



RECEIVED

OFFICE USE ONLY	
Project #	Increment #

### Project Application Information

#### Project

**Type**

<input type="checkbox"/> Alternate Method of Compliance	<input type="checkbox"/> Application for Seismic Extension (select one)	<input type="checkbox"/> Phase Segment
<input type="checkbox"/> Annual Building Permit	<input type="radio"/> NPC	<input type="checkbox"/> Post Approval Document
<input type="checkbox"/> Application for Building Permit	<input type="radio"/> SPC	<input type="checkbox"/> Seismic Retrofit Program (select one)
<input type="checkbox"/> Application for New Project	<input type="checkbox"/> Incremental (select one)	<input type="radio"/> Application for Seismic Evaluation Report
	<input type="radio"/> Increment	<input type="radio"/> Compliance Plan Review
	<input type="radio"/> Master	<input type="radio"/> Request for NPC or SPC Upgrade

#### Facility

Facility # \_\_\_\_\_ Facility Name \_\_\_\_\_

Type of Facility  Acute Psychiatric Hospital  General Acute Care Hospital  Skilled Nursing or Intermediate Care Facility  
 Correctional Treatment Center  Licensed Clinic

#### Address

Street Address \_\_\_\_\_

Address Line 2 \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State CA Zip Code \_\_\_\_\_

Phone \_\_\_\_\_

#### Contact

Primary Type **Legal Owner / Administrator** (Required for all applications)

First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

Organization Name \_\_\_\_\_

Street Address \_\_\_\_\_

Address Line 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ Phone 2 \_\_\_\_\_ Fax \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_ Email \_\_\_\_\_

Notes \_\_\_\_\_

Primary Type **Authorized Agent** (Authorization must be attached)

First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

Organization Name \_\_\_\_\_

Street Address \_\_\_\_\_

Address Line 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ Phone 2 \_\_\_\_\_ Fax \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_ Email \_\_\_\_\_

Notes \_\_\_\_\_



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### Project Application Information

#### Contact

Primary Type Facility Representative

First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

Organization Name \_\_\_\_\_

Street Address \_\_\_\_\_

Address Line 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ Phone 2 \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_

Notes \_\_\_\_\_

Primary Type  Accounting  Billing (duplicate page if needed)

First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

Organization Name \_\_\_\_\_

Street Address \_\_\_\_\_

Address Line 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ Phone 2 \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_

Notes \_\_\_\_\_

#### Professionals

Responsible Primary Type Architect License/Certificate Number \_\_\_\_\_

First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

Alternate Contact First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

Organization Name \_\_\_\_\_

Street Address \_\_\_\_\_

Address Line 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ Phone 2 \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_

Responsible Primary Type Civil License/Certificate Number \_\_\_\_\_

First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

Alternate Contact First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

Organization Name \_\_\_\_\_

Street Address \_\_\_\_\_

Address Line 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ Phone 2 \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_



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### Project Application Information

#### Professionals

Responsible Primary    Type **Contractor**    License/Certificate Number \_\_\_\_\_

First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

Alternate Contact First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

Organization Name \_\_\_\_\_

Street Address \_\_\_\_\_

Address Line 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ Phone 2 \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_

Responsible Primary    Type **Electrical**    License/Certificate Number \_\_\_\_\_

First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

Alternate Contact First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

Organization Name \_\_\_\_\_

Street Address \_\_\_\_\_

Address Line 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ Phone 2 \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_

Responsible Primary    Type **GeoTechnical**    License/Certificate Number \_\_\_\_\_

First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

Alternate Contact First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

Organization Name \_\_\_\_\_

Street Address \_\_\_\_\_

Address Line 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ Phone 2 \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_

Responsible Primary    Type **Mechanical**    License/Certificate Number \_\_\_\_\_

First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

Organization Name \_\_\_\_\_

Street Address \_\_\_\_\_

Address Line 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ Phone 2 \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_



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## Project Application Information

### Professionals

Responsible Primary    Type Structural    License/Certificate Number \_\_\_\_\_

First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

Alternate Contact First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

Organization Name \_\_\_\_\_

Street Address \_\_\_\_\_

Address Line 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ Phone 2 \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_

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**DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION  
OFFICE OF STATEWIDE HOSPITAL PLANNING AND DEVELOPMENT**

**INSTRUCTIONS FOR PROJECT APPLICATION INFORMATION  
(HCAI-OSH-100)**

**This form is required for all application submittals and is to be accompanied by all project specific forms.**

Note: If licensure by the California Department of Public Health is not required by your facility, review by the Department of Health Care Access and Information (HCAI) is not required; therefore this application is not required. Contact the local jurisdiction for submittal requirements.

**Project**

The selected box indicates the type of application for submittal.

**Facility**

- Enter the HCAI facility identification number. If this application is for construction of a new facility and an HCAI facility identification number has not yet been assigned, contact the office for this number.
- Enter the name of the facility as it appears on the facility license.
- Indicate the type of facility as it is licensed.

**Address**

- Enter the facility street address, city, county, zip code and phone number.

**Contact**

Note: Copies of all correspondence will be sent to the Facility Representative. If a Facility Representative address is not entered, copies of all correspondence will be sent to the facility address as indicated on the license, to the attention of Facility Administrator.

- Enter the contact information for the Legal Owner / Administrator (this information is required for all applications), Authorized Agent, and Facility Representative. Include the name, organization name, street address, city, state, zip code, phone number, fax number and email address. Information for the accounting or billing is optional. If additional space is needed, duplicate this page.
- A signature and date are required for the Legal Owner / Administrator and Authorized Agent. If an Authorized Agent is signing on behalf of the Legal Owner, the authorization must be attached.
- Indicate who will be the primary contact for this project.
- Provide any additional information in the notes area, as necessary.

**Professionals**

Note: Plans returned for correction or stamping will be sent to the responsible primary, as indicated in this section.

- Enter the contact information for the professionals responsible for this project. Include the license/certificate number, name, alternate contact, organization name, street address, city, state, zip code, phone number, fax number and email address.
- Indicate the discipline in responsible charge of the project by selecting Responsible Primary. If plans need to be returned, they will be sent to this individual. A licensed specialty contractor can be responsible on projects pursuant to Title 24, California Administrative Code, Section 7-115 (c).
- If additional space is necessary, duplicate the page.

**For construction in Northern California and Seismic Compliance Review submit to:**

**Email:** [OSHPDSacProjectSupport@hcai.ca.gov](mailto:OSHPDSacProjectSupport@hcai.ca.gov)

*"or by mail"*

**For construction in Southern California, submit to:**

**Email:** [OSHPDLAProjectSupport@hcai.ca.gov](mailto:OSHPDLAProjectSupport@hcai.ca.gov)

*"or by mail"*

Department of Health Care Access and Information  
Office of Statewide Hospital Planning and Development  
2020 W. El Camino Avenue, Suite 800  
Sacramento, CA 95833  
**Phone:** (916) 440-8300  
**Fax:** (916) 274-0102

Department of Health Care Access and Information  
Office of Statewide Hospital Planning and Development  
355 South Grand Avenue, Suite 1900  
Los Angeles, CA 90071  
**Phone:** (213) 897-0166  
**Fax:** (916) 274-0102