California Department of PublicHealth

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

General Acute Care Hospital and Acute Psychiatric Hospital 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: California Health Alert Network (CAHAN) (https://www.calhospitalprepare.org/cahan) • Signature
	HS 200	**LICENSING & CERTIFICATION APPLICATION** (Title 22 California Code of Regulations (CCR) Section 70107)

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
	Supporting Documents	**B.3-ORGANIZATIONAL CHART – OWNER TYPE** Submit an organizational chart if the owner is a profit, nonprofit corporation, limited liability company (LLC), or general partnership. The organizational chart needs to display the following: • Applicant's owners, directors, board members, corporate officers, LLC members/managers, and partners **Note:** Submit the HS 215A form for each of these individuals • Management company of applicant, if applicable, and all of their facilities • Parent company of applicant, if applicable, and all of the licensed agencies/facilities they are operating- see B.6
	Supporting Documents	**D.1-CONTROL OF PROPERTY** 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	**A.11-OFFICE OF STATEWIDE HEALTH PLANNING & DEVELOPMENT (OSHPD) AND/ OR CERTIFICATE OF OCCUPANCY**
		(Title 22 CCR Sections 70109, 70115, 70801, & 70803)
		(Health and Safety Code (HSC) 1765.150(b))
		
		If the facility is newly constructed or a remodeled building, or if this is not a previously licensed facility contact OSHPD or the local building authority for Title 24 clearance.
		
		• For on-site location
		  ○ Submit OSHPD Certificate of Occupancy (CO), Construction Final (CF) or Substantial Completion (SC)
		• For off-site location
		  ○ Submit CO from local building authority
		  ○ Submit CDPH 270 for both Certification Form for Clinics and Freestanding Outpatient Clinic Services of a Hospital

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
		▪ Signed by OSHPD or local building official • For adding a mobile unit not self-contained and utility hookups originate or pass through any GACH building or adding a mobile unit providing inpatient services ○ Submit OSHPD CO, CF, or CS • For adding a self-contained mobile unit ○ Submit a letter verifying the mobile unit is self-contained
	Supporting Documents	**E.11-MANAGEMENT COMPANY AGREEMENT** (If applicable) (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) on HS200 along with a copy of the Management Agreement. The Management Agreement must state that the licensee is responsible for the hospital.
	CDPH 609	**BED OR SERVICE REQUEST** • 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
	CDPH 241 - 267	**APPLICATIONS FOR SUPPLEMENTAL SERVICES (Title 22 CCR Sections 70301, 70351 and 71403)** Include the forms corresponding with the type of service the facility is requesting to add to the license • CDPH 241: Cardiovascular Surgery Service (Title 22 CCR Sections 70431 through 70439) • CDPH 242: Chronic Dialysis Service (Title 22 CCR Sections 70441 through 70449) • CDPH 243: Dental Service (Title 22 CCR Sections 70471 through 70479)

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
		• CDPH 245: Nuclear Medicine Service (Title 22 CCR Sections 70505 through 70513) • CDPH 246: Outpatient Service (Title 22 CCR Sections 70525 through 70533) • CDPH 247: Pediatric Service (Title 22 CCR Sections 70535 through 70543) • CDPH 248: Perinatal Unit (Title 22 CCR Sections 70545 through 70553) • CDPH 249: Podiatric Service (Title 22 CCR Sections 70565 through 70573) • CDPH 250: Psychiatric Unit (Title 22 CCR Sections 70575 through 70583) • CDPH 251: Radiation Therapy Service (Title 22 CCR Sections 70585 through 70593) • CDPH 252: Renal Transplant Center (Title 22 CCR Sections 70605 through 70513) • CDPH 253: Respiratory Care Service (Title 22 CCR Sections 70615 through 70623) • CDPH 255: Social Service (Title 22 CCR Sections 70629 through 70637) • CDPH 256: Standby Emergency Medical Service, Physician on Call (Title 22 CCR Sections 70649 through 70657) • CDPH 257: Basic Emergency Medical Service, Physician on Duty (Title 22 CCR Sections 70411 through 70419) • CDPH 258: Comprehensive Emergency Medical Service (Title 22 CCR Sections 70451 through 70459) • CDPH 259: Rehabilitation Center (Title 22 CCR Sections 70595 through 70603) • CDPH 260: Occupational Therapy Service (Title 22 CCR Sections 70515 through 70523) • CDPH 261: Physical Therapy Service (Title 22 CCR Sections 70555 through 70563) • CDPH 262: Speech Pathology and/or Audiology Service (Title 22 CCR Sections 70639 through 70647) • CDPH 263: Acute Respiratory Care Service (Title 22 CCR Sections 70401 through 70409) • CDPH 264: Burn Center (Title 22 CCR Sections 70421 through 70429)

