DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION
FACILITIES DEVELOPMENT DIVISION

RECEIVED

OFFICE USE ONLY

Project # ______ **Increment #** ______

Project Application Information

Project

Type

- ❑ Alternate Method of Compliance
- ❑ Annual Building Permit
- ❑ Application for Building Permit
- ❑ Application for New Project
- ❑ Application for Seismic Extension (select one)
  - ❍ NPC
  - ❍ SPC
- ❑ Incremental (select one)
  - ❍ Increment
  - ❍ Master
- ❑ Phase Segment
- ❑ Post Approval Document
- ❑ Seismic Retrofit Program (select one)
  - ❍ Application for Seismic Evaluation Report
  - ❍ Compliance Plan Review
  - ❍ Request for NPC or SPC Upgrade

Facility

Facility # ______ Facility Name ______

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

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 ______

OFFICE USE ONLY	
Project #	**Increment #**

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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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 ______

DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION
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Project #	**Increment #**

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 ____________

INSTRUCTIONS FOR PROJECT APPLICATION INFORMATION
(HCAI-FD-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 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 Department of Healthcare Access and Information (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, Seismic Review and Clinics, submit to:

Department of Healthcare Access and Information
Facilities Development Division
2020 W. El Camino Ave., Suite 800
Sacramento, CA 95833
(916) 440-8300 phone
(916) 274-0102 fax

For construction in Southern California, submit to:

Department of Healthcare Access and Information
Facilities Development Division
355 South Grand Avenue, Suite 1900
Los Angeles, CA 90071
(213) 897-0166 phone
(213) 217-8511 fax