Skilled Nursing Facility (SNF)
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.

NOTE: If the application is approved by CAB, see the section titled Final Transaction Documents Required for End Process. Refer to Health and Safety Code section 1253.3(i) for timeline requirements on the submission of the Final Transaction Documents.

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

CHECKLIST AND INSTRUCTIONS – *Please submit your documents in this order*

REQUIRED PRELIMINARY 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

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** **SNF:** Health and Safety Code (HSC) sections 1253.3 and 1265 **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 7, Section C, item 3 – The name of the proposed facility cannot have the word “Rehabilitation” in the facility name unless the facility has previously had a rehabilitation service’s which were separately surveyed and approved by the Department [Title 22 California Code of Regulations (CCR) Section 72509 (c)] • Page 10, Section C, item 6 – Submit evidence that the licensee has sufficient financial resourced to operate the facility for at least **90** Days - The amount is determined by multiplying: **90** Days x number of beds x Medi-Cal Rate

<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>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
If part of a chain, a diagram indicating the relationship between the applicant and the persons or entities that are part of the chain and the name, address, and license number, if applicable, for each person or entity in the diagram. [HSC 1253.39(c)(10)(B)]</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 Change)
Letter 147-C (EIN Confirmation Notification)
Form SS-4 (Confirmation Notification)</td></tr>
</table>

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<tr><th>Use this space to check if included</th><th>Forms and supporting documents</th><th>Additional Instructions
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<tr><td></td><td>Supporting Documents</td><td>C.1a and E.11 - MANAGEMENT COMPANY AGREEMENT (If applicable)
SNF: 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</td></tr>
<tr><td></td><td>Supporting Documents</td><td>D.1 - CONTROL OF PROPERTY
SNF: HSC sections 1253.3(c)(10)(C) and 1265(h)

Submit a copy of the Grant Deed, Bill of Sale, Proposed Lease, Sublease, or Rental Agreement between the owner of the property and the proposed licensee
Must include name and address of any persons, organizations, or entities that own the real property on which the facility seeking licensure</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)**
	HS 215A	**APPLICANT INDIVIDUAL INFORMATION** **SNF:** HSC sections 1253.3 and 1265 This form must be completed for the following individuals: • 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 **Tip** • Page 2, Section B — 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 4, 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 requested in section D • Page 5, 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 that answered yes to any question on Page 5, Section E of the HS 215A, 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 five 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
	HS 309 1st Page	**ADMINISTRATIVE ORGANIZATION** Along with the HS 309, the following supporting documents according to organizational type must be submitted:
	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

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
	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
	Supporting Documents	**PUBLIC AGENCY** Copy of signed Resolution
	Supporting Documents	**PARTNERSHIP** Copy of signed Partnership Agreement

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
	HS 602	**TRANSFER AGREEMENT** **SNF:** HSC section 1760.4 and 22 CCR section 72519 Copy of current written or proposed transfer agreement with a General Acute Care Hospital **Tip** • The facility may not have a Facility Provider Number yet, and may be left blank
	Supporting Documents	**PROPOSED PURCHASE OR SALE AGREEMENT** **SNF:** HSC section 1253.3(c)(14) Submit a copy of the copy of signed proposed "Purchase or Sale Agreement" **Note**: Proposed purchase agreement must be signed by both parties and include the information required by HSC section 1253.3(c)(13).

Final Transaction Documents Required for End Process

LICENSURE DOCUMENTS

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
	Approval Letter	**Provide your Approval Letter received from the Department of Public Health**
	Supporting Documents	**PURCHASE OR SALE AGREEMENT** Submit a copy of the copy of signed finalized "Purchase or Sale Agreement"

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
	Supporting Documents	**CONTROL OF PORPERTY** **SNF:** HSC sections 1253.3(c)(10)(C) and 1265(h) Submit a copy of the Grant Deed, Signed Finalized Lease, Sublease, or Rental Agreement between the owner of the property and the proposed licensee
	HS 215A	**APPLICANT INDIVIDUAL INFORMATION** **SNF:** HSC section 1261.4 and 22 CCR sections 72007 and 72327 This form must be completed for the following individuals: • Administrator, Director of Nursing, and Medical Director of the facility **Tip** • Page 2, 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 4, 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 requested in section D
	Supporting Documents	**RESUME** A resume is required for the Administrator, Director of Nursing (DON), and Medical Director **Note:** • Administrator must be a licensed Nursing Home Administrator (NHA) • DON must be a licensed Registered Nurse

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
	Supporting Documents	**CERTIFICATE (MEDICAL DIRECTOR)** **SNF:** HSC section 1261.4 Copy of Certified Medical Director certificate issued by the American Board of Post-Acute and Long-Term Care Medicine (ABPLM) **NOTE:** If Medical Director is not certified, provide proof of progress towards certification via: a. Copy of certification initiation letter issued by ABPLM that includes the Medical Directors expected date of certification. **OR** b. Attestation Letter – Signed by the applicant (Medical Director) affirming that they are aware and will comply with the requirements of Health and Safety Code section 1261.4.
	HS 400	**AFFIDAVIT REGARDING PATIENT MONEY** **SNF:** HSC section 1318 and 22 CCR section 72217 • 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 • 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 (if applicable)** **SNF**: HSC section 1318 and 22 CCR section 72217 • 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** **SNF:** HSC section 1760.4 and 22 CCR section 72519 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
	CDPH 609	**BED OR SERVICE REQUEST** **SNF:** HSC section 1265 and 22 CCR sections 72211, 72603, and 72201 • Complete the columns marked "Existing Beds" and "Existing Services" and the columns marked "Requested Beds" and "Requested Services" • The information marked in the "Existing" and "Requested" fields must be the same

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	Supporting Documents	**SAFEGUARDS FOR PATIENTS' MONIES AND VALUABLES** **SNF:** 22 CCR Section 72529 • Written verification (with amount) by a public accountant, accounting for all patient monies transferred to the custody of the new licensee • Copy of receipt (with amount) signed by the new licensee in exchange for such monies **Note:** If none, need statement from current licensee that they did not handle resident monies
	Supporting Documents	**PATIENTS' HEALTH RECORDS** **SNF:** 22 CCR Section 72543 A letter from the prospective licensee (to CDPH) stating: • That the new licensee shall have custody of the patients' health records and that these records or copies shall be available to the former licensee, the new licensee and other authorized persons; or • That other arrangements have been made by the licensee for the safe preservation and the location of the patients' health records, and that they are available to both the new and former licensees and other authorized persons; or • The reason for the unavailability of such records.

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

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the 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

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
	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: • Sign the bottom signature block entitled “Accepted for the Successor Provider of Services By”

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	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**
	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