Home Health Agency
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 • Facility name and ID number (if known) • Brief description of request • Previous and proposed/new location • 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

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	HS200	**LICENSURE & CERTIFICATION APPLICATION** [Title 22 California Code of Regulations (CCR) section 74661 Health and Safety Code (HSC) section 1728] **Note:** • Page 1, section A, item A & B – Specific capitalization evidence is required for a licensed-only HHA (i.e., with no Medi-Cal or Medicare): Any HHA that is going to be licensed-only will need to submit evidence that the licensee has sufficient financial resources to operate the HHA for the first 3 months [Title 22 CCR section 74661 (a)(6)] including: 1. Projected expenses for the first 3 months (90 days) of operation broken down by rent, utilities, salaries, overhead, etc. 2. A copy of an "official" bank statement, certificate of deposit, etc. (in the name of the licensee) providing current balances **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	**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

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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 IDs/EINs 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 it is 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** [CCR section 74661 (a)(5) & 74665 HSC section 1728] This form must be completed and signed for the following individuals: • Administrator, Administrator Designee and the Director of Patient Care Services of the facility • Owners, directors, board members, corporate officers, LLC members/managers, and partners of the applicant organization

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
		• Each individual having a beneficial interest of five percent or more in the applicant organization and/or parent 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 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 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
	Supporting Documents	**RESUME** A resume is required for the Administrator, Administrator Designee, and Director of Patient Care Services

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	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
	Supporting Documents	**PUBLIC AGENCY** Copy of signed Resolution
	Supporting Documents	**PARTNERSHIP** Copy of signed Partnership Agreement

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	CDPH 322	**TRANSMITTAL APPLICATION FOR CRIMINAL RECORD CLEARANCE** [HSC section 1728.1(a)(2)(A)] Submit the CDPH 322 form for the following individuals: • Owners with a five percent or more direct or indirect ownership • Administrator • Administrator's Designee • **Note:** Mail this form to the address indicated on the form
	CDPH 325	**CRIMINAL RECORD CLEARANCE SUBMISSIONS** [HSC section 1728.1(a)(2)(A)) Submit the CDPH 325 form with for the following individuals' names listed on the form: • Owners with a five percent or more direct or indirect ownership • Administrator • Administrator's Designee
	BCIA 8016	**REQUEST FOR LIVE SCAN SERVICE** For out-of-state fingerprint clearance, contact the Centralized Applications Branch at (916) 552-8632 or by e-mail: CAB@cdph.ca.gov Instructions for completion of the BCIA 8016 form are available on the Attorney General's website: https://oag.ca.gov/fingerprints Refer to the "Sample" BCIA 8016 form on the L&C "Applications for a Home Health Agency" website: https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/HealthAgency-HHA.aspx The ORI# must be "A1226." Submit the BCIA 8016 form for the following individuals: Owners, Administrator, and Administrator Designee

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	CMS 855A Page 23	**GEOGRAPHIC AREAS OF HHA** [CCR sections 74607, 74663, and 74664] • The service area of a parent HHA may not extend beyond four (4) hours surface travel time from the agency unless the agency serves a rural, scarcely populated area, under certain conditions • Submit a list of the geographical areas (including cities, counties, and zip codes) to be served • Submit a web-based map

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 the location where the stored patient medical records will be maintained and affirming the records will be made available to the previous licensee [Title 22 section 74731(g)] **Note:** ▪ A CHOW shall be deemed to have occurred where, when compared with the information contained in the last approved license application, the licensee has changed one of the following [Title 22 section 74667 (a)]: ▪ Transfer of 50 percent or more of the issued stock of a corporate licensee ▪ Transfer of 50 percent or more of the assets of the licensee ▪ Change in partners or partnership interest of 50 percent or greater in terms of capital share of profits ▪ Relinquishment by the licensee of the management of the agency

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
		▪ A transfer of stock less than 50 percent is a stock transfer change and a Report of Change Application must be submitted to the Department

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)**
	HS 328	**NOTICE – EFFECTIVE DATE OF PROVIDER AGREEMENT** If applying for both Medi-Cal and Medicare certification, only submit one copy of this form
	DHCS 9098	**MEDI-CAL 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
	Supporting Documents	**NATIONAL PROVIDER IDENTIFIER (NPI)** Submit NPI approval letter
	DHCS 6207	**MEDI-CAL DISCLOSURE STATEMENT** Section V only
	Capitalization Financial Resources	**CAPITALIZATION FINANCIAL RESOUCRES** • These capitalization requirements are only for a licensed HHA to be certified with Medi-Cal • The Provider Certification Unit must approve the capitalization plan prior to conducting a Medi-Cal certification survey

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
		• If an HHA applicant wants Medi-Cal "only" submit the following capitalization evidence: 1. Business Plan Structure 2. Projected Expenses for the first three months (90 days) of operation broken down by rent, utilities, salaries, overhead, etc. 3. Copy of an "official" bank statement, certificate of deposit, etc. (in the name of the licensee) providing current balances. Must show that the applicant has available funds to operate the HHA for the first three months and that at least 50% are non-borrowed funds 4. An attestation (signed and dated) from an Officer of the bank that the funds are in the account(s) and that the funds are immediately available 5. An attestation (signed and dated) from the licensee that the required funds are immediately available 6. Projected number of visits for the first three months of operation 7. Projected number of visits for the first year of operation following certification (this is N/A if licensed "only")

MEDICARE CERTIFICATION DOCUMENTS

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	HS 328	**NOTICE – EFFECTIVE DATE OF PROVIDER AGREEMENT** If applying for both Medi-Cal and Medicare certification, only submit one copy of this form
	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"

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
		• CHOW: Sign the bottom signature block entitled "Accepted for the Successor Provider of Services By"
	CMS 1572 (a)&(b)	**HOME HEALTH AGENCY SURVEY AND DEFICIENCY REPORT** • The CMS 1572 form is required • Complete pages (a) and (b), items 1-20, as indicated on the form **Note:** If licensed "only", the CMS 1572 form is required to document the services requested and to assist the local district office with the survey process. If requesting certification, the CMS 1572 form is required to apply for Medicare certification.
	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 online submission is completed, an electronic notification from OCR stating the **Assurance of Compliance** form was submitted successfully will be received by the applicant • Submit a copy of this notification
	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