



# 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 Title 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 Title 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.**



# APPLICATION REQUEST FOR A SKILLED NURSING FACILITY or INTERMEDIATE CARE FACILITY



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 Sections 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 Title 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



# APPLICATION REQUEST FOR A SKILLED NURSING FACILITY or INTERMEDIATE CARE FACILITY



## **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.



# APPLICATION REQUEST FOR A SKILLED NURSING FACILITY or INTERMEDIATE CARE FACILITY



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](mailto:CAU@cdph.ca.gov).

Attachment: Notice – Quality Assurance Fee Program



# APPLICATION REQUEST FOR A SKILLED NURSING FACILITY or INTERMEDIATE CARE FACILITY



## 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/QualityAssuranceFee.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 Jamie Carroll at (916) 650-0530.

Health and Safety Code Section 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.



# APPLICATION REQUEST FOR A SKILLED NURSING FACILITY or INTERMEDIATE CARE FACILITY



Form Number	Item Number on Form	APPLICANT CHECKLIST For a Skilled Nursing or Intermediate Care Facility	Check List	
		<p>The following is a quick reference of <b>SOME</b> of the questions found on the required forms. It includes the form number, name of form, and an explanation of <b>SPECIFIC</b> requirements and/or attachments needed for specific forms. This is <b>NOT</b> 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> <p style="margin: 0;">SKILLED NURSING or INTERMEDIATE CARE FACILITY</p> <p style="margin: 0;">Includes the forms and information required to be “licensed”</p>				
HS 200	<p><b>Licensure &amp; Certification Application (Title 22, Sections 72201 and 73203)</b></p> <p><b>NOTE:</b> Please read the instructions on the <b>HS 200</b> form prior to completion of the form. Also, pay close attention to the following items:</p>			
	A.11.	<p><b>Construction. (Title 22, Section 72205)</b> N/A for CHOWS, unless there has been construction and/or remodeling.</p> <p>If this <b>IS</b> a newly constructed and/or remodeled building, <b>OR</b> if this is <b>NOT</b> a previously licensed facility (i.e., existing building with no construction or remodeling required) applicant needs to contact the Office of Statewide Health Planning &amp; Development (OSHPD) at the following website for Title 24 clearance: <a href="http://www.oshpd.ca.gov">www.oshpd.ca.gov</a> (Title 22, Section 72601 &amp; 73601)</p>	OSHPD sends directly to District Office	
	B.1.	<p><b>Licensee’s name. [(Title 22, Sections 72509(c) and 73205(a)(1))]</b></p> <p>The licensee’s formal organization name must be consistent throughout all documents.</p>		
	B.3.	<p><b>Owner type.</b></p> <p><b>SUBMIT</b> an <b>organization chart/flow chart</b> if the owner is a profit or nonprofit corporation, limited liability company (LLC), or general partnership. The organization chart needs to display the following: <b>[(Title 22, Section 73205(a)(9))]</b></p> <ul style="list-style-type: none"> <li>• Applicant’s owners and their ownership percentages, directors, board members, corporate officers, LLC members/managers, and partners.</li> <li>• Management company of applicant, if applicable, and all of their facilities.</li> <li>• <b>PARENT</b> company of applicant, if applicable, and all the licensed agencies/facilities they are operating – see B.6.</li> </ul>		
	B.5.a.	<p><b>Licensee’s “other” Facility Involvement.</b></p> <p>Answer all aspects of the question.</p>		
	B.5.b.	<p><b>Revocation, suspension, etc. action.</b></p> <p>If applicable to the licensee, <b>SUBMIT</b> the information requested.</p>		
	B.6.	<p><b>Subsidiary (PARENT company) information.</b></p> <p>If there is a “subsidiary” (PARENT company) <b>SUBMIT:</b></p> <ul style="list-style-type: none"> <li>• An <b>organization chart</b> with the PARENT company name.</li> <li>• 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.</li> </ul>		



