



APPLICATION REQUEST FOR A SKILLED NURSING FACILITY or INTERMEDIATE CARE FACILITY



This letter is to assist you in preparing a skilled nursing facility (SNF) or intermediate care facility (ICF) 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 package for a SNF or ICF; or
- Change of ownership (CHOW) application package for a SNF or ICF.

A state license is required to operate a SNF or ICF in California, which are defined as:

- **SNF** means “a health facility that provides skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis,” pursuant to **Section 1250(c)** of the Health and Safety (H&S) Code.
- **ICF** means “a health facility that provides inpatient care to ambulatory or nonambulatory patients who have recurring need for skilled nursing supervision and need supportive care, but who do not require availability of continuous skilled nursing care,” pursuant to **Section 1250(d)** of the H&S Code.

An application package is required for: (1) a new (initial) SNF or ICF facility; and (2) whenever a CHOW occurs. A CHOW is the only “change” requiring a new application package to be submitted to L&C’s Centralized Applications Unit (CAU), pursuant to **Section 72201** of T.22 (T.22) of the California Code of Regulations (CCR). All other changes (besides a CHOW) must also be reported to the L&C District Office (DO) in writing within **10 days** of the change, pursuant to **Sections 72211 and 73225** of T.22 of the CCR. These other changes do not require submittal of a new application package. The DO will assist you on which forms on the **checklist** that must be submitted for the specific change to the license.

For your convenience, the **attached checklist** has instructions to complete the forms required for licensing and/or certification of SNF or ICF. 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.**



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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 H&S Code, 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 SNF or ICF 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 package is withdrawn or denied, pursuant to Sections 72203(a)(2) and 73208(a)(2) of T.22 of the CCR.

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 SNF and ICF **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 CAU to receive because of our CDPH in-house mail services



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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 application package for completion and forward it to the appropriate DO once the application package has been given a recommendation of "approved". 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>

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" application packages that are noted on the attached **checklist**.
2. An initial **licensing survey** is part of the application process for "new" SNF or ICF applications.
3. The initial **licensing survey** is a scheduled survey conducted by L&C DOs in the facility.
4. If your facility wants to provide services to **Medicare beneficiaries** (under Title 18) or **Medi-Cal beneficiaries** (under Title 19) you will need an additional **certification survey** that is unannounced and conducted by one of our L&C DOs. Submit justification to the DO for Medicare participation and the DO will submit it to Centers for Medicare & Medicaid Services (CMS) for approval. This only applies to an "initial" certification survey.
5. Once you have had your initial licensing survey, you need to notify the L&C DO that you are ready and prepared to have an initial certification survey, if you received approval from CMS.
6. In addition, you must be in compliance with state licensing laws and federal conditions of participation.



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For CHOWs “only”:

Within 30 days of approval and issuance of a new license for a CHOW, the skilled nursing facility shall send written notification to all current residents and patients and to the primary contacts listed in the admission agreement of each resident and patient. The notice shall disclose the name of the owner and licensee of the facility and the name and contact information of a single entity that is responsible for all aspects of patient care and the operation of the facility.

The facility will also notify the DO with a copy of the written notice and a copy of the list of individuals and mailing addresses to whom the facility sent the notification as satisfactory evidence that the facility provided the required written notification.

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 facility to be in substantial compliance, at the time of the visit, will result in the “denial” of the application package. 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 the CAU, at (916) 552-8630 or by e-mail at CAU@cdph.ca.gov.

Attachment: Notice – Quality Assurance Fee Program



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Notice – Quality Assurance Fee Program

The Department of Health Care Services recommends to facilities that apply for a Change of Ownership with California Department of Public Health (CDPH) to further review the information on the QAF program and the collection process available on-line at:

<http://www.dhcs.ca.gov/provgovpart/Pages/QAF.aspx>

Unpaid QAF shall become the liability of the purchaser. For information regarding a specific facility, the current owner must provide to the Department of Health Care Services authorization to release information before the facility will be discussed with the purchaser. Any questions should be addressed to John Beshara at (916) 650-6559.

Health and Safety Code **Sections 1324.20 through 1324.30** authorize the Department of Health Care Services (DHCS) to implement a Quality Assurance Fee (QAF) program for Freestanding and Skilled Nursing Facility Level-B (FS/NF-B) and Freestanding Skilled Adult Subacute Nursing Facilities (FSSA/NF-B). The QAF is imposed on all FS/NF-B and FSSA/NF-B, except those that are exempt pursuant to Health and Safety Code Section 1324.20(b).

Sections 1324 through 1324.14 of the Health and Safety Code govern the QAF imposed on Intermediate Care Facilities for the Developmentally Disabled (ICF-DD), Habilitative (ICF/DD-H) and Nursing (ICF/DD-N).

