Ambulatory Surgery Center
Medicare and/or Medi-Cal Certification

Policy These instructions apply to providers completing an ambulatory surgery center (ASC) application package for Medicare (Title 18) and Medi-Cal (Title 19) certification if requesting any of the following:

- Initial Medicare and/or Medi-Cal certification as an ASC
- Adding Medicare and/or Medi-Cal certification to an already licensed surgical clinic
- Change of ownership (CHOW) certification as an ASC

Authority Authority is under the federal process through the Affordable Care Act as well as the Health and Safety Code (HSC), California Code of Regulations (CCR), and Code of Federal Regulations (CFR) as detailed below:

- HSC sections 1226(f), 1226.5
- Title 22 CCR sections 51000.30(d)(12), 51000.35
- Title 42 CFR sections 416.41, 416.41(b), 455 Subpart B

Fee None

Submit to: Submit the completed application package to the following address:

California Department of Public Health
Licensing and Certification Program
Centralized Applications Branch
P.O. Box 997377, MS 3207
Sacramento, CA 95899-7377

Process Once the Centralized Applications Branch (CAB) receives the application package:

- A program technician enters the information into the Electronic Licensing Management System (ELMS). ELMS generates an application ID.
- The program technician creates an Acknowledgement Letter and distributes it to the provider.
- Assignment of applications is by date order of receipt.
- The analyst reviews the package to ensure all the applicable forms are present and completed appropriately.
- If information is missing or incorrect, a request for information process will begin:
    - The analyst generates a 60 day letter. Providers must return requested information within 60 days.

- If the provider does not submit the requested information within 60 days, the analyst generates a 30 day letter. The provider must return the requested information within 30 days or CAB will deny the application.

- Once the application is complete, the analyst forwards it to the appropriate district office (DO).

The ASC checklist below instructs the provider how to complete the application package required for Medicare and/or Medi-Cal certification of an ASC.

Read and complete each required item carefully and provide all required supplemental forms. Do not leave any items blank. Note the following:

- If a question does not apply, respond with "N/A".
- The applicant's formal name must be consistently the same throughout the application package.
- Do not make changes to the actual forms.
- Use "blue" ink to sign all forms.
- Do not use white out or 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.
- Retain a photocopy of the completed application package.

Please refer to the Medicare/Medi-Cal box below the title of each form to determine if the form is required for your application. A checkmark signifies the form is required. Submit one copy of each form unless otherwise specified in the description.

Form	Item #	Description
Initial & CHOW		
HS 200 – Licensure & Certification Application MEDICARE ☐ MEDI-CAL ✓	A.1.	*Type of Application* • Choose "a. Initial" or "b. Change of Ownership"
	A.2.	*Change of Ownership Only* • Complete if applicable
	A.5.	*Type of Facility, Agency, or Clinic* • Select "o. Other: Ambulatory Surgery Center"
	A.6.	*Medicare program* • Complete all fields
	A.7.	*Medi-Cal program*
	A.8.	*Bed capacity*
	A.9.	*Age range of clients*
	A.10.	*Days and hours of operation*

	A.11.	*Construction* • Select "Yes" or "No" • If yes, submit the new Certificate of Occupancy (CO) • If no, submit the most recent CO (N/A for CHOW) Authority: HSC 1226.5
	B.1.	*Licensee Name* • Enter the name (as filed with the Secretary of State) of the entity with direct ownership of the ASC • The entity's formal organization name must be consistent throughout all documents
	B.2.	*Federal employer's tax ID number*
	B.3.	*Owner Type* Indicate the owner type and submit an organization chart that displays ownership and governance information • See section B.6. as well as the instructions for organization charts below
	B.4.	*Licensee address* • Enter the physical address of the business entity with direct ownership of the ASC
	B.5.a.	*Identify entity's "other" facility involvement* • Complete fields if applicable • If not applicable, indicate "N/A"
	B.5.b.	*Revocation, suspension, etc. action* • If applicable to the facility, submit the information requested • If not applicable, indicate "N/A"
	B.6.	*Subsidiary (parent company) information* • If the owner is a subsidiary of another organization, include ownership and governance information for all parent/grandparent/etc. entities with **5% or more** ownership in the facility in the submitted organization chart(s) • See below for organization charts
	C.1.	*Management Agreement* • Select "Yes" or "No" for both sections
	C.2.	*Name of facility, agency, or clinic* • For initial certification, indicate "current" facility name • For a CHOW, indicate both "proposed" and "current" facility names

	C.3.	*Address of facility, agency or clinic* • Provide the physical address of the ASC
	C.4.	*Mailing address* • Complete if different from C.3.
	C.5.	*Name of person to be in charge of facility, agency, or clinic*
	C.6.a.	*Administrator information*
	C.6.b.	*Director of Nursing information* • Complete if applicable
	C.7.	*Relationship information* • Complete the required information for each individual with **5% or more** direct or indirect ownership interest in the facility (unless non-profit) • In addition, provide the requested information for each individual with a control interest (i.e., officer, director, partner) in the applicant entity
	D.1.	*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 entity

	D.2.	*Property Information*
		• Owner of Record
		  • Provide the name and address of the "Owner of Record" (Lessor) that is the owner of the property. The owner of the property must match the name on the grant deed.
		• Lessee:
		  • Provide the name and address of the Lessee (i.e., tenant). The Lessee is the entity (which is NOT the facility) that rents the property from the Lessor and is a corporation, LLC, person, or etc.
		• Sub-Lessee:
		  • Provide the name and address of the Sub-Lessee, if applicable. The Sub-Lessee is the entity (i.e., corporation, LLC, person, etc.) that subleases from the Lessee. The original lease must contain language that the owner of the property gives permission for the Lessee to sublease to another entity.

