California Department of PublicHealth

Center for Health Care Quality
Licensing and Certification Program
Centralized Applications Branch

Rural Health Clinic
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 (CHOW)**
☐ **Medicare** ☐ **Medi-Cal**

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

Prior to submitting a Rural Health Clinic (RHC) certification package, please submit the following forms to the Centralized Applications Branch (CAB) to determine whether the location qualifies based on the census tract number. In order to be certified as an RHC, the RHC must be located in an area that is not an urbanized area and in a medically underserved area (MUA) or health professional shortage area (HPSA). The Centers for Medicare and Medicaid Services (CMS) will determine if the location qualifies and the Office of Statewide Health Planning and Development (OSHPD) will determine if it is in a HPSA or MUA area. Once CAB receives the determination from CMS and OSHPD, CAB will notify the provider whether to submit a certification package.

DETERMINATION OF RHC NON-URBANIZED AREA STATUS

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 (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) • Signature
	HS 610	**MEDICALLY UNDERSERVED OR HEALTH PROFESSIONAL SHORTAGE AREAS** (Not required for a CHOW) • Clinic name and address • Census track number Note: Census track number can be found by going to the Federal Financial Institutions Examination Council (FFIEC) (https://geomap.ffiec.gov/FFIECGeocMap/GeocodeMap1.aspx) You may contact the FFIEC for any questions regarding the census track number.
	CMS 29	**VERIFICATION OF CLINIC DATA – RURAL HEALTH CLINIC PROGRAM** [Title 42 Code of Federal Regulations (42 CFR) section 491.7(a)(1), 491.8(a)(2)] • If applying for both Medi-Cal & Medicare Certification, only need one copy of this form • Provided name and title of individual in charge of Medical Direction of the facility. This individual must have a physician's license

REQUIRED DOCUMENTS FOR AN INITIAL CERTIFICATION

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 (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
	HS 200	**LICENSURE & CERTIFICATION APPLICATION** **Tip** • 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	**B.3-ORGANIZATIONAL CHART – OWNER TYPE** [42 CFR section 491.7(b)] Submit an organizational chart if the owner is a for profit corporation, nonprofit corporation, limited liability company

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
		(LLC), or general partnership. The organizational chart needs to display the following: • 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	**B.3 – NON-PROFIT STATUS – OWNER TYPE** Submit a copy of the IRS Tax Exempt Determination Letter showing the non-profit 501(c)(3) status. (If Applicable)
	Supporting Documents	**B.6 – ORGANIZATIONAL CHART** If licensee is a **subsidiary** of another organization, an organizational chart must be submitted
	HS 215A	**APPLICANT INDIVIDUAL INFORMATION** [42 CFR section 491.7(b)] This form must be completed for the following individuals and include original signatures: • Administrator of the facility • Each individual having a beneficial interest of exceeding five percent in the applicant organization and/or parent organization • Owners, directors, board members, corporate officers, LLC members/managers, and partners of the applicant organization and/or Management Company **Tip** • Page 1, section A — The date of birth is an identifier, as several people may have the same name. This will

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
		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 (except for the Administrator) 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: • Facility name • Facility address • Type of facility • Type of business entity (include EIN Number) • Individual's nature of involvement • Individual's dates of involvement
	HS 309 1st Page	**ADMINISTRATIVE ORGANIZATION** • If applying for both Medi-Cal and Medicare Certification only need one copy of this form • Administrator of Corporation or LLC is usually the Chief Executive Officer or President • Corporations complete page one • Do not submit any attachments

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
	HS 309 2nd Page	**ORGANIZATIONAL STRUCTURE** Only complete fields that are applicable to applicant's entity type

REQUIRED DOCUMENTS FOR A CHOW ONLY

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
	Supporting Documents	**In addition to the forms required for an Initial application listed above in addition to the documents requested below:** • Copy of Purchase Agreement or Operating Transfer Agreement • A letter from the prospective licensee to CDPH stating where the stored patient medical records will be maintained and affirming records will be made available to the previous licensee • Copy of "Interim Management Agreement" (If Applicable)

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 6207	**MEDI-CAL DISCLOSURE STATEMENT** Only complete Section V
	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, item C.4 on page 3

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
		• Notarized signature page is required • Submit the "Acknowledgement" page from the notary public, if applicable
	HS 328	**NOTICE – EFFECTIVE DATE OF PROVIDER AGREEMENT** If applying for both Medi-Cal and Medicare certification, only submit one copy of this form

MEDICARE CERTIFICATION ONLY DOCUMENTS

Use this space to check if included	**Forms and supporting documents**	**Additional Instructions (Each form listed also has instructions on the form)**
	CMS 855A	**MEDICARE GENERAL ENROLLMENT HEALTH CARE PROVIDER/SUPPLIER APPLICATION** • This application is from the Federal Department of Health and Human Services • The completed application should be mailed directly to the appropriate fiscal intermediary
	CMS 1561A	**HEALTH INSURANCE BENEFIT AGREEMENT – RURAL HEALTH CLINIC** Two (2) signed copies with “original” signatures
	HHS 690	**ASSURANCE OF COMPLIANCE** • **OCR’s online portal is:** Office for Civil Rights (https://ocrportal.hhs.gov/ocr/aoc/instruction.jsf) • Submit a copy of the notification stating the “Assurance of Compliance from was submitted successfully”