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.

A Change of Ownership (CHOW)[1] constitutes when one of the following occurs resulting in a takeover of an existing licensee and its operations:

- New company/licensee,
- New Employer's Identification Number (EIN) or Taxpayer identification Number (TIN) is issued by the Internal Revenue Services (IRS), or,
- New entity type. For example, For-profit corporation, limited partnership, general partnership, non-profit, Limited Liability Company (LLC), or other.

For any change of ownership, **first** complete and submit the CHOW application listed below to the California Department of Aging (CDA). CDA will ensure that the provider meets Medi-Cal[2] and CBAS standards prior to the California Department of Public Health (CDPH), Centralized Applications Branch (CAB) final review and approval for the requested change. CBAS providers 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.

Please report changes to the Department within 35 days[3] of any addition or change in the previously reported information.

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[1] California Code of Regulations (CCR) Title 22 § 51000.20.1(a)(1)(2)(3)(4)

[2] CCR Title 22 § 51000.50

[3] CCR Title 22 § 51000.40(a)

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:

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:

- 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. 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:	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).

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	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.
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.
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. **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
   a. Officer
   b. Director
   c. Member
IV. Administrator
V. Program Director
VI. 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:	**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 (SNF). Attach additional pages if necessary, include the same required content with the same formatting Title pages: "Section H - Facility Information Shee.t"

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7. **Administrative Organization, HS 309 (Rev. 10/11),** 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, 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.

8. **Staffing/Services Arrangement CDA ADH 0006 (Rev. 02/24),** signed by the Administrator or Program Director. Please refer to the Staffing/Services Arrangement instructions.
9. **Sale/transfer agreement** signed by Board of Director/legal representative.
10. **Legal and Fictious Name**
    - **A. Please submit documentation verifying your legal business name and employer identification number on file with the Internal Revenue Services. 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

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11. **Provide your business license issued by your local municipality.**
12. **Copy of the declarations page for your current General Liability Insurance.**
13. **Copy of the declarations page for your current Worker's Compensation Insurance.**
14. **ADHC/CBAS Balance Sheet CDA IMS 33 (Rev. 11/23),** which lists all assets, liabilities, and equities of the legal entity.
15. **ADHC/CBAS Cash Flow Forecast CDA IMS 35 (Rev. 02/24)** that projects monthly the center's actual cash revenues and expenditures for one year starting from the first month of service provision.
16. **ADHC/CBAS Operating Budget CDA IMS 37 (Rev. 02/24**) that indicates the center's projected total revenues and expenditures of the total year and for an average month.
17. **National Provider Identifier (NPI)** verification form.

The applicant is not required to obtain a new national provider identifier (NPI) when undergoing a change of ownership (CHOW). The provider is required to supply new ownership information to the National Plan and Provider Enumeration System (NPPES) for updating the provider's record. The NPPES website is: https://nppes.cms.hhs.gov/#/.

Note: Once CDA's review is complete, CDA will notify the applicant of its determination and forward the application, along with a notice of CDA's recommendation or non-recommendation, to CDPH–CAB for final review and processing. CDPH will then notify the provider whether the application has been approved or deemed incomplete based on compliance with state licensure requirements.

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