COVER LETTER

ABC Community Care
999 Beach Side Court, Sacramento, CA 95814
P: (999) 555-2626
F: (999) 555-2600
Email: JaneDoe@abccommunitycare.org

March 15, 2019

VIA PRIORITY MAIL:

California Department of Public Health
Licensing and Certification
P. O. Box 997377, MS 3207
Sacramento, CA 95899
Attn: Centralized Applications Branch

RE: **CHANGE OF CAPACITY** Application for Family First, located at 1800 Beach Drive, Sacramento, CA 95814 License #222222222

To Whom It May Concern,

We are submitting a **Change of Capacity** application for Family First, located at 1800 Beach Drive, Sacramento, CA 95814.

Family First has undergone a remodeling of current space. The construction has increased the number of available dialysis stations from the current licensed capacity of 30 to a total of 40 stations. Effective March 1, 2019, Family First is seeking to license the additional ten dialysis stations.

I enclosed the required application forms and supporting documents needed to process my Change of Capacity application.

Should you have any questions, I will be the direct contact regarding this Change of Capacity application.

Emergency Contact Information (available 365/24/7)
Name: Jane Doe
Email: JaneDoe@abccommunitycare.org Alternate Email: JaneDoe@cmail.com
Phone: (999) 555-2626 Phone (Text Messages): (999) 555-5555
Fax: (999) 555-2600

Sincerely,

Jane Doe

Jane Doe, Owner
ABC Community Care

HS 200

LICENSURE & CERTIFICATION APPLICATION

FOR DEPARTMENTAL USE ONLY	
District:	*ELMS Facility Number:*
Proposed name of facility/agency/clinic:	

A. APPLICATION INFORMATION

1. Type of application (check one):
   - ○ **a.** Initial
   - ○ **b.** Change of Ownership (see #2 below)
   - ○ **c.** Management company (see Sections C1-5, F, and Attachment E-1)
   - ◉ **d.** Other change (see Section A4): Change of Capacity

2. **Change of Ownership Only - For Certification Purposes:**
   We wish to make certain that our records correctly show the effective date of the ownership change for certification. This date should reflect the actual date on which you took charge of the financial management of the facility rather than the date of sale or date of state license change. Effective date of change:

3. Amount of fee enclosed: $

4. Type of Change (check all that apply):
   - ☐ **a.** Not applicable
   - ☑ **b.** Change of capacity (see # 8 below)
   - ☐ **c.** Change of location
   - ☐ **d.** Change of services
   - ☐ **e.** Change of facility type
   - ☐ **f.** Change of bed classification
   - ☐ **g.** Change of name
   - ☐ **h.** Construction of new or replacement facility
   - ☐ **i.** Stock transfer
   - ☐ **j.** Other (specify)

5. Type of facility, agency, or clinic (check one)
   - ○ **a.** Skilled Nursing Facility (SNF)
   - ○ **b.** Intermediate Care Facility (ICF)
   - ○ **c.** ICF/Developmentally Disabled (ICF/DD)
   - ○ **d.** ICF/DD-Habilitative (ICF/DD-H)
   - ○ **e.** ICF/DD-Nursing (ICF/DD-N)
   - ○ **f.** Primary care clinic – Free
   - ○ **g.** Primary care clinic – Community
   - ○ **h.** Surgical clinic
   - ○ **i.** Rural health clinic (for Certification "only")
   - ○ **j.** General acute care hospital
   - ○ **k.** Adult day health care center
   - ○ **l.** Home Health Agency (HHA)
   - ○ **m.** Hospice
   - ○ **n.** Chronic dialysis clinic
   - ◉ **o.** Other (specify) CDC/ESRD

6. **a.** Do you wish to apply for the Medicare program? ○ Yes ◉ No Medicare Provider #: 44-4444
   b. Fiscal Intermediary choice:

7. Do you wish to apply for the Medi-Cal (Medicaid) program? ○ Yes ◉ No

8. **a.** Current facility bed capacity: 30
   b. Proposed facility bed capacity: 40

9. Age range of clients: 0-100

10. Days and hours of operation: M-F 8am-5pm

11. Is construction required? Yes ◉ No ○
    If "yes", submit copy of "OSHPD" form (see instructions on page 6)
    If "yes", date construction to begin: 01/01/2019
    If "yes", date construction to be completed: 03/01/2019

B. LICENSEE INFORMATION

1. Licensee name: ABC Community Care

2. Federal employer's tax ID number: 555555555

3. Owner type (check one): ***Submit*** organizational chart for b, c, d, and e.

- ○ **a.** Sole proprietorship (Individual)
- ◉ **b.** Profit corporation
- ○ **c.** Nonprofit corporation
- ○ **d.** Limited Liability Company (LLC)
- ○ **e.** Partnership – General
- ○ **f.** Partnership – Limited
- ○ **g.** City
- ○ **h.** County
- ○ **i.** State agency
- ○ **j.** Other agency (specify)
- ○ **k.** Public agency (specify)

4. Licensee address (number & street): 999 Beach Side Court

Telephone number: (999) 555-2626

City, State, & Zip: Sacramento, CA 95814

E-Mail: JaneDoe@abcmedicalLLC.org

Fax number: (999) 555-2600

5. a. Identify other facilities, agencies, or clinics the licensee has been licensed for, operated, managed, held a **5%** or more interest in, or served as a director or officer. Include facilities both in and outside of California. ***Submit*** an attachment for additional facilities that includes all of the required information listed below.

