



# Home Care Services Consumer Protection Act

Stakeholders Meeting  
April 21, 2015

# The GoToMeeting Attendee Interface

The screenshot displays the GoToMeeting Attendee Interface. The main window, titled "GoToMeeting Viewer", shows a "Meet Now" session. The organizer is "GoToMeeting Training Team" and the presenter is also "GoToMeeting Training Team". The audio mode is set to "Call in using your telephone". The interface includes a "Webcams" dropdown menu and a "Waiting to view GoToMeeting Training Team's screen" message. A vertical toolbar on the right contains icons for audio, video, and chat. An "Audio" control panel is overlaid on the right, showing "Audio Mode" options: "Use Telephone" (selected) and "Use Mic & Speakers". Below this, there are fields for "Dial:", "Access Code:", and "Audio PIN:". A "Questions" section is also visible, with a "Send" button. The bottom of the interface shows the "Webinar ID: 850-780-150" and the "GoToWebinar™" logo. The Windows taskbar at the bottom indicates the time is 9:01 AM on 12/1/2010.

**Computer**

**GoToMeeting Viewer**  
Webcams  
Waiting to view GoToMeeting Training Team's screen

## Meet Now

**Organizer: GoToMeeting Training Team | Presenter: GoToMeeting Training Team**

**Audio: Call in using your telephone**

United States:  
Access Code:  
Audio PIN:

**Audio**

**Audio Mode:**  Use Telephone  Use Mic & Speakers **Edit**

Dial:  
Access Code:  
Audio PIN:

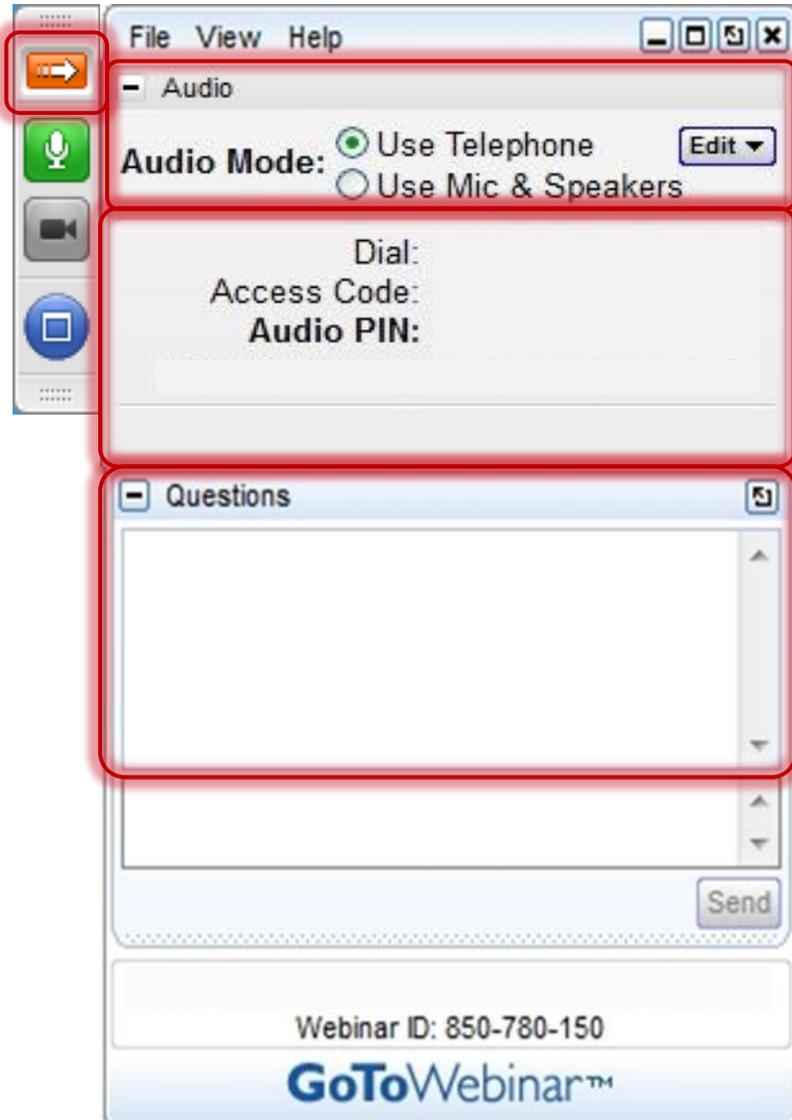
**Questions**

**Send**

Webinar ID: 850-780-150  
**GoToWebinar™**

Start | [Icons] | 9:01 AM 12/1/2010

# GoToMeeting Control Panel



- Expand & collapse your Panel
- Audio: Call in by Conference Call
  - Select “Use Telephone”
  - Dial: (415) 655-0059
  - Access Code: 256-548-677
  - Audio PIN: Input your unique PIN
- Chat/Questions: Submit a question or comment and receive responses

# Home Care Services Consumer Protection Act Implementation Team

Pam Dickfoss  
Deputy Director  
Community Care Licensing Division

Evon Lenerd, Chief  
Continuing Care Contracts Branch

McCaulie Feusahrens, Chief  
Home Care Services Bureau

Ayanna Gammel, Policy Analyst  
Home Care Services Bureau

Kathi Mowers-Moore, Chief  
Central Operations Branch

Dorette Pierce, Chief  
Caregiver Background Check Bureau

Paul Martinez, Assistant Chief  
Caregiver Background Check Bureau

Terece Williams, Manager  
Caregiver Background Check Bureau

Pallavi Shimoda, Analyst  
Caregiver Background Check Bureau

# Objectives

- ▶ Overview of State Processes
  - ▶ The Law as a Governing Principle
  - ▶ Hiring Process
  - ▶ Regulations Process
- ▶ Overview of the HCA Application and Forms
- ▶ Status Update for HCOs
- ▶ Wrap Up/Next Steps

# State Processes

- ▶ The Law as a Governing Principle
- ▶ State Hiring Process
  - ▶ <http://www.calhr.ca.gov/Pages/home.aspx>
  - ▶ Two Steps to get a State job
    1. Take an Exam - establish eligibility by passing the exam specified in the bulletin
    2. Apply for Job Vacancies - once eligibility has been established search and apply for job vacancies
  - ▶ Screening Applications
  - ▶ Interviews

