

Hospice Agency Report of Change Application Checklist for Change of Service

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.

Check all that apply: **Add** **Remove**

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

REQUIRED DOCUMENTS TO ADD/REMOVE A SERVICE

<i>Use this space to check if included</i>	Forms and supporting documents	Additional Instructions (Each form listed also has instructions on the form)
	Cover Letter	<p>COVER LETTER</p> <p>Letter on company letterhead with the following information:</p> <ul style="list-style-type: none"> • License number • Facility name and 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
	HS 200	<p>LICENSURE & CERTIFICATION APPLICATION [Health and Safety Code (HSC) section 1748(b)]</p> <p>Tips:</p> <ul style="list-style-type: none"> • Page 2, section B, item 6 — An organization must own 100 percent of the licensee to be considered a parent

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		<p>company. This parent company will have its own Employer Identification Number (EIN)</p> <ul style="list-style-type: none"> • 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)

MEDICARE CERTIFICATION DOCUMENTS

<i>Use this space to check if included</i>	Forms and supporting documents	Additional Instructions (Each form listed also has instructions on the form)
	CMS 417	<p>HOSPICE REQUEST FOR CERTIFICATION IN THE MEDICARE PROGRAM [HSC section 1749(b)(1) – (b)(7); Standards of Quality Hospice Care (SQHC, 2003, section 2.1)]</p> <ul style="list-style-type: none"> • The form requires an original signature and date • If this freestanding hospice is “licensed only” complete this form to identify the types of services