECHNICAL CHOW application and the applicant is asking for Medi-Cal for the first time (because the facility currently does NOT have Medi-Cal) then the forms below are required to be submitted. 			NA	FYI	N/A
		<ul style="list-style-type: none"> If this is a TECHNICAL CHOW application and the applicant already HAS Medi-Cal but the person (or persons) who signed the "original" forms (listed below) have changed, then the forms below are required to be resubmitted. 			NA	FYI	N/A
HS 328	Notice – Effective Date of Provider Agreement						
		If applying for BOTH Medi-Cal and Medicare certification, only need one copy of this form.					N/A
DHCS 9098	Medi-Cal Provider Agreement						
		<ul style="list-style-type: none"> Do not leave any questions blank. Enter N/A or "same" if not applicable. 					N/A
		<ul style="list-style-type: none"> The "mailing address" must be the same as reported on the HS 200 form on page 3, Item 4. 					N/A
		<ul style="list-style-type: none"> Signature page must be "notarized". 					N/A
		<ul style="list-style-type: none"> SUBMIT the "Acknowledgement" page from the Notary Public, if applicable. 					N/A
	<ul style="list-style-type: none"> If applying for BOTH Medi-Cal & Medicare certification, only need <u>one</u> copy of this form. 					N/A	
CMS 1572	Home Health Agency Survey and Deficiency Report						
		<ul style="list-style-type: none"> If applying for BOTH Medi-Cal and Medicare certification, only need one copy of this form. 					



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		The following is a quick reference of SOME of the questions found on the required forms. It includes the form number, name of form, and an explanation of SPECIFIC requirements and/or attachments needed for specific forms. This is NOT an all-inclusive list of the questions that need to be answered so read the questions and instructions on each form.			LICENSING and / or Certification	TECHNICAL CHOW	BRANCH OFFICE
Pages (a) & (b)		<ul style="list-style-type: none"> If this HHA is being certified for MEDI-CAL "only", the only reason this form is being requested is for the listing of the types of services. 	FYI		FYI		
		<ul style="list-style-type: none"> Complete pages (a) and (b), items 1-20, as indicated on the form. 					
		<ul style="list-style-type: none"> If this HHA is adding HOSPICE as a "service", identify the HOSPICE service on page 2, Item 18, number 13 (under "OTHER"), of the CMS 1572 form by writing in the word HOSPICE. 		N/A			
CAPITAL	Capitalization Requirements for MEDI-CAL "only" Certification of a HHA						
		<ul style="list-style-type: none"> If the HHA applicant wants MEDI-CAL and MEDICARE, refer to the instructions contained on the CMS 855A application (<i>Medicare General Enrollment Health Care Provider/Supplier Application</i>). This form is listed under the MEDICARE forms on the following pages. 	FYI	FYI	FYI		
		<p>Capitalization – Financial Resources for MEDI-CAL "only": (Title 42 CFR, Section 489.28)</p> <ul style="list-style-type: none"> These capitalization requirements are only for a licensed HHA to be certified with Medi-Cal The Provider Certification Section MUST approve the capitalization plan prior to conducting a MEDI-CAL certification survey. HHAs that are Medi-Cal "only" must SUBMIT evidence that the licensee has sufficient initial reserve operating funds (CAPITALIZATION) to operate for the first three (3) months (90 days) in the MEDI-CAL program. <p>This CAPITALIZATION evidence should consist of the following:</p>			N/A		
	1	Business plan/structure.			N/A		
	2	Projected expenses for the first three (3) months (90 days) of operation broken down by rent, utilities, salaries, overhead, etc.			N/A		
	3	A copy of an "official" bank statement, certificate of deposit, etc. (in the name of the licensee) providing current balances. Must show that the applicant has available funds to operate HHA first 3 months and that at least 50% of these funds are non-borrowed funds. Title 42, Section 489.28(d)]			N/A		
	4	An attestation (signed and dated) from an Officer of the bank that the funds are in the account(s) and that the funds are immediately available.			N/A		
	5	An attestation (signed and dated) from the licensee stating that the required funds are available immediately.			N/A		
	6	Projected number of visits for the first three (3) months of operation.			N/A		
	7	Projected number of visits for the first year of operation following certification (this N/A if licensed "only").			N/A		



