Hospice Agency and Hospice Facility (HOFA) Report of Change Application Checklist for Change of Stock Transfer

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.

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

REQUIRED DOCUMENTS FOR CHANGE OF STOCK TRANSFER

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 • 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 1748(b), (HSC) section 1339.41(c)(2)] **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	**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 ID/EIN # 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 they are 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	**STOCK PURCHASE AGREEMENT** Copy of the signed Purchase Agreement

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	HS 215A	**APPLICANT INDIVIDUAL INFORMATION** [HSC section 1748(b); Standards of Quality Hospice Care (SQHC, 2003, section 5.1 - 5.3, and 6.1)] This form must be completed and signed for the following individuals: • Owners, directors, board members, corporate officers, LLC members/managers, and partners of the applicant organization • Each individual having a beneficial interest of exceeding 5 percent or more in the applicant organization and/or parent organization **Tips** • 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:

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		• 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, Director of Patient Care Services, Director of Patient Care Services Designee, and Medical Director (Medical Director not applicable if contracted).
	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 located in the top right corner of the applicants 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)

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	HS 309 2nd Page	**ORGANIZATIONAL STRUCTURE** Only complete fields that are applicable to applicant's entity type **Tip** • Page 2, item 1 – Health care districts will fill in the circle for other
	Supporting Documents	**PUBLIC AGENCY** Copy of signed Resolution
	Supporting Documents	**PARTNERSHIP** Copy of signed Partnership Agreement

MEDI-CAL CERTIFICATION DOCUMENTS

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	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

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 1561	**HEALTH INSURANCE BENEFITS AGREEMENT** Submit two (2) signed copies with "original" signatures: • Sign the bottom signature block titled "Accepted for the Successor Provider of Services By"