(1) Facility Name:

Facility Type:

Facility address (number & street):

City, State, & Zip:

(2) Facility Name:

Facility Type:

Facility address (number & street):

City, State, & Zip:

(3) Facility Name:

Facility Type:

Facility address (number & street):

City, State, & Zip:

(4) Facility Name:

Facility Type:

Facility address (number & street):

City, State, & Zip:

5. b. If any facility, agency, or clinic identified in 5.a. has had a license revocation action filed, license placed on probation, suspended, or revoked (whether stayed or not) or, for agency or clinic resolved by settlement, receiver appointed, or had a final Medi-Cal decertification action taken, please ***submit*** additional information, including all ownership and facility information, date and any final action.

6. Is the licensee a **subsidiary** of another organization? ○ Yes ◉ No
If "yes", complete the information below and ***submit*** an organizational chart:

Parent organization name:

Parent federal tax ID Number:

P.O. Box or number & street:

City, State, & Zip:

C. FACILITY, AGENCY OR CLINIC INFORMATION

Management Agreement (this only applies to SNF's & ICF's):

1. **a.** Is the facility, agency, or clinic going to be operated under a management contract/agreement between the proposed owner and a management company? If "yes", proceed to **Section E** (below). ○ Yes ◉ No

b. Is there an "interim" management agreement, between the proposed owner and the current owner, to run the facility, agency, or clinic until the change of ownership is completed? If "yes", ***submit*** a copy of the "interim" management agreement. ○ Yes ◉ No

2. Name of **"proposed" facility**, agency, or clinic:
Current facility, agency, or clinic name (if change of ownership):
Family First Facility license number:

3. Address (number & street) of "proposed" facility, agency, or clinic: Telephone number:
1800 Beach Side Court (999) 555-0695
City, State, & Zip: Sacramento, CA 95814

4. Mailing address, if different from above: Telephone number:
Number & Street:
Fax number: E-mail address:
City, State, & Zip:

5. **Name of person to be in charge of facility, agency, or clinic:** Wain Jones
Title: Executive Director Professional License number:

6. **a.** Name of administrator: Wain Jones Date of hire: 05/13/2015
Professional License number: Expiration date:
b. Name of director of nursing: Amber Dixie Date of hire: 05/31/2015
Professional License number: 777777 Expiration date: 11/30/2019

7. List persons having **5 percent** or more direct or indirect (42 CFR, Section 455.102) interest in the ownership of this facility if applying for skilled nursing or intermediate care licensure, and **10 percent** for all other facilities, agencies, or clinics. Provide federal employer's tax ID number. Are any of these persons (listed below) related to one another as spouse, parent, child or sibling? ***Submit*** an attachment for additional names that includes all of the required information listed below.

	Name of individual	% Owned	EIN Number	Are they related to one another as a spouse, parent, child or sibling?		Relationship
(1)				○ Yes	◉ No	
(2)				○ Yes	◉ No	
(3)				○ Yes	○ No	
(4)				○ Yes	○ No	
(5)				○ Yes	○ No	

8. **Financial resources -- Only applies to SNF and ICF:**
Submit evidence, i.e., bank statements, line of credit, certificate(s) of deposit, satisfactory to the department(s) that the licensee possesses financial resources sufficient to operate the facility for a period of at least 45 days. (The amount is determined by multiplying 45 days X number of beds X rate).

9. **Over-concentration -- Only applies to ICF/DD, ICF/DD-H and ICF/DD-N:**
a. Are there any ICF/DD, ICF/DD-H, ICF/DD-N, RCF (residential care facility), or pediatric day health or respite care facilities within 300 feet of this facility? (H&S Code, Section 1267.9) ○ Yes ○ No ○ Don't know
b. Are there any congregate living health facilities within 1,000 feet of this facility? ○ Yes ○ No ○ Don't know

10. **Program Plan -- Only applies to ICF/DD, ICF/DD-H and ICF/DD-N (H&S Code, Section 1275.3(b)(3))**
Has the program plan been approved by the Department of Developmental Services? ○ Yes ○ No
If "yes", ***Submit*** a copy of the approval letter. The "current licensee" can grant permission for their Program Plan to be used for 6 months if they ***submit*** a letter to CDPH. If "no", the application package will be delayed until a copy of the approved program letter is received.

D. PROPERTY INFORMATION

1. Property ownership: Check one and ***submit*** evidence of control of property: ○ Own ○ Rent ○ Lease ○ Sublease ○ Other (specify):

2. **Owner of Record** name in the real estate: Sandy Beach Plaza, Inc
Address (number & street): 554 Crystal Beach Blvd, Suite 10
City, State, & Zip: Sacramento, CA 95814

Lessee name: ABC Community Care
Address (number & street): 999 Beach Side Court
City, State, & Zip: Sacramento CA 95814

Sub-Lessee name:
Address (number & street):
City, State, & Zip:

E. MANAGEMENT COMPANY

If the proposed facility, agency, or clinic will be operated by a management company, under a management contract between the proposed owner and a management company, complete Attachment E-1 (next page). NOTE: if the facility is a SNF or ICF, the management company will have to SUBMIT a separate application to the Department, unless previously approved.

F. I (we) Accept responsibility to:

a. Comply with local ordinances concerning zoning, sanitation, building, and other appropriate ordinances.
b. Comply with the Labor Code on employment practices concerning nondiscrimination, liability insurance, wages, hour and working conditions.
c. Comply with Health and Safety Code and regulations concerning licensing and fire safety.