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
		• CDPH 265: Coronary Care Service (Title 22 CCR Sections 70461 through 70469) • CDPH 266: Intensive Care Newborn Nursery Service (Title 22 CCR Sections 70481 through 70489) • CDPH 267: Intensive Care Service (Title 22 CCR Sections 70491 through 70499)
	CDPH 709	**CLIENT ACCOMMODATION ANALYSIS** • Complete this form in its entirety • Must be signed
	Supporting Documents	**FLOOR PLAN** Submit a floor plan that coincides with the room schematics on the CDPH 709.
	HS 215A	**APPLICANT INDIVIDUAL INFORMATION** (Title 22 CCR Section 70107) (HSC Section 1265.1(b)) This form must be completed for the following individuals and include original signatures: • Administrator of the facility and the Director of Nursing • 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 10% in the applicant organization and/or parent organization
	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 3 years. The following must be completed for each facility and/or agency:

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
		• Facility name • Facility address • Type of facility • Type of business entity (include EIN Number) • Individual's nature of involvement • Individual's dates of involvement • This Sheet must also include any facilities licensed by the California Department of Social Service
	Supporting Documents	**RESUME** A resume is only required for the Administrator(s) and Director of Nursing.
	HS 309 1st Page	**ADMINISTRATIVE ORGANIZATION** Along with the HS 309, depending on organizational type, the following supporting documents 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)
	Supporting Documents	**LIMITED LIABILITY COMPANY (LLC)** • Filing Statement from the Secretary of State • Articles of Incorporation • 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.

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** (Title 22 CCR Section 70137) • 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 • **Note:** HS 400 is only required when applicable
	HS 402	**SURETY BOND VERIFICATION** (Title 22 CCR Section 70137) • Is signed by the bonding agency • Possesses the embossed seal of the bonding agency • Submit an "original" bond or an "embossed" Power of Attorney • **Note:** HS 402 is only required when applicable
	HS 602	**TRANSFER AGREEMENT** (HSC Section 1250.3) (Only required for rural hospitals without surgery and anesthesia) Copy of current written transfer agreement with a hospital that meets the requirements of the Code of Federal Regulations.
	STD 850	**FIRE SAFETY INSPECTION REQUEST** (Title 22 CCR Section 70745) The STD 850 form is required. The OSHPD 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

REQUIRED DOCUMENTS FOR A CHOW ONLY

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
	Supporting Documents	**All of the forms required for an "Initial" application listed above in addition to the documents requested below:** • Copy of "Purchase Agreement" or "Operating Transfer Agreement" • When applicable, written verification (with amount) by public accountant, accounting for all patient monies transferred to the custody of the new licensee. If none, need statement from current licensee that they did not handle resident monies [Title 22 CCR Section 70755(g)] • When applicable, 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 stored patient medical records will be maintained, and that the records will be made available to the previous licensee [Title 22 CCR Section 70751(e)]

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)**
	DHCS 6207	**MEDICAL DISCLOSURE STATEMENT** Only complete for Section V.
	DHCS 9098	**MEDICAL 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
	Supporting Documents	**NATIONAL PROVIDER IDENTIFIER (NPI)** Submit NPI approval letter.
	Supporting Documents	**IRS- INTERNAL REVENUE SERVICE DOCUMENTATION** Submit **one** of the following IRS tax documents showing 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)
	HS 328	**NOTICE – EFFECTIVE DATE OF PROVIDER AGREEMENT** If applying for both Medi-Cal & Medicare certification, only submit one copy of this form.

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 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"
	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** • **OCR's online portal is:** Office for Civil Rights (https://ocrportal.hhs.gov/ocr/aoc/instruction.jsf) • Once the on-line 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
	HS 328	**NOTICE – EFFECTIVE DATE OF PROVIDER AGREEMENT** If applying for both Medi-Cal & Medicare certification, only submit one copy of this form.