The purpose of the QAF program is to provide additional reimbursement for, and to support quality improvement efforts in, the above listed facilities. The QAF is assessed on each facility on an annual basis irrespective of any changes in ownership, interest or control, or the transfer of any portion of the assets of a facility to another.



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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>	
<h2 style="margin: 0;"><u>LICENSURE</u></h2> <h3 style="margin: 0;">SKILLED NURSING or INTERMEDIATE CARE FACILITY</h3> <p style="margin: 0;">Includes the forms and information required to be “licensed”</p>			
	A.11.	<p>Construction. (T.22 72205) N/A for CHOWS, unless there has been construction and/or remodeling.</p> <p>If this <u>IS</u> a newly constructed and/or remodeled building, <u>OR</u> if this is <u>NOT</u> a previously licensed facility (i.e., existing building with no construction or remodeling required) applicant needs to contact the Office of Statewide Health Planning & Development (OSHPD) at the following website for Title 24 clearance: www.oshpd.ca.gov (T.22 72601 & 73601)</p>	OSHPD sends directly to District Office
	B.1.	<p>Licensee’s name. (T.22 72509(c) & 73205(a)(1)) The licensee’s formal organization name must be consistent throughout all documents.</p>	
	B.3.	<p>1 Owner type. This question must be answered.</p> <p>2 If nonprofit, SUBMIT a copy of Internal Revenue Service letter of determination status for this entity.</p> <p>3 SUBMIT an organization/ flow chart for this organization that displays the following (N/A for Sole Proprietorship): (T.22 73205(a)(9))</p> <p>1 LICENSEE name & tax ID number.</p> <p>2 A listing of the LICENSEE’s OWNERS. “Ownership” is N/A for non-profit.</p> <p>3 A listing of the LICENSEE’s directors, board members, corporate officers, LLC members/managers, partners, and trustees.</p> <p>4 If any of the above ENTITIES and/or INDIVIDUALS owns, leases, manages or operates any other licensed agency/facility, a second organization chart MUST be SUBMITTED. This organization chart needs to list the licensed agency/facility name & address, the EIN number, and their ownership percentage. This should also include out-of-state facilities and community care facilities.</p>	
	B.5.a	<p>Licensee’s “other” Facility Involvement. Answer all aspects of the question to identify other facilities, agencies, or clinics the licensee has been involved with.</p>	
	B.5.b	<p>Revocation, suspension, etc. action. If applicable to the licensee, SUBMIT the information requested.</p>	
	B.6.	<p>Subsidiary (PARENT company) information. If there is a “subsidiary” (PARENT company) SUBMIT:</p> <p>1 An organization chart with the PARENT company name.</p>	



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	2	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. [H&S 1265(i)]	
	3	A listing of all facilities the PARENT company is operating.	
C.1.a		Management Company. (H&S 1265 & 1267.5) (H&S 1265 & 1267.5 & 1575.1) Applicant needs to indicate "YES" or "NO" if the facility is operated under a Management Agreement between the licensee and a management company. If the answer is "YES" and the facility is an ADHC, GACH, ICF or SNF , you need to SUBMIT Item E-1 below.	
C.1.b		"Interim" Management Agreement. (H&S 1265 & 1267.5) ONLY if CHOW: If there is an "interim" Management Agreement, between the current and the prospective licensee, SUBMIT a signed and dated copy of The Agreement. The agreement must state that the licensee still maintains control of the property and is still financially responsible for the facility.	
C.2.		Name of "proposed" and "current" facility.	
	1	Enter both facility names if this is a CHOW.	
	2	For a CHOW, the name of the "proposed" facility can NOT have REHABILITATION in the facility name unless the facility has previously had rehabilitation services which were separately approved by the Department unless the facility is applying for certification. If not, you must apply for a separate survey for the rehabilitation services to be approved after the CHOW application package has been processed.	
	3	For an "initial" application the applicant must apply for a separate survey for the rehabilitation services to be approved after the "initial" application package has been processed. [T.22 72509(c)]	
C.6.a		ADMINISTRATOR. SNF & ICF: Insert Administrator's name and requested information.	
C.6.b		DIRECTOR OF NURSING: SNF "only" -- Insert DON name and requested information.	
C.7.		Ownership. [T.22 73205 for ICF & H&S 1267.5(a)(1) for SNF]	
	1	List all individuals having 5% or more ownership, unless "nonprofit".	
	2	SUBMITTED organizational chart listing all owners & their percentages.	
C.8.		Financial resources. SUBMIT evidence that the licensee has sufficient financial resources to operate the facility for at least 45 days. [H&S 1265(g)] The evidence should be in the form of a bank statement, certificate of deposit, letter of credit, etc. in the name of the licensee. The amount is determined by multiplying: 45 days x number of beds x Medi-Cal facility rate.	