I (we) declare under penalty of perjury that the statements on this application and on the accompanying attachments are correct to my (our) knowledge.

Signature	Title	Date
	Executive Director	03/11/2019
Signature	**Title**	**Date**
Signature	**Title**	**Date**
Signature	**Title**	**Date**

Release of Information Statement

This information shall be provided to the state department upon initial licensure. ***Any changes must be provided to the state department within 10 days of the change***. The information shall be made available to the public upon request and shall be included in the public file of the facility.

The information provided on this form is mandatory and is necessary for licensure approval. It will be used to determine individual applicants or applicant facility's ability to provide health services. The information is requested by the California Department of Public Health, Licensing and Certification, in accordance with Health and Safety Code, Sections 1212, 1253, 1265, 1267.5, and 1728, and California Code of Regulations (CCR), Title 22, Sections 70107, 71107, 73205, 74105, 75022, 76205, and 78205.

Failure to provide the information as requested may result in nonissuance of a license or license revocation.

The information is considered public information and will be made available to the public upon request. The information shall be included and maintained in the individual facility's public files located in Licensing and Certification district offices.

ATTACHMENT E-1

MANAGEMENT COMPANY INFORMATION ONLY FOR SNF's or ICF's

1. ***Submit*** a copy of the Management Agreement with this application.

Name of management company: EIN:
Address (number & street):
City, State, & Zip:

Name of facility to be managed: EIN:
Address (number & street):
City, State, & Zip:

2. Provide the following information for ***each*** individual having a **5 percent** or more interest in the management company. ***Submit*** an attachment for additional names that includes all of the required information listed below.

(1) Individual's name: % Owner:
Address (number & street):
City, State, & Zip:

(2) Individual's name: % Owner:
Address (number & street):
City, State, & Zip:

(3) Individual's name: % Owner:
Address (number & street):
City, State, & Zip:

(4) Individual's name: % Owner:
Address (number & street):
City, State, & Zip:

3. Provide a list of all facilities, agencies, or clinics with which you have entered into a management agreement. ***Submit*** an attachment for additional facility, agency, or clinic names that includes all of the required information listed below.

(1) Facility, agency, or clinic name:
Address (number & street):
City, State, & Zip: Dates of involvement:

(2) Facility, agency, or clinic name:
Address (number & street):
City, State, & Zip: Dates of involvement:

(3) Facility, agency, or clinic name:
Address (number & street):
City, State, & Zip: Dates of involvement:

(4) Facility, agency, or clinic name:
Address (number & street):
City, State, & Zip: Dates of involvement:

INSTRUCTIONS

SNF or ICF Management Company Application: See Attachment E-1 below.

Type or print clearly. Return original and maintain a copy for your records. The Licensee's name must be consistent throughout all documents submitted. ***Submit*** all supplemental paperwork requested to complete your application. **Do not leave items blank. If not applicable, mark N/A.**

A. APPLICATION INFORMATION

1. Type of application: select items a, b, c, or d.
   If b is selected, provide effective date of change in number 2.
   If c is selected, complete Sections C1-5; F, and Attachment E-1.
   If d is selected you must select an option in number 4 -- "Type of Change."
2. Provide actual date applicant took charge of the financial management of facility.
   This date is used to show effective date of the ownership change for certification purposes only.
3. Amount of fee enclosed: enter the amount of money enclosed with this application.
   If no fee is required, enter "N/A". (Refer to fee schedule for appropriate fee requirements.)
4. Type of change: check all that apply.
5. Type of facility, agency, or clinic: select the appropriate category.
6. (a) Check "yes" if requesting certification for Medicare. ICF/DD, ICF/DD-N, ICF/DD-H facilities and primary care clinics that are not certified as rural health clinics are not eligible for Medicare.
   (b) If "yes" to item 6(a), provide name of fiscal intermediary under item 6(b).
7. Check "yes" if requesting participation in Medi-Cal (Medicaid).
8. (a) Current facility bed capacity: enter the total number of persons for whom care can currently be provided in any 24-hour period. This figure must agree with the "Certificate of Occupancy".
   (b) Proposed facility bed capacity: enter the proposed total number of persons for whom care will be provided in any 24-hour period.
9. Enter age range of persons to receive/receiving care.
10. Enter days and hours of facility operation.
11. Enter date construction is to begin, and date construction is to be completed (not applicable for ICF/DD, ICF/DD-N, ICF/DD-H facilities).

    ☐ ***Submit*** a copy of the form *"Construction Advisory Board "* (form OSH-FDD 377) if OSHPD has approved construction.

    ☐ ***Submit*** a copy of the above form to the local district office *prior* to the survey if OSHPD has not yet approved construction.

B. LICENSEE INFORMATION

1. Licensee name: enter the full legal organization name (LLC, partnership, and corporation) or individual(s) responsible for the facility/agency. If "Inc." is included in your legal name, it must appear in the name. Individuals enter first, middle, and last name. Husband and wife, if joint applicants, must both be listed.

   NOTE: All individuals including owners, partners, principal officers of corporations/LLCs, members, managers, and administrators (clinics only) must complete "Applicant Individual Information" (HS 215A).

2. Enter the federal employer's tax ID number.
3. Owner Type: select one of the options and then:

   ☐ ***Submit*** an organizational chart, for items b, c, d, or e showing entity, persons, facilities, and tax EIN numbers.

   ☐ ***Submit*** a copy of the Internal Revenue Service and Franchise Tax Board letters of determination of nonprofit status, if item c, "nonprofit corporation" is selected, and the facility is a primary care Clinic.

