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 change in location, capacity, ownership, and shareholders may be obtained on the CDA website. Other center change applications may be obtained from your CDPH Licensing District Office.

Part I – Required Certification Renewal Forms:

Complete and submit the requested information below. 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 or abbreviations when completing the certification renewal application documents.

1. Cover Letter

Include a cover letter with your certification renewal application with 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. 7/2023), signed by the provider or legal representative. *

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

Section:	Instruction:
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 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.

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

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 (09/2024)),** 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 provider or legal representative. *
6. **"*Administrative Organization*" HS 309 (10/2011),** 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.

   <u>Section/Instruction:</u>

   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).
7. **"*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

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- Officer
- Director
- Member

4. Administrator
    - Assistant Administrator
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").

8. **"*Contractual Agreement Listing*" CDA CBAS 4007 (12/2023),** signed by the provider or legal representative. *
9. **"*Staffing/Services Arrangement*" CDA ADH 0006 (02/2024),** signed by the Administrator or Program Director.
10. **"*Acknowledgment of Regulatory Responsibilities and Practice Acts*" CDA ADH 1038 (09/2023),** signed by the center's Administrator, Program Director, and

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each specified discipline completing the form.

11. **Copy of your current Adult Day Health Care license.**
12. **Copy of the declarations page for your current General Liability Insurance.**
13. **"*CBAS Home and Community-Based Settings Provider Self-Assessment*" CDA 7019 (11/2023).**

Part II – Pre-Survey Review Information

The CBAS Bureau will contact you to discuss additional information needed for CDA staff to complete the pre-survey review process. You will need to complete and submit specific information from participant health records.
Please maintain updated and current information as 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.

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