# State Processes (cont'd)

- ▶ Statute vs Regulations

- ▶ Statute is an act by the Legislature

- ▶ States the Legislative intent

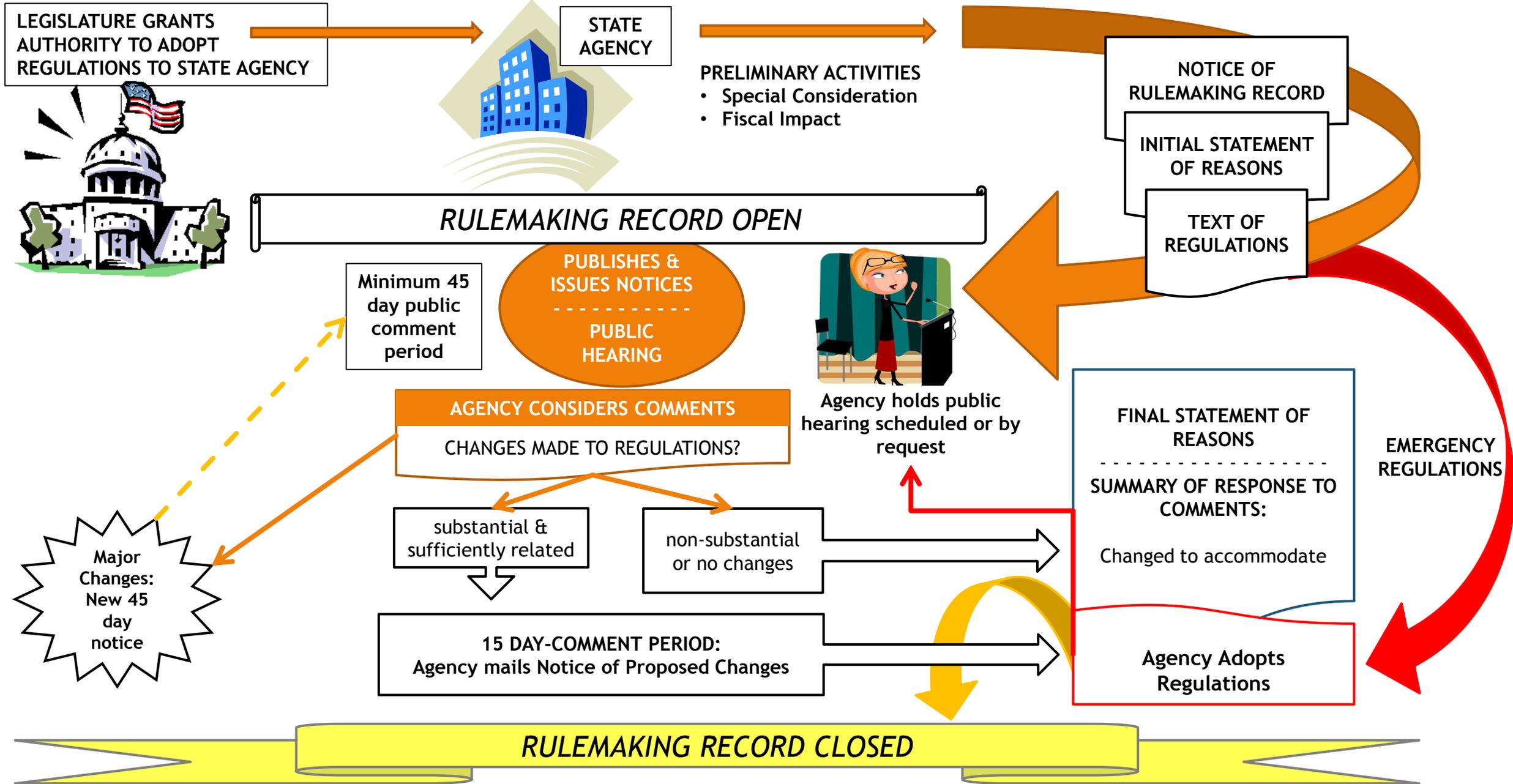
- ▶ Provides authority

- ▶ Cannot be waived, excepted, or modified without Legislative change to the law

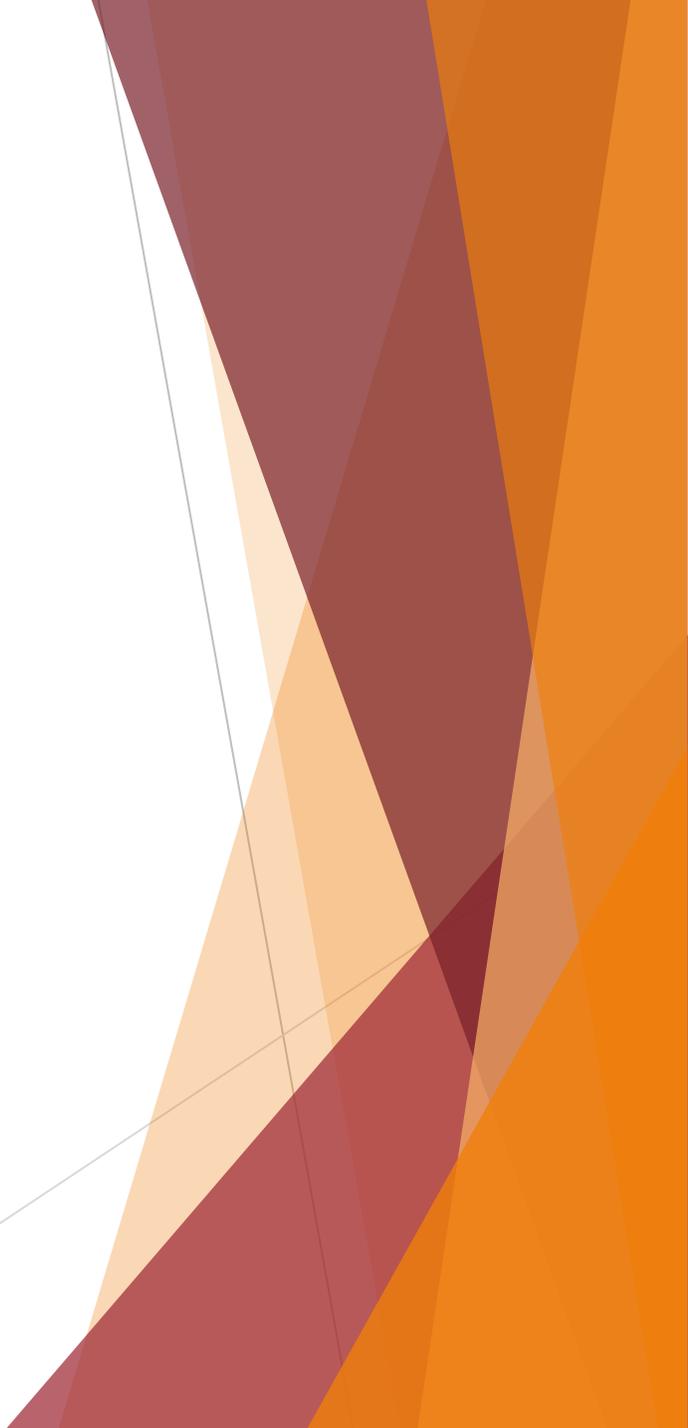
# State Processes (cont'd)

