California Department of PublicHealth

Hospice Agency
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)] **Tips:** • 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)

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
		• 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- CERTIFICATE OF OCCUPANCY (CO)**
		
		If the facility is newly constructed, remodeled, or not a previously licensed, it shall be under the jurisdiction of the local building department
		
		• Freestanding Hospice Facility [HSC 1339.43(d)(1)(2)]
		    o Shall be under the jurisdiction of the local building department
		    o 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.
	CMS 855A (Page 23 Only)	**GEOGRAPHIC SERVICE AREA** • Submit a list of the geographical areas (including cities, counties, and zip codes) to be served • Submit a web-based map • Hospice agencies must obtain prior approval of an expansion of their geographic service area from the Centers for Medicare and Medicaid Services (CMS) and the California Department of Public Health, Licensing & Certification Program

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 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

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
	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”, complete this form to identify the types of services
	CMS 855A	**MEDICARE GENERAL ENROLLMENT HEALTH CARE PROVIDER/SUPPLIER APPLICATION** • This application is from the Centers for Medicare and Medicaid Services • The completed application should be mailed directly to the appropriate fiscal intermediary