COMMUNITY-BASED ADULT SERVICES (CBAS)

CHANGE OF OWNERSHIP APPLICATION INSTRUCTIONS

Upload Change of Ownership Application to:

https://peach.aging.ca.gov

Please use the Peach Provider Portal Upload Instructions for Certification Renewal/Change Application file types.

CBAS providers requesting to change ownership-CHOW (new company/Licensee, new Employer's Identification Number (EIN), and/or new owner type), must **first** 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), Centralized Applications Branch (CAB) final review and approval for 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 Adult Day Health Care (ADHC) license
- A record of substantial compliance with certification laws and regulations
- No current Medi-Cal administrative sanctions

Review all instructions carefully and provide complete, accurate, and consistent information throughout the application.

Pursuant to Welfare and Institutions (WIC) 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 Instructions:

Complete and submit the change of ownership documents listed below. You may access the application documents through the CDA website:

https://aging.ca.gov/Providers_and_Partners/Community-Based_Adult_Services/Forms_and_Instructions/Application_Materials/

Do not use acronyms when completing the application documents.

1. **Cover Letter**

Include a cover letter with your change of ownership application request on company letterhead with the following information:

- For Initial, if Licensee owns other existing ADHC centers, provide license numbers of those centers
- For CHOW, provide license number of current center
- Facility name and address
- National Provider Information (NPI)
- Facility ID number
- Brief description of request
- Contact information (name, title, phone number, and email address)
- Emergency Contact Information (name, email, alternate email, phone, fax, and phone number that will receive text messages).
- Signature

2. **"Licensure & Certification Application," HS 200 (Rev. 7/2023),** signed by the provider or legal representative. *

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

Section:	**Instruction:**
A.1.	Select “d. Change of Ownership”
A.2.	Provide actual date applicant took charge of the financial management of the facility. This date is used to show effective date of the ownership change for certification purposes only.
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). **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.

*Provider or legal representative means the Board Chairperson, President, or Managing Employee.

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.
B.4.b.	If any of the facilities listed in section B.4.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.
B.5.a	**Must** select “yes” and complete 5.b., c., and d.
C.2.	Enter the center’s current name in the field marked **Current Facility**. 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.

3. **"Provider Participation Agreement," CDA IMS 36 (07/2022),** signed by the provider or legal representative. *
4. **"Medi-Cal Provider Agreement," DHCS 9098 (07/2017),** signed by the provider or legal representative. * Note: this form must be notarized, and the person signing the Medi-Cal Provider Agreement must also submit the Applicant Individual Information form (HS 215A (Rev. 7/2023)).
5. **"Disclaimer of Conflict of Interest," CDA CBAS 406 (11/2023),** signed by the current Board Chairperson or President.
6. **"Applicant Individual Information," HS 215A (Rev. 7/2023),** 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

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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.

Section:	**Instruction:**
B.4.	Provide your Driver's License Number. If not available, provide a State-Issued Identification Card Number. In addition, attach a legible, active copy of your Driver's License or State-Issued Identification Card.
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. 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 Action").
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").

7. **"Administrative Organization," HS 309 (10/2011),** 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.	List all health facilities the applicant has ever owned or operated by this licensee. Include all information as

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requested in the form. The applicant in this case is considered the licensee.

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 (7/23) form).

8. **"Staffing/Services Arrangement" CDA ADH 0006 (02/2024),** signed and dated by the Administrator or Program Director**.**
9. **A resume and three references for any Administrator, Assistant Administrator, Program Director.** A separate reference sheet is acceptable**.**
10. **Sale/transfer agreement** signed by Board of Director/legal representative.
11. **"ADHC/CBAS Balance Sheet" CDA IMS 33 (11/2023\),** which lists all assets, liabilities, and equities of the legal entity.
12. **"ADHC/CBAS Cash Flow Forecast" CDA IMS 35 (03/2022)** that projects monthly the center's actual cash revenues and expenditures for one year starting from the first month of service provision.
13. **"ADHC/CBAS Operating Budget" CDA IMS 37 (06/2021**) that indicates the center's projected total revenues and expenditures of the total year and for an average month.
14. **"Proposal to Share Space," CDA ADH 0007 (02/2021),** if applicable.
15. **Brochure,** if applicable.
16. **"National Provider Identifier (NPI)"** verification form.

Notes: Upon submission of a change application packet, CDA will conduct an initial review and determine if the provider meets the minimum CBAS program standards. After CDA's initial review is complete, CDA will notify the CBAS provider of its determination and then forward the application with a notice of CDA's recommendation or non-recommendation to CDPH–CAB for final review and processing. CDPH will notify the provider if the application packet is approved or deemed incomplete based on compliance with state licensure requirements.

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