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

RECEIVED

OFFICE USE ONLY	
Project#	Increment #
PAD-	

Amended Construction Document

Facility

Project # ____________________

Facility # ____________________ Facility Name ____________________

HCAI Building # BLD - ____________ Building Name ____________________

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

Record Detail

Change Initiated By:
- ❑ As-Built Condition
- ❑ Contractor Requested
- ❑ Design Professional Requested
- ❑ Discovered Condition
- ❑ Document Clarification
- ❑ Owner Requested
- ❑ Required for Code Compliance
- ❑ Other (Specify): ____________________

Record/Project Name ____________________

Detailed Description

Application Specific Information – Amended Construction Document

Applicant Tracking Number ____________________

Reason for Change

Scope of Change

PROFESSIONAL

By my signature below, I acknowledge that the documents for the submittal type above have been reviewed and have been found to be in general conformance with the design of the project.

Signature of Architect or Engineer in Responsible Charge ____________________ Date ____________

Signature of Structural Engineer ____________________ Date ____________
(Required on projects that include primary gravity and/or lateral load elements/systems)

Application Specific Information – Critical Path Expedite Review

❑ Critical Path Expedite Review Requested

Justification

OFFICE USE ONLY	
Project#	**Increment #**
PAD-	

Amended Construction Document

Costs

Cost Type ❑ Estimated ❑ Contract

Change in Construction Costs
*(**excluding** fixed equipment, imaging equipment, design fees, inspection fees, and off-site improvements)*
Note: For SB 1838 projects, this amount must not exceed $50,000 $ ____________ ❑ Add ❑ Deduct

Change in Fixed Equipment Costs
*(sterilizers, chillers, boilers, etc., **excluding** installation)* $ ____________ ❑ Add ❑ Deduct

Change in Cost of Imaging Equipment
*(X-ray, MRI, CT Scan, etc., **excluding** installation cost)* $ ____________ ❑ Add ❑ Deduct

Note: See Instructions for Fee Information

Reason

Enclosures

Number of Copies	Enclosure Type	Number of Copies	Enclosure Type
______	Contract Information	______	Site Data Reports
______	Design Program	______	Specifications
______	Equipment Anchorage Calculations	______	Structural Calculations
______	Geotechnical Reports (for Buildings and Additions)	______	Testing, Inspection and Observation Program (TIO)
______	Letter of Authorization	______	Verification of Conformance to Local Codes
______	Plans	______	Other ______________________
______	Project Schedule		

List all drawing sheets included with submittal:

OFFICE USE ONLY - HCAI APPROVAL

Printed Name ______________________ Title ______________________

Signature ______________________ Date ______________________

INSTRUCTIONS FOR AMENDED CONSTRUCTION DOCUMENT APPLICATION
(HCAI-OSH-125)

Note: If licenser by the California Department of Public Health is not required by your facility, review by HCAI is not required; therefore this application is not required. Contact the local jurisdiction for submittal requirements.

Facility

- Enter the Department of Health Care Access and Information (HCAI) project number.
- Enter the HCAI facility identification number.
- Enter the name of the facility as it appears on the facility license.
- Enter the HCAI building number and building name where the work is to be performed.
- Indicate the type of facility as it is licensed.

Record Detail

- Indicate the reason this change is being initiated; if you select "Other", you must specify why the change was initiated.
- Enter the record/project name from the parent project.
- Enter a detailed description of the work from the parent project.

Application Specific Information – Amended Construction Document

Note: A non-refundable application fee of $250.00 will be assessed for each Amended Construction Document Submittal.

- Provide an applicant tracking number, if applicable.
- Provide a detailed description of the reason why this change is being requested.
- Provide a detailed description of the scope of the change being requested.
- Provide the signature of the architect or engineer in responsible charge of the project, and date. If this application is for a project that includes primary gravity and/or lateral load elements/systems, provide the signature of the Structural Engineer, and date.

Application Specific Information – Critical Path Expedite Review

- Indicate if requesting a Critical Path Expedite Review (CPER).
- Provide justification for this request, if applicable.

Costs

- Select whether the costs indicated are estimated costs or contract costs.
- Enter the **amount of change** in the construction cost of the project excluding fixed equipment to be permanently attached (electrically, mechanically or structurally) to the building, imaging equipment, design fees, inspection fees, and off-site improvements. For SB 1838 projects, this amount must not exceed $50,000.
- Enter the **amount of change** in the cost or value of fixed equipment (items that are permanently affixed to the building or permanently connected to a service distribution system that is designed and installed for the specific use of the equipment), excluding installation costs.
- Enter the **amount of change** in cost or value of imaging equipment (X-ray, MRI, CT Scan, etc.), excluding installation cost.

Enclosures

- Indicate the number of copies enclosed in the space provided, next to the applicable enclosure type.
- List all drawing sheets included with this submittal.

INSTRUCTIONS FOR AMENDED CONSTRUCTION DOCUMENT (continued)
(HCAI-OSH-125)

Fee Information:

Acute Care Hospital fees shall be 2.0% of the contract/estimated construction cost, including fixed and imaging equipment for any project less than $250,000.

Acute Care Hospital fees shall be 1.64% of the contract/estimated construction cost, including fixed and imaging equipment for any project $250,000 or more.

The fee rate is based upon the initial contract/estimated costs and will remain constant for the project's duration.

Skilled Nursing Facility fees shall be 1.5% of the contract/estimated construction cost, including fixed and imaging equipment.

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

Email: *OSHPDSacProjectSupport@hcai.ca.gov*

"or by mail"

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

For construction in Southern California, Submit to:

Email: *OSHPDLAProjectSupport@hcai.ca.gov*

"or by mail"

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