California Department of PublicHealth

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

Intermediate Care Facility (ICF)
Initial and Change of Ownership (CHOW) 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 and may result in denial of the application.

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 address • Facility 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) • Contact Information for the Privacy Officer or Designee responsible for submitting and responding to medical breach incidents (name, title/position, mailing address, phone number, and email address) • Signature

<table>
<tr><th>Use this space to check if included</th><th>Forms and supporting documents</th><th>Additional Instructions
(Each form listed also has instructions on the form)</th></tr>
<tr><td></td><td>HS 200</td><td>LICENSURE & CERTIFICATION APPLICATION
ICF: Health and Safety Code (HSC) section 1265 and 22 CCR section 73203

Tip
Page 6, Section B, item 6 — This parent company will have its own Employer Identification Number (EIN).
If applying for Med-Cal, applicant must complete the “Subcontractor Information and Significant Business Transactions” attachment
Note:
Page 10, Sections C, Item 6 – Submit evidence that the licensee has sufficient financial resourced to operate the facility for at least 90 Days
- CHOWs: The amount is determined by multiplying: 90 Days x number of beds x Medi-Cal Rate
- Initial: The Provider will need to contact CAB to obtain the rate for Initials.</td></tr>
<tr><td></td><td>Supporting Documents</td><td>A.11 – DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION (HCAI) AND/ OR CERTIFICATE OF OCCUPANCY
ICF: HSC section 1276 and 1275 and 22 CCR section 73213 and 73601 and 73603

If this is a newly constructed and/or remodeled building, or if this is not a previously licensed facility (i.e., existing building with no construction or remodeling required) applicant needs to contact the HCAI at the following website for Title 24 clearance: https://hcai.ca.gov/ [22 CCR sections 72601 & 73601]</td></tr>
</table>

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<tr><td></td><td>Supporting Documents</td><td>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
• Parent company of applicant, if applicable, and all of the licensed agencies/facilities they are operating- see B.6
• Management company of applicant, if applicable, and all of their facilities</td></tr>
<tr><td></td><td>Supporting Documents</td><td>IRS - INTERNAL REVENUE SERVICE DOCUMENTATION

Submit one of the following IRS tax documents showing the entity’s legal name and Tax Identification Number:

• Form 941 (Employer’s Quarterly Federal Tax Return)
• Form 8109-C (FTD Address Chang)
• Letter 147-C (EIN Confirmation Notification)
• Form SS-4 (Confirmation Notification)</td></tr>
</table>

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
	Supporting Documents	**C.1a and E.11 - MANAGEMENT COMPANY AGREEMENT** (If applicable) **ICF:** HSC section 1265 Facilities operated under a management agreement between the licensee and a management company must complete and submit Attachment E-1 (Management Company Information) and submit a copy of the management agreement • The management agreement must state that the licensee is responsible for the skilled nursing facility and intermediate care facility
	Supporting Documents	**C.1b – INTERIM MANAGEMENT AGREEMENT** (If applicable) **CHOW Only:** HSC section 1267.5 If there is an interim management agreement, between the current and prospective licensee, submit a signed and dated copy of the agreement • The interim agreement must state that the licensee is responsible for the skilled nursing facility
	Supporting Documents	**D.1 - CONTROL OF PROPERTY** **ICF:** HSC section 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
	Supporting Documents	**FLOOR PLAN (For Initial Application Only)** Submit a floor plan that coincides with your office space

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
	HS 215A	**APPLICANT INDIVIDUAL INFORMATION** This form must be completed for the following individuals: • Administrator of the facility • Owners, directors, board members, corporate officers, LLC members/managers, and partners of the applicant organization and/or Management Company • Each individual having a beneficial interest of exceeding five percent or more in the applicant organization and/or parent organization **Tip** • Page 1, Section A — The date of birth is an identifier, as several people may have the same name. This will ensure that each individual is associated with the correct facility or entity. • Page 2, Section D – Submit ten years of employment history, indicating the start and end dates of employment, job title, employer name and address. The applicant may submit a resume in lieu of completing section D; however, the resume must contain all required information included in section D • Page 2, Section E – If answering yes to any question in this section, complete and attach the facility information sheet

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
	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** **ICF:** 22 CCR section 73003 A resume is required for the Administrator **Note:** • Administrator must be a licensed Nursing Home Administrator (NHA) [HSC section 1416.2]
	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 is located in the top right corner of the applicant Articles of Incorporation • In addition to this page, corporations are required to complete item 5 on page 2
	Supporting Documents	**LIMITED LIABILITY COMPANY (LLC)** • Filing Statement from the Secretary of State • Articles of Organization • LLC Operating Agreement • List of Managing Members (only if additional space is needed to input all managing members) **Tip** • Page 1, item 3 — The incorporation date is located in the top right corner of the Articles of Organization • Ensure the operating agreement identifies the Capital Contributions, which lists each individual and/or entity that is contributing to the LLC
	HS 309 2nd Page	**ORGANIZATIONAL STRUCTURE** Only complete fields that are applicable to applicant's entity type **Tip** • Page 2, item 1 — Health care districts will fill in the circle for other