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	C.9. & C.10.	Over-concentration and Program Plan. These questions are "N/A" for SNFs and ICFs.	N/A
	D.1. & D.2.	Property ownership. [H&S 1265(h)] 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.	
	E.	Management Company. (H&S 1265 & 1267.5 & 1575.1) Is this facility an ADHC, GACH, ICF or SNF ? Is this facility is operated under a Management agreement between the licensee and a management company? If "YES" RECEIVED Item E-1 below.	
	E-1	Management Company Information. 1 SUBMIT Attachment E-1 (Management Company Information) form. This form will capture the owners, ownership percentages, plus other facilities/agencies that the management Company may own, lease manage, or operate. All of these have to initially be APPROVED by the Centralized Applications Unit 2 SUBMIT a copy of the Management Agreement, which must state the current licensee still has responsibility for the facility.	
	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 [H&S 1265(i) & 1267.5 & T.22 73205 for ICF "only"]		
	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: SUBMIT the HS 215A form plus any other required documents (which will be listed below) for the following individuals:		
	ADMINISTRATOR of the Facility		
		1 HS 215A form for the Administrator. [T.22 72211(b), 72513 & 73205(a)(4)] 2 "RESUME" for the Administrator. 3 Administrator is required to be a licensed Nursing Home Administrator. (T.22 73205(a)(4) & 73511(a) & Title 42, CFR 483.75) The Nursing Home website is: http://www.cdph.ca.gov/certlic/occupations/Pages/NursingHomeAdministrator.aspx	
	DIRECTOR of NURSING - SNF "only" (T.22 72327)		
		1 SNF "only" -- HS 215A form for Director of Nursing 2 SNF "only" -- copy of professional License. 3 SNF "only" -- RESUME.	N/A
APPLICANT Organization			



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	1	HS 215A form for each individual having a beneficial interest of 5% or more in the APPLICANT Organization (list their percentages).	
	2	HS 215A form for directors, board members, corporate officers, LLC members/managers, and partners of the APPLICANT Organization.	
		PARENT Company	
	1	HS 215A form for each individual having a beneficial interest of 5% or more in the PARENT company (list their percentages).	
	2	HS 215A form for directors, board members, corporate officers, LLC members/managers, and partners of the PARENT company.	
		MANAGEMENT Company	
	1	HS 215A form for each individual having a beneficial interest of 5% or more in the MANAGEMENT company (list their percentages).	
	2	HS 215A form for directors, board members, corporate officers, LLC members/managers, and partners of the MANAGEMENT company.	
Section D		Employment/Business Summary. A resume or attachment will be acceptable in lieu of Section "D" being filled out.	
Sign		Signature. Original "signature" is required on all the HS 215A forms.	
Facility Info Sheet		<p>Facility Information Sheet [H&S 1267.5(c)]</p> <p>If you answer "YES" in Section E above, you must complete the Facility Information Sheet needs to be completed for each HS 215A form SUBMITTED (except for the Administrator, unless they are the owner). The Facility Information Sheet must include facilities licensed by CA Department of Social Services. An attachment may be SUBMITTED in lieu of the Facility Information Sheet, if all applicable information is on the attachment. 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 MUST be completed for each facility and/or agency:</p> <ol style="list-style-type: none"> 1 Facility name and address 2 Type of facility 3 Type of business entity (include EIN Number) 4 Individual's <u>nature</u> and <u>dates</u> of involvement 5 This Sheet must also include any facilities licensed by the California Department of Social Services 	
HS 309 1 st page	Administrative Organization		
	Item 2.	This form is N/A for a sole proprietor.	FYI
	3 thru	Corporations need to SUBMIT: _____ ; LLCs need to SUBMIT: _____	



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	7	1	Copy of Filing Statement from CA Secretary of State (only required if Articles of Incorporation are NOT endorsed by the CA Secretary of State).	1
		2	Copy of "all" Articles of Incorporation (endorsed by CA Secretary of State).	2
		3	Copy of By-Laws.	3
	9.	Governing Board of Directors.		
		1	Enter the number of board members or LLC members/holders	
		2	SUBMIT a list of the board of directors or the LLC members/holders.	
10.	Board Officers. Enter the names of the board officers or the LLC officers/managers.			
HS 309 2 nd page	Organizational Structure			
	Item 1.	California Out-of-State Corporations, LLC, etc. SUBMIT a copy of the Certificate of Qualification from the California Secretary of State.		
	3. thru 4.	Public Agency. SUBMIT a copy of the signed Resolution		
	5.	Item 5. Corporations, LLCs and Partnerships need to complete Item 5. N/A for nonprofit.		
	Bottom of page	Partnerships need to SUBMIT:		
		1	Copy of the Partnership Agreement	
		2	Copy of the California Secretary of State filing	
HS 400	Affidavit Regarding Patient Money (T.22 72217 and 73241)			
	Be sure to mark either A or B box. Even though the form allows the applicant to indicate that they will not handle any money – this is NOT an option if the GACH or SNF want to be "CERTIFIED". They have to obtain a BOND for at least \$1,000.00. Enter amount of money to be handled and SUBMIT bond required on form HS 402 form. [Centers for Medicare & Medicaid Services, HHS, Section 483.10(c)(7)]			
HS 402	Surety Bond Verification (T.22 72217 and 73241)			
		1	Be sure the HS 402 form is a California Department of Public Health form	
		2	Is signed by the Bonding agency	
		3	Possesses the embossed seal of the Bonding Agency	
		4	SUBMIT an "original" bond or an "embossed" Power of Attorney	
HS 602	Transfer Agreement Between (T.22 72519 and 73503)			
	SUBMIT a current copy of the Transfer Agreement.			



