COMMUNITY-BASED ADULT SERVICES

CERTIFICATION RENEWAL INSTRUCTIONS AND APPLICATION

Upload Original Application to:

The Peach Provider Portal at https://peach.aging.ca.gov/

The Peach Provider Portal allows CBAS centers to securely submit files to the California Department of Aging (CDA)

Files containing confidential and protected health information (PHI), are subject to regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

*Do **not** share your Peach Provider Portal username and/or password with anyone*

For more information to submit via the Peach Provider Portal, please see the following instructions https://aging.ca.gov/download.ashx?lE0rcNUV0zZYEM4ujuyp3w%3d%3d

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

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: This application is for certification renewal only. Do not include requests for changes such as capacity, location, ownership, or shareholders which require separate applications. Applications for change in location, capacity, ownership, and shareholders may be obtained on the CDA website. Other center change applications may be obtained from your Licensing District Office.

Part I – Required Certification Renewal Forms

Complete and submit the information below, as applicable, by the date indicated in the application's cover letter. You may access the application documents through the CDA website: https://aging.ca.gov/ProgramsProviders/ADHC-CBAS/Forms/Application_Materials/.

Do not use acronyms or abbreviations.

1. "*Licensure & Certification Application*" (HS 200 (02/21)), signed by the provider or legal representative.* Provider or legal representative means the Board Chairperson, President, or Managing Employee.

In addition to the HS 200 instructions, use the guidance and assistance

provided below when completing the form.

Section:	**Instruction:**
A.3.	**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 that **this licensee** has been licensed for, operated, managed, held 5 percent interest in, or served as a Director or Officer.
B.5.b.	Submit additional information for any of the facilities listed in section B.5.a that have had a licensure or Medi-Cal Certification action taken against them, including those resolved by a settlement agreement.
C.2. Current Facility	Enter the **center's legal** name.
C.3.	Enter the **center's** mailing address and phone number.
C.4.	Enter the **center's fax and e-mail address**. There is no need to enter the address if it is the same as above.
C.6.a.	Complete section C.6.a. for the center's Administrator even if the name of the Administrator is recorded in C.5.
E.	**Answer questions C.1-C.5 and complete and submit** Attachment E-1 if the center operates under a management company contract.

2. "*CBAS Provider Participation Agreement*" (IMS 36 (01/21)), signed by the provider or legal representative. *

3. "*Medi-Cal Provider Agreement*" (DHCS 9098 (07/17)), signed by the provider or legal representative. * Note: this form must be notarized and the person signing the Medi-Cal Provider Agreement also must submit the Applicant Individual Information (HS 215A (02/08)).

4. "*Disclaimer of Conflict of Interest*" (CDA CBAS 406 (05/20)), signed by the current Board Chairperson or President. Submit only if there has been a change of Board Chairperson or President since your last certification renewal application was submitted.

5. "*Administrative Organization*" (HS 309 (10/11)) The organization is required to complete only the section of the form that applies to their organization:

- Corporation
- Public Agency
- Partnership

Question 8 requires that the applicant list the name(s) of each facility ever owned or operated. The applicant in this case is considered the licensee.

In addition to listing the Board Officers, the applicant is required to submit an organizational chart.

6. "*Applicant Individual Information*" (HS 215A (02/08)), 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, 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 any of the adverse actions listed. Note: Suspension includes Temporary Suspension.
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.

7. "*CBAS Contractual Agreement Listing*" (CDA CBAS 4007 (03/20)) signed by the provider or legal representative. *

8. "*Staffing Services Arrangement*" and *ADH 0006* "*Instructions*" (ADH 0006 (04/20)) signed by the Administrator or Program Director.

9. "*Acknowledgment of Regulatory Responsibilities and Practice Acts"* (CDA ADH 1038 (03/20)), signed by the center's Administrator, Program Director, and each specified discipline completing the form.

10. Copy of your current Adult Day Health Care license.

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

12. "*CBAS Provider Self-Assessment Tool*" and "*instructions.*"

13. "*Personal Identifying Information*," CDA 7006 (04/18). Refer to CDA 7006i for further instructions.

Part II – Pre-Survey Review Information

The CBAS Bureau will contact you to discuss additional information that will be needed for CDA staff to complete a pre-survey review process. You will be requested to complete and asked to submit specific information from participant health records. Therefore, please maintain updated and current information indicated below:

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