

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

FACILITIES DEVELOPMENT DIVISION ~

400 "R" Street, Suite 200 ~ Sacramento, California 95811
 700 N. Alameda Street, Suite 2-500, Los Angeles, California 90012

Phone (916) 440-8300 FAX (916) 324-9188
 Phone (213) 897-0166 FAX (213) 897-0168

www.oshpd.state.ca.gov/fdd



Application for Incremental Project (Master)

A	Name of Facility: _____ _____ _____ Email: _____ Address - Street: _____ Phone: _____ _____ FAX #: _____ City: _____ County: _____ Zip: _____	<p style="text-align:center;">OFFICE USE ONLY</p> OSHPD #: _____ Facility I.D. #: _____
	Name of Facility Representative/Administrator: _____ _____ Email: _____ Address - Street: _____ Phone: _____ _____ FAX #: _____ City: _____ State: _____ Zip: _____	<p style="text-align:center;">SUBMITTAL</p> <input type="checkbox"/> Preliminary <input type="checkbox"/> Examination <input type="checkbox"/> Geotech
	Scope of Project (45 characters max): _____ Applicant Job #: _____	<p style="text-align:center;">DISTRIBUTION</p> <input type="checkbox"/> OSHPD <input type="checkbox"/> Project File <input type="checkbox"/> Rad. Health <input type="checkbox"/> L & C <input type="checkbox"/> _____ <input type="checkbox"/> _____
B	Description of Project: _____ _____ _____ _____ _____ <input type="checkbox"/> Geotech Only <input type="checkbox"/> Preliminary <input type="checkbox"/> SB 1953 Mitigation Construction Project (Complete "J")	
(Please complete Section K)		
C	Kind of Project: <input type="checkbox"/> New Facility (N) <input type="checkbox"/> Addition (A) <input type="checkbox"/> Remodel (R) Type of Facility: <input type="checkbox"/> General Acute Care <input type="checkbox"/> Skilled Nursing (SNF) and Intern. Care Facility (ICF) <input type="checkbox"/> Psychiatric Hospital <input type="checkbox"/> Correctional Treatment Center (CTC) <input type="checkbox"/> Clinic	
D	Legal Owner: _____ Phone: _____ _____ FAX #: _____ _____ E-mail: _____ Address: _____ City: _____ State: _____ Zip: _____	<p style="text-align:center;">OSHPD RECEIPT STAMP</p>
E	ESTIMATED COSTS 1. Estimated construction cost of project (Including Fixed Equipment, <u>excluding</u> Radiology Equipment, Design Fees, Inspection Fees, and Off Site work)\$ _____ 2. Estimated cost of Radiology Equipment (X-ray, MRI, CT Scans, etc)\$ _____ FEES WILL BE BASED UPON: <u>Skilled Nursing Facilities (SNF) are 1.5% (.015) of estimated cost</u> <u>Acute Care Hospitals (Hosp) fees are 1.64% (.0164) of estimated cost</u> <u>Preliminary Submittal if applicable is 10% of Total Filing Fee</u>	
F	Application for Plan Review made by (Name typed): _____ _____ Signature: _____ Date: _____ Title: _____ Phone #: _____ Address: _____ FAX #: _____ City: _____ State: _____ Zip: _____ E-mail: _____ Who is to be known as: <input type="checkbox"/> Legal Owner/Administrator <input type="checkbox"/> Agent for the Legal Owner/Administrator (Authorization must be attached)	

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G	Name of Facility (from front page)	OSHPD #
H	Enclosed with this application are the following documents: _____ Transmittal Letter (Section 7-131) _____ Plans _____ Specifications _____ Structural Calculations _____ Equipment Anchorage Calculations _____ Design Program (Optional) _____ Site Data Reports _____ Geotechnical Reports (For New Facilities and Additions) Date sent: _____ _____ Verification of conformance to Local Codes (for New Facilities and Additions) _____ Project Schedule _____ _____ _____	
I	Plans and Specifications prepared by the following:	
	Check discipline in general responsible charge of project <input checked="" type="checkbox"/>	
	Architect – Firm: <input type="checkbox"/>	
	Individual Responsible:	Lic. #: E-mail:
	Alternate:	Lic. #: E-mail:
	Address:	Phone #:
	City:	State: Zip: FAX #:
	Structural Engineer – Firm <input type="checkbox"/>	
	Individual Responsible:	Lic. #: E-mail:
	Alternate:	Lic. #: E-mail:
	Address:	Phone #:
	City:	State: Zip: FAX #:
	Mechanical Engineer – Firm <input type="checkbox"/>	
	Individual Responsible:	Lic. #: E-mail:
	Alternate:	Lic. #: E-mail:
	Address:	Phone #:
	City:	State: Zip: FAX #:
	Electrical Engineer – Firm <input type="checkbox"/>	
	Individual Responsible:	Lic. #: E-mail:
	Alternate:	Lic. #: E-mail:
	Address:	Phone #:
	City:	State: Zip: FAX #:
	Geotechnical Report – Firm <input type="checkbox"/>	
	Individual Responsible:	Lic. #: E-mail:
	Alternate:	Lic. #: E-mail:
	Address:	Phone #:
	City:	State: Zip: FAX #:

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**Application for Incremental Project (Master)
PROJECT SCHEDULE**

K	<p>Name of Facility: _____</p> <p>Name of Building: _____ Building #: _____</p> <p>Master Scope: _____</p> <p>Master Description:</p> <div style="border: 1px solid black; height: 80px; width: 100%;"></div>	<p style="text-align: center;"><u>OFFICE USE ONLY</u></p> <p>OSHPD #: _____</p> <hr/> <p>Region: _____</p> <p>Date: _____</p>
	<p>Increment #: _____</p> <p>Increment Scope: _____</p> <p>Increment Description:</p> <div style="border: 1px solid black; height: 80px; width: 100%;"></div>	
	<p>Estimated Start Date: _____</p> <p>Estimated Completion Date: _____</p> <p>Critical Path: <input type="checkbox"/> Yes <input type="checkbox"/> No Dependents: _____</p>	
	<p>Increment #: _____</p> <p>Increment Scope: _____</p> <p>Increment Description:</p> <div style="border: 1px solid black; height: 80px; width: 100%;"></div>	
	<p>Estimated Start Date: _____</p> <p>Estimated Completion Date: _____</p> <p>Critical Path: <input type="checkbox"/> Yes <input type="checkbox"/> No Dependents: _____</p>	

(Please duplicate page "K" for more increments)

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Full Compliance should only be chosen if this SB 1953 Mitigation Construction Project meets all requirements for SPC/NPC compliance for the listed Building as designated in the Compliance Plan. **Incremental Projects are for 1 building only.**

- K Provide the following information for the Master project:
- Name of Facility
 - Name of building and building number
 - Description of the Master project

Provide the following information for each increment (attach additional pages if necessary):

- Increment number (1, 2, 3, etc.)
- Increment scope
- Increment description
- Estimated start and completion dates
- Critical Path - Is completion of this increment critical to the start of another increment or must it follow another increment?
- Dependents – If Critical Path is "Yes," indicate increment(s) to be completed prior to or following this increment.