FORM NUMBER	FORM NAME	REV. DATE
HCS 001	Home Care Organization Suboffice Request	12/2015
HCS 101	Home Care Aide Registration Renewal	10/2017
HCS 100	Application For Home Care Aide Registration	12/2015
HCS 200	Application For A Home Care Organization License (note: this is the same application used for both initial and renewal)	8/2015
HCS 215	Home Care Organization Licensee Applicant Information	8/2015
HCS 308	Designation Of Home Care Organization Responsibility	8/2015
HCS 309	Partnership/Corporation/Limited Liability Company Organization Structure	8/2015
HCS 402	Home Care Organization Dishonesty Bond	12/2015
HCS 501	Personnel Record	6/2017
HCS 9165	Board Of Director Statement	8/2015
LIC 301E	Reference Request	7/2003
LIC 500	Personnel Record	11/2003
LIC 508	Criminal Record Statement	7/2015
LIC 9163	Request for Live Scan Service- Community Care Licensing	12/2015
LIC 9188	Criminal Record Exemption Transfer Request	11/2015
SOC 341 A	Statement Acknowledging Requirement To Report Suspected Abuse Of Dependent Adults And Elders	3/2015

Link to HCS Forms: http://www.cdss.ca.gov/inforesources/Forms-Brochures/Forms-Alphabetic-List/E-H

Link to LIC Forms: http://www.cdss.ca.gov/inforesources/Forms-Brochures/Forms-Alphabetic-List/I-L

Link to SOC Forms: http://www.cdss.ca.gov/inforesources/Forms-Brochures/Forms-Alphabetic-List/Q-T

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

ADOPT

COMMUNITY CARE LICENSING DIVISION
HOME CARE SERVICES BUREAU

HOME CARE ORGANIZATION SUBOFFICE REQUEST

This form must be completed by all Home Care Organizations who wish to operate a suboffice. One form must be submitted for each suboffice location. A suboffice is defined in Section 90-000(s)(5) of the written directive and the administrative responsibilities are outlined in Section 90-030. If more space is required, attach additional sheet and please type or print clearly. For instructions on how to complete this form, refer to page two.

REQUEST TYPE

☐ Initial ☐ Renewal ☐ Change of Ownership ☐ Update

A. HOME CARE ORGANIZATION INFORMATION

HOME CARE ORGANIZATION NAME			HOME CARE ORGANIZATION NUMBER
HOME CARE ORGANIZATION ADDRESS	CITY	STATE	ZIP CODE
LICENSEE NAME(S)			AREA CODE/TELEPHONE ( )

B. SUBOFFICE INFORMATION

STREET ADDRESS	CITY	STATE	ZIP CODE

OPERATING DAYS AND OPERATING HOURS (no more than 24 hours within a seven calendar-day period)

C. SUBOFFICE DESIGNEE

DESIGNEE NAME(S)	DESIGNEE(S) TITLE

D. QUESTIONS (if more space is needed, please attach a separate sheet.)

1. What is the primary purpose for the suboffice?

2. How will the Home Care Organization ensure the following:

a. No full-time staff

b. No permanently stored records with confidential client and/or Home Care Aide information

I DECLARE UNDER PENALTY OF PERJURY THAT THE STATEMENTS ON THIS FORM ARE CORRECT TO THE BEST OF MY KNOWLEDGE

HOME CARE ORGANIZATION LICENSEE SIGNATURE	COUNTY WHERE SIGNED	DATE

HOME CARE ORGANIZATION SUBOFFICE REQUEST INSTRUCTIONS:

Please type or print clearly and ensure that the form is filled out completely.

- Request Type: Check appropriate box.
- **Section A: Home Care Organization Information**
  - Home Care Organization Name: Enter the name used to designate the primary Home Care Organization.
  - Home Care Organization Number: Enter the Home Care Organization Number for the primary Home Care Organization.
  - Home Care Organization Address: Enter the physical location address of the Home Care Organization.
  - Licensee(s): Enter the name(s) of the person(s) or organization legally responsible for the primary Home Care Organization. Enter full names (Individuals enter first, middle name, and last name). Please enter the area code with telephone number of the Home Care Organization.
- **Section B: Suboffice Information**
  - Suboffice Address: Enter the physical location address of the suboffice.
  - Operating Days and Operating Hours: Enter the day and hours that the suboffice will be utilized. The suboffice cannot be used more than 24 hours within a seven calendar day time period.
- **Section C: Suboffice Designee**
  - Designee Name and Title: Please enter the name and title of person who will represent the suboffice.
- **Section D: Questions**

1. Please explain the primary purpose of the suboffice including how the Home Care Organization will utilize the suboffice.

2a. Please describe how the Home Care Organization will ensure that staff is not present at the suboffice full-time (no more than 24 hours within a seven calendar day time period).

2b. Please describe how the Home Care Organization will ensure that confidential records containing client, staff, volunteer, or Home Care Aide personal identifying information will not be permanently stored at the suboffice.

ADOPT

State of California – Health and Human Services Agency

California Department of Social Services

HOME CARE AIDE REGISTRATION RENEWAL

Please type or print clearly. Please ensure that you include a check or money order in the amount of $35.00 payable to the California Department of Social Services. Mail this completed application and a check or money order to: The California Department of Social Services, Home Care Services Bureau, 744 P Street, MS T8-3-90, Sacramento, CA 95814. **Your renewal application and fee must be postmarked on or before your expiration date or your registration will be forfeited.**

Name (Last, First, Middle):	Per ID#:

☐ **I wish to renew my home care aide registration. I have included my $35.00 renewal fee by check or money order.**

☐ **I do not wish to renew my home care aide registration. I hereby relinquish my registration. The relinquishment date will reflect the date this letter is received by the Home Care Services Bureau (if postmarked on or before my expiration date).**

If your address, email address, or telephone numbers have changed, please update your information below:

RESIDENCE ADDRESS:

Street Address:				Apt:
City:	State:	Zip Code:	County:	

MAILING ADDRESS (If different than above):

P.O. Box/Street Address:				Apt:
City:	State:	Zip Code:	County:	

E-MAIL (Voluntary):	**TELEPHONE NUMBERS:**	
	Day:	Evening:

If you need to change your name, you must submit a Home Care Aide Registry Request for Name/Address Change (HCS 105) to the address listed above. You can obtain this form at: http://www.cdss.ca.gov/cdssweb/entres/forms/English/HCS105.pdf.

Please note, you are required to notify the Department of Social Services within ten (10) days of an address change or your registration may be forfeited.

I declare under penalty of perjury that the statements on this form are correct to the best of my knowledge.

Signature:	Date:

ADOPT

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

COMMUNITY CARE LICENSING DIVISION HOME CARE SERVICES BUREAU

APPLICATION FOR HOME CARE AIDE REGISTRATION

Please type or print clearly. For instructions on how to complete this form refer to page two. Please ensure that you include a check or money order in the amount of $25.00 payable to the California Department of Social Services and complete LiveScan form (LIC 9163) and submit fingerprints. Mail this completed application, the complete Criminal Record Statement (LIC 508) and a check or money order to: The California Department of Social Services, Home Care Services Bureau 744 P Street, MS T8-3-90, Sacramento, CA 95814.

☐ **New Application** ☐ **Renewal Application**

For Department Use Only	
LIC 508 FILED WITH APPLICATION? ☐ YES ☐ NO	
FEES INCLUDED? ☐ YES ☐ NO	AMOUNT

1. NAME

LAST:	FIRST:	MIDDLE:

2. LIST ALL OTHER NAMES YOU HAVE EVER USED, SUCH AS MAIDEN OR ALIASES (AKAs)

3. RESIDENCE ADDRESS

STREET:	APT:	CITY:	STATE:	ZIP:	COUNTY:

4. MAILING ADDRESS (If Different):

P.O. BOX/STREET:	APT:	CITY:	STATE:	ZIP:	COUNTY:

5. E-MAIL (Voluntary)	6. DATE OF BIRTH	7. SEX

8. SOCIAL SECURITY NUMBER (Voluntary)	9. DRIVERS LICENSE NUMBER/IDENTIFICATION CARD NUMBER

10. TELEPHONE NUMBERS

DAY:	EVENING:

TRANSFER PROCESS

11. Are you currently registered on TrustLine Registry Program, or licensed by or working in a facility that is licensed by the California Department of Social Services, Community Care Licensing Division? ☐ YES ☐ NO If YES, please list below.

    11a. Please provide the Personnel ID (Per ID) number _____

12. Do you want to transfer your background clearance from TrustLine Registry Program or Community Care Licensing facility to the Home Care Aide Registry? ☐ YES ☐ NO If YES, please list below.