# APPLICATION REQUEST FOR A SKILLED NURSING FACILITY or INTERMEDIATE CARE FACILITY



Form Number	Item Number on Form	APPLICANT CHECKLIST For a Skilled Nursing or Intermediate Care Facility	Check List
		<p>The following is a quick reference of <b>SOME</b> of the questions found on the required forms. It includes the form number, name of form, and an explanation of <b>SPECIFIC</b> requirements and/or attachments needed for specific forms. This is <b>NOT</b> an all-inclusive list of the questions that need to be answered so read the questions and instructions on each form.</p>	
		<ul style="list-style-type: none"> <li>• A listing of all facilities the PARENT company is operating.</li> </ul>	
	C.1.a.	<p><b>Management Agreement.</b> (H&amp;S Code, Sections 1265 and 1267.5)</p> <p>Indicate "YES" or "NO" if the facility is operated under a Management Agreement between the licensee and a management company. If "YES", refer to <b>Section E</b>, below.</p>	
	C.1.b.	<p><b>"Interim" Management Agreement.</b></p> <p><b>NOTE if CHOW:</b> If there is an "interim" Management Agreement, between the current and the prospective licensee, <b>SUBMIT</b> a signed and dated copy of Agreement.</p>	
	C.2.	<p><b>Name of "proposed" and "current" facility.</b></p> <ul style="list-style-type: none"> <li>• Enter both facility names if this is a CHOW.</li> <li>• For a CHOW, the name of the "proposed" facility can <b>NOT</b> have <b>REHABILITATION</b> in the facility name unless the facility has previously had rehabilitation services which were separately approved by the Department. If not, you must apply for a separate survey for the rehabilitation services to be approved <b>after the</b> CHOW application package has been processed.</li> <li>• For an "initial" application the applicant must apply for a separate survey for the rehabilitation services to be approved <b>after the</b> "initial" application package has been processed. [Title 22, Section 72509(c)]</li> </ul>	
	C.6.a.	<p><b>ADMINISTRATOR.</b></p> <p><b>SNF &amp; ICF:</b> Insert Administrator's name and requested information.</p>	
	C.6.b.	<p><b>DIRECTOR OF NURSING:</b></p> <ul style="list-style-type: none"> <li>• <b>SNF "only"</b> -- Insert DON name and requested information.</li> </ul>	
	C.7.	<p><b>Ownership.</b> (Title 22, Section 73205 for ICF and H&amp;S Code 1267.5(a)(1) for SNF)</p> <ul style="list-style-type: none"> <li>• List all individuals having <b>5% or more</b> ownership, unless "nonprofit".</li> </ul>	
	C.8.	<p><b>Financial resources.</b></p> <p><b>SUBMIT</b> evidence that the licensee has sufficient financial resources to operate the facility for at least <b>45 days.</b> [H&amp;S Code, Section 1265(g)]</p> <p>The evidence should be in the form of a bank statement, certificate of deposit, etc. in the name of the licensee. <b>The amount is determined by multiplying 45 days x number of beds x Medi-Cal rate.</b></p>	
	C.9. & C.10.	<p><b>Over-concentration and Program Plan.</b></p> <p>These questions are "N/A" for SNFs and ICFs.</p>	N/A



# APPLICATION REQUEST FOR A SKILLED NURSING FACILITY or INTERMEDIATE CARE FACILITY



Form Number	Item Number on Form	APPLICANT CHECKLIST For a Skilled Nursing or Intermediate Care Facility	Check List
		<p>The following is a quick reference of <b>SOME</b> of the questions found on the required forms. It includes the form number, name of form, and an explanation of <b>SPECIFIC</b> requirements and/or attachments needed for specific forms. This is <b>NOT</b> an all-inclusive list of the questions that need to be answered so read the questions and instructions on each form.</p>	
	D.1. & 2.	<p><b>Property ownership. [H&amp;S Code, Section 1265(h)]</b>  <b>SUBMIT</b> a copy of the Grant Deed, Bill of Sale, Lease, Sublease, or Rental Agreement between the owner of the property and the proposed licensee.</p>	
	E. and Attach E-1	<p><b>Management Company Information. (H&amp;S Code, Sections 1265 and 1267.5)</b>            Skilled nursing facility, intermediate care facility, general acute care hospital, and adult day health care management company applicants must complete this Attachment.</p> <ul style="list-style-type: none"> <li>• <b>SUBMIT ATTACHMENT E-1</b> if facility is operated under a Management Agreement <u>between</u> the licensee and a management company (approved by the Centralized Applications Unit).</li> <li>• <b>SUBMIT</b> a copy of the Management Agreement.</li> <li>• The Agreement must state the current licensee still has responsibility for the facility.</li> </ul> <p><b>NOTE: If the management company applicant has not been previously approved by the Department, they need to download the Management Company application package from the L&amp;C website.</b></p>	
	F.1.	<p><b>Signature.</b>            Original "signature" is required and <b>MUST</b> be signed by the <b>APPLICANT</b> (not the Administrator unless the owner is the Administrator).</p>	
<b>HS 215A</b>	<p><b>Applicant Individual Information</b>  <b>(H&amp;S Code, Sections 1265(i) and 1267.5 and Title 22, Section 73205 for ICF "only")</b></p> <p><b>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:</b></p> <p><b>SUBMIT</b> the <b>HS 215A</b> form plus any other required documents (which will be listed below) for the following individuals:</p>		
	<p><b>APPLICANT Organization</b></p> <p><b>HS 215A</b> form for each individual having a beneficial interest of <b>5% or more</b> in the APPLICANT organization (<u>list their percentages</u>).  <b>[H&amp;S Code, Section 1265.1(b)]</b></p> <p><b>HS 215A</b> form for directors, board members, corporate officers, LLC members/managers, and partners of the APPLICANT organization.</p>		
	<p><b>PARENT Company</b></p> <p><b>HS 215A</b> form for each individual having a beneficial interest of <b>5% or more</b> in the PARENT company (<u>list their percentages</u>).</p> <p><b>HS 215A</b> form for directors, board members, corporate officers, LLC members/managers, and partners of the PARENT company.</p>		



