



Home Care Services Consumer Protection Act

Stakeholders Meeting
October 29, 2015

The GoToMeeting Attendee Interface

The screenshot displays the GoToMeeting Attendee Interface. The main window, titled "GoToMeeting Viewer", shows a "Meet Now" screen with the following information:

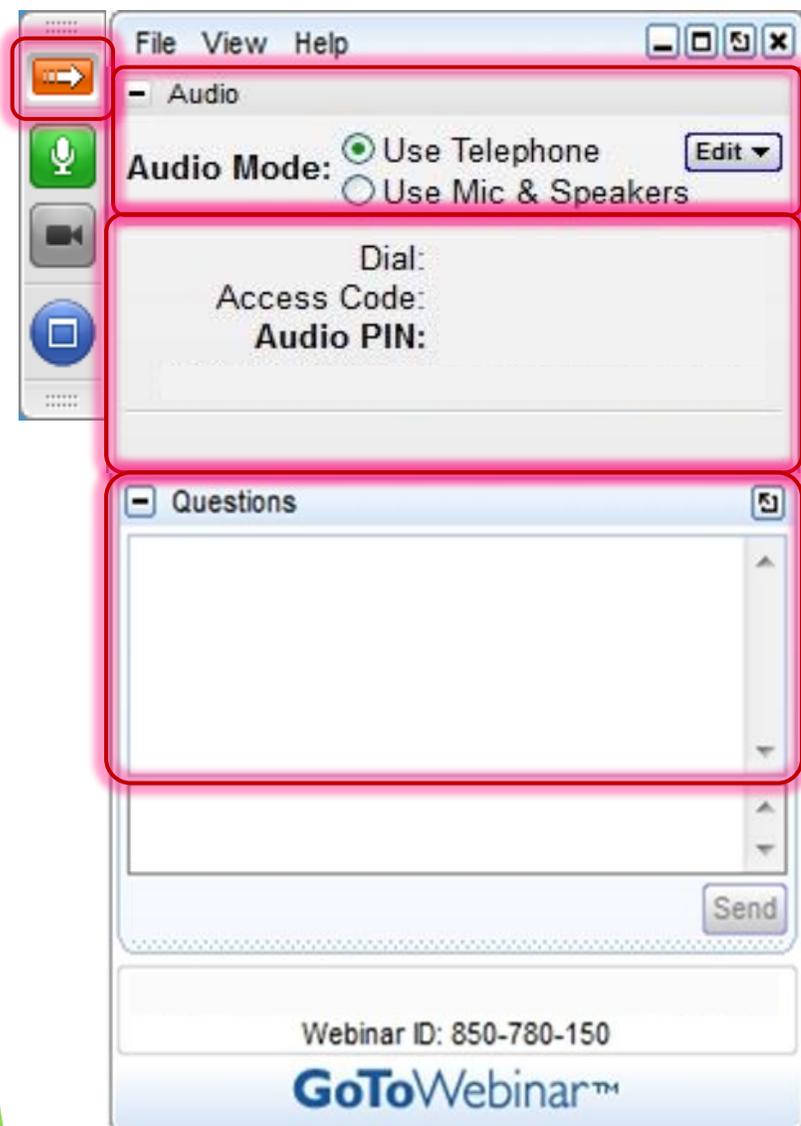
- Organizer:** GoToMeeting Training Team | **Presenter:** GoToMeeting Training Team
- Audio:** Use your microphone and speakers (VoIP) or call in using your telephone.
- United States:**
 - Access Code:
 - Audio PIN:

The Citrix logo is visible in the bottom left corner of the main window. A vertical toolbar on the right side of the main window contains icons for audio, video, and chat. Overlaid on the right is a "GoToWebinar" control panel with the following sections:

- Audio:** Includes "Audio Mode" with radio buttons for "Use Telephone" (selected) and "Use Mic & Speakers", and an "Edit" button. Below are fields for "Dial:", "Access Code:", and "Audio PIN:".
- Questions:** A text input area with a "Send" button.
- Webinar ID:** 850-780-150
- GoToWebinar™** logo

The Windows taskbar at the bottom shows the Start button, icons for Explorer, Internet Explorer, Chrome, and Mail, and a system tray with the time 9:01 AM and date 12/1/2010.

GoToMeeting Control Panel



- Expand & collapse your Panel
- Audio: Use your microphone and speakers **or** Call in by telephone.
 - Select “Use Telephone” **OR** “Use Mic & Speakers”
 - Dial: (646) 558-2121
 - Access Code: 795-833-438
 - Audio PIN: N/A
- Chat/Questions: Submit a question or comment and receive responses

Home Care Services Consumer Protection Act Implementation Team: Executive Team

Pam Dickfoss
Deputy Director
Community Care Licensing Division

```
graph TD; A["Pam Dickfoss  
Deputy Director  
Community Care Licensing Division"] --- B["Evon Lenerd, Chief  
Continuing Care Contracts Branch"]; A --- C["Kathi Mowers-Moore, Chief  
Central Operations Branch"]
```