    Please note: If you elect to transfer, fingerprints are not required; however, you must provide a photocopy of your ID with this application.

    12a. Please enter the TrustLine Registry number or facility number transferring from:

HOME CARE ORGANIZATION AFFILIATION

13. Are you currently affiliated to or applying to become affiliated with a Home Care Organization? ☐ YES ☐ NO If YES, please list below.

Home Care Organization Name	Home Care Organization Number
Home Care Organization on the LiveScan form:	

I DECLARE UNDER PENALTY OF PERJURY THAT THE STATEMENTS ON THIS FORM ARE CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE	DATE

Federal law (at Title 5 United States Code Section 552a Note) states that: Any federal, state, or local government agency which requests an individual to disclose his social security account number shall inform that individual whether that disclosure is mandatory or voluntary, by what statutory or other authority such number is solicited, and what uses will be made of it.

APPLICATION FOR HOME CARE AIDE REGISTRATION INSTRUCTIONS

To become listed on the Home Care Aide Registry, you must complete and mail the attached application (HCS 100) and the Criminal Record Statement (LIC 508) and a check or money order to the address listed on the top of the application form. You will also need to complete the LiveScan form (LIC 9163) and submit fingerprints. If you are applying as an Independent Home Care Aide, please contact the Home Care Services Bureau at (916) 657-3570 to obtain the Home Care Aide Registry facility number for LiveScan fingerprinting.

For the application type, please check the appropriate box.

1. Print your full legal name and do not use nicknames.
   - **NOTE:** It is recommended you use the name that is on your ID card. If your ID lists your maiden name but you are using a married name, use the married name as the main name and maiden name as the AKA.
2. List all other names you have ever used.
   - **NOTE:** This includes aliases such as 'Beth' if used as a legal name.
3. Print your complete residence address.
   - **NOTE:** City names must be spelled out. Abbreviated city names will not be accepted.
4. Print your complete mailing address, if different than residence address.
   - **NOTE:** Once you are registered, failure to notify the Home Care Registry Program of a change of mailing address within 10 days will result in forfeiture of your registration.
5. Please list your email address.
6. Please list your date of birth in MM/DD/YY format.
   - **NOTE:** You must be 18 years of age or older to apply to be listed on the Home Care Aide Registry.
7. Please list "M" for male or "F" for female.
8. Print your Social Security Number.
   - **NOTE:** Pursuant to the Federal Privacy Act (P.L. 93-579) and the Information Practices Act of 1977 (Civil Code Sections 1798 et seq.) notice is given for the request of your Social Security Number (SSN) on this form. The requested SSN is voluntary; however, failure to provide the SSN may delay the processing of this form and the criminal record check. The law requires that you complete a background check (Health and Safety Code Section 1796.24). The Department will create a file concerning your criminal background check that will contain certain documents, including information that you provide. You have a right to access certain records containing your personal information maintained by the Department (Civil Code Section 1798 et seq.). Under the California Public Records Act and the Freedom of Information Act, the Department may have to provide copies of some of the records in the file to members of the public who ask for them, including newspaper and television reporters.
9. Print your ID number, which is required.
   - **NOTE:** You must list one of these four IDs: California Driver's License; California ID card; Permanent Resident Card; or a numbered, picture ID issued from a state other than California. If the application only has a Social Security Number without one of these four acceptable IDs, it will be returned.
10. List a daytime and evening telephone number.

Transfer Process

If you are currently licensed by the Community Care Licensing Division, working in a facility/ Home Care Organization licensed by the Community Care Licensing Division, or registered with the TrustLine Registry Program, you may be eligible to transfer your background clearance.

11. Please check the appropriate box.

11a. Please list your Personnel Identification number (Per ID).

12. Please check the appropriate box. If you check "YES" fingerprints are not required. Please submit the completed Application for Home Care Aide Registration (HCS 100), the Criminal Record Statement (LIC 508) along with a photocopy of your ID to the address listed on the top of the page.

12a. If you check "YES" please enter the TrustLine Registry number or facility number transferring from:
   - **NOTE:** If you have marked "YES" fingerprints are not required.

Home Care Organization Affiliations

13. Please check the appropriate box. If "YES", list home care organization information in this section. To affiliate to additional home care organizations, a transfer request may be submitted only after your application has been approved.
   - **NOTE:** Ensure that the Home Care Organization Name and Number listed on the first row matches the Home Care Organization Name and Number on the LiveScan form.

Signature Block

You must sign and date the application. If your signature or the date is missing, the application will be returned as incomplete.

Have you remembered the following?

- ☑ Used exactly the same name on the application form (HCS 100) and page one (1) of the Criminal Record Statement (LIC 508)?
- ☑ Included the appropriate ID number (i.e. California Driver's License)?
- ☑ Submitted your fingerprints through Live Scan?
- ☑ Signed and dated the application?
- ☑ Included a check or money order as payment of fees?
- ☑ Completed, signed, and dated the Criminal Record Statement (LIC 508)?

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

ADOPT

COMMUNITY CARE LICENSING DIVISION
HOME CARE SERVICES BUREAU

APPLICATION FOR A HOME CARE ORGANIZATION LICENSE

FOR DEPARTMENT USE ONLY

HOME CARE ORGANIZATION NUMBER: _____

COUNTY: _____

REPLY TO:

1. APPLICANT(S) NAME(S) (PLEASE PRINT)

2. REQUESTED ACTION (CHECK ONE)
   - ☐ A. INITIAL APPLICATION
   - ☐ B. APPLICATION RENEWAL
   - ☐ C. CHANGE OF LOCATION
   - ☐ D. CHANGE WITHIN CORPORATION
   - ☐ E. OTHER (specify)

3. APPLICANT MAILING ADDRESS	CITY	STATE	ZIP CODE	AREA CODE/TELEPHONE ( )

4. **APPLICATION FILED BY:** ☐ A. INDIVIDUAL ☐ B. PARTNERSHIP ☐ C. NON PROFIT CORPORATION ☐ G. LIMITED LIABILITY CORPORATION ☐ D. PROFIT CORPORATION ☐ E. COUNTY ☐ F. OTHER PUBLIC AGENCY

5. HOME CARE ORGANIZATION NAME	EMAIL ADDRESS	AREA CODE/TELEPHONE ( )

6. HOME CARE ORGANIZATION STREET ADDRESS	CITY	COUNTY	ZIP CODE	ALT. PUBLIC TELEPHONE ( )
7. HOME CARE ORGANIZATION MAILING ADDRESS	CITY		STATE	ZIP CODE
8. DESIGNEE OF HOME CARE ORGANIZATION	TITLE		9. TOTAL NUMBER OF HOME CARE AIDES	

10. BUSINESS OFFICE HOURS:

11. PROPERTY OWNERSHIP: ☐ OWN ☐ RENT ☐ OTHER (SPECIFY)

11A. NAME, ADDRESS AND PHONE NUMBER OF PROPERTY OWNER, IF RENTING OR LEASING:

12. WAS THIS HOME CARE ORGANIZATION PREVIOUSLY LICENSED? ☐ YES ☐ NO

IF YES, HOME CARE ORGANIZATION NAME AND LICENSE NUMBER:

13. IF CURRENTLY OPERATING ANY COMMUNITY CARE FACILITY, RESIDENTIAL CARE FACILITY, RESIDENTIAL CARE FACILITY FOR THE ELDERLY, RESIDENTIAL CARE FACILITY FOR PERSONS WITH CHRONIC LIFE-THREATENING ILLNESS, CHILD DAY CARE FACILITY, DAY CARE CENTER, FAMILY DAY CARE HOME, EMPLOYER-SPONSORED CHILD CARE CENTER, OR HOME CARE ORGANIZATION, PLEASE ENTER THE INFORMATION BELOW:

	FACILITY/HOME CARE ORGANIZATION NAME	FACILITY/HOME CARE ORGANIZATION NUMBER
A.		
B.		
C.		
D.		