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		The following is a quick reference of SOME of the questions found on the required forms. It includes the form number, name of form, and an explanation of SPECIFIC requirements and/or attachments needed for specific forms. This is NOT an all-inclusive list of the questions that need to be answered so read the questions and instructions on each form.			LICENSING and / or Certification	TECHNICAL CHOW	BRANCH OFFICE
HS 328		Notice – Effective Date of Provider Agreement					N/A
		If applying for BOTH Medi-Cal and Medicare certification, only need one copy of this form.					N/A
CMS 855A		Medicare General Enrollment Health Care Provider/Supplier Application					
		Capitalization / Financial Resource requirement (listed above) does NOT apply to BRANCH Offices .			N/A	N/A	FYI
		<ul style="list-style-type: none"> This application is from the Federal Department of Health and Human Services. 					
		<ul style="list-style-type: none"> The completed application should be mailed directly to the appropriate FISCAL INTERMEDIARY 					
		<ul style="list-style-type: none"> This application is required for “INITIAL”, “CHOW” and TECHNICAL CHOW applications. 					
		<ul style="list-style-type: none"> Part of the instructions on the CMS 855A application require that all HHAs must SUBMIT evidence that the licensee has sufficient initial reserve operating funds (CAPITALIZATION) to operate for the first three (3) months (90 days) in the MEDICARE program. (Title 42 CFR, Section 489.28) 					
		This CAPITALIZATION evidence should consist of the following:					
		1	Business plan/structure.				
		2	Projected expenses for the first three (3) months (90 days) of operation broken down by rent, utilities, salaries, overhead, etc.				
		3	A copy of an “official” bank statement, certificate of deposit, etc. (in the name of the licensee) providing current balances. Must show that the applicant has available funds to operate HHA first 3 months and that at least 50% of these funds are non-borrowed funds. [Title 42 CFR, Section 489.28(d)]				
		4	An attestation (signed and dated) from an Officer of the bank that the funds are in the account(s) and that the funds are immediately available.				
		5	An attestation (signed and dated) from the licensee stating that the required funds are available immediately.				
	6	Projected number of visits for the first three (3) months of operation.					
	7	Projected number of visits for the first year of operation following certification (this N/A if licensed “only”).					
	8	Provide the type of ownership (free standing or provider based).					
	9	Provide the geographic location of the HHA and urban/rural status.					
CMS 1561		Health Insurance Benefit Agreement					
		<ul style="list-style-type: none"> SUBMIT Two (2) signed copies with “original” signatures. Initial Application: Sign the top signature block entitled “Accepted for the Provider of Services By.” 					



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		The following is a quick reference of SOME of the questions found on the required forms. It includes the form number, name of form, and an explanation of SPECIFIC requirements and/or attachments needed for specific forms. This is NOT an all-inclusive list of the questions that need to be answered so read the questions and instructions on each form.			LICENSING and / or Certification	TECHNICAL CHOW	BRANCH OFFICE
		<ul style="list-style-type: none"> • CHOW: Sign the bottom signature block entitled "Accepted For The Successor Provider of Services By." 					
CMS 1572 Pages (a) & (b)	Home Health Agency Survey and Deficiency Report					N/A	
	<ul style="list-style-type: none"> • Complete pages (a) and (b), items 1-20, as indicated on the form. The remaining pages will be completed during the survey. • If applying for BOTH Medi-Cal and Medicare certification, only need one copy of this form. 			FYI	FYI	N/A	
OMB No. 0990-0243	Civil Rights Information Request for Medicare Certification					N/A	
	<ul style="list-style-type: none"> • Complete and "sign" form (original signature). • SUBMIT all of the documents required on <u>Part 11</u> of this OMB form. All of these documents need to be "identified" by the corresponding number on the OMB form. The first document required is the HHS 690 form below. 					N/A	
	These items will be reviewed and approved by OCR.			FYI	FYI	N/A	
HHS 690	Assurance of Compliance					N/A	
	SUBMIT 1 copy. This HHS 690 form is the first document required to be submitted on the above OMB No. 0990-0243 form.					N/A	
<p><u>MEDI-CAL CERTIFICATION</u></p> <p>HOSPICE – Certified part of a Licensed HHA</p>							
HOSPICE MEDI-CAL CERTIFICATION	HOSPICE MEDI-CAL Certification						
	<p>To become a MEDI-CAL "certified" HOSPICE, the HOSPICE needs to be A MEDI-CAL certified part under a "<u>licensed</u>" HHA (Hospice has to be a "Service" under a licensed HHA). If this is the case, complete the forms below:</p> <p>NOTE: If this is a separately "licensed" HOSPICE that wants to be certified for MEDI-CAL and/or MEDICARE, use the HOSPICE application letter and checklist located on the L&C website. Do NOT use this Checklist.</p>						
HS 200	Licensing & Certification Application					N/A	
	If applying for BOTH Medi-Cal & Medicare certification, only need <u>one</u> copy of this form.				N/A	N/A	
HS 328	Notice – Effective Date of Provider Agreement					N/A	
	If applying for BOTH Medi-Cal & Medicare certification, only need <u>one</u> copy of this form.				N/A	N/A	