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CDPH 609	Bed or Service Request (T.22 72201, 72401 and 73445)		
	Top of page	Under "Requested Beds" category, the "Approved Capacity" should be left blank.	
	Bottom of page	Check the types of services on this portion of the form.	
DHCS 1051	Civil Rights Compliance Review		
		Send directly to Office of Civil Rights – address is on last page of the form.	
CHOW	Change of Ownership (T.22 72201 & 73203)		
		SUBMIT all of the forms required for an "initial" application, listed above, plus the following:	
	1	Copy of "Purchase Agreement" or "Operating Transfer Agreement".	
	2	Written verification (with amount) by a certified public accountant, accounting for all patient monies being transferred to the custody of the new licensee. If none, need statement from current licensee that they didn't handle resident monies. [T.22 72529(a)(10) & 73557(a)(8)]	
	3	Copy of receipt (with amount) signed by the new licensee in exchange for such monies. [T.22 72529(a)(10) & 73557(a)(8)]	
	4	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. [T.22 72543(e) & 73543(e)]	
<p><u>MEDI-CAL CERTIFICATION</u> SKILLED NURSING or INTERMEDIATE CARE FACILITY Includes the forms and information required for MEDI-CAL certification</p>			
HS 328	Notice – Effective Date of Provider Agreement		
		If applying for both Medi-Cal & Medicare certification, only need one copy of this form.	
DHCS 9098	Medi-Cal Provider Agreement		
	1	Do not leave any questions blank. Enter N/A or "same" if not applicable.	
	2	The "mailing address" must be the same as reported on the HS 200 form, page 3, Item 4.	
	3	Signature page (page 9) must contain original signatures.	
	4	SUBMIT the "Acknowledgement" page from the Notary Public, if applicable.	



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<h2 style="margin: 0;">MEDICARE CERTIFICATION</h2> <p style="margin: 0;">Only applies to SKILLED NURSING FACILITIES Includes the forms and information required for MEDICARE certification</p>			
HS 328		Notice – Effective Date of Provider Agreement	
		If applying for both Medi-Cal & Medicare certification, only need one copy of this form.	
CMS 671		Long Term Care Facility Application for Medicare and Medicaid	
	1 st page	<ol style="list-style-type: none"> 1 Item A.F9 is “03” if you want both Medi-Cal and Medicare. 2 If Item F12 is an “LLC”, insert “03”, which is for corporations and LLCs. 3 Items F28 & F30 and F29 & F31 are required to be completed. Enter N/A, if not applicable. 	
	2 nd page	<p>Facility Staffing Form:</p> <ol style="list-style-type: none"> 1 Enter staff hours worked in the most recent complete pay period. 2 Enter either a “Y” (for yes) or “N” (for no) under Column A, sub-columns 1, 2 and 3 in the “unshaded” areas. If you have entered “Y”, enter hours in the appropriate “unshaded” areas. 3 Original signature required along with the time and date form was completed. 	
CMS 855A		Medicare General Enrollment Health Care Provider/Supplier Application	
		<ol style="list-style-type: none"> 1 This application is from the Federal Department of Health and Human Services. 2 The completed application should be mailed directly to the appropriate Fiscal Intermediary. 	
CMS 1561		Health Insurance Benefit Agreement	
		<p>SUBMIT two (2) signed copies with “original” signatures.</p> <ol style="list-style-type: none"> 1 Initial Application: Sign the top signature block entitled “Accepted for the Provider of Services By.” 2 CHOW: Sign the bottom signature block entitled “Accepted For The Successor Provider of Services By.” 	
OMB No. 0945-0006		Civil Rights Information Request for Medicare Certification	
		<ol style="list-style-type: none"> 1 Complete and “sign” form (original signature). 2 SUBMIT all of the documents required on Part 11 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. 3 These items will be reviewed and approved by OCR. 	
HHS		Assurance of Compliance	



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690		<p>SUBMIT 1 copy. This HHS 690 form is the first document required to be submitted on the above OMB No. 0945-0006 form.</p>	