14. *HOME CARE ORGANIZATION APPLICANT(S)/HOME CARE ORGANIZATION LICENSEE(S) RESPONSIBILITIES:*
   - a. *IN ADDITION TO COMPLYING WITH THE HEALTH AND SAFETY CODES AND REGULATIONS APPLICABLE TO LICENSING. I/WE UNDERSTAND THAT THERE MAY BE OTHER STATE, FEDERAL AND/OR LOCAL LAWS, WHICH ARE NOT ENFORCED BY THIS DEPARTMENT THAT MAY NEED TO BE MET SUCH AS: ZONING, BUILDING, SANITATION AND LABOR REQUIREMENTS.*
   - b. *I/WE HAVE READ AND UNDERSTAND THE STATUTES, WRITTEN DIRECTIVES AND/OR REGULATIONS WHICH PERTAIN TO MY/OUR LICENSING CATEGORY PRIOR TO THE ISSUANCE OF MY/OUR LICENSE.*
   - c. *I/WE SHALL ENSURE THAT ALL PERSONS SUBJECT TO FINGERPRINT REQUIREMENTS SHALL HAVE A CALIFORNIA DEPARTMENT OF JUSTICE CLEARANCE OR A CRIMINAL RECORD EXEMPTION PRIOR TO EMPLOYMENT, RESIDENCE OR INITIAL PRESENCE IN THE ORGANIZATION AS REQUIRED.*
   - d. *I/WE SHALL OBTAIN APPROVAL FROM THE DEPARTMENT PRIOR TO MAKING ANY CHANGE(S) THAT AFFECTS THE TERMS OF THE LICENSE.*

15. *I/WE UNDERSTAND THAT I/WE HAVE THE RIGHT TO APPEAL ANY DECISION REGARDING THE DISPOSITION OF THIS APPLICATION.*

16. *I/WE DECLARE UNDER PENALTY OF PERJURY THAT THE STATEMENTS ON THIS APPLICATION AND ON THE ACCOMPANYING ATTACHMENTS ARE CORRECT TO THE BEST OF MY/OUR KNOWLEDGE.*

17. *I/WE AM/ARE AUTHORIZED TO SIGN THIS APPLICATION ON BEHALF OF THE NAMED APPLICANT.*

SIGNED _____ TITLE _____ COUNTY WHERE SIGNED _____ DATE _____

SIGNED _____ TITLE _____ COUNTY WHERE SIGNED _____ DATE _____

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

ADOPT

COMMUNITY CARE LICENSING DIVISION
HOME CARE SERVICES BUREAU

HOME CARE ORGANIZATION LICENSEE APPLICANT INFORMATION

This form must be completed by all applicants for a Home Care Organization license, (i.e., all individuals, each partner in a partnership, or chief executive officer or authorized representative in a corporation.) If more space is required, attach additional sheet. Please type or print clearly.

IDENTIFYING INFORMATION

NAME	SOCIAL SECURITY NUMBER (VOLUNTARY FOR I.D. ONLY)	SEX (M/F)	DATE OF BIRTH
TITLE	DRIVER'S LICENSE NUMBER/IDENTIFICATION CARD NUMBER	STATE ISSUED	ALIEN REGISTRATION CARD NUMBER
HOME ADDRESS			AREA CODE/TELEPHONE ( )

OTHER NAME(S) USED BY HOME CARE ORGANIZATION APPLICANT

PRIOR LICENSURE STATUS

STATUS OF DISCIPLINARY ACTIONS

A. HAVE YOU EVER BEEN REVOKED, DENIED, EXCLUDED, FORFEITED, OR HAD OTHER DISCIPLINARY ACTION TAKEN, OR ARE YOU IN THE PROCESS OF ACTION BEING TAKEN AGAINST A LICENSED CLINIC, HEALTH CARE FACILITY, COMMUNITY CARE FACILITY, RESIDENTIAL CARE FACILITY FOR PERSONS WITH CHRONIC LIFE-THREATENING ILLNESS, RESIDENTIAL CARE FACILITY FOR THE ELDERLY, CHILD DAY CARE FACILITY, DAY CARE CENTER, FAMILY DAY CARE HOME, EMPLOYER-SPONSORED CHILD CARE CENTER, OR HOME CARE ORGANIZATION? ☐ YES ☐ NO *IF YES, COMPLETE A1 – A5 BELOW.*

A1. NAME AND ADDRESS OF FACILITY/HOME CARE ORGANIZATION/LICENSED CLINIC	A2. EFFECTIVE DATES OF LICENSURE _____ TO _____	A3. FACILITY TYPE

A4. PLEASE EXPLAIN THE ACTIONS TAKEN?

A5. HOW WAS THE ACTION(S) RESOLVED?

STATUS OF LICENSE/REGISTRATION

B. DO YOU HAVE PRIOR OR PRESENT SERVICE AS AN ADMINISTRATOR, GENERAL PARTNER, CORPORATE OFFICER, OR DIRECTOR IN A COMMUNITY CARE FACILITY, RESIDENTIAL CARE FACILITY, RESIDENTIAL CARE FACILITY FOR THE ELDERLY, CHILD DAY CARE FACILITY, DAY CARE CENTER, FAMILY DAY CARE HOME, EMPLOYER-SPONSORED CHILD CARE CENTER, OR HOME CARE ORGANIZATION? ☐ YES ☐ NO *IF YES, COMPLETE B1 – B3 BELOW.*

B1. NAME AND ADDRESS OF FACILITY/HOME CARE ORGANIZATION	B2. EFFECTIVE DATES OF LICENSURE _____ TO _____	B3. FACILITY TYPE

C. HAVE YOU EVER HELD OR CURRENTLY HOLD A BENEFICIAL OWNERSHIP INTEREST OF 10% OR MORE IN A COMMUNITY CARE FACILITY, RESIDENTIAL CARE FACILITY, RESIDENTIAL CARE FACILITY FOR THE ELDERLY, CHILD DAY CARE FACILITY, DAY CARE CENTER, FAMILY DAY CARE HOME, EMPLOYER-SPONSORED CHILD CARE CENTER, OR HOME CARE ORGANIZATION? ☐ YES ☐ NO *IF YES, COMPLETE C1 – C3 BELOW.*

C1. NAME AND ADDRESS OF FACILITY/HOME CARE ORGANIZATION/LICENSED CLINIC	C2. EFFECTIVE DATES OF LICENSURE _____ TO _____	C3. FACILITY TYPE

D. HAVE YOU EVER BEEN REGISTERED WITH THE TRUSTLINE REGISTRY PROGRAM? ☐ YES ☐ NO

BUSINESS EXPERIENCE

A. HAVE YOU WORKED IN THE HOME CARE SERVICES INDUSTRY WITHIN THE LAST FIVE (5) YEARS? ☐ YES ☐ NO *IF YES, PLEASE COMPLETE THE FOLLOWING:*

B. HAVE YOU OWNED/CO-OWNED OR OPERATED ANY BUSINESS WITHIN THE LAST THREE (3) YEARS? ☐ YES ☐ NO *IF YES, PLEASE COMPLETE THE FOLLOWING:*

Name of Business	Number of Employees	Your Title	Date Started	Date Ended	Reason for Leaving
			/ /	/ /	
			/ /	/ /	
			/ /	/ /	
			/ /	/ /	

I DECLARE UNDER PENALTY OF PERJURY THAT THE STATEMENTS ON THIS FORM ARE CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE	COUNTY WHERE SIGNED	DATE

Federal law (at Title 5 United States Code Section 552a Note) states that: Any federal, state, or local government agency which requests an individual to disclose his social security account number shall inform that individual whether that disclosure is mandatory or voluntary, by what statutory or other authority such number is solicited, and what uses will be made of it.

ADOPT

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

COMMUNITY CARE LICENSING DIVISION
HOME CARE SERVICES BUREAU

DESIGNATION OF HOME CARE ORGANIZATION RESPONSIBILITY

Licensed Home Care Organizations are required to have a designee continuously present during operational hours to represent the Home Care Organization, perform administrative processes, and to accept licensing reports. Home Care Organization applicants/Home Care Organization licensees shall use this form to delegate the above authority to appropriate staff member(s). More than one staff member may be designated on this form. Home Care Organization applicants/Home Care Organization licensees who are corporations shall attach board resolutions authorizing this delegation.

DATE	HOME CARE ORGANIZATION NAME	HOME CARE ORGANIZATION NUMBER	
HOME CARE ORGANIZATION ADDRESS	CITY	STATE	ZIP CODE
COUNTY	AREA CODE/TELEPHONE ( )		

I understand my roles and responsibilities as a designee for the above-named Home Care Organization. I also understand that the Home Care Organization operation is governed by laws and regulations that are enforced by the California Department of Social Services.

PRINTED NAME OF DESIGNEES(s)	SIGNATURE OF DESIGNEES(s)

In the event of my absence I authorize the abovementioned person(s) to perform administrative processes on my behalf at the above-named Home Care Organization, including but not limited to: managing the Home Care Organization, responding to questions, receiving documents including reports of inspections and consultations, accusations, and civil penalties.

When delegating authority to appropriate staff, Home Care Organizations shall comply with statute and regulations.