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		The following is a quick reference of SOME of the questions found on the required forms. It includes the form number, name of form, and an explanation of SPECIFIC requirements and/or attachments needed for specific forms. This is NOT an all-inclusive list of the questions that need to be answered so read the questions and instructions on each form.			LICENSING and / or Certification	TECHNICAL CHOW	BRANCH OFFICE
DHCS 9098	Medi-Cal Provider Agreement						
		• Must enter N/A or “same” if not applicable.		N/A	N/A		
		• The “mailing” address must match the mailing address on Item C.4., of the HS 200 form, page 3, Item 4.		N/A	N/A		
		• Signature page must be “notarized”.		N/A	N/A		
CMS 417	Hospice Request for Certification in the Medicare Program						
		• If this HOSPICE is being certified for MEDI-CAL “only” , this form is being requested is for the listing of the types of services.		N/A	N/A		
		• If applying for BOTH Medi-Cal & Medicare certification, only need <u>one</u> copy of this form.		N/A	N/A		
MEDICARE CERTIFICATION HOSPICE – Certified part of a Licensed HHA							
HOSPICE MEDICARE CERTIFICATION	HOSPICE MEDICARE Certification						
	<p>To become a MEDICARE “certified” HOSPICE, the HOSPICE needs to be A MEDICARE certified part under a “licensed” HHA (Hospice has to be a “Service” under a licensed HHA). If this is the case, complete the forms below:</p> <p>NOTE: If this is a separately “licensed” HOSPICE that wants to be certified for MEDI-CAL and/or MEDICARE, use the HOSPICE application letter and checklist located on the L&C website -- Do NOT use this Checklist.</p>						
HS 200	Licensing & Certification Application						
		If applying for BOTH Medi-Cal & Medicare certification, only need <u>one</u> copy of this form.			N/A		
HS 328	Notice – Effective Date of Provider Agreement						
		If applying for BOTH Medi-Cal & Medicare certification, only need <u>one</u> copy of this form.			N/A		
CMS 417	HOSPICE Request for Certification in the Medicare Program						
		If applying for BOTH Medi-Cal & Medicare certification, only need <u>one</u> copy of this form.			N/A		
CMS 855A	Medicare General Enrollment Health Care Provider/Supplier Application						
		This application is from the Federal Department of Health and Human Services.		FYI	FYI	N/A	
	This application is required for “initial” and “CHOW” applications.		FYI	FYI	N/A		



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		The following is a quick reference of SOME of the questions found on the required forms. It includes the form number, name of form, and an explanation of SPECIFIC requirements and/or attachments needed for specific forms. This is NOT an all-inclusive list of the questions that need to be answered so read the questions and instructions on each form.		LICENSING and / or Certification	TECHNICAL CHOW	BRANCH OFFICE
		The completed application should be mailed directly to the appropriate FISCAL INTERMEDIARY.				N/A
CMS 1561	Health Insurance Benefit Agreement					
		• SUBMIT Two (2) signed copies with "original" signatures.				N/A
		• Initial Application: Sign the top signature block entitled "Accepted for the Provider of Services By."				N/A
		• CHOW: Sign the bottom signature block entitled "Accepted For The Successor Provider of Services By."				N/A
OMB No. 0900-0243	Civil Rights Info Request for Medicare Certification					
		• Complete and "sign" form (original signature).				N/A
		• SUBMIT copy of all items required on the form. All <u>9</u> items need to be "identified" and accounted for. However, if less than 15 employees, Item #6 does not apply.				N/A
		• SUBMIT all of the documents required on <u>Part 11</u> of this OMB form. All of these documents need to be "identified" by the corresponding number on the OMB form. The first document required is the HHS 690 form below.				N/A
		• These items will be reviewed and approved by OCR.		FYI	FYI	N/A
HHS 690	Assurance of Compliance					
		SUBMIT 1 copy. Actually, this is Item #1 of the OMB No. 0990-0243 form. SUBMIT 1 copy. This HHS 690 form is the first document required to be submitted on the above OMB No. 0990-0243 form.				N/A