



COMMUNITY-BASED ADULT SERVICES (CBAS)
CHANGE OF OWNERSHIP APPLICATION

Mail Original Application to: Community-Based Adult Services Branch
 California Department of Aging
 1300 National Drive, Suite 200
 Sacramento, CA 95834

CBAS providers requesting to change ownership (new company/Licensee, new Employer’s Identification Number (EIN), and/or new owner type), must complete and submit the change of ownership application listed below to the California Department of Aging (CDA).

CDA will ensure that the provider meets CBAS standards prior to the California Department of Public Health (CDPH), Licensing & Certification District Office processing/approving the requested change. CBAS provider change requests will not be considered unless the CBAS provider meets the following minimum standards

- ✓ No restrictions on the provider’s Medi-Cal/Medicaid enrollment status
- ✓ An unencumbered ADHC license
- ✓ A record of substantial compliance with certification laws and regulations
- ✓ No current Medi-Cal administrative sanctions

The instructions below have been updated as of June 2015. Please review all instructions carefully and provide complete, accurate, and consistent information throughout the application

Pursuant to Welfare and Institutions Code 14043.2, failure to disclose required information or disclosure of false or inaccurate information may result in denial of your application for change in ownership.

Required Forms and Information:

Complete and submit the information below, as applicable. Please **do not** use acronyms.

1. [Licensure & Certification Application](#)," HS 200 (2/08), signed by the provider or legal representative.*

In addition to the HS 200 instructions, use the guidance and assistance provided below when completing the form.

<u>Section:</u>	<u>Instruction:</u>
A.3	Enter the license fee. Please refer to CDPH website@: http://www.cdph.ca.gov/pubsforms/fiscalrep/Documents/LicCertFeeListing12.pdf .)

- A.8.a.** Enter the center's **license** capacity.
- A.10.a.** Enter the days and hours of operation (business hours) **and** the hours of service (program hours).
- B.1.** Enter the **licensee's legal** name.
- B.4.** Enter the licensee's e-mail address and fax number if different from the center.
- B.5.a.** List the names of other facilities, agencies or clinics **this licensee** has been licensed for, operated, managed, held 5 percent interest in or served as a director or officer.
- B.5.b.** If any of the facilities listed in section B.5.a, has had a licensure or Medi-Cal Certification action taken against it or has had a settlement agreement, submit additional information as requested in the form.
- C.2. Current Facility** Enter the **center's legal** name.
- C.3.** Enter the **center's** mail address and phone number.
- C.4.** If the mail address is not different from the center's address, **enter** the **center's** fax number and e-mail address.
- C.6.a.** If the center's administrator is the name of the person indicated in C.5., complete C.6.a., as requested.
- E.** If the center operates under a management company contract, answer questions C.1 through 5 and complete and submit Attachment E-1.
2. "[Medi-Cal Participation Agreement](#)," IMS 36 (12/11), signed by the provider or legal representative.*
3. "[Medi-Cal Provider Agreement](#)," DHCS 9098 (6/10), signed by the provider or legal representative.*
4. "[Disclaimer of Conflict of Interest](#)," MC 406 (6/00), signed by the current Board Chairperson or President.
5. [Applicant Individual Information](#)," HS 215A (2/08), signed and dated by

- Each individual having 5 percent or more ownership interest in the applicant facility;
- A management company/agency staff operating the facility (not the center's administrator or program director);
- Any individual serving as the facility's Board:
 - Officer
 - Director
 - Member
- The center's administrator
- The center's program director.
- The center's Office/Business manager (not necessarily from another agency; not the center's administrator or program director);
- Administrative Assistants.

In addition to the HS 215A instructions, use the guidance and assistance provided below when completing the form.

Section:

Instruction:

E.1.

Answer "Yes" if the individual completing the form has been involved (owned, worked in, etc.) with a business that operated a health or community care facility.

E.2.

Answer "Yes" if the individual completing the form has operated or managed one of the provider types listed

E.3.

Answer "Yes" if the individual completing the form had or currently has ownership of 5 percent or more in any of the provider types listed in E.2

F.

Answer "Yes" and provide an explanation if the individual completing the form has been affiliated with any facility, in the past or present, that has had any of the adverse actions listed. Note: Suspension includes Temporary Suspension.

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The Facility Information Sheet is required to be completed for the center and completed when answering "yes" to questions E.1. - E.3.

6. "[Administrative Organization](#)," HS 309 (3/03), Signed by the provider or legal representative.* **Note: Only complete the applicable section of the form ("Corporation," Public Agency, Partnership, etc.) for your organization.**

In addition to the HS 309 instructions, use the guidance and assistance provided below when completing the form.

Section:

Instruction:

Item 8. Only list "Other" facilities owned or operated by this licensee. Include all information as requested in the form.

Item 10. In addition to listing Board Officers, provide a list of all Board members (Note: All Board members must complete an "[Applicant Individual Information](#)," HS 215A (2/08) form).

7. "[Staffing/Services Arrangement](#)," ADH 0006 (9/14), signed and dated by the administrator or program director.
8. "[Administrator and Program Director Information](#)" CDA 278 (5/02), for a **new** administrator and/or **new** program director.
9. Sale/transfer agreement signed by Board of Director/legal representative.
10. "[Balance Sheet](#)" IMS 33 (6/00), which lists all assets, liabilities, and equities of the legal entity.
11. "[Cash Flow Forecast](#)" IMS 35, (10/02) that projects on a monthly basis the center's actual cash revenues and expenditures for one year starting from the first month of service provision.
12. "[Operating Budget](#)" IMS 37, (10/02) that indicates the center's projected total revenues and expenditures of the total year and for an average month.
13. "[Proposal to Share Space](#)", ADH 0007 (4/99), if applicable.
14. Brochure, if applicable.
15. "[National Provider Identifier \(NPI\)](#)" verification form.

Note: Please be aware that the list of documents above reflects CDA requirements. Upon completion of review, CDA will forward copies of the application to CDPH for processing. CDPH may require additional information at the time of their review.