I (We) shall notify the Department, in writing, within 10 calendar days of any change in the above authorization.

SIGNATURE OF HOME CARE ORGANIZATION APPLICANT/ HOME CARE ORGANIZATION LICENSEE				
NAME OF HOME CARE ORGANIZATION APPLICANT/ HOME CARE ORGANIZATION LICENSEE		TITLE		
MAILING ADDRESS	CITY	COUNTY	STATE	ZIP CODE

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

ADOPT

COMMUNITY CARE LICENSING DIVISION
HOME CARE SERVICES BUREAU

PARTNERSHIP/CORPORATION/LIMITED LIABILITY COMPANY ORGANIZATION STRUCTURE

(Page one (1) is for corporations and Limited Liability Companies only. Please see page two (2) for public agencies, partnerships, and other associations.)

IMPORTANT: This form must be updated and submitted to the Department each time there is a change in partners, officers or changes in the corporation or Limited Liability Company.

DATE
HOME CARE ORGANIZATION NAME
HOME CARE ORGANIZATION MAILING ADDRESS
HOME CARE ORGANIZATION NUMBER

I. CORPORATION/LIMITED LIABILITY COMPANY (LLC)

1. NAME *(AS FILED WITH THE SECRETARY OF STATE)*

2. CHIEF EXECUTIVE OFFICER OR EQUIVALENT

3. INCORPORATION/REGISTRATION DATE

4. PLACE OF INCORPORATION/REGISTRATION

5. CORPORATION/LIMITED LIABILITY COMPANY NUMBER

6. PLEASE ATTACH (1) A COPY OF ARTICLES OF INCORPORATION OR ORGANIZATION AND ANY AMENDMENTS (2) A COPY OF BY-LAWS OR OPERATING AGREEMENT AND ANY AMENDMENTS (3) A COPY OF RESOLUTION AUTHORIZING THE FILING OF THIS APPLICATION (FOR CORPORATIONS ONLY).

7. PRINCIPAL OFFICE OF BUSINESS | CITY | COUNTY | ZIP CODE

7a. CONTACT PERSON | TITLE | AREA CODE/TELEPHONE ( )

7b. AGENT FOR SERVICE OF PROCESS | ADDRESS

8. OUT OF STATE OR FOREIGN APPLICANTS COMPLETE THE FOLLOWING:

8a. NAME OF CALIFORNIA REPRESENTATIVE | MAILING ADDRESS | ZIP CODE | AREA CODE/TELEPHONE ( )

8b. PLEASE ATTACH A COPY OF A FOREIGN CORPORATION'S OR FOREIGN LIMITED LIABILITY COMPANY'S REGISTRATION TO DO BUSINESS IN CALIFORNIA.

9. NAMES AND ADDRESSES OF ALL PERSONS WHO HOLD A TEN PERCENT (10%) OR MORE BENEFICIAL OWNERSHIP INTEREST IN CORPORATION OR LIMITED LIABILITY COMPANY (ATTACH SHEET FOR ADDITIONAL SPACE). IF OWNERSHIP INTEREST IS INDIRECTLY HELD, PROVIDE A DIAGRAM SHOWING A CHAIN OF OWNERSHIP AND THE INTERESTS HELD AT EACH LEVEL.

NAME	PERCENTAGE HELD	ADDRESS

10. DIRECTORS (CORPORATION)/MANAGERS AND MANAGING MEMBERS (LIMITED LIABILITY COMPANY)

10a. NUMBER OF DIRECTORS/MANAGERS AND MANAGING MEMBERS | 10b. TERM OF OFFICE (IF APPLICABLE) | 10c. FREQUENCY OF MEETINGS (IF APPLICABLE)

10d. METHOD OF SELECTION (CORPORATIONS ONLY)

11. OFFICERS (FOR LLCs WITHOUT OFFICERS, SKIP NUMBERS 11 - 12 AND GO TO SECTION II)

OFFICE	NAME	PRINCIPAL OFFICE OF BUSINESS ADDRESS (OTHER THAN HOME CARE ORGANIZATION ADDRESS)	AREA CODE/TELEPHONE	TERM EXPIRATION DATE
PRESIDENT/CHAIRMAN			( )	
VICE PRESIDENT			( )	
SECRETARY			( )	
TREASURER			( )	
CHIEF EXECUTIVE OFFICER/EXECUTIVE DIRECTOR			( )	

12. LIST ALL DIRECTORS (CORPORATION)/MANAGERS AND MANAGING MEMBERS (LIMITED LIABILITY COMPANY). ATTACH SHEET FOR ADDITIONAL SPACE.

NAME	MAILING ADDRESS (OTHER THAN HOME CARE ORGANIZATION ADDRESS)	AREA CODE/TELEPHONE	TERM EXPIRATION DATE
		( )	
		( )	
		( )	
		( )	
		( )	
		( )	
		( )	
		( )	
		( )	

II. PUBLIC AGENCY

1. CHECK TYPE OF PUBLIC AGENCY ☐ FEDERAL ☐ STATE ☐ COUNTY ☐ CITY ☐ OTHER (SPECIFY BELOW)

2. AGENCY PROVIDING SERVICES

2a. AGENCY NAME	ADDRESS	CITY	STATE	ZIP CODE

2b. MAILING ADDRESS (IF DIFFERENT FROM ABOVE)

3. DISTRICT OR AREA TO BE SERVED (ATTACH MAP IF NECESSARY)

4. PLEASE ATTACH A COPY OF RESOLUTION OR LEGAL DOCUMENT AUTHORIZING THIS APPLICATION

III. PARTNERSHIPS

1ST GENERAL PARTNER	NAME		AREA CODE/TELEPHONE ( )	
	PRINCIPLE BUSINESS ADDRESS (OTHER THAN HOME CARE ORGANIZATION ADDRESS)	CITY	STATE	ZIP CODE
2ND GENERAL PARTNER	NAME		AREA CODE/TELEPHONE ( )	
	PRINCIPLE BUSINESS ADDRESS (OTHER THAN HOME CARE ORGANIZATION ADDRESS)	CITY	STATE	ZIP CODE
3RD GENERAL PARTNER	NAME		AREA CODE/TELEPHONE ( )	
	PRINCIPLE BUSINESS ADDRESS (OTHER THAN HOME CARE ORGANIZATION ADDRESS)	CITY	STATE	ZIP CODE
4TH GENERAL PARTNER	NAME		AREA CODE/TELEPHONE ( )	
	PRINCIPLE BUSINESS ADDRESS (OTHER THAN HOME CARE ORGANIZATION ADDRESS)	CITY	STATE	ZIP CODE
5TH GENERAL PARTNER	NAME		AREA CODE/TELEPHONE ( )	
	PRINCIPLE BUSINESS ADDRESS (OTHER THAN HOME CARE ORGANIZATION ADDRESS)	CITY	STATE	ZIP CODE

CONTACT PERSON	TITLE	AREA CODE/TELEPHONE
		( )

IV. OTHER ASSOCIATIONS

OTHER ASSOCIATES MUST ALSO PROVIDE, AND ATTACH TO THIS FORM, A SIMILAR LIST OF PERSONS LEGALLY RESPONSIBLE FOR THE ORGANIZATION, CONTACT PERSON, AND APPROPRIATE LEGAL DOCUMENTS WHICH SET FORTH LEGAL RESPONSIBILITY OF THE ORGANIZATION AND ACCOUNTABILITY FOR OPERATING THE HOME CARE ORGANIZATION.

ADOPT

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

COMMUNITY CARE LICENSING DIVISION
HOME CARE SERVICES BUREAU

HOME CARE ORGANIZATION DISHONESTY BOND

(Original sent to the Home Care Services Bureau at 744 P Street, M.S. T8-3-90, Sacramento, CA 95814)

HOME CARE ORGANIZATION APPLICANT/LICENSEE ("LICENSEE") NAME			
HOME CARE ORGANIZATION APPLICANT/LICENSEE MAILING ADDRESS	CITY	STATE	ZIP CODE
SURETY COMPANY		AREA CODE/TELEPHONE ( )	
SURETY COMPANY ADDRESS	CITY	STATE	ZIP CODE
LOCAL AGENT NAME		AREA CODE/TELEPHONE ( )	
HOME CARE ORGANIZATION NAME (If doing business in name other than that of Applicant/Licensee above)			
HOME CARE ORGANIZATION ADDRESS (If different from that of Applicant/Licensee)	CITY	STATE	ZIP CODE
HOME CARE ORGANIZATION NUMBER (IF APPLICABLE)			

BE IT KNOWN THAT:

Licensee, as Principal, and Bonding Company, as Surety, are held and firmly bound to the State of California for the use and benefit of Licensee's clients or members of their household (collectively referred to as "Clients"). In the amount of _____, for the payment of which the Principal and Surety bind themselves, their respective heirs, successors and assigns, jointly and severally;

WHEREAS Health and Safety Code Sections 1796.37(a)(4) and 1796.42(d) require certain applicants for license as a Home Care Organization to maintain a bond against employee dishonesty that incudes third party coverage; and

WHEREAS the Licensee has applied to operate a Home Care Organization;

NOW, THEREFORE, the Surety is liable on this bond in the event that any Clients are damaged by any dishonest or fraudulent act, including but not limited to theft, embezzlement, conversion or common law fraud or deceit by Principal or the Principal's employees.

