



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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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 _____



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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 _____



**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 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:

Email: OSHPDSacProjectSupport@hcai.ca.gov

"or by mail"

For construction in Southern California, submit to:

Email: OSHPDLAProjectSupport@hcai.ca.gov

"or by mail"

Department of Healthcare Access and Information
Office of Statewide Hospital Planning and Development
00 El Camino ve Site 00
Sacramento CA 95833
Phone 916 300
Fax 916 00

Department of Healthcare Access and Information
Office of Statewide Hospital Planning and Development
355 South Grand Avenue, Suite 1900
Los Angeles, CA 90071
Phone 213 9701
Fax 213 7010