# APPLICATION REQUEST FOR A SKILLED NURSING FACILITY or INTERMEDIATE CARE FACILITY



Form Number	Item Number on Form	APPLICANT CHECKLIST For a Skilled Nursing or Intermediate Care Facility	Check List
		<p>The following is a quick reference of <b>SOME</b> of the questions found on the required forms. It includes the form number, name of form, and an explanation of <b>SPECIFIC</b> requirements and/or attachments needed for specific forms. This is <b>NOT</b> an all-inclusive list of the questions that need to be answered so read the questions and instructions on each form.</p>	
		<p><b>MANAGEMENT Company</b></p> <p><b>HS 215A</b> form for each individual having a beneficial interest of <b>5% or more</b> in the MANAGEMENT company (list their percentages).</p> <p><b>HS 215A</b> form for directors, board members, corporate officers, LLC members/managers, and partners of the MANAGEMENT company.</p>	
		<p><b>ADMINISTRATOR of the Facility</b></p> <p><b>HS 215A</b> form for Administrator of the facility.  <b>[Title 22, Sections 72211(b), 72513 &amp; 73205(a)(4)]</b>            Administrator is required to be a licensed <b>Nursing Home Administrator</b>.  <b>(Title 22 Sections 73205(a)(4) &amp; 73511(a) &amp; Title 42, CFR, Section 483.75)</b></p>	
		<p><b>DIRECTOR of NURSING (Title 22, Section 72327)</b></p> <p><b>SUBMIT</b> copy of professional License.</p> <p><b>SUBMIT RESUME</b>, if new.</p>	
	Section D	<p><b>Employment/Business Summary.</b>            A resume or attachment will be acceptable in lieu of Section "D" being filled out.</p>	
	Signature	<p><b>Signature.</b>            Original "signature" is required on all the <b>HS 215A</b> forms.</p>	
	Facility Info Sheet	<p>If applicable, each individual must complete and <b>SUBMIT</b> 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. <b>The following <u>MUST</u> be completed for each facility and/or agency:</b></p> <ul style="list-style-type: none"> <li>• Facility name and address</li> <li>• Type of facility</li> <li>• Type of business entity (include EIN Number)</li> <li>• Individual's <u>nature</u> and <u>dates</u> of involvement</li> <li>• This Sheet must also include any facilities licensed by the California Department of Social Services <b>[H&amp;S Code, Section 1267.5(c)]</b></li> </ul>	
<b>HS 309</b> 1 <sup>st</sup> page	<b>Administrative Organization</b>		
	2.	<p><b>This form is N/A for a sole proprietor.</b></p> <p><b>Administrator</b> of Corporation or LLC – This is usually the CEO/President.</p>	
	3. thru 7.	<p><b>Corporations</b> need to <b>SUBMIT:</b></p> <ul style="list-style-type: none"> <li>• Copy of Filing Statement from CA Secretary of State (only required if Articles of Incorporation are NOT endorsed by the CA Secretary of State).</li> </ul>	<p><b>LLCs</b> need to <b>SUBMIT:</b></p> <ul style="list-style-type: none"> <li>• Copy of Filing Statement from CA Secretary of State (only required if Articles of Organization CA Secretary of State).</li> </ul>