Any Clients of the Principal, damaged as a result of the dishonest or fraudulent acts of the Principal or the Principal's employees, may file a claim with the Surety or bring an action in a proper court on the bond for the amount of damages suffered thereby to the extent covered by the bond.

Regardless of the number of years this bond is in effect, the number of licensee renewal terms, the number of premiums paid, or the number of claims made, the Surety's aggregate liability shall not be more than the penal sum of this bond.

This bond may be canceled by the Surety in accordance with Code of Civil Procedure section 996.330, and notice of cancellation must be sent in accordance with Code of Civil Procedure section 996.320 to the attention of the California Department of Social Services, Home Care Services Bureau. This bond is effective as of (Date) _____, and remains in effect as long as the license is valid.

I certify under penalty of perjury under the laws of the State of California.

SURETY COMPANY SIGNATURE	BOND NUMBER	DATE
NAME OF ATTORNEY IN FACT FOR SURETY COMPANY	SIGNATURE OF ATTORNEY IN FACT FOR SURETY COMPANY	
PRINCIPAL	SIGNATURE OF PRINCIPAL	DATE

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

ADOPT

COMMUNITY CARE LICENSING DIVISION
HOME CARE SERVICES BUREAU

PERSONNEL RECORD

(Form to be kept current at all times)

FOR HOME CARE ORGANIZATION (HCO) USE ONLY
HCO NUMBER
HCO ADDRESS
DATE OF EMPLOYMENT
DATE OF SEPARATION

PERSONAL

NAME (LAST FIRST MIDDLE)

AREA CODE/TELEPHONE ( )

ADDRESS

DATE OF BIRTH

SOCIAL SECURITY NUMBER: (VOLUNTARY FOR ID ONLY)

DATE OF TB TEST UPON HIRE

RESULTS OF LAST TB TEST

ADDITIONAL TB TEST DATES (PLEASE INCLUDE TEST RESULTS)

PLEASE LIST ANY ALTERNATE NAMES USED (FOR EXAMPLE- MAIDEN NAME)

DO YOU POSSESS A VALID CALIFORNIA DRIVER'S LICENSE? ☐ YES ☐ NO CDL NUMBER:

POSITION INFORMATION

TITLE OF POSITION

EMPLOYMENT

(List most recent experience first. If additional space is needed, please attach a separate page.)

NAME AND ADDRESS OF EMPLOYER	AREA CODE/ TELEPHONE	JOB TITLE AND TYPE OF WORK	REASON FOR LEAVING	DATES	
				FROM	TO
	( )				
	( )				
	( )				
	( )				
	( )				

Notes:

I hereby certify under penalty of perjury that I am 18 years of age or older and that the above statements are true and correct. I give my permission for any necessary verification.

EMPLOYEE SIGNATURE

DATE

ADOPT

BOARD OF DIRECTOR STATEMENT

IMPORTANT– Before completing this page, please read the Application Instructions for a Home Care Organization License (HCS 281).

Licensees are required to provide evidence that every member of the board of directors understands his or her legal duties and obligations as a member of the board of directors and that the Home Care Organization's operation is governed by the laws and regulations that are enforced by the Department.

All members of the board of directors and prospective members of the board are required to read, complete, and sign the statement below as a condition of licensure.

I have read and understand my legal duties and obligations as a member or prospective member of the board of directors and I also understand that the Home Care Organization's operation is governed by laws and regulations that are enforced by the California Department of Social Services.

I declare that I have received a copy and I have read and understand the information contained in the Health and Safety Code Division 2, Chapter 13. I have also received a copy and have read the written directives released while the Department is finalizing the California Code of Regulations Title 22, Division 6, Chapter 10.

1. HOME CARE ORGANIZATION NAME		2. HOME CARE ORGANIZATION NUMBER	
3. BOARD MEMBER/PROSPECTIVE BOARD MEMBER NAME (Print Clearly)		4. AREA CODE/TELEPHONE) ( )	
5. BOARD MEMBER/PROSPECTIVE BOARD MEMBER HOME ADDRESS	6. CITY	7. STATE	8. ZIP CODE
9. SIGNATURE		10. DATE	

Note: Boards of directors should ensure that they are informed of law and regulation changes.

ADOPT

REFERENCE REQUEST FOR: _____

To operate or work in facility type: _____

You must enter your full name and facility type before you give this form to your reference for completion.

The above named person has applied to operate, work or reside in a community care facility serving the client group indicated above. This person has selected you to write a reference statement on his/her behalf. **If you work at the facility, are a client of the facility, or are related to this person in any way, you may not complete this reference statement.**

Please complete the entire form. Your honest reply will help us ensure high quality care in our licensed facilities.

Your Name: _____

Street Address: _____

City _____ State _____ Zip _____

Day Time Telephone Number: (_____) _____

1. How long have you known the person you are writing this reference for? _____

2. How do you know this person? _____

REFERENCE REQUEST FOR: _____

3. Please give your opinion of this person's character. _____

4. Please describe any interaction you have observed between this person and the client group he/she is requesting to work with. For example: Clients may be children, developmentally disabled children or adults, mentally impaired adults, or elderly. _____

5. Please add any comments you feel are relevant about this person and his/her desire to work in a community care facility. _____

PRINT YOUR NAME	YOUR SIGNATURE	DATE

ADOPT

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

PERSONNEL REPORT

INSTRUCTIONS: *This form is intended for keeping a current roster of all the facility personnel, other adults and licensees residing in the facility, including backup persons, volunteers and licensee if administrator/director. Show license/certificate number if applicable for specialized staff [e.g., Social Worker and other consultant(s)]. Show coverage for twenty-four hour supervision in residential facilities. Report any changes in personnel to the licensing agency as required by regulations. Send original to Licensing Agency and retain copy in facility file.*

NAME OF FACILITY	FACILITY TYPE	FACILITY NUMBER
PREPARED BY		DATE

A. **STAFF SUBJECT TO CRIMINAL BACKGROUND CHECK REQUIREMENTS:** The following staff members are subject to a criminal background check pursuant to Sections 1522, 1568.09, 1569.17 and 1596.871 of the Health and Safety Code. A California background clearance or a criminal record exemption shall be obtained prior to employment, residence or initial presence in the facility.

NAME	DATE EMPL'D	JOB TITLE	SPECIFY DAYS AND HOURS ON DUTY			SPECIFY DAYS AND HOURS ON DUTY			SPECIFY DAYS AND HOURS ON DUTY		
			DAYS	FROM	TO	DAYS	FROM	TO	DAYS	FROM	TO
Licensee/Administrator											

B. STAFF EXEMPT FROM CRIMINAL BACKGROUND CHECK REQUIREMENTS: The following are believed exempt from criminal background check requirements pursuant to Sections 1522, 1568.09, 1569.17 and 1596.871 of the Health and Safety Code. The licensee or designated representative shall sign below to verify that he or she believes the indicated persons are exempt from criminal background check requirements pursuant to statute.

Signature _____ Date _____

NAME	DATE EMPL'D	JOB TITLE	SPECIFY DAYS AND HOURS ON DUTY			SPECIFY DAYS AND HOURS ON DUTY			SPECIFY DAYS AND HOURS ON DUTY		
			DAYS	FROM	TO	DAYS	FROM	TO	DAYS	FROM	TO

ADOPT

CRIMINAL RECORD STATEMENT

State law requires that persons associated with licensed facilities or Home Care Aide Registry applicants be fingerprinted and disclose any conviction. A conviction is any plea of guilty or nolo contendere (no contest) or a verdict of guilty. The fingerprints will be used to obtain a copy of any criminal history you may have.

Have you ever been convicted of a crime in California ? . . . . . ☐ YES ☐ NO

You need not disclose any marijuana-related offenses covered by the marijuana reform legislation codified at Health and Safety Code sections 11361.5 and 11361.7.