Evon Lenerd, Chief
Continuing Care Contracts Branch

Kathi Mowers-Moore, Chief
Central Operations Branch

Home Care Services Consumer Protection Act Implementation Team: HCSB

McCaulie Feusahrens, Chief
Home Care Services Bureau

Ayanna Gammel
Manager

Steve David
Analyst

Jamie Mason
Analyst

Ruben Perez
Analyst

Barbora Rejmanek
Analyst

Francina Williams
Analyst

Jackie Galvin
Manager

Jacqui Gonzalez
Analyst

Karen Cross
Manager

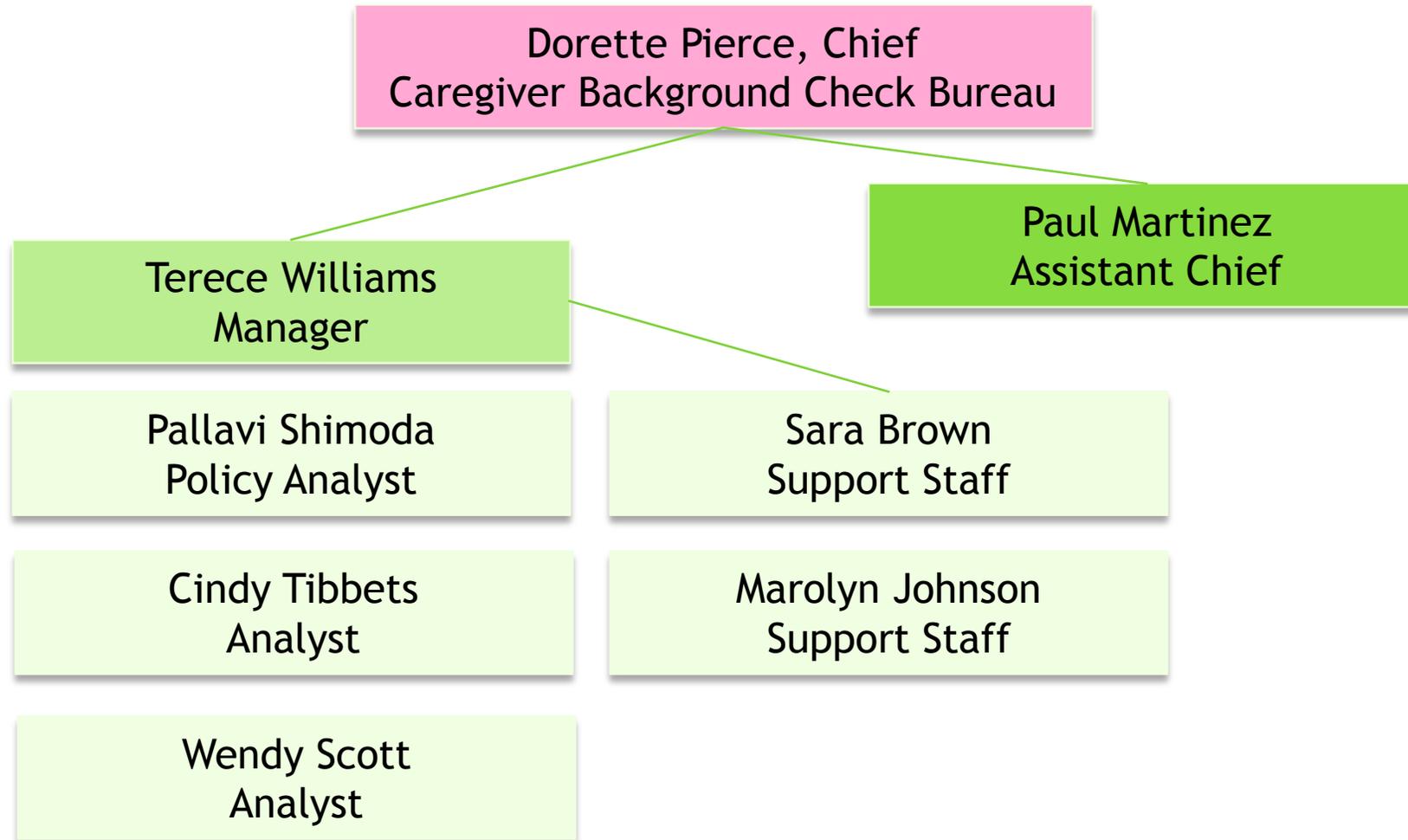
Chester Hoang
Analyst

Paul Pazirandeh
Analyst

Jessica Swol
Analyst

Shelby Whedon
Analyst

Home Care Services Consumer Protection Act Implementation Team: CBCB



Objectives

- ▶ Provide updates on implementation
- ▶ HCA Manual Application process
- ▶ HCO Application Intent Form
- ▶ Preview HCA Intent Spreadsheet

Updates

Updates

- ▶ Hiring
- ▶ Written Directives/Regulations
- ▶ HCS 402
- ▶ HCO Number
- ▶ Fingerprinting

