Hospice Facility (HOFA)
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
	HS 200	**LICENSURE & CERTIFICATION APPLICATION** [Health and Safety Code (HSC) section 1339.41(b)] **Tips** • Page 2, section B, item 6 — An organization must own 100 percent of the licensee to be considered a parent

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		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 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

	Supporting Documents	**A.11 - OFFICE OF STATEWIDE HEALTH PLANNING & DEVELOPMENT (OSHPD) AND/ OR CERTIFICATE OF OCCUPANCY (CO)**
		
		If the facility is newly constructed or a remodeled building, or if this is not a previously licensed facility the facility shall be under the jurisdiction of OSHPD or the local building department
		
		• Hospice Facility located within the physical plant of another facility (HSC 1339.43(e)(1))
		  ○ Shall be under the jurisdiction of OSHPD
		  ○ Submit OSHPD CO, Construction Final (CF) or Substantial Completion (SC)
		• Freestanding Hospice Facility located on the site of or is physically connected to a health facility that is under the jurisdiction of both (HSC 1339.43(f))
		  ○ Submit new construction or renovation plans to OSHPD for review and approval
		  ○ Submit OSHPD CO, CF or SC
		• Freestanding Hospice Facility (HSC 1339.43(d)(1)(2))
		  ○ Shall be under the jurisdiction of the local building department
		  ○ Submit CO from local building department

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	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 ID/EIN # 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
	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 1339, (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)

<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></td><td>• Owners, directors, board members, corporate officers, LLC members/managers, and partners of the applicant organization
• Each individual having a beneficial interest of exceeding 5 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. 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 require 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</td></tr>
<tr><td></td><td>Supporting Documents</td><td>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</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	**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:
	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
	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

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		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
	STD 850	**FIRE SAFETY INSPECTION REQUEST** [HSC section 1339.43(b)(c)] • 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. The OSHPD Fire Life & Safety (FLS) Inspection approval does not replace this form
		CRIMINAL BACKGROUND INVESTIGATION (HSC section 1339.42) The licensee is required to obtain background checks for its employees, volunteers and contractors in accordance with federal Medicare conditions of participation (42 CFR part 418), and as may be required by state law. The HOFA licensee pays the cost of obtaining the criminal background check.

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" • 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 [SHQC, 2003, section 6.3(g)]

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
	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

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
	CMS 417	**HOSPICE REQUEST FOR CERTIFICATION IN THE MEDICARE PROGRAM** • If this freestanding hospice is “licensed only” the completed form is required to identify the types of services
	CMS 643	**HOSPICE SURVEY AND DEFICIENCIES REPORT** • Submit both pages • Fill out the name of facility only
	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 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

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		• Submit a copy of this notification