Have you ever been convicted of a crime from another state, federal court, military or jurisdiction outside of U.S.? . . . . . ☐ YES ☐ NO

Criminal convictions from another State or Federal court are considered the same as criminal convictions in California.

If you answer YES, give details on the back of this page indicating the nature and circumstances of each crime and the date and the location in which each crime occurred.

You must disclose convictions, including reckless and drunk driving convictions even if:

1. It happened a long time ago;
2. It was only a misdemeanor;
3. You didn't have to go to court (your attorney went for you);
4. You had no jail time or the sentence was only a fine or probation;
5. You received a certificate of rehabilitation;
6. The conviction was later dismissed, set aside or the sentence was suspended.

NOTE: IF THE CRIMINAL BACKGROUND CHECK REVEALS ANY CONVICTION(S) THAT YOU DID NOT DISCLOSE ON THIS FORM, YOUR FAILURE TO DISCLOSE THE CONVICTION(S) WILL RESULT IN AN EXEMPTION DENIAL, LICENSE APPLICATION DENIAL, LICENSE REVOCATION, OR EXCLUSION FROM A LICENSED FACILITY/ORGANIZATION.

I declare under penalty of perjury under the laws of the State of California that I have read and understand the information contained in this affidavit and that my responses and any accompanying attachments are true and correct.

FACILITY/ORGANIZATION NAME		FACILITY/ORGANIZATION NUMBER	
YOUR NAME *(PRINT CLEARLY)*	YOUR ADDRESS	CITY	ZIP
SOCIAL SECURITY NUMBER *(SEE PRIVACY STATEMENT ON REVERSE SIDE)*	DATE OF BIRTH	DMV LICENSE NUMBER	
SIGNATURE		DATE	

I. Instructions to Respondents:

If you have been convicted of a crime in California, another state or in federal court, provide the following information:

(You need not disclose any marijuana-related offenses covered by the marijuana reform legislation codified at Health and Safety Code sections 11361.5 and 11361.7.)

What was the offense? _____

_____

_____

_____

In which state and city did you commit the offense? _____

_____

_____

When did this occur? _____

_____

_____

Tell us what happened. (Use additional sheets of paper if needed) _____

_____

_____

_____

_____

_____

I certify under penalty of perjury that the above information is true and correct to the best of my knowledge.

Signature _____ ***Date*** _____

II. Instructions to Licensees:

If the person discloses a criminal conviction, review the person's statement and discuss it with your Licensing Program Analyst (LPA). Maintain this form in your facility/organization personnel file and send a copy to your LPA.

PRIVACY STATEMENT

Pursuant to the Federal Privacy Act (P.L. 93-579) and the Information Practices Act of 1977 (Civil Code section 1798 et seq.), notice is given for the request of the Social Security Number (SSN) on this form. The California Department of Justice uses a person's SSN as an identifying number. The requested SSN is voluntary. Failure to provide the SSN may delay the processing of this form and the criminal record check.

In order to be licensed, work at, or be present at, a licensed facility/organization, the law requires that you complete a criminal background check. (Health and Safety Code sections 1522, 1568.09, 1569.17, 1596.871, and 1796.19). The Department will create a file concerning your criminal background check that will contain certain documents, including information that you provide. You have the right to access certain records containing your personal information maintained by the Department (Civil Code section 1798 et seq.). Under the California Public Records Act, the Department may have to provide copies of some of the records in the file to members of the public who ask for them, including newspaper and television reporters.

NOTE: IMPORTANT INFORMATION
The Department is required to tell people who ask, including the press, if someone in a licensed facility/organization has a criminal record exemption. The Department must also tell people who ask, the name of a licensed facility/organization that has a licensee, employee, resident, or other person with a criminal record exemption.

If you have any questions about this form, please contact your local licensing regional office.

ADOPT

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

REQUEST FOR LIVE SCAN SERVICE - COMMUNITY CARE LICENSING

Applicant Submission

1. ORI: **A0448**

2. Working Title: *(Check ✔ one)*
☐ Adult Resident other than Client ☐ Employee ☐ License, Certification, Applicant ☐ Volunteer ☐ Home Care Aide Registry Applicant

3. Authorized Applicant Type - Enter from list on Page 2, "DOJ Abbreviated CCLD Facility/Organization Type."

4. Agency Address Set Contributing Agency:

CA Dept of Social Services
Agency authorized to receive criminal history information

03502
Mail Code *(five-digit code assigned by DOJ)*

PO BOX 94244 — Street No.
Mail Station 9-15-62 — Street or PO Box

N/A
Contact Name *(Mandatory for all school submissions)*

Sacramento, — City
CA — State
94244-2430 — Zip Code

( ) **N/A**
Contact Telephone No.

5. Applicant Information:

Name of Applicant: *(Please print)* _____ LAST _____ FIRST _____ MI

AKA's: _____ LAST _____ FIRST

CDL No. _____

DOB: _____ SEX: ☐ Male ☐ Female

Misc. No. BIL - _____ AGENCY BILLING NUMBER *(IF APPLICABLE)*

HT: _____ WT: _____

Misc. No.: _____ PERMANENT RESIDENT (I-551), OUT OF STATE DRIVER'S LICENSE OR I.D.

EYE Color: _____ HAIR Color: _____

Home Address: *(All applicants must complete)*

POB: _____

_____ STREET OR PO BOX

SOC: _____
(See Privacy Statement on Page 4)

_____ CITY, STATE AND ZIP CODE

6. Facility/Organization Number: _____ Level of Service ☑ DOJ ☑ FBI

If resubmission for fingerprint quality (select R2), list Original ATI No. _____

7. Employer: *(Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)*

Employer Name

Street No. — Street or PO Box

Mail Code *(five digit code assigned by DOJ)*

City — State — Zip Code

Agency Telephone No. *(Optional)*

8.

Live Scan Transaction Completed By: _____ Name of Operator _____ Date _____

Transmitting Agency — LSID# — ATI No. — Amount Collected/Billed

GUIDELINES FOR COMMUNITY CARE LICENSING (CCLD) APPLICANTS WHO USE A LIVE SCAN SITE (CCLD or DOJ SITE) FOR FINGERPRINTING
Instructions for the LIC 9163

1. **Originating Response Indicator (ORI):** Preprinted

2. **Working Title:** Check the appropriate box

3. **Authorized Applicant Type:** Indicate the facility type where you will be working.

   Select your licensed facility type from the left column, and in the right column find its corresponding DOJ abbreviated facility type. **Enter the corresponding DOJ abbreviated facility type on this line.**

Note: In the following table you may be able to identify yourself with more than one facility type within each category. Please select only one facility type in any category using the facility that you are most associated with on a day-to-day basis.

If this is your applicable facility type ⇨ **Enter this abbreviated facility type on your application.**

CCLD Facility Type by Category	DOJ Abbreviated CCLD Facility Type
Home Care Aide	Home Care Aide
Home Care Organization	Home Care Organization
Adult Day Care Facility Adult Day Support Center Adult Residential Facility Social Rehabilitation Facility	Adult Day/Resident/Rehab
Child Care Center Infant Center Mildly Ill Center School Age Child Care Center	Day Care Center more/6 Child
Family Child Care Home	Family Day Care
Foster Family Agency Foster Family / Adoptions Agency Foster Family Agency Sub Office	Foster Family/Adopt Employment
Foster Family Agency - Certified Home Foster Family Home	Foster Family Home
Group Home (6 or less children)	Group Home 6/child less
Group Home (7 or more) Community Treatment Facility	Group Home more/6 child
Residential Care Facility for the Chronically Ill Residential Care Facilities for the Elderly	Residential Care Facility Elderly
Small Family Home Transitional Housing Placement Program	Residential Child Care 6/less

4. **Agency Address Set Contributing Agency:**

Agency authorized to receive criminal history information:
The following information is pre-printed:
Agency: CA Dept of Social Services **Mail Code:** 03502

Street No.: P.O. BOX 94244, M.S. 9-15-62 **Contact Name:** N/A

City, State, Zip: Sacramento, CA 94244-2430 **Contact Telephone No.:** N/A

5. **Applicant Information:** Print your full name (last, first, middle initial).

AKA's: Other names the applicant has used **CDL No:** CA Drivers License or CA ID

DOB: Date of Birth **SEX:** Male or Female **MISC No: BIL -** Enter the agency billing number, if applicable

HT: Height **WT:** Weight **MISC No.:** Enter any other identification numbers (PERMANENT RESIDENT, OUT OF STATE DRIVER'S LICENSE OR I.D.)