4. Licensee address: enter address of legal organization (LLC, corporation, partnership) or individual(s) responsible for the facility, agency, or clinic. Provide phone number with area code, fax number, and e-mail address.

5. Other Facilities:
   (a) Identify all other facilities, agencies, or clinics the licensee (LLC, corporation, partnership, individual) has been involved in, both in and outside of California.
   ☐ ***Submit*** an attachment, if needed, for additional entities, which includes the facility, agency or clinic type (including "affiliate" clinics), name, address, nature of involvement, and dates of involvement. This attachment must include all of the required information listed.
   ☐ ***Submit*** an attachment, if needed, for any entity identified in number 5a, which has had a license revocation action filed, license placed on probation, suspended, or revoked (whether stayed or not) or, for SNFs and ICFs, resolved by settlement, receiver appointed, or has a final Medi-Cal decertification action taken. Include all ownership and facility information, dates, and any final action.

6. Subsidiary: check "yes" if the licensee is a subsidiary of another organization and complete the information requested.
   ☐ ***Submit*** a detailed organizational chart, including parent and all subsidiary information, and federal tax ID numbers.

C. FACILITY, AGENCY, OR CLINIC INFORMATION

1. Management Agreement:
   (a) Check "yes" if the facility, agency, or clinic is going to be operated under a management contract/agreement, between the proposed owner and a management company. Proceed to Section "E" (below).
   (b) Check "yes" if there is an "interim" management agreement, between the proposed owner and the current owner, to run the facility until the change of ownership is completed.
   ☐ ***Submit*** a copy of the "interim" management agreement, if applicable.

2. Facility, agency, or clinic name: Enter the name used to designate the single facility, agency or clinic under the license being requested. Also, provide the current facility, agency, or clinic name, and current license number (if different). Change of ownership usually results in a name change.

3. Provide facility, agency, or clinic address, including phone number with area code, fax number, and e-mail.

4. Provide facility, agency, or clinic mailing address, if different from number 3 (above).

5. Provide the name and title of the individual to be in charge of the facility, agency, or clinic as well as any professional license number (if applicable).

6. Administrator:
   (a) Provide the name of the facility administrator, date of hire, license number, and license expiration date.
   (b) Provide the name of the director of nursing services (if applicable), date of hire, license number, and license expiration date.

7. Provide name(s) of all individuals having a **5 percent** or more interest in the ownership of this facility, if applying for SNF or ICF licensure. For all other facility, agency, or clinic types, provide the name(s) of those having **10 percent** or more interest in the ownership. Specify how these persons are related to one another as spouse, parent, child or sibling.
   ☐ ***Submit*** an attachment for all additional names. This attachment must include all of the required information.

8. Financial Resources: Only applies to SNF, ICF, and ICF/DD:
   ☐ ***Submit*** evidence, satisfactory to the Department, that the licensee has sufficient financial resources to operate the facility for at least 45 days (bank statement, certificate of deposit etc.). The amount is determined by multiplying 45 days X number of beds X rate.

9. Over-concentration -- Only applies to ICF/DD, ICF/DD-H and ICF/DD-N:
   (a) Are there other ICF/DD, ICF/DD-H, ICF/DD-N residential care, pediatric day health, or respite care facilities within 300 feet of this facility? Check "yes", "don't know" or "no".
   (b) Are there any congregate living health facilities within 1,000 feet of this facility? Check "yes", "don't know" or "no".

10. Program Plan -- Only applies to ICF/DD, ICF/DD-H and ICF/DD-N:
Indicate if the program plan has been approved by the Department of Developmental Services. The "current licensee" can grant permission for their Program Plan to be used for 6 months if a letter is submitted to CDPH. If "no" is checked, the application package will be held until a copy of the approved program plan letter is received.

☐ ***Submit*** a letter to CDPH from the "current" licensee that the "proposed" licensee has their permission to use the "current" licensee's Program Plan for up to 6 months, if applicable.

☐ ***Submit*** a copy of the Program Plan approval letter, if "yes".

D. PROPERTY INFORMATION

1. Licensee must show evidence of control of property.

☐ ***Submit*** **a** copy of the deed and/or bill of sale, if property is owned.

☐ ***Submit*** a copy of the rental agreement, if property is rented.

☐ ***Submit*** a copy of the lease agreement, if property is leased.

☐ ***Submit*** a copy of the original lease plus a copy of the sublease, if property is subleased.

☐ ***Submit*** appropriate evidence if "other" is checked.

2. Provide name and address of the Owner of Record, Lessee and Sub-lessee as applicable.

E. MANAGEMENT COMPANY INFORMATION
(Complete Sections A1, C1-5, F & ATTACHMENT E-1)

F. STATEMENT OF RESPONSIBILITIES
Application must be signed by licensee or authorized representative.

ATTACHMENT E-1

MANAGEMENT COMPANY INFORMATION ONLY FOR SNF's OR ICF's

1. If the proposed facility, agency, or clinic will be operated by a management company, under a management contract between the proposed owner and a management company, provide the name, address, and federal tax ID number of Management Company and name of facility to be managed.

☐ ***Submit*** a copy of the Management Agreement.

2. Provide the name, address, and percent of ownership for each person having a **5 percent** or more interest in the Management Company.

☐ ***Submit*** an attachment for additional names. This attachment must include all of the required information.

3. Provide a list of all facilities, agencies, or clinics that you have contracted to manage.

☐ ***Submit*** an attachment for additional facilities, agencies, or clinics. This attachment must include all of the required information.

