

## Alternative Birth Center (ABC) Report of Change Application Checklist for Change of Location

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.

### CHECKLIST AND INSTRUCTIONS - *Please submit your documents in this order*

#### REQUIRED DOCUMENTS FOR A CHANGE OF LOCATION

<i>Use this space to check if included</i>	<b>Forms and supporting documents</b>	<b>Additional Instructions (Each form listed also has instructions on the form)</b>
	Cover Letter	<p><b>COVER LETTER</b></p> <p>Letter on company letterhead with the following information:</p> <ul style="list-style-type: none"> <li>• License number</li> <li>• Facility name and ID number (if known)</li> <li>• Brief description of request</li> <li>• Previous and proposed/new location</li> <li>• Contact information (name, title, phone number, and email address)</li> <li>• 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: <a href="https://www.calhospitalprepare.org/cahan">CAHAN</a> (<a href="https://www.calhospitalprepare.org/cahan">https://www.calhospitalprepare.org/cahan</a>)</li> <li>• Signature</li> </ul>
	HS 200	<p><b>LICENSURE &amp; CERTIFICATION APPLICATION</b> [Health and Safety Code (HSC) section 1212]</p> <p><b>Tips</b></p> <ul style="list-style-type: none"> <li>• Page 2, section B, item 6 — An organization must own 100 percent of the licensee to be considered a parent</li> </ul>

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		<p>company. This parent company will have its own Employer Identification Number (EIN)</p> <ul style="list-style-type: none"> <li>• 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)</li> </ul>
	Supporting Documents	<p><b>A.11 – OFFICE OF STATEWIDE HEALTH PLANNING &amp; DEVELOPMENT (OSHPD) AND/ OR CERTIFICATE OF OCCUPANCY</b> [California Building Code (CBC) section 1226] [HSC section 1226]</p> <p><b>If the facility is newly constructed or a remodeled building, or if this is not a previously licensed facility, submit the following:</b></p> <ul style="list-style-type: none"> <li>• <b>Written certification:</b> a California licensed architect or the local building authority must provide written certification of Title 24 compliance (OSHPD 3 Standards) stating the building meets the current applicable codes and the following building requirements: <ul style="list-style-type: none"> <li>• California Building Code (CBC)</li> <li>• California Fire Code (CFC)</li> <li>• California Electrical Code (CEC)</li> <li>• California Mechanical Code (CMC)</li> <li>• California Plumbing Code (CPC)</li> <li>• California Administrative Code (CAC)</li> </ul> </li> <li>• <b>CDPH 270:</b> Certification Form for Clinics and Freestanding Outpatient Clinic Services of a Hospital, to certify the facility conforms to current applicable Title 24 (OSHPD 3 Standards). This form must be signed by a local building authority or OSHPD</li> </ul>
	Supporting Documents	<b>D.1 - CONTROL OF PROPERTY</b> [HSC section 1212]

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		Submit a signed copy of the Grant Deed, Bill of Sale, Lease, Sublease, or Rental Agreement between the owner of the property and the licensee
	STD 850	<b>FIRE SAFETY INSPECTION REQUEST</b>  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.

**MEDI-CAL CERTIFICATION DOCUMENTS REQUIRED REHABC ONLY**

<i>Use this space to check if included</i>	<b>Forms and supporting documents</b>	<b>Additional Instructions (Each form listed also has instructions on the form)</b>
	DHCS 9098	<b>MEDI-CAL PROVIDER AGREEMENT</b> <ul style="list-style-type: none"> <li>• Do not leave any questions blank. Enter "same" or "N/A" if not applicable</li> <li>• The mailing address must be the same as reported on the HS 200 form, section C, Page 3, item 4</li> <li>• Notarized signature page is required</li> <li>• Submit the "Acknowledgement" page from the notary public</li> </ul>

**MEDICARE CERTIFICATION DOCUMENTS REQUIRED FOR REHABC ONLY**

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	CMS 855A	<b>MEDICARE GENERAL ENROLLMENT HEALTH CARE PROVIDER/SUPPLIER APPLICATION</b> <ul style="list-style-type: none"> <li>• This application is from the Centers of Medicare and Medicaid Services</li> </ul>

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		<ul style="list-style-type: none"> <li>The completed application should be mailed directly to the appropriate fiscal intermediary</li> </ul>
	CMS 359	<p><b>COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY REPORT FOR CERTIFICATION TO PARTICIPATE IN THE MEDICARE PROGRAM</b></p> <p>Submit the CMS 359 form with original signature</p>