- ▶ Statute vs Regulations (cont'd)
  - ▶ Regulations are rules that the Department administers
    - ▶ Clarifies any ambiguity in the statute
    - ▶ Identifies how the Department is to carry out the statute

# The Rulemaking Process (Regulations)



# HCA Application and Forms



# HOME CARE AIDE REGISTRY APPLICATION (HCS 100)

## HOME CARE AIDE REGISTRY APPLICATION

New Application  Renewal Application

See page 2 for complete instructions. Use ball point pen and print clearly.

1. NAME

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

3. RESIDENCE ADDRESS

Street:	Apt:	City:	State:	Zip:	County:
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4. MAILING ADDRESS (IF DIFFERENT):

P.O. Box/Street:	Apt:	City:	State:	Zip:	County:
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5. E-MAIL (Voluntary) DATE OF BIRTH SEX

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6a. SOCIAL SECURITY NUMBER (Voluntary) 6b. DRIVERS LICENSE OR ID#/ALIEN REGISTRATION/OUT-OF-STATE ID #

--	--

7. TELEPHONE NUMBERS

Day:	Evening:
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8. TRANSFER PROCESS

Are you currently registered on TrustLine, or licensed by, or working in a facility/organization licensed by, the California Department of Social Services Community Care Licensing?  Yes  No

Do you want to transfer your background clearance from TrustLine or Community Care Licensing to the Home Care Aide Registry? (If yes, fingerprints are not required.)  Yes  No

Enter the Facility/Organization # \_\_\_\_\_ (include photocopy of ID)

9. AFFILIATED HOME CARE ORGANIZATION

Are you currently affiliated to or applying to become affiliated with a Home Care Organization?  Yes  No

If yes, please list facility/organization name and facility/organization ID number or personal ID number.

Facility/Organization Name:	Facility/Organization ID # or Personal ID #:
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10. SIGNATURE

_____ SIGNATURE (REQUIRED)	_____ DATE (REQUIRED)
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11. FEES: Make a check or money order in the amount of \$xx.00 payable to the California Department of Social Services.

### 12. SUBMISSION

Mail this application, fees, copy of Live Scan Form, and the LIC 508 to:  
Department of Social Services  
Caregiver Background Check Bureau  
Attn: Home Care Aide Registry Program  
P.O. Box 944243, M.S. 9-15-62  
Sacramento, CA 94244-2430

Applicant, have you ...

- Used exactly the same name on the application form and page 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 and included a copy of the Live Scan form?
- 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)?

## HOME CARE AIDE REGISTRY APPLICATION INSTRUCTIONS

To become listed on the Home Care Aide Registry, you must complete the attached application (HCS 100) and the Criminal Record Statement (LIC 508).

