CDSS

APPLICATION FOR QUALIFIED AGENCY CERTIFICATION

(See instructions on page 3)

Note: CDSS will process a completed application package within 120 days

FOR DEPARTMENT USE ONLY

RECEIVED DATE:	REVIEWED BY:	ACTION TYPE:

1. AGENCY NAME(S) *(PLEASE PRINT)*

2. REQUESTED CERTIFICATION TYPE *(CHECK ALL THAT APPLY):*

☐ A. AUTOMATICALLY CERTIFIED ☐ C. NEW CERTIFICATION
☐ B. RE-CERTIFICATION ☐ D. EXPANSION OR SERVICE

3. DATE *(MM/DD/YYYY)*

4. NON-REFUNDABLE FEE ENCLOSED

☐ A. $3,000 AUTOMATICALLY CERTIFIED ☐ B. $10,000 NEW CERTIFICATION ☐ C. $10,000 RE-CERTIFICATION
☐ D. $5,000 GEOGRAPHICAL OR SERVICE EXPANSION ☐ E. $10,000 AUTOMATICALLY CERTIFIED - FIRST EXPANSION

5. AGENCY'S PRIMARY CONTACT NAME	TITLE:	E-MAIL ADDRESS (OPTIONAL)	AREA CODE/TELEPHONE ( )

6. TYPE OF AGENCY OWNERSHIP/STRUCTURE:

☐ A. INDIVIDUAL (SOLE PROPRIETOR) ☐ B. PROFIT CORP. ☐ C. PARTNERSHIP ☐ D. COUNTY ☐ E. OTHER (SPECIFY) _____

7. AGENCY STREET ADDRESS	CITY	STATE	ZIP CODE	AREA CODE/TELEPHONE ( )
8. AGENCY MAILING ADDRESS (IF DIFFERENT)	CITY	STATE	ZIP CODE	AREA CODE/TELEPHONE ( )

9. CURRENT GEOGRAPHICAL AREA	10. EXPANSION/SERVICE ADDITIONS	11. # OF IHSS CAREGIVER EMPLOYEES (ESTIMATE)	12. #OF IHSS RECIPIENTS (ESTIMATE)

13. ADDITIONAL AGENCY BUSINESS NAMES *(DBA, FICTITIOUS NAME STATEMENT, PRIOR LEGAL NAMES, ETC.)*

14, AGENCY BUSINESS INFORMATION *(CHECK AND COMPLETE ALL THAT APPLY, ALL INFORMATION WILL BE KEPT CONFIDENTIAL)*

☐ A. SOCIAL SECURITY NUMBER (SSN) _____ ☐ C. CA. BUSINESS LICENSE NUMBER _____
☐ B. FEDERAL EMPLOYER ID NUMBER (FEIN)_____ ☐ D. OTHER (SPECIFY) _____

15. AGENCY ORGANIZATIONAL STRUCTURE *(LIST EACH OFFICER OR ATTACH AGENCY ORGANIZATIONAL CHART)*

OFFICER NAME_____ OFFICER TITLE _____
OFFICER NAME_____ OFFICER TITLE _____
OFFICER NAME_____ OFFICER TITLE _____
OFFICER NAME_____ OFFICER TITLE _____
_____ OR _____

☐ ATTACH ORGANIZATION CHART, LIST OF DIRECTORS, ETC.

16. AGENCY FINANCIAL INFORMATION *(CHECK ALL THAT APPLY)*

☐ A. 3 MOST RECENT AUDITED FINANCIAL STATEMENTS) ☐ C. W-9 FORM ☐ E. OTHER/ADDITIONAL INFORMATION
☐ B. BUSINESS PLAN AND BUDGET NARRATIVE ☐ D. LETTERS OF RECOMMENDATIONS/SUPPORT

17. DECLARATION OF NO BANKRUPTCY HISTORY *(PLEASE CHECK AND ATTACH SUPPORTING DOCUMENTATION IF AVAILABLE)*

☐ THE APPLICANT AGENCY/BUSINESS HAS NOT BEEN INVOLVED IN BANKRUPTCY PROCEEDINGS WITHIN THE LAST 5 YEARS FROM THE DATE THIS APPLICATION WAS FILED.

18. INSURANCE REQUIREMENTS *(GENERAL LIABILITY, WORKER'S COMPENSATION, AND AUTOMOTIVE LIABILITY)*

GENERAL LIABILITY
INSURANCE CARRIER_____ POLICY #_____ COVERAGE AMOUNT $ _____ CONTACT PHONE ( ) _____

WORKER'S COMPENSATION
INSURANCE CARRIER_____ POLICY #_____ COVERAGE AMOUNT $ _____ CONTACT PHONE ( ) _____

AUTOMOTIVE LIABILITY
INSURANCE CARRIER_____ POLICY #_____ COVERAGE AMOUNT $ _____ CONTACT PHONE ( ) _____

_____ OR _____

☐ ATTACH GENERAL LIABILITY PROOF OF COVERAGE ☐ ATTACH WORKER'S COMP PROOF OF COVERAGE ☐ ATTACH AUTO LIABILITY PROOF OF COVERAGE

