Hospice Facility (HOFA)
Report of Change Application Checklist for Change of Location

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

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

REQUIRED DOCUMENTS TO RELOCATE A FACILITY

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
	HS 200	**LICENSURE & CERTIFICATION APPLICATION** [Health and Safety Code (HSC) section 1339.41(d)(5) and 1748(b)] **Tips:** • Page 2, section B, item 6 — An organization must own 100 percent of the licensee to be considered a parent

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		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	**A.11 - OFFICE OF STATEWIDE HEALTH PLANNING & DEVELOPMENT (OSHPD) AND/ OR CERTIFICATE OF OCCUPANCY (CO)** If the facility is newly constructed or a remodeled building, or if this is not a previously licensed facility the facility shall be under the jurisdiction of OSHPD or the local building department • Hospice Facility located within the physical plant of another facility [HSC 1339.43(e)(1)] ○ Shall be under the jurisdiction of OSHPD ○ Submit OSHPD CO, Construction Final (CF) or Substantial Completion (SC) • Freestanding Hospice Facility located on the site of or is physically connected to a health facility that is under the jurisdiction of both [HSC 1339.43(f)] ○ Submit new construction or renovation plans to OSHPD for review and approval ○ Submit OSHPD CO, CF or SC • All other freestanding Hospice Facility [HSC 1339.43(d)(1) and (2)] ○ Shall be under the jurisdiction of the local building department ○ Submit CO from local building department
	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

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	Supporting Documents	**FLOOR PLAN** Submit a floor plan that coincides with your office space
	STD 850	**FIRE SAFETY INSPECTION REQUEST** [HSC section 1339.43(c)(d)(1)] 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

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	DHCS 9098	**MEDI-CAL PROVIDER AGREEMENT (only required for changes to the business or pay-to address)** • 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

MEDICARE CERTIFICATION DOCUMENTS

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	CMS 417	**HOSPICE REQUEST FOR CERTIFICATION IN THE MEDICARE PROGRAM** • The form requires an original signature and date • If this freestanding hospice is "licensed only" the completed form is required to identify the types of services
	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