

Outpatient Physical Therapy/Speech-Language Pathology Providers (OPT/SP) 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** **Change of Ownership**
 Medi-Cal **Medicare**

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

REQUIRED DOCUMENTS FOR AN INITIAL LICENSE OR CHOW

<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 (only applicable for CHOW) • Facility name and address • Facility 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

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	HS 200	<p>LICENSURE & CERTIFICATION APPLICATION [Title 42 Code of Federal Regulations (42 CFR) section 485.709]</p> <p>Tip</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 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	<p>A.11 - OFFICE OF STATEWIDE HEALTH PLANNING & DEVELOPMENT (OSHPD) AND/OR CERTIFICATE OF OCCUPANCY [California Building Code section 1226] [42 CFR section 485.723(a)(1)]</p> <p>For newly constructed or a remodeled building, one of the three documents are required:</p> <ul style="list-style-type: none"> • Written certification: The local building authority must provide written certification of Title 24 compliance (OSHPD 3 Standards) stating the building meets the current applicable codes and the following building requirements: <ul style="list-style-type: none"> ○ California Building Code (CBC) ○ California Fire Code (CFC) ○ California Electrical Code (CEC) ○ California Mechanical Code (CMC) ○ California Plumbing Code (CPC) ○ California Administrative Code (CAC) • CDPH 270: Certification Form for Clinics and Freestanding Outpatient Clinic Services of a Hospital, to certify the facility conforms to current applicable Title 24 (OSHPD 3 Standards). This form must be signed by the local building authority

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		<p>Note: Title 24 compliance does not apply to CHOWs unless there has been construction and/or remodeling.</p> <p>If construction occurred and if the construction resulted in a new building or addition:</p> <ul style="list-style-type: none"> • Submit a Certificate of Occupancy • This is not applicable if there were alterations or repairs to existing buildings performed or conversion of space
	Supporting Documents	<p>B.3 – ORGANIZATIONAL CHART – OWNER TYPE [42 CFR section 485.709(a)]</p> <p>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:</p> <ul style="list-style-type: none"> • 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	<p>B.3 – NON-PROFIT STATUS – OWNER TYPE</p> <p>Submit a copy of the IRS Tax Exempt Determination Letter showing the non-profit 501(c)(3) status (if applicable)</p>
	Supporting Documents	<p>B.5.b - LICENSE REVOCATION (if applicable)</p> <p>Submit additional information, including all ownership and facility information, date and any final action</p>

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	Supporting Documents	<p>B.6 - ORGANIZATIONAL CHART [42 CFR section 485.709(a)]</p> <p>If licensee is a subsidiary of another organization, an organizational chart must be submitted</p>
	HS 215A	<p>APPLICANT INDIVIDUAL INFORMATION [42 CFR sections 455.101, 455.104, 485.709(a)]</p> <p>This form must be completed and signed for the following individuals:</p> <ul style="list-style-type: none"> • Administrator of the facility and Medical Director • Owners, directors, board members, corporate officers, LLC members/managers, and partners of the applicant organization • Owners, directors, board members, corporate officers, LLC members/managers, and partners of the parent, grandparent, great grandparent, and etc. organization, if applicable • Each individual having a beneficial interest of exceeding five percent or more in the applicant organization and/or parent, grandparent, great grandparent, and etc. organization <p>Tips</p> <ul style="list-style-type: none"> • 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

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	Supporting Documents	<p>FACILITY INFORMATION SHEET</p> <p>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:</p> <ul style="list-style-type: none"> • 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	<p>RESUME</p> <p>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 N/A if contracted)</p>
	Supporting Documents	<p>BACHELOR'S DEGREE [42 CFR section 485.705(c)(1)]</p> <ul style="list-style-type: none"> • A bachelor's degree is required for the Administrator • Provide a copy or transcripts from the educational institution
	Supporting Documents	<p>PROFESSIONAL LICENSES/CERTIFICATES [42 CFR 485.705(b)(1)]</p> <ul style="list-style-type: none"> • An active registered medical license is required for the Medical Director • Provide a printout of the current license from the Department of Consumer Affairs (https://search.dca.ca.gov/)

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	HS 309 1 st Page	<p>ADMINISTRATIVE ORGANIZATION [42 CFR section 485.709(a)]</p> <ul style="list-style-type: none"> • Corporations complete page one • Do not submit any attachments
	HS 309 2 nd Page	<p>ORGANIZATIONAL STRUCTURE</p> <p>Only complete fields that are applicable to applicant’s entity type</p> <p>Tip</p> <ul style="list-style-type: none"> • Page 2, item 1 — Health care districts will fill in the circle for other
	STD 850	<p>FIRE SAFETY INSPECTION REQUEST [42 CFR section 485.723(a)(1)]</p> <p>The STD 850 form is required. The OSHPD Fire Life & Safety (FLS) Inspection approval does not replace this form.</p> <ul style="list-style-type: none"> • This form is not required for a CHOW • 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.

REQUIRED DOCUMENTS FOR A CHOW ONLY

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	Supporting Documents	<p>In addition to the forms required for an Initial application listed above submit the documents requested below:</p> <ul style="list-style-type: none"> • Copy of Purchase Agreement or Operating Transfer Agreement • Copy of Interim Management Agreement (If applicable) • A letter from the prospective licensee (to CDPH) stating where the stored patient medical records will be maintained, and that the records will be made available to the previous licensee

MEDI-CAL 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)
	DHCS 6207	<p>MEDI-CAL DISCLOSURE STATEMENT</p> <p>Only complete section V</p>
	DHCS 9098	<p>MEDI-CAL PROVIDER AGREEMENT</p> <ul style="list-style-type: none"> • 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, section C, Page 3, item 4 • Notarized signature page is required • Submit the "Acknowledgement" page from the notary public
	HS 328	<p>NOTICE – EFFECTIVE DATE OF PROVIDER AGREEMENT</p> <p>If applying for both Medi-Cal and Medicare certification, only submit one copy of the HS 328 form with signature</p>

MEDICARE CERTIFICATION DOCUMENTS

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	CMS 1561	<p>HEALTH INSURANCE BENEFITS AGREEMENT</p> <p>Submit two (2) signed forms with “original” signatures:</p> <ul style="list-style-type: none"> • Initial Application: Sign the top signature block entitled “Accepted for the Provider of Services By” • CHOW: Sign the bottom signature block entitled “Accepted for the Successor Provider of Services By”
	CMS 1856	<p>REQUEST FOR CERTIFICATION IN THE MEDICARE AND/OR MEDICAID PROGRAM TO PROVIDE OUTPATIENT PHYSICAL THERAPY AND/OR SPEECH PATHOLOGY SERVICES</p> <p>Submit a copy of the CMS 1856</p>
	HS 328	<p>NOTICE – EFFECTIVE DATE OF PROVIDER AGREEMENT</p> <p>If applying for both Medi-Cal and Medicare certification, only submit one copy of the HS 328 form with original signature</p>
	HHS 690	<p>ASSURANCE OF COMPLIANCE</p> <ul style="list-style-type: none"> • 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