Insert Certificate of Occupancy Here

CDPH 270

CERTIFICATION FORM FOR CLINICS AND FREESTANDING OUTPATIENT CLINIC SERVICES OF A HOSPITAL

I certify that the following facility conforms to current applicable edition of the California Building Standards Code* and as such meets the applicable clinic standards (OSHPD 3) propounded by the Office of Statewide Health Planning and Development.

Facility Family First

Street Address 1800 Beach Drive

City Sacramento

Type of Facility

- (●) Chronic Dialysis Clinic (see note 1)
- ( ) Surgical Clinic (see note 1)
- ( ) Rehabilitation Clinic
- ( ) Primary Care Clinic
- ( ) Birthing Clinic
- ( ) Psychology Clinic
- ( ) Out Patient Clinic Service of a Hospital
  Service(s): _____

Name _____

Title _____

Street Address _____

City _____

Signature _____

Date _____

*2015 IBC and 2016 California Amendments (2016 California Building Code – Part 2, Title 24, CCR)
2014 NEC and 2016 California Amendments (2016 California Electrical Code – Part 3, Title 24, CCR)
2015 UMC and 2016 California Amendments (2016 California Mechanical Code – Part 4, Title 24, CCR)
2015 UPC and 2016 California Amendments (2016 California Plumbing Code – Part 5, Title 24, CCR)
2015 IFC and 2016 California Amendments (2016 California Fire Code – Part 9, Title 24, CCR)

Also see attached amended CAN 1.

Note 1: Per Health and Safety Code § 129885 certification of chronic dialysis and surgical services are required to be provided by city or county building department with jurisdiction over the project. If the building jurisdiction will not be providing this certification, plans shall be submitted to OSHPD for certification review.

Enforceable Codes
The following are the enforceable codes for facilities under the authority of the Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983:

Application means the submission of a Preliminary or Final Application for Plan Review.

Code means the official compilation and publication of the adoptions, amendments and repeal of administrative regulations to California Code of Regulations, Title 24, also referred to as the California Building Standards Code.

APPLICATION		CODE
All applications submitted on or after January 1, 2017	**2016**	**California Administrative Code (CAC)** Part 1, Title 24, California Code of Regulations (CCR)
	2016	**California Building Code (CBC)** Part 2, Title 24, CCR *Based on the 2015 International Building Code (IBC)*
	2016	**California Electrical Code (CEC)** Part 3, Title 24, CCR *Based on the 2014 National Electrical Code (NEC)*
	2016	**California Mechanical Code (CMC)** Part 4, Title 24, CCR *Based on the 2015 Uniform Mechanical Code (UMC)*
	2016	**California Plumbing Code (CPC)** Part 5, Title 24, CCR *Based on the 2015 Uniform Plumbing Code (UPC)*
	2016	**California Fire Code (CFC)** Part 9, Title 24, CCR *Based on the 2015 International Fire Code (IFC)*
All applications submitted between January 1, 2014 and December 31, 2016.	**2013**	**California Administrative Code (CAC)** Part 1, Title 24, California Code of Regulations (CCR)
	2013	**California Building Code (CBC)** Part 2, Title 24, CCR *Based on the 2012 International Building Code (IBC)*
	2013	**California Electrical Code (CEC)** Part 3, Title 24, CCR *Based on the 2011 National Electrical Code (NEC)*
	2013	**California Mechanical Code (CMC)** Part 4, Title 24, CCR *Based on the 2012 Uniform Mechanical Code (UMC)*
	2013	**California Plumbing Code (CPC)** Part 5, Title 24, CCR *Based on the 2012 Uniform Plumbing Code (UPC)*
	2013	**California Fire Code (CFC)** Part 9, Title 24, CCR *Based on the 2012 International Fire Code (IFC)*

Insert
Control of Property
Document
Here

Insert
Facility Floor Plan
Here

STD 850

STATE OF CALIFORNIA - FORESTRY AND FIRE PROTECTION

FIRE SAFETY INSPECTION REQUEST

STD. 850 (REV. 4-2000)

See instructions on reverse.

AGENCY CONTACT'S NAME	TELEPHONE NUMBER	REQUEST DATE	PROGRAM
Centralized Applications Branch	916-552-8632	03/15/2019	Licensing & Certification

EVALUATOR'S NAME	REQUESTING AGENCY FACILITY NUMBER	REQUEST CODE
		1.A.

LICENSING AGENCY NAME AND ADDRESS

California Department of Public Health
Licensing and Certification Program
Centralized Applications Branch
P.O. Box 997377, MS 3207
Sacramento, CA 95899-7377

CODES

1. ORIGINAL — A. FIRE CLEARANCE
2. RENEWAL — B. LIFE SAFETY
3. CAPACITY CHANGE
4. OWNERSHIP CHANGE
5. ADDRESS CHANGE
6. NAME CHANGE
7. OTHER

AMBULATORY		NONAMBULATORY		BEDRIDDEN		TOTAL CAPACITY
CAPACITY	PREVIOUS CAPACITY	CAPACITY	PREVIOUS CAPACITY	CAPACITY	PREVIOUS CAPACITY	