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
	Supporting Documents	**PUBLIC AGENCY** Copy of signed Resolution
	Supporting Documents	**PARTNERSHIP** Copy of signed Partnership Agreement
	HS 400	**AFFIDAVIT REGARDING PATIENT MONEY** **ICF**: HSC section 1318 and 22 CCR section 73241 • Mark either A or B box. If B is checked, enter the amount of patient monies managed and submit the bond required on form HS 402 **Tip** • If you are a sole proprietor, you would enter your legal name • Even though the form allows the applicant to indicate that they will not handle any money, this is not an option if a SNF, wishes to be "Certified". You are required to obtain a bond for at least $1,000 • If the application is for a change of ownership, the amount handled must be the same or less than the amount of the Audit and Receipt of patient monies. • If the money you are going to handle is outside the table, your bond should be $1,000 more. For example, you will handle $25,000, your required bond amount will be $26,000

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	HS 402	**SURETY BOND VERIFICATION** **ICF**: HSC section 1318 and 22 CCR section 73241 • Must be signed by the bonding agency • Provide a copy of the seal and copy of the bonding agency • Submit a copy of the bond or Power of Attorney form Tip • Please check the upper right-hand corner of this form to ensure you are submitting the CA Department Public Health form (not the Department of Social Services' form) • Licensee name dba facility name is acceptable • Submit the original form with the raised embossed seal on all documents
	HS 602	**TRANSFER AGREEMENT** **ICF:** HSC section 1760.4 and 22 CCR section 73503 Copy of current written transfer agreement with a General Acute Care Hospital **Tip** • The Facility Administrator has the authority to sign this form • The facility may not have a Facility Provider Number yet, and may be left blank

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
	CDPH 609	**BED OR SERVICE REQUEST** **ICF:** HSC section 1265 • For new facilities or initial licensure, complete the columns marked “Requested Beds” and “Requested Services” • For currently licensed facilities or Change of Ownership complete the columns marked “Existing Beds” and “Existing Services” and the columns marked “Requested Beds” and “Requested Services” • For CHOW applications, the information marked in the “Existing” and “Requested” fields must be the same
	STD 850	**FIRE SAFETY INSPECTION REQUEST** **ICF**: 22 CCR section 73213 The STD 850 form is required for initial applications or construction. The HCAI Fire Life & Safety (FLS) Inspection approval does not replace this form. • This form is NOT required for a CHOW • The STD 850 form must be submitted or a similar form from the fire authority that contains equivalent information as the STD 850 form
	Supporting Documents	**APPLICATIONS FOR SUPPLEMENTAL SERVICES (INTIALS)** **ICF:** HSC sections 1252,1253,1265, and 1268 and 22 CCR section 73445 **Include the forms corresponding with the type of service the SNF is requesting to add to the license** • CDPH 242: Chronic Dialysis Service • CDPH 259: Rehabilitation Center (Outpatient Only) • CDPH 260: Occupational Therapy Service (Outpatient Only) • CDPH 261: Physical Therapy Service (Outpatient Only) • CDPH 262: Speech Pathology and/or Audiology Service (Outpatient Only) • CDPH 255: Social Work Service

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	CLIA	**Clinical Laboratory Improvement Amendments (CLIA) Waiver (Initial Application Only)** Submit a copy of approved CLIA waiver

REQUIRED DOCUMENTS FOR A CHOW ONLY

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	Supporting Documents	**All of the forms required for an "Initial" application listed above in addition to the documents requested below:** **ICF:** 73557 and 73543 • Copy of "Purchase Agreement" or "Operating Transfer Agreement" • Written verification (with amount) by a public accountant, accounting for all patient monies transferred to the custody of the new licensee **Note:** If none, need statement from current licensee that they did not handle resident monies • Copy of receipt (with amount) signed by the new licensee in exchange for such monies • A letter from the prospective licensee (to CDPH) stating where the patient medical records will be stored including address, and that the records will be made available to the previous licensee new and other authorized

MEDI-CAL CERTIFICATION DOCUMENTS

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
	HS 328	**NOTICE – EFFECTIVE DATE OF PROVIDER AGREEMENT** If applying for both Medi-Cal and Medicare certification, only submit one copy of this form
	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, section C, Page 3, item 4 • Notarized signature page is required • Submit the "Acknowledgement" page from the notary public

MEDICARE CERTIFICATION DOCUMENTS

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	CMS 671	**Long Term Care Facility Application for Medicare & Medicaid** **Note:** F14 – if a parent company was identified on the HS 200, B.6., enter the same name here
	CMS 1561	**HEALTH INSURANCE BENEFITS AGREEMENT** Submit two (2) signed forms with 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”

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