### PRINT ALL INFORMATION EXCEPT SIGNATURE

- Print your full legal name. 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. If your signature is missing on the application or LIC 508, the application will be returned.*
- List all other names you have ever used. *NOTE: This includes aliases such as 'Beth' if used as a legal name.*
- Print your complete residence address. *NOTE: City names must be spelled out. Abbreviated city names will not be accepted.*
- Print your complete mailing address, if different than residence address. **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.**
- List your e-mail address, date of birth, and sex ("M" for male or "F" for female). *NOTE: You must be 18 years of age or older to apply to be listed on the Home Care Aide Registry.*
- Print your Social Security Number, 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. 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.
  - Print your ID number, which is required. *NOTE: You must list one of these four IDs: California Driver's License; California ID card; Alien Registration 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.*
- List a daytime and evening telephone number.
- TRANSFER PROCESS: If you are currently licensed by the Community Care Licensing Division, working in a facility/organization licensed by Community Care Licensing, or registered with the TrustLine Registry, you may be eligible to transfer your background clearance. Check the appropriate boxes Yes or No in section 8 and submit the completed Home Care Aide Registry application (page 1) along with a photocopy of your ID to the address listed in box 11. If you have marked "Yes" in section 8, fingerprints are not required.
- AFFILIATED HOME CARE ORGANIZATION: If you are applying to become affiliated with a home care organization, mark the appropriate box Yes or No. 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.
- You must sign and date the application. If your signature or the date is missing, the application will be returned as incomplete.
- You must include a check or money order for \$xx.00, payable to the California Department of Social Services**
- Mail your application, a copy of the Live Scan form and the Criminal Record Statement (LIC 508) to the address shown in box 12.  
You must answer the questions on the **CRIMINAL RECORD STATEMENT (LIC 508), Page 1. IF YOU DO NOT INCLUDE THIS FORM, YOUR APPLICATION WILL BE CONSIDERED INCOMPLETE AND WILL BE CLOSED. YOUR NAME WILL NOT BE PLACED ON THE HOME CARE AIDE REGISTRY UNTIL YOU SUBMIT THE CRIMINAL RECORD STATEMENT (LIC 508).**

# CRIMINAL BACKGROUND TRANSFER REQUEST (LIC 9182)

## CRIMINAL BACKGROUND CLEARANCE TRANSFER REQUEST

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

The license applicant or licensee who is seeking the transfer must verify the individual's identity and include a copy of the person's driver's license or a valid photo identification issued by the California Department of Motor Vehicles or by another state of the United States government if the person is not a California resident. Additionally, a Child Abuse Central Index (CACI) check must be submitted if the transfer is to a facility serving children and the individual has not previously submitted a CACI check or the date of the previous CACI inquiry was made prior to January 1, 1999. The CACI must be mailed directly to the Department of Justice with the applicable fee. Note: This transfer request is for clearances only. Contact your licensing office for information about exemption transfers.

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

PLEASE TYPE OR PRINT LEGIBLY

PLEASE TRANSFER THE CRIMINAL RECORD CLEARANCE FOR THE FOLLOWING INDIVIDUAL:

LAST NAME		FIRST NAME		MIDDLE INITIAL	
CA DRIVER'S LICENSE #OR ID #:		DOB:		SSN (OPTIONAL)	
LICENSING INFORMATION SYSTEM ID#:					

FROM THE FOLLOWING FACILITY:

NAME OF FACILITY:		FACILITY NUMBER:	
STREET ADDRESS:			
CITY		STATE	
		ZIP CODE:	

TO THE FOLLOWING FACILITY:  PLEASE ALSO KEEP THIS INDIVIDUAL ASSOCIATED WITH ABOVE FACILITY

NAME OF FACILITY:		DATE OF EMPLOYMENT:	
FACILITY NUMBER:			
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

Title (licensee, administrator, director)

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

Signature \_\_\_\_\_

FOR DISTRICT OFFICE USE ONLY

DATE OF TRANSFER ENTRY:	INITIAL OF PERSON ENTERING TRANSFER:
-------------------------	--------------------------------------

FILE IN NEWLY ASSOCIATED FACILITY 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 the law requires that you complete a criminal background check. (Health and Safety Code sections 1522, 1568.09, 1569.17, and 1536.871). 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 has a criminal record exemption. The Department must also tell people who ask the name of a licensed facility 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.