19. HAS THIS AGENCY/BUSINESS PREVIOUSLY APPLIED FOR CERTIFICATION WITH CDSS? ☐ YES ☐ NO

IF YES, AGENCY/BUSINESS NAME_____ DATE APPLIED_____

20. IS THIS AGENCY CURRENTLY IN CONTRACT WITH A COUNTY OR PUBLIC AUTHORITY TO PROVISION IHSS? ☐ YES ☐ NO

☐ COPY OF CONTRACT ATTACHED

IF YES, ENTER COUNTY/PA NAME_____ DATE CONTRACT EXPIRES_____

21. AGENCY AGREES AND ATTESTS TO ALL OF THE FOLLOWING:

A. GUARANTEES THE CONTINUITY AND RELIABILITY OF SERVICES TO RECIPIENTS.

- THE AGENCY SHOULD HAVE SUFFICIENT FUNDING TO SUSTAIN 180 DAYS OF IHSS OPERATING EXPENSES.
- THE AGENCY MUST MAINTAIN A PHYSICAL BUSINESS STRUCTURE TO OPERATE WHICH MUST BE IN A PROPERLY ZONED LOCATION FOR A BUSINESS, CANNOT BE OPERATED FROM A PRIVATE RESIDENCE, AND MUST HAVE SUFFICIENT OFFICE SPACE, EQUIPMENT, AND SUPPORT TO FULLFILL ITS REQUIREMENTS TO PROVIDE IHSS.THE AGENCY SHALL CONFIRM THAT IT HAS NOT BEEN THE SUBJECT OF BANKRUPTCY PROCEEDINGS WITHIN THE LAST FIVE (5) YEARS FROM THE DATE ENTERED ON THIS APPLICATION.

B. GUARANTEES THE SUPERVISION OF CONTRACT PROVIDERS.

- THE AGENCY WILL HAVE SUFFICIENT PROVIDER STAFFING TO MEET ITS SERVICE OBLIGATIONS. EACH PROVIDER WILL BE PROPERLY TRAINED, SUPERVISED, AND MONITORED THROUGHOUT THEIR EMPLOYMENT TENURE. SUPERVISORY STAFF SHOULD BE AVAILABLE ON-CALL 24 HOURS PER DAY, 7 DAYS PER WEEK. THE AGENCY IS CAPABLE OF PROVIDING HIGH-QUALITY AND RELIABLE IN-HOME SUPPORTIVE SERVICES.

C. GUARANTEES EACH CONTRACT PROVIDERS HAS BEEN SCREENED IN ACCORDANCE WITH WELFARE AND INSTITUTIONAL CODE SECTIONS 12305.81 AND 12305.87.

- THE AGENCY SHALL PERFORM FINGERPRINTING AND BACKGROUND CHECKS WITH THE CALIFORNIA DEPARTMENT OF JUSTICE ON ALL EMPLOYEES THAT WILL BE PROVIDING IHSS SERVICES. THE AGENCY SHALL NOT EMPLOY AS AN IHSS PROVIDER ANY PERSON THAT IS INELIGIBLE TO BE A PROVIDER DUE TO A CONVICTION FOR CERTAIN CRIMES WITHIN THE STATUTORY FRAMEWORK OF WIC SECTIONS 12305.81 AND 12305.87.

E. GUARANTEES THAT EACH PROVIDER IS CAPABLE OF AND IS PROVIDING THE SERVICE AUTHORIZED.

- THE AGENCY SHALL RECORD AND MAINTAIN PROPER DOCUMENTATION OF PROVIDER EMPLOYEE AND RECIPIENT INFORMATION AVAILABLE FOR REVIEW BY CDSS UPON REQUEST.

F. THE AGENCY GUARANTEES COMPLIANCE WITH ALL APPLICABLE RULES AND REGULATIONS REGARDING CIVIL RIGHTS.

G. THE AGENCY IS CAPABLE OF PROVIDING HIGH QUALITY AND RELIABLE IN-HOME SUPPORTIVE SERVICES.

H. THE AGENCY IS CAPABLE OF COMPLYING WITH ANY RULES OR REGULATIONS PROMULGATED UNDER THE WELFARE AND INSTITUTIONS CODE AND ANY APPLICABLE FEDERAL RULES AND REGULATIONS.

I. THE AGENCY HAS NOT DEMONSTRATED A PATTERN AND PRACTICE OF VIOLATIONS OF STATE AND FEDERAL LAWS AND REGULATIONS BASED ON ANY AVAILABLE INFORMATION.