	E.	*Management Company* • Complete if applicable and submit a copy of the management agreement

	F.1.	*Signature* • Original signature - must be signed by the applicant • Owners must sign if the applicant is for-profit • Officers may sign if the applicant is non-profit
Organization Chart(s) MEDICARE ✓ MEDI-CAL ✓		Please include the following information for all owners and indirect owners (individuals and/or legal entities) with **5% or more** ownership interest in the facility: • Entity name, address, tax ID number, and ownership percentage • If any of the above entities owns, leases, manages or operates any other licensed and/or certified agency/facility, an additional organization chart must be submitted (include names, addresses, tax IDs, and ownership percentages) • Include out-of-state facilities and community care facilities • A listing of each entity's directors, officers, board members, corporate officers (CEO, President, etc.), LLC members/managers, partners and/or trustees

HS 215A – Applicant Individual Information
MEDICARE
MEDI-CAL ✓
		Please complete for each of the following:
		• Each individual with **5% or more** direct or indirect ownership interest in the facility
		• Each managing employee
		  • Administrator, general manager, and/or etc.
		  • Each officer, director, board member, corporate officer, LLC member/manager, partner, and/or trustee of each entity with 5% or more direct or indirect ownership interest in the facility
		Authority:42 CFR 455 Subpart B

	A.	*Identifying Information* • Complete all fields
	B.	*Criminal Record* • Complete all fields
	F.	*Adverse Actions* • Complete all fields
	Signature	*Signature* is required
		Administrative Organization
	1.	*Name (as filed with Secretary of State)*
	2.	*Administrator*
	3.	*Incorporation Date*
	4.	*Place of Incorporation*

HS 309 – Administrative Organization & Organizational Structure MEDICARE ✓ MEDI-CAL ✓	5.	Submit a copy of the Articles of Incorporation (Corporation) **OR** Articles of Organization (LLC) endorsed by the California Secretary of State • If originally incorporated/organized in a different state, submit a copy of the filing statement from the California Secretary of State
		Submit a copy of the By-laws **OR** the Operating Agreement • By-laws must state the size of the board
	6.	*Principal Office of Business*
	7.a.&b.	*Foreign (out-of-state) applicants* • Complete fields if applicable
	8.	*If applicant has ever owned or operated a facility* • Complete and include requested information
	9.	*Governing Board of Directors* • Provide the requested information for the board members or LLC members
	10.	*Board Officers* • Provide the requested information for the board officers or the LLC officers/managers
		Organizational Structure
	Public Agency: (Complete fields if applicable)	
	1.	*Check type of public agency*
	2.	*Agency providing services*
	3.	*District or area to be served*
	4.	*Attach a copy of Resolution or legal document authorizing this application*
	5.	For profit corporations and partnerships, list names and business addresses of each person with a direct or indirect ownership interest of **5% or more** in the applicant corporation or partnership
	Partnerships: (Complete fields if applicable)	
		• Provide requested information for all partners • Attach a copy of partnership agreement
	Other Associations/Business Entities: (If applicable)	
		• Provide a similar list of persons legally responsible for the organization, appropriate legal documents which set forth legal responsibility of the organization, and accountability for operating the facility
HS 602 OR Transfer Agreement		• Submit the HS 602 Transfer Agreement **OR** • Copy of a current written transfer agreement with a hospital that meets the requirements of the Code of Federal Regulations **OR**

MEDICARE ✓ MEDI-CAL ✓		• Evidence that all physicians performing surgery have admitting privileges at a hospital that meets the requirements of the Code of Federal Regulations Authority: 42 CFR Section 416.41(b)
CMS 370 – Health Insurance Benefits Agreement MEDICARE ✓ MEDI-CAL		Submit two signed copies with original signatures
CMS 377 – Ambulatory Surgical Center Request for Initial Certification MEDICARE ✓ MEDI-CAL		Submit one copy of this form
CMS 855B – Medicare Enrollment Application for Clinics/Group Practices and Certain Other Suppliers MEDICARE ✓ MEDI-CAL		This form is available from the Federal Department of Health and Human Services • Submit this form to the Medicare Administrative Contractor (MAC) and send a copy to CAB
DHCS 9098 – Medi-Cal Provider Agreement MEDICARE MEDI-CAL ✓		The "mailing" address must match the mailing address on the HS 200 form, page 3, Item C.4.
		Signature page must be notarized
		Include "Acknowledgement" page from the Notary Public, if applicable
DHCS 6207 – Medi-Cal Disclosure Statement MEDICARE MEDI-CAL ✓		Only complete Section V Authority: 42 CFR 455.104(b); 22 CCR 51000.35

Internal Revenue Service (IRS) Documentation MEDICARE: ☐ MEDI-CAL: ✓		Submit **one** of the following IRS tax documents showing the entity's legal name and Tax Identification Number: • Form 941 • Form 8109-C • Letter 147-C • Form SS-4 (Confirmation Notification) Authority: 42 CFR 455.104(b)(1)(iii); 22 CCR 51000.30(d)(12)
	Additional Requirement – Initial Only	
STD 850 – Fire Safety Inspection Request MEDICARE: ✓ MEDI-CAL: **		• Must be completed by local fire authority • If fire authority requires CAB to provide the STD 850 form to them, provide CAB with contact information for the fire authority • If the STD 850 is not submitted, the fire authority form must contain equivalent information to the STD 850 form **N/A if currently Medicare-certified and now seeking Medi-Cal certification Authority: HSC 1226(f)
	Additional Requirements – CHOW Only	
Purchase Agreement OR Operating Transfer Agreement MEDICARE: ✓ MEDI-CAL: ✓		Submit evidence of CHOW • Copy of Purchase Agreement **OR** Operating Transfer Agreement