



**COMMUNITY-BASED ADULT SERVICES (CBAS)**  
**CHANGE IN LICENSE CAPACITY 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 license capacity must complete and submit the change in capacity 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

Providers requesting an increase in license capacity may be required to submit documentation in addition to that listed below, depending on the size of the capacity increase, past deficient practice, and demonstration of compliance through the plan of correction (POC) process. CDA may conduct a site review prior to approving the application.

The instructions below have been updated as of May 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 license capacity.**

**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.**

**Section:                      Instruction:**

- A.3. Please **do not enclose** the licensure fee, there is no fee.
- 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. [Applicant Individual Information](#)," HS 215A (2/08), signed and dated by:
- Each individual having 5 percent or more direct or indirect ownership interest in the applicant facility,
  - A management company/agency staff person 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 as requested if the individual completing the form has been affiliated with any facility, in the past or present, that has had adverse actions listed.

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

- 3.** "[Administrative Organization](#)," HS 309 (3/03), signed by the provider or legal representative.\* **Note: Complete only 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).

4. [Staffing Services Arrangement](#) (ADH 0006 (09/14)) signed by the administrator or program director.
5. Floor Plan: Submit a detailed and legible floor plan indicating the square footage of each program area to be used and label where basic services will be provided. The floor plan must include:
  - Office space
  - Bathrooms (number of toilets in each room)
  - Entrances and emergency exits
  - Outdoor space

**Note:** Please be aware that the list of required 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.