# CRIMINAL RECORD EXEMPTION TRANSFER REQUEST (LIC 9188)

## CRIMINAL RECORD EXEMPTION TRANSFER REQUEST

Active criminal record exemptions may be transferred from one state licensed facility 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 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 verify the individual's identity and include a copy of the person's driver's license 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 must be submitted if the exemption transfer is to a facility serving children and the individual has not previously submitted a CACI check or the date of the previous CACI inquiry was prior to January 1, 1999. The CACI 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. To request a transfer between county and state licensed facilities, the requesting Licensing Agency must contact their county liaison.

PLEASE TYPE OR PRINT LEGIBLY

### PLEASE TRANSFER THE CRIMINAL RECORD EXEMPTION FOR:

LAST NAME		FIRST NAME	MIDDLE INITIAL
CA DRIVER'S LICENSE # or ID #:		DOB:	
LICENSING INFORMATION SYSTEM ID #:		SSN: (OPTIONAL)	

### FROM THE FOLLOWING FACILITY:

NAME OF FACILITY:		FACILITY NUMBER:	
STREET ADDRESS:			
CITY	STATE	ZIP CODE	

### TO THE FOLLOWING FACILITY:

NAME OF FACILITY:		DATE OF EMPLOYMENT:	
FACILITY NUMBER:		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
- Associated Home Care Aide**

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

Title (licensee, administrator, director)

Signature

#### FOR DISTRICT OFFICE USE ONLY

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

FILE IN NEWLY ASSOCIATED FACILITY 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.

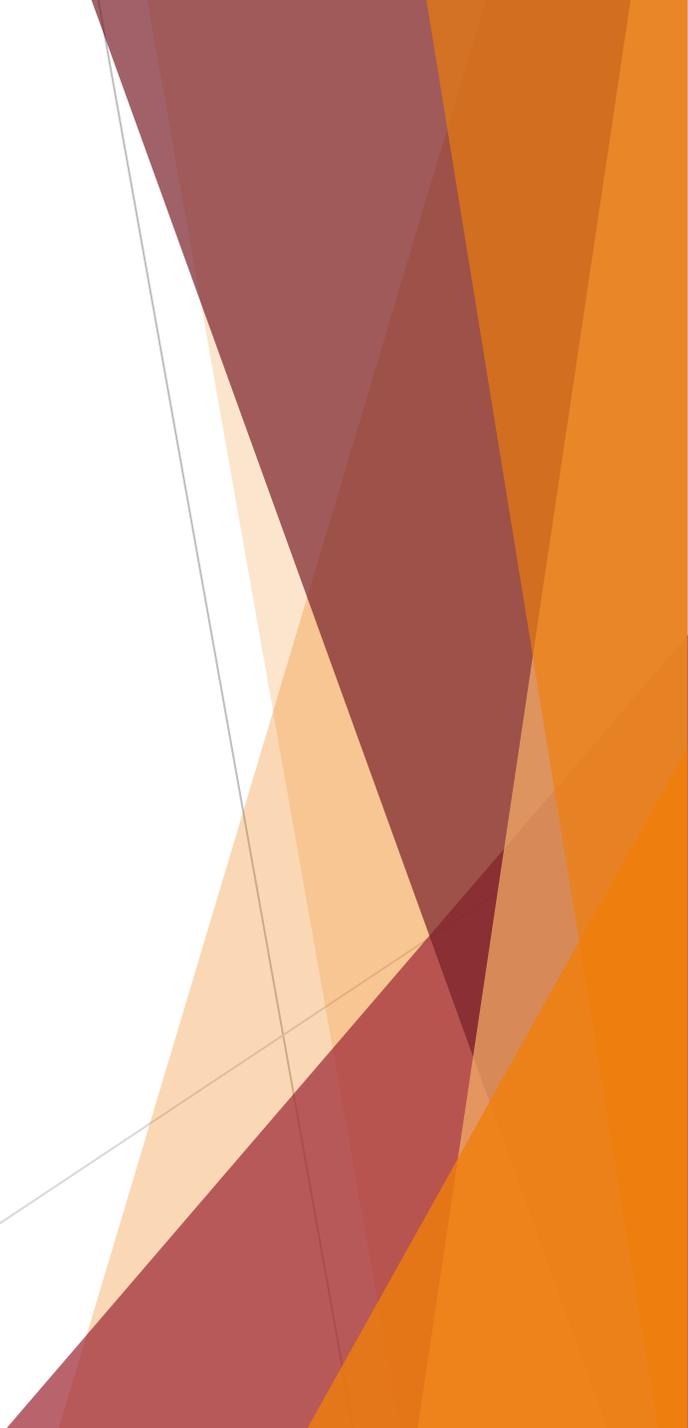
In order to be licensed, work at, or be present at, a licensed facility the law requires that you complete a criminal background check. (Health and Safety Code sections 1522, 1568.09, 1569.17, and 1596.87). The Department will create a file concerning your criminal background check that will contain 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 has a criminal record exemption. The Department must also tell people who ask the name of a licensed facility 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.

