



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:
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1. AGENCY NAME(S) (PLEASE PRINT)	2. REQUESTED CERTIFICATION TYPE (CHECK ALL THAT APPLY): <input type="checkbox"/> A. AUTOMATICALLY CERTIFIED <input type="checkbox"/> C. NEW CERTIFICATION <input type="checkbox"/> B. RE-CERTIFICATION <input type="checkbox"/> D. EXPANSION OR SERVICE
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3. DATE (MM/DD/YYYY)	4. NON-REFUNDABLE FEE ENCLOSED <input type="checkbox"/> A. \$3,000 AUTOMATICALLY CERTIFIED <input type="checkbox"/> B. \$10,000 NEW CERTIFICATION <input type="checkbox"/> C. \$10,000 RE-CERTIFICATION <input type="checkbox"/> D. \$5,000 GEOGRAPHICAL OR SERVICE EXPANSION <input type="checkbox"/> E. \$10,000 AUTOMATICALLY CERTIFIED - FIRST EXPANSION		
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5. AGENCY'S PRIMARY CONTACT NAME	TITLE:	E-MAIL ADDRESS (OPTIONAL)	AREA CODE/TELEPHONE ()
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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 ()
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8. AGENCY MAILING ADDRESS (IF DIFFERENT)	CITY	STATE	ZIP CODE	AREA CODE/TELEPHONE ()
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9. CURRENT GEOGRAPHICAL AREA	10. EXPANSION/SERVICE ADDITIONS	11. # OF IHSS CAREGIVER EMPLOYEES (ESTIMATE)	12. # OF IHSS RECIPIENTS (ESTIMATE)
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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

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.

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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.