# ADULT DAY HEALTH CARE (ADHC) APPLICATION

# TO ADD

# ADULT DAY PROGRAM SERVICES

Mail the "original" application to Add Adult Day Program Services to the California Department of Public Health (CDPH), Licensing and Certification at the following address:

## California Department of Public Health

Licensing and Certification - Centralized Applications Branch

PO Box 997377, MS 3207

Sacramento, CA 95899-7377

Carefully read all instructions and answer all applicable questions on the appropriate forms below with complete and accurate information. Ensure information provided is consistent on all forms (licensee/center name, addresses, etc.) before application submission to the CDPH - Centralized Applications Branch (CAB).

**Pursuant to Welfare and Institutions Code (WIC) 14043.2, failure to disclose required information or disclosure of false or inaccurate information may result in denial of your application.**

Please visit the CBAS website to access the required forms https://aging.ca.gov/Providers_and_Partners/Community-Based_Adult_Services/Forms_and_Instructions/Application_Materials/

## Required Forms:

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

1. "**Licensure & Certification Application**," HS 200 (Rev. 7/2023), signed by the licensee.

   **In addition to the HS 200 instructions located on the CDPH website, use the guidance provided below when completing the HS 200 (Rev. 7/2023 form.**

   | Section: | Instruction: |
   | --- | --- |
   | **A.1.** | Select "g. Other Change" |

| | |
|---|---|
| **A.3.** | Select “p. other” and indicate “Add Adult Day Program to ADHC License.” |
| **A.4.** | Select “b. Adult Day Health Center (ADHC). |
| **A.5.** | Not applicable to CBAS providers – select “no.” |
| **A.6.** | Applicable to CBAS providers – select “yes.” |
| **A.7.a**. | Enter the center’s license capacity. Indicate “Proposed bed capacity” only for change in capacity applications. |
| **A.9.** | **b.** Enter the days and hours of operation (**business hours**).<br>**c.** List service days/hours (CBAS program hours) in the space provided if different than the days/hours of operation. |
| **B.1.** | Enter the **licensee’s legal** name as reported to the IRS. Indicate the licensee’s legal name as filed with the CA Secretary of State, if different from that reported to the IRS. |
| **B.4.a.** | Identify other facilities, agencies, or clinics the licensee is currently or has been licensed for, operated, managed, held a 5 percent or more (direct or indirect) ownership interest and/or control interest in, or served as a director or officer. Include facilities both in and outside of California. **Submit** an attachment for additional facilities that includes all the required information listed below. |
| **B.4.b.** | If any of the facilities listed in section B.4.a, has had a licensure revocation or Medi-Cal Certification action taken against it or has had a settlement agreement, submit additional information as requested in the form. |
| **B.5.** | Select “yes” and complete 5.b.,c., and d. |
| **C.2.a.** | Enter the centers current name in the field marked **Current facility, agency, or clinic name**. The *“proposed” facility* field should be left blank except if change of ownership, change of location, change of mailing address, or change of name. |
| **F-1**. | If the current or proposed facility, agency, or clinic is applying for Medi-Cal certification, complete Attachment F-1: Subcontractor Information and Significant Business Transactions. |

2. "**Proposal to Share Space**,” ADH 0007 (02/2021)

3. "**Applicant Individual Information**," HS 215A (02/2008) signed and dated by:
    1. Each individual having 5 percent or more ownership interest in the applicant facility
    2. A management company/agency staff operating the facility (not the center's Administrator or Program Director)
    3. Any individual serving as the facility's Board
        - Officer
        - Director
        - Member
    4. Administrator
        - Assistant Administrator
    5. Program Director
        - Assistant Program Director
    6. Office/Business Manager

**In addition to the HS 215A instructions found on the CDPH website, use the guidance and assistance provided below when completing the form.**

| <u>Section:</u> | <u>Instruction:</u> |
|---|---|
| **B.4.** | Provide your Driver's License Number. If not available, provide a State-Issued Identification Card Number. |
| **B.5.** | Applicant must provide Social Security Number information as required per Title 42 Code of Federal Regulations (CFR) Section 455.104(b)(1). |
| **G.** | Select "yes" or "no" if the applicant has ever been affiliated with any facility, either past or present, that has been identified as having one or more of the listed adverse actions.<br><br>If "yes" is selected, check all adverse actions listed that apply and explain the adverse action including the facility name, address, and dates of adverse action. (Any additional pages should be titled: "Section G- Adverse Actions Continued".) |
| **H.** | This must be completed for each facility (including all facilities in all business entities) that the applicant has a current relationship with or has had a past relationship with in the last 3 years – going back 5 years for SNFs. (Attach additional pages if necessary, include the same required content with the same formatting Title pages: |

"Section H - Facility Information Sheet").