# HCO Status Update



# HCO Updates

- ▶ Multiple locations
  - ▶ HSC 1796.17 (a): Each HCO shall be separately licensed.
- ▶ Pre-Licensing Visits
- ▶ Fees/Payments
- ▶ Application Updates

# LICENSEE APPLICANT INFORMATION (HCS 215)

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. 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
ADDRESS			AREA CODE/TELEPHONE ( )
OTHER NAME(S) USED BY APPLICANT			

### PRIOR LICENSURE STATUS

A. HAVE YOU EVER BEEN A LICENSEE OR CO-LICENSEE OF 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 E AND F BELOW.

B. HAVE YOU EVER HELD A BENEFICIAL OWNERSHIP OF 10% OR MORE IN 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 OR BEEN AN ADMINISTRATOR, GENERAL PARTNER, CORPORATE OFFICER, OR DIRECTOR OF ANY SUCH FACILITY?  YES  NO IF YES, COMPLETE E AND F BELOW.

C. HAVE YOU EVER BEEN DENIED A LICENSE OR CO-LICENSE OF A 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 E AND F BELOW.

D. HAVE YOU EVER BEEN REGISTERED WITH THE TRUSTLINE REGISTRY PROGRAM?  YES  NO IF YES, COMPLETE F BELOW.

E. NAME AND ADDRESS OF FACILITY/HOME CARE ORGANIZATION \_\_\_\_\_ EFFECTIVE DATES OF LICENSURE \_\_\_\_\_ TO \_\_\_\_\_ FACILITY TYPE (IF NOT A HOME CARE ORGANIZATION) \_\_\_\_\_

F. WERE ANY DISCIPLINARY ACTIONS TAKEN?  YES  NO IF YES, PLEASE EXPLAIN \_\_\_\_\_

### BUSINESS EXPERIENCE

A. HAVE YOU OWNED, CO-OWNED OR OPERATED ANY BUSINESS?  YES  NO IF YES, PLEASE COMPLETE THE FOLLOWING:

Type	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
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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.

# PARTNERSHIP/CORPORATION/LIMITED LIABILITY COMPANY ORGANIZATION STRUCTURE (HCS 309)

## 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.)

**INSTRUCTIONS:** This form must be updated and submitted to the Department each time there is a change in partners, officers or changed in the corporation or Limited Liability Company as provided in the California Code of Regulation, Title 22, Section XXXXX.