22. AGENCY UNDERSTANDS THE RIGHT TO APPEAL REGARDING THE DISPOSITION OF THIS APPLICATION AND/OR CERTIFICATION PROCESS.

23. UNDER THE PENALTY OF PERJURY, I/WE HEREBY CERTIFY THAT I AM/WE ARE A RESPONSIBLE PARTY AND AUTHORIZED REPRESENTATIVE OF THE AGENCY AND HAVE THE LEGAL AUTHORITY TO EXECUTE THIS APPLICATION AND ATTESTATION FORM ON BEHALF OF THE AGENCY AND THAT THE INFORMATION CONTAINED HEREIN IS TRUE AND CORRECT.

SIGNED_____ TITLE_____ COUNTY_____ DATE_____

SIGNED_____ TITLE _____COUNTY_____ DATE _____

STATE OF _____ }
}ss.
COUNTY OF _____ }

On _____ before me, _____, a notary public, personally appeared _____ , who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s)) or the entity upon behalf of which the person(s)) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____

(This area for official notarial seal.)

INSTRUCTIONS FOR THE APPLICATION FOR CCI QUALIFIED AGENCY CERTIFICATION

Please print clearly. Prepare application in duplicate. Return the original and maintain a copy for your records. Attach to this application form a copy of all requested forms and documents listed below. Complete the application accurately to avoid delays in the certification process. All applications should be received by CDSS no later than September 1st of each calendar year. However, applications will be accepted on a continuous basis.

1. Enter the current or proposed official business name(s) of the Agency that is applying for certification.

2. Check the appropriate box for the type of certification. Please check only one box.

3. Enter today's date in this format: mm/dd/yyyy.

4. Check the appropriate box for the non-refundable fee amount. Do not forget to enclose a check or cashier's check for the selected non-refundable fee amount. The non-refundable fee amount will not be returned under any circumstances.

5. Enter the information of the contact person CDSS can call with any questions or issues related to this application. Enter the name, title, e-mail address, and phone number.

6. Check the appropriate box that identifies the Agency's current business ownership structure. If the choice is "Other", please specify.

7. Enter the physical mailing address of the Agency's business office and phone number. Please note each Agency must maintain a physical structure in which services will be provided. The structure must be in a properly zoned location for a business and cannot be operated from a private residence.

8. Enter an optional mailing address (if different from item number 7 above).

9. Enter the geographical location(s) the prospective Agency plans on servicing. This must be a county, and a zip code.
   Note: if an Agency plans on changing or expanding the geographical service area, they must re-apply for certification.

10. Enter the geographical area and/or type(s) of services provided that the Agency is seeking to be expanded.

11. Enter the approximate number of employee healthcare providers your Agency has hired, or is expected to hire, to provide IHSS services.

12. Enter the approximate number of IHSS recipients your Agency anticipates servicing in your selected geographical region(s).

13. Enter all previous business names your Agency has used in the past (if applicable). This would include DBA, fictitious name statement, or prior legal names. Attach copies.

14. Check and complete any applicable business identification information (depending on the Agency's ownership structure). If there are other types of business identification information available, then please specify.

15. Specify each Agency officer with an associated title. Attach a list of officers and/or directors, organizational chart, etc.

16. Each Agency applicant must submit sufficient financial information to show that it has the necessary funding to support a minimum of 180 days of IHSS operating expenses. The Agency must submit the three (3) most recently audited financial statements prepared by a Certified Public Accountant. If these are available, please check the box and attach copies of the appropriate documentation.

    In some limited cases, an Agency applicant may not have the required prepared financial statements. CDSS will accept and consider other forms of financial documentation if these shows the Agency can remain financially viable for the 180 days timeframe. For example, this could be a letter of financial support and backing from a managed health organization or public entity stating they will provide funding if necessary. Other forms of financial and banking information may also fulfill the financial requirements. Check and attach all that apply.

17. A prospective Agency is required to check the box that declares it has not been involved in bankruptcy proceedings within the last five years from the date of the application. CDSS will use the information on this application to verify the bankruptcy history of the business.

18. Each Agency must possess three types of insurance with the associated insurance minimum coverage amounts:

    (1) General and Professional Liability ($1 million per occurrence/$3 million aggregate).

    (2) Worker's Compensation ($1 million).

    (3) Motor Vehicle ($1 million which includes uninsured motorist and medical).

    An Agency can either complete the insurance related information (insurance company/carrier name, policy number(s), coverage amounts, contact phone), or attach the appropriate proof of insurance coverage/policy statements to the application. Since CDSS will need to verify this information, please confirm the proof of insurance coverage statements have all the required information necessary for verification.

19. Check "Yes" if the Agency has applied previously. Enter the Agency name and approximate date the Agency applied.

20. Check "Yes" if the Agency is currently under contract to provide IHSS services with a County or Public Authority. Provide a copy of the contract and please check the box. Enter the name of the County or Public Authority and the date the contract expires.

21. Please read carefully all statements of each attestation and responsibilities of compliance (items A-I) before signing.

22. Notice of the rights of Agency to appeal the certification decision of CDSS.

23. Pre-signature attestations.

PLEASE HAVE APPLICATION NOTARIZED.