California Department of PublicHealth

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

General Acute Care Hospital and Acute Psychiatric Hospital Report of Change Application Checklist for Change of Name

The following is a list of application forms and supporting documents required for a complete application packet. Failure to include each of these items will delay processing.

Check all that apply: ☐ **Facility** ☐ **Licensee** ☐ **Service**

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

REQUIRED DOCUMENTS TO CHANGE THE NAME OF THE FACILITY, LICENSEE, OR SERVICE

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form has instructions on the form)**
	Cover Letter	**COVER LETTER** Letter on company letterhead with the following information: • License number • Facility name and ID number (if known) • Brief description of request. Include previous and proposed/new name • 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 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 has instructions on the form)**
	HS 200	**LICENSING & CERTIFICATION APPLICATION** (Title 22 California Code of Regulations (CCR) section 70107) **Tips** • Page 2, section B, item 6 — An organization must own 100% 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 owning direct or indirect ownership of the facility in section C, provide the EIN (do not enter a social security number in this field)
	Supporting Document	**C.2.-NAME OF "PROPSED" FACILITY, AGENCY, OR CLINIC** (Title 22 CCR sections 70127 & 71125) Submit company resolution from Board of Directors authorizing the name change with the effective date.
	CDPH 609	**BED OR SERVICE REQUEST (only required if adding "Rehab" or "Rehabilitation" to a facility name)** Complete the following information only: • Under the "Existing Services" category: o Place a checkmark next to the service type requesting a change of name

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 9098	**MEDI-CAL PROVIDER AGREEMENT (only required for changes to the business or legal name)** • Do not leave any questions blank. Enter "same" or "N/A" if not applicable

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
		• 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

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 855A	**MEDICARE GENERAL ENROLLMENT HEALTH CARE PROVIDER/SUPPLIER APPLICATION** • This application is from the Centers of Medicare and Medicaid Services • The completed application should be mailed directly to the appropriate fiscal intermediary