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

### I. CORPORATION/LIMITED LIABILITY COMPANY (LLC)

1. NAME (AS FILED WITH THE SECRETARY OF STATE)		2. CHIEF EXECUTIVE OFFICER	
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 ( )	
8. OUT OF STATE OR FOREIGN APPLICANTS COMPLETE THE FOLLOWING:			
8a. NAME OF CALIFORNIA REPRESENTATIVE	ADDRESS	ZIP CODE	AREA CODE/TELEPHONE ( )
8b. PLEASE ATTACH A COPY OF A FOREIGN CORPORATION'S OR FOREIGN LLC'S REGISTRATION TO DO BUSINESS IN CALIFORNIA.			
9. NAMES AND ADDRESSES OF ALL PERSONS WHO OWN TEN PERCENT (10%) OR MORE INTEREST IN CORPORATION OR LLC. ATTACH SHEET FOR ADDITIONAL SPACE.			
NAME	PERCENTAGE HELD	ADDRESS	

### 12. LIST ALL DIRECTORS (CORPORATION)/MANAGERS AND MANAGING MEMBERS (LLC). 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 <input type="checkbox"/> FEDERAL <input type="checkbox"/> STATE <input type="checkbox"/> COUNTY <input type="checkbox"/> CITY <input type="checkbox"/> OTHER (SPECIFY BELOW)				
2a. AGENCY NAME		ADDRESS	CITY	STATE ZIP CODE
2b. MAILING ADDRESS (IF DIFFERENT FROM ABOVE)				
2c. CONTACT PERSON		TITLE	AREA CODE/TELEPHONE ( )	
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

1 <sup>st</sup> PARTNER	<input type="checkbox"/> GENERAL	NAME	AREA CODE/TELEPHONE ( )		
	<input type="checkbox"/> LIMITED	PRINCIPLE BUSINESS ADDRESS	CITY	STATE	ZIP CODE
2 <sup>nd</sup> PARTNER	<input type="checkbox"/> GENERAL	NAME	AREA CODE/TELEPHONE ( )		
	<input type="checkbox"/> LIMITED	PRINCIPLE BUSINESS ADDRESS	CITY	STATE	ZIP CODE
3 <sup>rd</sup> PARTNER	<input type="checkbox"/> GENERAL	NAME	AREA CODE/TELEPHONE ( )		
	<input type="checkbox"/> LIMITED	PRINCIPLE BUSINESS ADDRESS	CITY	STATE	ZIP CODE
4 <sup>th</sup> PARTNER	<input type="checkbox"/> GENERAL	NAME	AREA CODE/TELEPHONE ( )		
	<input type="checkbox"/> LIMITED	PRINCIPLE BUSINESS ADDRESS	CITY	STATE	ZIP CODE
5 <sup>th</sup> PARTNER	<input type="checkbox"/> GENERAL	NAME	AREA CODE/TELEPHONE ( )		
	<input type="checkbox"/> LIMITED	PRINCIPLE BUSINESS 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.


Next Steps

The background features a series of overlapping, semi-transparent triangles in various shades of orange, from light peach to deep, dark brown. The triangles are arranged in a way that creates a sense of depth and movement, primarily concentrated on the right side of the frame. The overall aesthetic is clean and modern.

# References

- ▶ Home Care Services Bureau  
<http://www.cclld.ca.gov/PG3654.htm>
- ▶ Caregiver Background Check Bureau  
<http://www.cclld.ca.gov/PG399.htm>
- ▶ Health and Safety Code  
[http://leginfo.legislature.ca.gov/faces/codes\\_displayexpandedbranch.xhtml](http://leginfo.legislature.ca.gov/faces/codes_displayexpandedbranch.xhtml)

# Acronyms

Acronym	Term
AB	Assembly Bill
CBCB	Caregiver Background Check Bureau
CCLD	Community Care Licensing Division
CDSS	California Department of Social Services
DOJ	Department of Justice
EM	Evaluator Manual
FAQ	Frequently Asked Questions
H&SC	Health and Safety Code
HCA	Home Care Aide
HCO	Home Care Organization
HCS	Home Care Services
HCSB	Home Care Services Bureau
HCSCPA	Home Care Services Consumer Protection Act
LPA	Licensing Program Analyst
RO	Regional Office
TL	TrustLine

# Contact Us

For more information regarding the Home Care Services Consumer Protection Act, please contact the Home Care Services Bureau by e-mail at [HCSB@dss.ca.gov](mailto:HCSB@dss.ca.gov) or by telephone at (916) 657-2592.