FACILITY NAME

LICENSE CATEGORY

STREET ADDRESS *(Actual Location)*

CITY

RESTRAINT

FACILITY CONTACT PERSON'S NAME

HOURS

SPECIAL CONDITIONS

TO BE COMPLETED BY INSPECTING AUTHORITY

FIRE AUTHORITY NAME AND ADDRESS

CLEARANCE /DENIAL CODE

CODES

1. FIRE CLEARANCE GRANTED
2. FIRE CLEARANCE DENIED
   - A. EXITS
   - B. CONSTRUCTION
   - C. FIRE ALARM
   - D. SPRINKLERS
   - E. HOUSEKEEPING
   - F. SPECIAL HAZARD
   - G. OTHER

INSPECTOR'S NAME *(Typed or Printed)*	TELEPHONE NUMBER	CFIRS NUMBER	OCCUPANCY CLASS

INSPECTION DATE	INSPECTOR'S SIGNATURE *(Typed or Printed)*

EXPLAIN DENIAL OR LIST SPECIAL CONDITIONS

STATE OF CALIFORNIA - FORESTRY AND FIRE PROTECTION

FIRE SAFETY INSPECTION REQUEST

STD. 850 (REV. 4-2000) (REVERSE)

INSTRUCTIONS

This form is designed for use with a window envelope

Licensing or Requesting Agencies--Complete the following 19 sections on this form before submitting it to the fire authority having jurisdiction.

1. AGENCY CONTACT, 2. TELEPHONE NUMBER, 5. EVALUATOR. Enter the name and telephone number of agency contact person.

3. PROGRAM. Licensing agency use.

4. REQUEST DATE. Enter date request was prepared.

6. REQUESTING AGENCY FACILITY NUMBER. This is the file number assigned by the licensing agency.

7. REQUEST CODE. Use the seven codes shown and insert the appropriate number in the box following "Request Code". If NAME CHANGE, please list previous name. Insert date of original request is other than an original.

8. AGENCY NAME AND ADDRESS. Enter the name and address of the licensing facility requesting the inspection.

9. AMBULATORY--NONAMBULATORY--BEDRIDDEN.

Capacity: Insert in the appropriate section, the capacity of licensed ambulatory or nonambulatory occupants covered by this request.

Previous Capacity: If request is for renewal or capacity change, insert capacity of previous clearance.

Total Capacity: Show total licensed capacity. If the facility is intended to house part ambulatory, nonambulatory, and part bedridden, show the total of the three types of occupants.

10. FACILITY NAME. Insert the name of the facility as it will appear on the license. List identifying sub name if known (i.e., Hacienda Corp/Medina Lodge).

11. LICENSE CATEGORY. Insert the category of license being sought as it will appear on the license certificate.

12. ADDRESS. Insert street address and city only. A post office box is not acceptable as only location.

13. NUMBER OF BUILDINGS. Insert the total number of buildings to be used for housing of the occupants covered by the license.

14. RESTRAINT. Indicate if physical restraint (locked in a room or the building) is to be used in the housing of the occupants.

15. FACILITY CONTACT PERSON--TELEPHONE NUMBER. Indicate the name and telephone number of the responsible individual at the facility to be contacted by the fire authority.

16. HOURS. Indicate the number of hours the occupants are housed at the facility (less than 24 or 24+).

17. SPECIAL CONDITIONS. Indicate any conditions unique to this request. As an example, if the inspection request is for one building in a multi-building facility.

FIRE AUTHORITY CONDUCTING THE INSPECTION--COMPLETE THE FOLLOWING:

18. FIRE AUTHORITY, NAME AND ADDRESS. Insert the name and address of the fire authority where the facility is located.

19. CLEARANCE/DENIAL CODE. Use the two codes: 1 for clearance granted, and 2 for clearance denied. If denied, also include the appropriate letter code. As an example, Denial based upon exiting would be coded 2A.

20. INSPECTOR'S NAME. Print the initial of the inspector's first name and full last name; insert the telephone number where the inspector may be contacted.

21. CFIRS I.D. NUMBER. Insert the fire department's number assigned by California Fire Incident Reporting System.

22. OCCUPANCY CLASSIFICATION. Use California Building Code occupancy classifications and insert the occupancy determined by the inspector.

23. INSPECTION DATE. Enter the actual date of the inspection.

24. INSPECTOR'S SIGNATURE. To be signed by the inspector conducting the inspection.

25. EXPLAIN DENIALOR SPECIAL CONDITIONS. If clearance code #2 is used, briefly explain reason. This space is also to be used to specify any additional limitations placed by the fire authority, such as the use of certain floors or sleeping rooms approved for nonambulatory clients.

CMS 3427

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0360

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-0360**. The time required to complete this information collection is estimated to average of **20 minutes** per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

END STAGE RENAL DISEASE APPLICATION AND SURVEY AND CERTIFICATION REPORT

PART I – APPLICATION – TO BE COMPLETED BY FACILITY

1. Type of Application/Notification (check all that apply; if "Other," specify in "Remarks" section [Item 33]): (V1)
☐ 1. Initial ☐ 2. Recertification ☐ 3. Relocation ■ 4. Expansion/change of services ☐ 5. Change of ownership
☐ 6. Other, specify

