California Department of PublicHealth

Center for Health Care Quality
Licensing and Certification Program
Centralized Applications Branch

Hospice Agency
Initial and Change of Ownership Application Checklist

The following is a list of application forms and supporting documents required for a complete application packet. Failure to include each of the forms and documents will delay processing.

Check all that apply**:** ☐ **Initial License** ☐ **Change of Ownership (CHOW)** ☐ **Medicare** ☐ **Medi-Cal**

CHECKLIST AND INSTRUCTIONS- *Please submit your documents in this order.*

REQUIRED DOCUMENTS FOR AN INITIAL LICENSE OR CHOW

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
	Cover Letter	**COVER LETTER** Letter on company letterhead with the following information: • License number (only applicable for CHOW) • Facility name and ID number (if known) • Brief description of request • Contact information (name, title, phone number, and e-mail address) • Emergency Contact Information (name, email, alternate email, phone, fax, and phone number that will receive text messages). The Department will use this information to contact the provider in the event of an emergency using the California Health Alert Network (CAHAN). All information provided must allow CAHAN to contact the provider on a 24/7/365 basis for distribution of health alerts. For additional information: (CAHAN) (https://www.calhospitalprepare.org/cahan) • Signature

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
	HS 200	**LICENSURE & CERTIFICATION APPLICATION** [Health and Safety Code (HSC) section 1748(b)] **Tips** • Page 2, section B, item 6 — An organization must own 100 percent of the licensee to be considered a parent company. This parent company will have its own Employer Identification Number (EIN) • Page 3, section C, item 7 — When listing the names of individuals with direct or indirect ownership of the facility in section C, provide the EIN (do not enter a Social Security number in this field)
	Supporting Documents	**IRS- INTERNAL REVENUE SERVICE DOCUMENTATION** Submit **one** of the following IRS tax documents showing the licensee's legal name and Tax Identification Number: • Form 941 - Employer's Quarterly Federal Tax Return • Form 8109 C - FTD Address Change • Letter 147-C - EIN Confirmation Notification • Form SS-4 - Confirmation Notification
	Supporting Documents	**B.3 - ORGANIZATIONAL CHART – OWNER TYPE** Submit an organizational chart if the owner is a for profit corporation, nonprofit corporation, limited liability company (LLC), or general partnership. The organizational chart needs to display the following: • Applicant's owners, including ownership percentages, Tax IDs/EINs and all directors, board members, corporate officers, LLC members/managers, and/or partners **Note:** Submit the HS 215A form for each of these individuals

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		• Parent company of applicant, if applicable, and all of the licensed agencies/facilities it is operating - see B.6
	Supporting Documents	**D.1 - CONTROL OF PROPERTY** Submit a signed copy of the Grant Deed, Bill of Sale, Lease, Sublease, or Rental Agreement between the owner of the property and the proposed licensee
	Supporting Documents	**FLOOR PLAN** Submit a floor plan that coincides with your office space
	HS 215A	**APPLICANT INDIVIDUAL INFORMATION** [HSC section 1748(b); Standards of Quality Hospice Care (SQHC, 2003, section 5.1 - 5.3, and 6.1] This form must be completed for the following individuals and include original signatures: • Administrator, Administrator Designee, Director of Patient Care Services, Director of Patient Care Services Designee, and Medical Director (Medical Director N/A if contracted) • Owners, directors, board members, corporate officers, LLC members/managers, and partners of the applicant organization • Each individual having a beneficial interest of five percent or more in the applicant organization and/or parent organization **Tips** • Page 1, section A — The date of birth is an identifier, as several people may have the same name, and will ensure that each individual is associated with the correct facility or entity

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		• Page 2, section D — Submit ten years of employment history, indicating the start and end dates of employment, job titles, employer names and addresses. The applicant may submit a resume in lieu of completing section D; however, the resume must contain all required information requested in section D • Page 2, section E — If answering yes to any question in this section, complete and attach the Facility Information Sheet
	Supporting Documents	**FACILITY INFORMATION SHEET** Each individual must complete and submit the Facility Information Sheet for each facility and/or agency with which the individual has a current or past relationship within the last three years. This sheet must also include any facilities licensed by the California Department of Social Services. The following must be completed for each facility and/or agency: • Facility name • Facility address • Type of facility • Type of business entity (include EIN Number) • Individual's nature of involvement • Individual's dates of involvement
	Supporting Documents	**RESUME** A resume is required for the Administrator, Administrator Designee, Director of Patient Care Services, Director of Patient Care Services Designee, and Medical Director (Medical Director N/A if contracted)
	HS 309 1st Page	**ADMINISTRATIVE ORGANIZATION** Along with the HS 309, the following supporting documents according to organizational type must be submitted:

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
	Supporting Documents	**CORPORATION** • Filing Statement from the Secretary of State • Articles of Incorporation • By-Laws • List of Board of Directors (only if additional space is needed to input all board of directors) **Tip** • Page 1, item 3 — The incorporation date located in the top right corner of the applicant Articles of Incorporation
	Supporting Documents	**LIMITED LIABILITY COMPANY (LLC)** • Filing Statement from the Secretary of State • Articles of Organization • Operating Agreement • List of Managing Members (only if additional space is needed to input all managing members)
	HS 309 2nd Page	**ORGANIZATIONAL STRUCTURE** Only complete fields that are applicable to applicant's entity type
	Supporting Documents	**PUBLIC AGENCY** Copy of signed Resolution
	Supporting Documents	**PARTNERSHIP** Copy of signed Partnership Agreement

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	CMS 855A Page 23	**GEOGRAPHIC SERVICE AREA** • Submit a list of the geographical areas (including cities, counties, and zip codes) to be served • Submit a web-based map • Hospice providers must obtain prior approval of an expansion of their geographic service area from the Centers for Medicare and Medicaid Services (CMS), and the California Department of Public Health (CDPH) Licensing & Certification Program

REQUIRED DOCUMENTS FOR A CHOW ONLY

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	Supporting Documents	**In addition to the forms required for an Initial application listed above submit the documents requested below:** • Copy of Purchase Agreement or Operating Transfer Agreement • A letter from the prospective licensee (to CDPH) stating the location where the stored patient medical records will be maintained and affirming the records will be made available to the previous licensee [SQHC, 2003, Section 6.3 (B)(3)(g)]

MEDI-CAL CERTIFICATION DOCUMENTS

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	DHCS 6207	**MEDI-CAL DISCLOSURE STATEMENT** Section V only
	DHCS 9098	**MEDI-CAL PROVIDER AGREEMENT** • Do not leave any questions blank. Enter “same” or “N/A” if not applicable • The mailing address must be the same as reported on the HS 200 form • Notarized signature page is required • Submit the "Acknowledgement" page from the notary public, if applicable
	HS 328	**NOTICE – EFFECTIVE DATE OF PROVIDER AGREEMENT** If applying for both Medi-Cal and Medicare certification, only submit one copy of this form

MEDICARE CERTIFICATION DOCUMENTS

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	CMS 417	**HOSPICE REQUEST FOR CERTIFICATION IN THE MEDICARE PROGRAM** [HSC section 1749(b)(1) – (b)(7); SQHC, 2003, section 2.1] • The form requires an original signature and date • If this freestanding hospice is "licensed only", complete this form to identify the types of services
	CMS 643	**HOSPICE SURVEY AND DEFICIENCIES REPORT** • Fill out the Name of Facility only • Submit both pages
	CMS 855A	**MEDICARE GENERAL ENROLLMENT HEALTH CARE PROVIDER/SUPPLIER APPLICATION** • This application is from the Federal Department of Health and Human Services • The completed application should be mailed directly to the appropriate fiscal intermediary
	CMS 1561	**HEALTH INSURANCE BENEFITS AGREEMENT** Submit two (2) signed copies with "original" signatures: • Initial Application: Sign the top signature block entitled "Accepted for the Provider of Services By" • CHOW: Sign the bottom signature block entitled "Accepted for the Successor Provider of Services By"
	HHS 690	**ASSURANCE OF COMPLIANCE** • **The Office of Civil Rights (OCR) online portal is:** Office for Civil Rights (https://ocrportal.hhs.gov/ocr/aoc/instruction.jsf) • Once the online submission is completed, an electronic notification from OCR stating the

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		Assurance of Compliance form was submitted successfully will be received by the applicant • Submit a copy of this notification