# APPLICATION REQUEST FOR A SKILLED NURSING FACILITY or INTERMEDIATE CARE FACILITY



Form Number	Item Number on Form	APPLICANT CHECKLIST For a Skilled Nursing or Intermediate Care Facility	Check List
		<p>The following is a quick reference of <b>SOME</b> of the questions found on the required forms. It includes the form number, name of form, and an explanation of <b>SPECIFIC</b> requirements and/or attachments needed for specific forms. This is <b>NOT</b> an all-inclusive list of the questions that need to be answered so read the questions and instructions on each form.</p>	
		<ul style="list-style-type: none"> <li>• Copy of "all" Articles of Incorporation (endorsed by CA Secretary of State).</li> <li>• Copy of By-Laws.</li> </ul>	
		<ul style="list-style-type: none"> <li>• Copy of Articles of Organization (endorsed by CA Secretary of State).</li> <li>• Copy of Operating Agreement.</li> </ul>	
	9.	<b>Governing Board of Directors.</b> <ul style="list-style-type: none"> <li>• Enter the number of board members or LLC members/holders</li> <li>• <b>SUBMIT</b> a list of the board of directors or the LLC members/holders.</li> </ul>	
	10.	<b>Board Officers.</b> Enter the names of the board officers or the LLC officers/managers.	
<b>HS 309</b> 2 <sup>nd</sup> page	<b>Organizational Structure</b>		
	1.	<b>California Out-of-State Corporations, LLC, etc.</b> <b>SUBMIT</b> a copy of the Certificate of Qualification from the California Secretary of State.	
	3. thru 4.	<b>Public Agency.</b> <b>SUBMIT</b> a copy of the signed Resolution	
	5.	<b>Item 5.</b> <b>Corporations, LLCs and Partnerships need to complete Item 5.</b> <b>N/A for nonprofit.</b>	
	Bottom of page	<b>Partnerships need to SUBMIT:</b> <ul style="list-style-type: none"> <li>• Copy of the Partnership Agreement</li> <li>• Copy of the California Secretary of State filing</li> </ul>	
<b>HS 400</b>	<b>Affidavit Regarding Patient Money (Title 22, Sections 72217 and 73241)</b>		
		Be sure to mark either A or B box. If B is checked, enter the amount of money to be handled and <b>SUBMIT</b> bond required on form <b>HS 402</b> form.	
<b>HS 402</b>	<b>Surety Bond Verification (Title 22, Sections 72217 and 73241)</b>		
		<ul style="list-style-type: none"> <li>• Be sure the <b>HS 402</b> form is a California Department of Public Health form</li> <li>• Is signed by the Bonding agency</li> <li>• Possesses the embossed seal of the Bonding Agency</li> <li>• <b>SUBMIT</b> an "original" bond or an "embossed" Power of Attorney</li> </ul>	
<b>HS 602</b>	<b>Transfer Agreement Between (Title 22, Sections 72519 and 73503)</b>		
		<b>SUBMIT</b> a current copy of the Transfer Agreement (within one year of submission of application).	
<b>CDPH 609</b>	<b>Bed or Service Request (Title 22, Sections 72201, 72401 and 73445)</b>		
	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.	



# APPLICATION REQUEST FOR A SKILLED NURSING FACILITY or INTERMEDIATE CARE FACILITY



Form Number	Item Number on Form	APPLICANT CHECKLIST For a Skilled Nursing or Intermediate Care Facility	Check List
		<p>The following is a quick reference of <b>SOME</b> of the questions found on the required forms. It includes the form number, name of form, and an explanation of <b>SPECIFIC</b> requirements and/or attachments needed for specific forms. This is <b>NOT</b> an all-inclusive list of the questions that need to be answered so read the questions and instructions on each form.</p>	
<b>DHCS 1051</b>	<b>Civil Rights Compliance Review</b>		
		Send directly to Office of Civil Rights – address is on last page of the form.	
<b>CHOW</b>	<b>Change of Ownership (Title 22, Sections 72201 and 73203)</b>		
		<ul style="list-style-type: none"> <li>• <b>SUBMIT</b> all of the forms required for an “initial” application, listed above, plus the following:</li> <li>• Copy of “Purchase Agreement” or “Operating Transfer Agreement”.</li> <li>• Written verification (with amount) by a 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. <b>[Title 22, Sections 72529(a)(10) and 73557(a)(8)]</b></li> <li>• Copy of receipt (with amount) signed by the new licensee in exchange for such monies. <b>[Title 22, Section 72529(a)(10) and 73557(a)(8)]</b></li> <li>• 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. <b>[Title 22, Sections 72543(e) and 73543(e)]</b></li> </ul>	
<p><b><u>MEDI-CAL CERTIFICATION</u></b> SKILLED NURSING or INTERMEDIATE CARE FACILITY Includes the forms and information required for <b>MEDI-CAL certification</b></p>			
<b>HS 328</b>	<b>Notice – Effective Date of Provider Agreement</b>		
		If applying for both Medi-Cal & Medicare certification, only need one copy of this form.	
<b>DHCS 9098</b>	<b>Medi-Cal Provider Agreement</b>		
		<ul style="list-style-type: none"> <li>• Do not leave any questions blank. Enter N/A or “same” if not applicable.</li> <li>• The “mailing address” must be the same as reported on the <b>HS 200</b> form, page 3, Item 4.</li> <li>• Signature page <b>must be notarized</b>.</li> <li>• <b>SUBMIT</b> the “Acknowledgement” page from the Notary Public, if applicable.</li> </ul>	