2. Name of Dialysis Facility: Family First
3. CCN: Pending
4. Street Address: 1800 Beach Drive, Sacramento, CA 95814
5. NPI: 6666666666
6. City: Sacramento
7. County: Sacramento
8. Fiscal Year End Date: 2019
9. State: California
10. Zip Code: 95814-9999
11. Administrator's Email Address: WainJones@abccommunitycare.org
12. Telephone No.: (999) 555-0695
13. Facsimile No.: (999) 555-0696
14. Medicare Enrollment (CMS 855A) completed? ■ Yes ☐ No ☐ NA
15. Dialysis Facility Administrator Name: Wain Jones
Business Address: 1800 Beach Drive
City: Sacramento State: CA Zip Code: 95814 Telephone No: (999) 555-0695
16. Ownership (V2) ■ 1. For Profit ☐ 2. Not for Profit ☐ 3. Public
17. Is this dialysis facility independent (i.e., not owned or managed by a hospital)? (V3) ■ 1. Yes ☐ 2. No
Is this dialysis facility owned and managed by a hospital and on the hospital campus (i.e., hospital-based)? (V4) ☐ 1. Yes ■ 2. No
Is this dialysis facility owned and managed by a hospital and located off the hospital campus (i.e., satellite)? (V5) ☐ 1. Yes ■ 2. No
18. Is this dialysis facility located in a SNF/NF (LTC) (check one): (V6) ☐ 1. Yes ■ 2. No
If SNF/NF owned and managed by a hospital: hospital name: (V7) N/A CCN: (V8) N/A
If Yes, SNF/NF name: (V9) N/A CCN: (V10) N/A
19. Is this dialysis facility owned &/or managed by a multi-facility organization? (V11) ■ 1. No ☐ 2. Yes, Owned ☐ 3. Yes, Managed
If Yes, name of multi-facility organization: (V12)
Multi-facility organization's address:
20. Current modalities/services for dialysis facilities requesting recertification only (check all that apply): (V13)
☐ 1. In-center Hemodialysis (HD) ☐ 2. In-center Peritoneal Dialysis (PD) ☐ 3. In-center Nocturnal HD
☐ 4. Home HD Training & Support ☐ 5. HD in LTC
☐ 6. Home PD Training & Support ☐ 7. PD in LTC ☐ 8. Dialyzer Reuse
21. New modalities/services being requested (check all that apply; must have 1 permanent patient for any modality requested): (V14)
■ 1. In-center HD ☐ 2. In-center PD ☐ 3. In-center Nocturnal HD
☐ 4. Home HD Training & Support ☐ 5. HD in LTC
☐ 6. Home PD Training & Support ☐ 7. PD in LTC ☐ 8. Dialyzer Reuse ☐ 9. N/A

NOTE: For dialysis in more than 1 LTC facility, record this same information in the "Remarks" (item 33) section or attach list

22. Does the dialysis facility have any dialysis (PD/HD) patients physically receiving dialysis within long-term care (LTC) facilities? (V15)
☐ 1. Yes ■ 2. No LTC (SNF/NF) facility name: (V16) CCN: (V17)
Staffing for home dialysis in LTC provided by: (V18) ☐ 1. This dialysis facility ☐ 2. LTC staff ☐ 3. Other, specify:
Number of dialysis residents by modality receiving dialysis within this LTC facility: (V19) ☐ 1. HD_____ ☐ 2. PD_____
23. Number of dialysis patients currently on census:

END STAGE RENAL DISEASE APPLICATION AND SURVEY AND CERTIFICATION REPORT

In-Center HD: (V20) 0 In-Center Nocturnal HD: (V21) 0 In-Center PD: (V22) 0

Home PD: (V23) 0 Home HD <= 3x/week: (V24) 0 Home HD >3x/week: (V25) 0

24.Number of **currently** approved in-center dialysis stations: (V26) 30 Are onsite home training room(s) provided? (V27) ☐ 1. Yes ■ 2. N/A

25. Additional in-center stations requested: (V28) 10 or ☐ None

26. How is isolation provided? (V29) ■ 1. Room ☐ 2. Area (existing 2/9/2009 only) ☐ 3. CMS Waiver/Agreement (Attach copy)

27. If applicable, number of hemodialysis stations designated for isolation: (V30)_____

28. Days/times for in-center shifts or operating hours if home only (check all days that apply and complete time field in military time): (V31)

1st in-center shift starts or home only facility opens: M 0330 T 0330 W 0330 Th 0330 F 0330 Sat 0330 Sun_____

Last in-center shift ends or home only facility closes: M 1800 T 1800 W 1800 Th 1800 F 1800 Sat 1800 Sun_____

29. Dialyzer reprocessing: (V32) ☐1. Onsite ☐ 2. Centralized/Offsite ■ 3. N/A

30. Staff (List full-time equivalents): Registered Nurse: (V33) 6.0 Certified Patient Care Technician: (V34) 10

LPN/LVN: (V35) 0 Technical Staff (water, machine): (V36) 1

Registered Dietitian: (V37) 1 Masters Social Worker: (V38) 1

Others: (V39) Unit Assistant

31. State license number (if applicable): (V40) 44-4444444	32. Certificate of Need required? (V41) ☐ 1. Yes ■ 2. No ☐ 3. NA

33. Remarks (copy if more and attach additional pages if needed):

34. The information contained in this Application Survey and Certification Report (Part I) is true and correct to the best of my knowledge. I understand that incorrect or erroneous statements may cause the request for approval to be denied, or facility approval to be rescinded, under 42 C.F.R. 494.1 and 488.604 respectively.

I have reviewed this form and it is accurate:

Signature of Administrator/Medical Director	Title	Date
	Administrator	03/11/2019

PART II TO BE COMPLETED BY STATE AGENCY

35. Medicare Enrollment (CMS 855A recommended for approval by the Medicare Administrative Contractor)? (V42) ☐ 1. Yes ☐ 2. No

(Note: approved CMS 855A required prior to certification)

36. Type of Survey: (V43) ☐ 1. Initial ☐ 2. Recertification ☐ 3. Relocation ☐ 4. Expansion/change of services ☐ 5. Change of ownership ☐ 6. Complaint ☐ 7. Revisit ☐ 8. Other, specify_____

37. State Region: (V44)_____	38. State County Code: (V45) _____

39. Network Number: (V46)_____

My signature below indicates that I have reviewed this form and it is complete.