EYE Color: Color of eyes **HAIR Color:** Color of hair **Home Address:** Applicant's home address

POB: State or Country of Birth

SOC: Social Security Number (optional) (See Privacy Statement on Page 4)

6. **Facility Number:** Enter the facility number or assigned OCA number (Agency Identifying Number).

Level of Service: Preprinted
Note: If a Child Abuse Central Index (CACI) check is required, it will automatically be completed by DOJ and all applicable fees will be charged. There is no entry necessary on the applicant's part.

If resubmission for fingerprint quality, list Original Applicant Tracking Information (ATI) No.: If your fingerprints were rejected and this is a resubmission of your prints, enter the original ATI number provided on the reject notice to avoid paying an additional processing fee.

7. **Employer:** Enter the facility name and address for which you are being printed.

Employer Name:	Enter the facility/organization name.
Street No.:	Enter the facility/organization address.
Mail Code:	Enter the facility/organization mail code (if applicable).
City, State, Zip:	Enter the facility/organization city, state and zip.
Agency Telephone No.:	Enter the facility/organization phone number.

8. **Live Scan Transaction Completed By:** This section will be completed by the Live Scan operator.

Take two copies of this form with you the day you are fingerprinted. The Live Scan Operator will complete section 8. One copy will be retained by the Operator and the other you may retain for your records.

PRIVACY STATEMENT

Pursuant to the Federal Privacy Act (P.L. 93-579) and the Information Practices Act of 1977 (Civil Code section 1798 et seq.), notice is given for the request of the Social Security Number (SSN) on this form. The California Department of Justice uses a person's SSN as an identifying number. The requested SSN is voluntary. Failure to provide the SSN may delay the processing of this form and the criminal record check.

In order to be licensed, work at, or be present at, a licensed facility/organization, the law requires that you complete a criminal background check. (Health and Safety Code sections 1522, 1568.09, 1569.17 and 1596.871). The Department will create a file concerning your criminal background check that will contain certain documents, including information that you provide. You have the right to access certain records containing your personal information maintained by the Department (Civil Code section 1798 et seq.). Under the California Public Records Act, the Department may have to provide copies of some of the records in the file to members of the public who ask for them, including newspaper and television reporters.

NOTE: IMPORTANT INFORMATION
The Department is required to tell people who ask, including the press, if someone in a licensed facility/organization has a criminal record exemption. The Department must also tell people who ask the name of a licensed facility/organization that has a licensee, employee, resident, or other person with a criminal record exemption.

If you have any questions about this form, please contact your local licensing regional office.

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

ADOPT

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

CRIMINAL RECORD EXEMPTION TRANSFER REQUEST

Active criminal record exemptions may be transferred from one state licensed facility/organization to another by a license applicant or licensee. **The transfer must be approved by the Department before the individual who is the subject of the transfer has client contact or the facility/organization will be in violation of the law and subject to a $100 civil penalty.**

The license applicant or licensee who is seeking the exemption transfer must provide a LIC 508, and verify the individual's identity and include a copy of the person's driver's license, permanent resident card or a valid photo identification issued by the California Department of Motor Vehicles or by another state or the United States government if the person is not a California resident. Additionally, a Child Abuse Central Index (CACI) check form must be submitted if the exemption transfer is to a facility serving children and the individual has not previously submitted a CACI check form or the date of the previous CACI inquiry was made prior to January 1, 1999. The CACI check form must be mailed directly to the Department of Justice with the applicable fee.

This form may only be used to request an exemption transfer between state licensed facilities/organizations. To request a transfer between county and state licensed facilities, the requesting Licensing Agency must contact their county liaison.

PLEASE TYPE OR PRINT LEGIBLY | DATE:

PLEASE TRANSFER THE CRIMINAL RECORD EXEMPTION FOR:

LAST NAME | FIRST NAME | MIDDLE INITIAL

CA DRIVER'S LICENSE or ID #/PERMANENT RESIDENT ID (I-551): | DOB:

LICENSING INFORMATION SYSTEM ID #: | SSN: (OPTIONAL) — —

FROM THE FOLLOWING FACILITY/ORGANIZATION:

NAME OF FACILITY/ORGANIZATION: | FACILITY/ORGANIZATION NUMBER:

STREET ADDRESS:

CITY | STATE | ZIP CODE

TO THE FOLLOWING FACILITY/ORGANIZATION:

NAME OF FACILITY/ORGANIZATION:

FACILITY/ORGANIZATION NUMBER: | DATE OF EMPLOYMENT:

STREET ADDRESS:

CITY | STATE | ZIP CODE

Transferee Association Type

- ☐ Facility Administrator
- ☐ Corporation Board Member
- ☐ Employee
- ☐ Certified Home
- ☐ Licensee/Applicant
- ☐ Non-client Adult Resident
- ☐ Partnership Member
- ☐ Spouse of Licensee
- ☐ Affiliated Home Care Aide

I certify I have verified the above individual's identity and have enclosed a copy of the individual's LIC 508 and photo I.D.

Signature

Title *(licensee, administrator, director)*

FOR DISTRICT OFFICE USE ONLY

DATE OF EXEMPTION TRANSFER ENTRY: | INITIAL OF PERSON ENTERING TRANSFER:

FILE IN NEWLY ASSOCIATED FACILITY/ORGANIZATION FILE

PRIVACY STATEMENT

Pursuant to the Federal Privacy Act (P.L. 93-579) and the Information Practices Act of 1977 (Civil Code section 1798 et seq.), notice is given for the request of the Social Security Number (SSN) on this form. The California Department of Justice uses a person's SSN as an identifying number. The requested SSN is voluntary. Failure to provide the SSN may delay the processing of this form and the criminal record check.

In order to be licensed, work at, or be present at, a licensed facility/organization the law requires that you complete a criminal background check. (Health and Safety Code sections 1522, 1568.09, 1569.17, 1596.871 and 1796.19). The Department will create a file concerning your criminal background check that will contain certain documents, including information that you provide. You have the right to access certain records containing your personal information maintained by the Department (Civil Code section 1798 et seq.). Under the California Public Records Act, the Department may have to provide copies of some of the records in the file to members of the public who ask for them, including newspaper and television reporters.

NOTE: IMPORTANT INFORMATION
The Department is required to tell people who ask, including the press, if someone in a licensed facility/organization has a criminal record exemption. The Department must also tell people who ask the name of a licensed facility/organization that has a licensee, employee, resident, or other person with a criminal record exemption.

If you have any questions about this form, please contact your local licensing regional office.

ADOPT

STATEMENT ACKNOWLEDGING REQUIREMENT TO REPORT SUSPECTED ABUSE OF DEPENDENT ADULTS AND ELDERS

NOTE: RETAIN IN EMPLOYEE/ VOLUNTEER FILE

NAME

POSITION

FACILITY

California law REQUIRES certain persons to report known or suspected abuse of dependent adults or elders. As an employee or volunteer at a licensed facility, you are one of those persons - a "mandated reporter."

PERSONS WHO ARE REQUIRED TO REPORT ABUSE

Mandated reporters include care custodians and any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not paid for that responsibility (Welfare and Institutions Code (WIC) Section 15630(a)). **Care custodian** means an administrator or an employee of most public or private facilities or agencies, or persons providing care or services for elders or dependent adults, including members of the support staff and maintenance staff (WIC Section 15610.17).

PERSONS WHO ARE THE SUBJECT OF THE REPORT

Elder means any person residing in this state who is 65 years of age or older (WIC Section 15610.27). **Dependent Adult** means any person residing in this state, between the ages of 18 and 64, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age and those admitted as inpatients in 24-hour health facilities (WIC Section 15610.23).

REPORTING RESPONSIBILITIES AND TIME FRAMES

Any mandated reporter, who in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be abuse or neglect, or is told by an elder or dependent adult that he or she has experienced behavior constituting abuse or neglect, or reasonably suspects that abuse or neglect occurred, shall complete form SOC 341, "Report of Suspected Dependent Adult/Elder Abuse" for each report of known or suspected instance of abuse (physical abuse, sexual abuse, financial abuse, abduction, neglect (self-neglect), isolation, and abandonment) involving an elder or dependent adult.

Reporting shall be completed as follows:

- If the abuse occurred in a Long-Term Care (LTC) facility (as defined in WIC Section 15610.47) and resulted in serious bodily injury (as defined in WIC Section 15610.67), report by telephone to the local law enforcement agency immediately and no later than two (2) hours after observing, obtaining knowledge of, or suspecting physical abuse. Send the written report to the local law enforcement agency, the local Long-Term Care Ombudsman Program (LTCOP), and the appropriate licensing agency (for long-term health care facilities, the California Department of Public Health; for community care facilities, the California Department of Social Services) within two (2) hours of observing, obtaining knowledge of, or suspecting physical abuse.

