COMMUNITY-BASED ADULT SERVICES (CBAS)

CERTIFICATION RENEWAL APPLICATION INSTRUCTIONS

Upload Certification Renewal Application and Corresponding Documents to:

https://peach.aging.ca.gov/

Please use the Peach Provider Portal Upload Instructions for Certification Renewal/Change Application file types. The Peach Provider Portal allows CBAS centers to securely submit files to the California Department of Aging (CDA). For more information to submit via the Peach Provider Portal, please see the following *instructions.*

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

CBAS provider Certification Renewal 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

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 for certification renewal.

Note: Completion of this application package and corresponding documents is for certification renewal only. Do not include requests for changes such as capacity, location, ownership, or shareholders which require separate applications. Applications for changes in location, capacity, ownership, and shareholders can be obtained on the CDA website. Other center change applications can be obtained from the California Department of Public Health (CDPH).

Part I – Required Certification Renewal Forms:

Please complete and submit the documents listed below. All required application materials are available on the CDA website.

Do not use acronyms or abbreviations when completing any of the application documents.

1. Cover Letter

Your cover letter must include the following information:

- License number
- National Provider Information (NPI)
- Facility name and address
- 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. 07/23), signed by the provider or legal representative.*

In addition to the HS 200 instructions available on the CDPH website, please follow the guidance provided below when completing the form.

Section:	**Instructions:**
A.1.	Select "g. Other Change"
A.3.	Select "p. other" and indicate "CBAS Recertification."
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 **Internal Revenue Services** (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.
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.

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

C.2.	Enter the center's current name in the field labeled Current Facility. The Proposed Facility field should remain blank unless the application involves a change of ownership, change of location, change of mailing address, or change of name.
C.5.	List each person having 5 percent or more (direct or indirect) ownership interest and/or control interest in the applicant facility.
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 (Rev. 09/24), signed by the provider or legal representative.*

4. Medi-Cal Provider Agreement DHCS 9098 (Rev. 07/25), 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 (Rev. 11/23), signed by the current Board Chairperson or President.

6. Administrative Organization HS 309 (Rev. 10/11)

Note: Complete only the section of the form that applies to your organization (e.g., Corporation, Public Agency, Partnership, etc.)

In addition to the HS 309 instructions, please follow the guidance provided below when completing the form.

Item 8. List all health facilities the applicant has ever owned or operated by this licensee. Include all information as 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 and submit an organizational chart. (Note: All Board members must complete an **Applicant Individual Information,** (HS 215A (Rev. 7/2023) form).

Please note: If a business owns stock in the licensee, an additional HS 309 must be completed and submitted out for that business in addition to the center's licensee. Please see Title 22, CCR, § 51000.9 for more information on Indirect Ownership Interest and requirements.

7. Applicant Individual Information HS 215A (Rev. 07/23), signed and dated by:

I. Each person having five (5) percent or more (direct or indirect) ownership interest and/or control interest in the applicant facility.

II. A management company/agency staff operating the facility (not the center's

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Administrator or Program Director)

III. Any individual serving as the facility's Board
   - Officer
   - Director
   - Member

IV. Administrator

V. Program Director

VI. Office/Business Manager

In addition to the HS 215A instructions available on the CDPH website, please follow the guidance provided below when completing the form.

Section:	**Instructions:**
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 Skilled Nursing Facilities (SNFs). Attach additional pages if necessary, include the same required content with the same formatting Title pages: "Section H - Facility Information Sheet."

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8. **Contractual Agreement Listing CDA CBAS 4007 (Rev. 02/24),** signed by the provider or legal representative.*

9. **Staffing/Services Arrangement" CDA ADH 0006 (Rev. 02/24),** signed by the Administrator or Program Director. Please refer to the Staffing/Services Arrangement instructions.

10. **Acknowledgment of Regulatory Responsibilities and Practice Acts CDA ADH 1038 (Rev. 02/24),** signed by the center's Administrator, Program Director, and each specified discipline completing the form.

11. **Copy of your current Adult Day Health Care License.**

12. **Provide your business license issued by your local municipality.**

13. **Legal and Fictitious Business Name**

    A. **Please submit documentation verifying your legal business name and employer identification number on file with the IRS. For example:**
        - Letter 147-C (EIN Confirmation Notification)
        - Form 941 (Employer's Quarterly Federal Tax Return)
        - Form 8109-C (Federal Tax Deposit Address Change)
        - Form SS-4 (Confirmation Notification)

    B. **If the applicant or provider is using a fictitious name, a copy of the Fictitious Business Name Statement shall be submitted with the application.** Nonprofit organizations are not subject to this requirement per the California Business and Professions Code (BPC) § 17911

14. **Copy of the declarations page for your current General Liability Insurance.**

15. **Copy of the declarations page for your current Worker's Compensation Insurance.**

16. **CBAS Home and Community-Based Settings Provider Self-Assessment CDA 7019 (Rev. 11/23).**

Part II – Pre-Survey Review Information

CBAS will contact at a later date you to discuss additional information required for CDA staff to complete the pre-survey review process. You will be required to provide specific information from participant health records. Please ensure that the following information is kept current and up to date:

- Monthly nutrition, therapy, and consultation hours.
- List of employees, including dates of hire and contact telephone numbers.
- Participant health record information for participants authorized for CBAS.

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