# APPLICATION REQUEST FOR A SKILLED NURSING FACILITY or INTERMEDIATE CARE FACILITY



Form Number	Item Number on Form	APPLICANT CHECKLIST For a Skilled Nursing or Intermediate Care Facility	Check List
		<p>The following is a quick reference of <b>SOME</b> of the questions found on the required forms. It includes the form number, name of form, and an explanation of <b>SPECIFIC</b> requirements and/or attachments needed for specific forms. This is <b>NOT</b> an all-inclusive list of the questions that need to be answered so read the questions and instructions on each form.</p>	
<p><b>MEDICARE CERTIFICATION</b> Only applies to SKILLED NURSING FACILITIES Includes the forms and information required for <b>MEDICARE</b> certification</p>			
HS 328	<b>Notice – Effective Date of Provider Agreement</b>		
		If applying for both Medi-Cal & Medicare certification, only need one copy of this form.	
CMS 671	<b>Long Term Care Facility Application for Medicare and Medicaid</b>		
	1 <sup>st</sup> page	<ul style="list-style-type: none"> <li>• <b>Item A.F9</b> is “03” if you want both Medi-Cal and Medicare.</li> <li>• If <b>Item F12</b> is an “LLC”, insert “03”, which is for corporations and LLCs.</li> <li>• <b>Items F28 &amp; F30 and F29 &amp; F31</b> are required to be completed. Enter N/A, if not applicable.</li> </ul>	
	2 <sup>nd</sup> page	<p><b>Facility Staffing Form:</b></p> <ul style="list-style-type: none"> <li>• Enter staff hours worked in the most recent complete pay period.</li> <li>• 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.</li> <li>• Original signature required along with the time and date form was completed.</li> </ul>	
CMS 855A	<b>Medicare General Enrollment Health Care Provider/Supplier Application</b>		
		<ul style="list-style-type: none"> <li>• This application is from the Federal Department of Health and Human Services.</li> <li>• The completed application should be mailed directly to the appropriate Fiscal Intermediary.</li> </ul>	
CMS 1561	<b>Health Insurance Benefit Agreement</b>		
		<p><b>SUBMIT</b> two (2) signed copies with “original” signatures.</p> <ul style="list-style-type: none"> <li>• <b>Initial Application:</b> Sign the top signature block entitled “Accepted for the Provider of Services By.”</li> <li>• <b>CHOW:</b> Sign the bottom signature block entitled “Accepted For The Successor Provider of Services By.”</li> </ul>	
OMB No. 0990-0243	<b>Civil Rights Information Request for Medicare Certification</b>		
		<ul style="list-style-type: none"> <li>• <b>Complete</b> and “sign” form (original signature).</li> <li>• <b>SUBMIT</b> all of the documents required on <u>Part 11</u> of this <b>OMB</b> form. All of these documents need to be “identified” by the corresponding number on the <b>OMB</b> form. The first document required is the <b>HHS 690</b> form below.</li> <li>• These items will be reviewed and approved by OCR.</li> </ul>	



# APPLICATION REQUEST FOR A SKILLED NURSING FACILITY or INTERMEDIATE CARE FACILITY



Form Number	Item Number on Form	<p style="text-align: center;">APPLICANT CHECKLIST</p> <p style="text-align: center;">For a Skilled Nursing or Intermediate Care Facility</p> <p>The following is a quick reference of <b>SOME</b> of the questions found on the required forms. It includes the form number, name of form, and an explanation of <b>SPECIFIC</b> requirements and/or attachments needed for specific forms. This is <b>NOT</b> an all-inclusive list of the questions that need to be answered so read the questions and instructions on each form.</p>	Check List
HHS 690		<p><b>Assurance of Compliance</b></p> <p><b>SUBMIT</b> 1 copy. This <b>HHS 690</b> form is the first document required to be submitted on the above <b>OMB No. 0990-0243</b> form.</p>	