- If the abuse occurred in a LTC facility, was physical abuse, but did not result in serious bodily injury, report by telephone to the local law enforcement agency within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse. Send the written report to the local law enforcement agency, the local LTCOP, and the appropriate licensing agency (for long-term health care facilities, the California Department of Public Health; for community care facilities, the California Department of Social Services) within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse.

- If the abuse occurred in a LTC facility, was physical abuse, did not result in serious bodily injury, and was perpetrated by a resident with a physician's diagnosis of dementia, report by telephone to the local law enforcement agency or the local LTCOP, immediately or as soon as practicably possible. Follow by sending the written report to the LTCOP or the local law enforcement agency within 24 hours of observing, obtaining knowledge of, or suspecting physical abuse.

- If the abuse occurred in a LTC facility, and was abuse other than physical abuse, report by telephone to the LTCOP or the law enforcement agency immediately or as soon as practicably possible. Follow by sending the written report to the local law enforcement agency or the LTCOP within two working days.

- If the abuse occurred in a state mental hospital or a state developmental center, mandated reporters shall report by telephone or through a confidential internet reporting tool (established in WIC Section 15658) immediately or as soon as practicably possible and submit the report within two (2) working days of making the telephone report to the responsible agency as identified below:
  - If the abuse occurred in a State Mental Hospital, report to the local law enforcement agency or the California Department of State Hospitals.
  - If the abuse occurred in a State Developmental Center, report to the local law enforcement agency or to the California Department of Developmental Services.
- For all other abuse, mandated reporters shall report by telephone or through a confidential internet reporting tool to the adult protective services agency or the local law enforcement agency immediately or as soon as practicably possible. If reported by telephone, a written or an internet report shall be sent to adult protective services or law enforcement within two working days.

PENALTY FOR FAILURE TO REPORT ABUSE

Failure to report abuse of an elder or dependent adult is a MISDEMEANOR CRIME, punishable by jail time, fine or both (WIC Section 15630(h)). The reporting duties are individual, and no supervisor or administrator shall impede or inhibit the reporting duties, and no person making the report shall be subject to any sanction for making the report (WIC Section 15630(f)).

CONFIDENTIALITY OF REPORTER AND OF ABUSE REPORTS

The identity of all persons who report under WIC Chapter 11 shall be confidential and disclosed only among APS agencies, local law enforcement agencies, LTCOPs, California State Attorney General Bureau of Medi-Cal Fraud and Elder Abuse, licensing agencies or their counsel, Department of Consumer Affairs Investigators (who investigate elder and dependent adult abuse), the county District Attorney, the Probate Court, and the Public Guardian. Confidentiality may be waived by the reporter or by court order. Any violation of confidentiality is a misdemeanor punishable by jail time, fine, or both (WIC Section 15633(a)).

DEFINITIONS OF ABUSE

Physical abuse means any of the following: (a) Assault, as defined in Section 240 of the Penal Code; (b) Battery, as defined in Section 242 of the Penal Code; (c) Assault with a deadly weapon or force likely to produce great bodily injury, as defined in Section 245 of the Penal Code; (d) Unreasonable physical constraint, or prolonged or continual deprivation of food or water; (e) Sexual assault, that means any of the following: (1) Sexual battery, as defined in Section 243.4 of the Penal Code; (2) Rape, as defined in Section 261 of the Penal Code; (3) Rape in concert, as described in Section 264.1 of the Penal Code; (4) Spousal rape, as defined in Section 262 of the Penal Code; (5) Incest, as defined in Section 285 of the Penal Code; (6) Sodomy, as defined in Section 286 of the Penal Code; (7) Oral copulation, as defined in Section 288a of the Penal Code; (8) Sexual penetration, as defined in Section 289 of the Penal Code; or (9) Lewd or lascivious acts as defined in paragraph (2) of subdivision (b) of Section 288 of the Penal Code; or (f) Use of a physical or chemical restraint or psychotropic medication under any of the following conditions: (1) For punishment; (2) For a period beyond that for which the medication was ordered pursuant to the instructions of a physician and surgeon licensed in the State of California, who is providing medical care to the elder or dependent adult at the time the instructions are given; or (3) For any purpose not authorized by the physician and surgeon (WIC Section 15610.63).

Serious bodily injury means an injury involving extreme physical pain, substantial risk of death, or protracted loss or impairment of function of a bodily member, organ, or of mental faculty, or requiring medical intervention, including, but not limited to, hospitalization, surgery, or physical rehabilitation (WIC Section 15610.67).

Neglect (a) means either of the following: (1) The negligent failure of any person having the care or custody of an elder or a dependent adult to exercise that degree of care that a reasonable person in a like position would exercise; or (2) The negligent failure of an elder or dependent adult to exercise that degree of self care that a reasonable person in a like position would exercise. (b) Neglect includes, but is not limited to, all of the following: (1) Failure to assist in personal hygiene, or in the provision of food, clothing, or shelter; (2) Failure to provide medical care for physical and mental health needs. No person shall be deemed neglected or abused for the sole reason that he or she voluntarily relies on treatment by spiritual means through prayer alone in lieu of medical treatment; (3) Failure to protect from health and safety hazards; (4) Failure to prevent malnutrition or dehydration; or (5) Failure of an elder or dependent adult to satisfy the needs specified in paragraphs (1) to (4), inclusive, for himself or herself as a result of poor cognitive functioning, mental limitation, substance abuse, or chronic poor health (WIC Section 15610.57).

Financial abuse of an elder or dependent adult occurs when a person or entity does any of the following: (1) Takes, secretes, appropriates, obtains, or retains real or personal property of an elder or dependent adult for a wrongful use or with intent to defraud, or both; (2) Assists in taking, secreting, appropriating, obtaining, or retaining real or personal property of an elder or dependent adult for a wrongful use or with intent to defraud, or both; or (3) Takes, secretes, appropriates, obtains, or retains, or assists in taking, secreting, appropriating, obtaining, or retaining, real or personal property of an elder or dependent adult by undue influence, as defined in Section 15610.70 (WIC Section 15610.30(a)).

Abandonment means the desertion or willful forsaking of an elder or a dependent adult by anyone having care or custody of that person under circumstances in which a reasonable person would continue to provide care and custody (WIC Section 15610.05).

Isolation means any of the following: (1) Acts intentionally committed for the purpose of preventing, and that do serve to prevent, an elder or dependent adult from receiving his or her mail or telephone calls; (2) Telling a caller or prospective visitor that an elder or dependent adult is not present, or does not wish to talk with the caller, or does not wish to meet with the visitor where the statement is false, is contrary to the express wishes of the elder or the dependent adult, whether he or she is competent or not, and is made for the purpose of preventing the elder or dependent adult from having contact with family, friends, or concerned persons; (3) False imprisonment, as defined in Section 236 of the Penal Code; or (4) Physical restraint of an elder or dependent adult, for the purpose of preventing the elder or dependent adult from meeting with visitors (WIC Section 15610.43).

Abduction means the removal from this state and the restraint from returning to this state, or the restraint from returning to this state, of any elder or dependent adult who does not have the capacity to consent to the removal from this state and the restraint from returning to this state, or the restraint from returning to this state, as well as the removal from this state or the restraint from returning to this state, of any conservatee without the consent of the conservator or the court (WIC Section 15610.06).

AS AN EMPLOYEE OR VOLUNTEER OF THIS FACILITY, YOU MUST COMPLY WITH THE DEPENDENT ADULT AND ELDER ABUSE REQUIREMENTS, AS STATED ABOVE. IF YOU DO NOT COMPLY, YOU MAY BE SUBJECT TO CRIMINAL PENALTY. IF YOU ARE A LONG-TERM CARE OMBUDSMAN, YOU MUST COMPLY WITH FEDERAL AND STATE LAWS, WHICH PROHIBIT YOU FROM DISCLOSING THE IDENTITIES OF LONG-TERM RESIDENTS AND COMPLAINANTS TO ANYONE UNLESS CONSENT TO DISCLOSE IS PROVIDED BY THE RESIDENT OR COMPLAINANT OR DISCLOSURE IS REQUIRED BY COURT ORDER (Title 42 United States Code Section 3058g(d)(2); WIC Section 9725).

I, _____, have read and understand my responsibility to report known or suspected abuse of dependent adults or elders. I will comply with the reporting requirements.

SIGNATURE	DATE