California Department of PublicHealth

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

End-Stage Renal Disease Clinic (Certification Only) 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** ☐ **Change of Ownership (CHOW)** ☐ **Medicare** ☐ **Medi-Cal**

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

REQUIRED DOCUMENTS FOR AN INITIAL 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 address • Facility 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

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
	HS 200	**LICENSURE & CERTIFICATION APPLICATION** [Title 42 Code of Federal Regulations (42 CFR) section 420(c) and 455 (b)] **Tip** • Page 2, section B, item 6 — An organization must own 100 percent of the licensee to be considered a parent 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	**B.3 - ORGANIZATIONAL CHART – OWNER TYPE** [42 CFR section 494.180] 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 IDs/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 • 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	**B.3 – NON-PROFIT STATUS – OWNER TYPE** Submit a copy of the IRS Tax Exempt Determination Letter showing the non-profit 501(c) (3) status, if applicable

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.6 – ORGANIZATIONAL CHART** [42 CFR section 494.180 (j)] If licensee is a **<u>subsidiary</u>** of another organization, include an organizational chart
	Supporting Documents	**FLOOR PLAN** [HSC section 1212(a)(9)] Submit a floor plan that coincides with your office space
	HS 215A	**APPLICANT INDIVIDUAL INFORMATION** [(42 CFR section 420.206, 455.101, 455.104), 494.180 (a)(b)(j))] This form must be completed for the following individuals: • Administrator of the facility, the Director of Nursing, and the Medical Director • Owners, directors, board members, corporate officers, LLC members/managers, and partners of the applicant organization • Owners, directors, board members, corporate officers, LLC members/managers, and partners of the parent, grandparent, great grandparent, and etc. organization, if applicable • Each individual having a beneficial interest of exceeding five percent or more in the applicant organization and/or parent, grandparent, great grandparent, and etc. organization **Tip** • 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

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
		submit a resume in lieu of completing section D; however, the resume must contain all required 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
	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 three years. This Sheet must also include any facilities licensed by the California Department of Social Service 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
	Supporting Documents	**RESUME** A resume is only required for the Administrator(s), Director of Nursing and Medical Director
	Supporting Documents	**PROFESSIONAL LICENSES/CERTIFICATES** [HSC sections 1212 (a) and 1225 (c)(l)] [42 CFR 494.140 (a)] • An active registered medical license is required for the Medical Director and Director of Nursing • Provide a printout of the current license from the Department of Consumer Affairs (https://search.dca.ca.gov/)

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
	HS 309 1st Page	**ADMINISTRATIVE ORGANIZATION** [42 CFR 494.180] • Corporations complete page one • Do not submit any attachments
	HS 309 2nd Page	**ORGANIZATIONAL STRUCTURE** Only complete fields that are applicable to applicant's entity type
	HS 602	**TRANSFER AGREEMENT** [42 CFR 494.180(g)(3)] Copy of current (within one year of submission of application) written transfer agreement with hospital appropriate to meet medical emergencies
	STD 850	**FIRE SAFETY INSPECTION REQUEST** [42 CFR 494.60 (d)(3)] 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. The OSHPD Fire Life & Safety (FLS) Inspection approval does not replace this 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	**In addition to the forms required for an initial application listed above submit the documents requested below:** • Copy of Purchase Agreement or Operating Transfer Agreement • A letter from the prospective licensee (to CDPH) stating the location where the stored patient medical records will be maintained, and affirming that the records will be made available to the previous licensee • Copy of “Interim Management Agreement” (if applicable)

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	**MEDI-CAL DISCLOSURE STATEMENT** [Title 22 California Code of Regulation (CCR) section 51000.35] [42 CFR section 455.104] Section V only
	DHCS 9098	**MEDI-CAL PROVIDER AGREEMENT** [42 CFR section 431.107(b)] [22 CCR section 51000.35] • 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, item C.4 on page 3 • Notarized signature page is required • Submit the "Acknowledgement" page from the notary public, if applicable

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
	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)**
	Business Plan Letter	**Business Plan Letter** Letter explaining in detail the Business Plan for operation of the ESRD, including a description of all services to be provided
	CMS 855A	**MEDICARE GENERAL ENROLLMENT HEALTH CARE PROVIDER/SUPPLIER APPLICATION** • This application is from the U.S. Department of Health and Human Services • The completed application should be mailed directly to the appropriate fiscal intermediary
	CMS 3427	**END RENAL DISEASE APPLICATION/NOTIFICATION AND SURVEY AND CERTIFICATION REPORT** [State Operation Manual 2274B] Items 1-24 must be completed with applicable information. The surveyor will bring a copy of the form to update and add information when the certification survey is conducted
	HS 328	**NOTICE – EFFECTIVE DATE OF PROVIDER AGREEMENT** If applying for both Medi-Cal & Medicare certification, only submit one copy of this form

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
	Life Safety Code	**Life Safety Code Attestation for Exempt ESRD Facilities** [42 CFR section 494.60 (d)] • Life Safety Code exemption attestation for ESRD • Signed by the facility Administrator