40. Surveyor Team Leader (sign)	41. Name/Number (print)	42. Professional Discipline *(Print)*	43. Survey Exit Date
			:

INSTRUCTIONS FOR FORM CMS-3427

PART I – DOCUMENTATION NEEDED TO PROCESS FACILITY APPLICATION/NOTIFICATION TO BE COMPLETED BY APPLICANT

A completed request for approval as a supplier of End Stage Renal Disease (ESRD) services in the Medicare program (Part I – Form CMS-3427) must include a copy of the Certificate of Need approval, if such approval is required by the state.

TYPE OF APPLICATION (ITEM 1)

Check appropriate category. A "change of service" refers to an addition or deletion of services, e.g. home dialysis, dialysis in LTC, dialyzer reuse, in-center nocturnal HD, in-center PD, etc. "Expansion" refers to addition of in-center stations. If you relocate one of your services to a different physical location, you may be required to obtain a separate CCN for that service at the new location.

IDENTIFYING INFORMATION (ITEMS 2-19)

Enter the name and address *(actual physical location)* of the dialysis facility where the services are performed. If the mailing address is different, show the mailing address in Remarks (*Item 33*). Check the applicable blocks (*Item 17* and *Item 18*) to indicate the dialysis facility's hospital and/or SNF/NF affiliation, if any. If so, enter the CCN of the hospital and/or SNF/NF. Check whether the dialysis facility is owned and/or managed by a "multi-facility" organization (*Item 19*) and provide the name and address of the parent organization. A "multi-facility organization" is defined as a corporation or a LLC that owns more than one dialysis facility.

TYPES OF MODALITIES/SERVICES, DIALYSIS STATIONS, AND DAYS/HOURSOF OPERATION (ITEMS 20-29)

Check the modalities/services that are already offered ("current modalities/services") by a dialysis facility requesting recertification (*Item 20*). Check N/A or check each **NEW** modality/service for which you are requesting approval. Any new modality/service must be requested on the CMS-3427 and filed with the State agency. At the time of survey, one permanent patient must be on the dialysis facility's census in-center or in training/trained by the facility for each modality requested (*Item 21*). Note that dialysis facilities providing home therapies must provide both training and support. If you are requesting to offer home training and support **only** (*Item 21*), you must have a functional plan/arrangement to provide backup dialysis as needed. If you request any home training and support program (*Item 21*), you must also indicate "Yes" for a training room (only count stations for in-center dialysis, not for home training) (*Item 24*). **If you currently provide or support dialysis within one or more LTC facilities (SNF/NF), complete *Item 22* and list for all LTCs: name, CCN, staffing provided by, and number of dialysis patients treated by modality under Remarks (*Item 33*). New requests for dialysis within any LTC facility require completion of *Item 22* (and 33 if applicable) and submission of this form to the State agency prior to survey.** You must answer *Yes* (*Item 22*) and have at least one LTC dialysis resident for addition of services for dialysis in LTC. Enter the number of additional in-center stations for which you are asking approval (*Item 25*). Provide information on isolation *(Items 26-27)*. Dialysis facilities not existing prior to October 14, 2008 which do not have an isolation room must attach evidence of CMS waiver and written agreement with geographically proximal facility with isolation room. Provide current information on all days and start time for the first shift and end time for the last shift of in-center patients (in military time) for each day of operation. If the dialysis facility offers home training and support only, provide current operating hours for each day *(Item 28)*. Provide information on dialyzer reprocessing *(Item 29)*.

STAFFING (ITEM 30)

"Other" includes non-certified patient care technicians, administrative personnel, etc. To calculate the number of full-time equivalents of any discipline (*Item 30*), add the total number of hours that all members of that discipline work at this dialysis facility and enter that number in the numerator. Enter into the denominator the number of hours that facility policy defines as full-time work for that discipline. Report FTEs in 0.25 increments only. Example: An RD works 20 hours a week at Facility A. Facility A defines full time work as 40 hours/week. To calculate FTEs for the RD, divide 20 by 40. The RD works 0.50 FTE at Facility A.

LICENSING AND CERTIFICATE OF NEED, IF APPLICABLE (Items 31-32)

If your state requires licensing for ESRD facilities, include your current license number in Item 31. If your state requires a Certificate of Need (CON) for an initial ESRD or for the change you are requesting, mark the applicable box in Item 32 and include a copy of the documentation of the CON approval.

REMARKS (ITEM 33)

You may use this block for explanatory statements related to Items 1-32.

The administrator/medical director signs and dates. Upon completion, forward a copy of form CMS-3427 (Part I) to the State agency.

PART II - TO BE COMPLETED BY STATE AGENCY

The surveyor should review and verify the information in Part I with administrator or medical director and complete Part II of this form.

Recognize that CMS cannot issue a CCN for an initial survey until all required steps are complete, including recommended approval of the CMS-855A by the applicable MAC. Complete the Statement of Deficiencies (CMS Form 2567) in ASPEN. Complete the CMS-1539 in ASPEN entering recommended action(s). All required information must be entered in ASPEN and uploaded in order for the survey to be counted in the state workload.