HCA Manual Application Process

HCA Paper Application Process

- ▶ WHO needs to complete a HCA Application
- ▶ WHO needs to complete the background check process
- ▶ HOW to submit fingerprints
- ▶ HOW to submit a complete Home Care Aide Registry Application Package
 - ▶ How to apply as a HCA working for multiple HCOs
 - ▶ How to apply as an aide with a CDSS clearance or exemption

Background Check Process

The screenshot shows a web browser window with the following content:

- Address bar: <http://www.cdss.ca.gov/cdssweb/PG166.htm#>
- Menu: File Edit View Favorites Tools Help
- Page: On-line Forms and Publicat... x
- Page Content:
 - [LIC 9106 \(2/05\) - Statement Acknowledging Requirement To Report Suspected Child Abuse](#)
 - [LIC 9111 \(12/99\) - Noncompliance Conference Summary](#)
 - [LIC 9112 \(12/99\) - Facility Compliance Plan](#)
 - [LIC 9118 \(11/03\) - Facility Visit Checklist Child Care Centers And Infant Centers](#)
 - [LIC 9119 \(11/03\) - Facility Visit Checklist - Group Homes](#)
 - [LIC 9120 \(11/03\) - Facility Visit Checklist Adult Residential Facility](#)
 - [LIC 9121 \(11/03\) - Facility Visit Checklist Family Child Care](#)
 - [LIC 9122 \(11/03\) - Facility Visit Checklist Foster Family Home](#)
 - [Lic 9122A \(11/03\) - Facility Visit Checklist Small Family Home](#)
 - [LIC 9123 \(11/03\) - Facility Visit Checklist - Residential Care Facility For The Elderly](#)
 - [LIC 9128 \(6/99\) - Foster Family Agency Program Statement](#)
 - [LIC 9139 \(2/05\) - Renewal Of Continuing Education Course Approval](#)
 - [LIC 9140 \(7/04\) - Request For Course Approval](#)
 - [LIC 9140A \(12/12\) - Request To Add Or Change Instructor](#)
 - [LIC 9141 \(3/04\) - Vendor Application/Renewal](#)
 - [LIC 9142A \(3/06\) - Roster Of Participants - For Vendor Use Only - 35/40 Hour Initial Or CEU Courses](#)
 - [LIC 9148 \(9/00\) - Earthquake Preparedness Checklist \(EPC\)](#)
 - [LIC 9149 \(2/05\) - Family Child Care Home Property Owner/Landlord Consent Form](#)
 - [LIC 9150 \(8/08\) - Parent Notification - Additional Children in Care](#)
 - [LIC 9151 \(3/05\) - Property Owner/Landlord Notification Family Child Care Home](#)
 - [LIC 9158 \(11/04\) - Telecommunications Device Notification](#)
 - [LIC 9163 \(10/15\) - Request For Live Scan Service - Community Care Licensing](#) ←
 - [LIC 9163B \(7/11\) - Request For Live Scan Service - Long Term Care Ombudsman](#)
 - [LIC 9165 \(2/99\) - Board Of Director Statement](#)
 - [LIC 9166 \(2/01\) - Nebulizer Care Consent/Verification \(Child Care Facilities\)](#)

The taskbar at the bottom shows the Windows Start button, several application icons, and the system tray with the time 11:04 AM and 100% zoom level.

Background Check Process - LIC 9163

REQUEST FOR LIVE SCAN SERVICE - COMMUNITY CARE LICENSING

Applicant Submission

1. ORI: A0448			
2. Working Title: (Check <input checked="" type="checkbox"/> one) <input type="checkbox"/> Adult Resident other than Client <input type="checkbox"/> Employee <input type="checkbox"/> License, Certification, Applicant <input type="checkbox"/> Volunteer <input checked="" type="checkbox"/> Home Care Aide			
3. Authorized Applicant Type - Enter from list on Page 2, "DOJ Abbreviated CCLD Facility/Organization Type." ADULT DAY / RESIDENT / REHAB			
4. Agency Address Set Contributing Agency: CA Dept of Social Services 03502 <small>Agency authorized to receive criminal history information</small> <small>Mail Code (five-digit code assigned by DOJ)</small>			
PO BOX 944243	Mail Station 9-15-62	N/A	
<small>Street No.</small>	<small>Street or PO Box</small>	<small>Contact Name (Mandatory for all school submissions)</small>	
Sacramento, CA	94244-2430	()	N/A
<small>City</small>	<small>State</small>	<small>Zip Code</small>	<small>Contact Telephone No.</small>
5. Applicant Information:			
Name of Applicant: (Please print) SMITH		JANE	H
<small>LAST</small>		<small>FIRST</small>	<small>M.I.</small>
AKA's: JOHNSON		JANE	
<small>LAST</small>		<small>FIRST</small>	
DOB: 05/17/1974		CDL No. A1234567	
SEX: <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female		Misc. No. BIL -	
		<small>AGENCY BILLING NUMBER (IF APPLICABLE)</small>	
HT: 5'6"	WT: 145	Misc. No. _____	
		<small>PERMANENT RESIDENT (FASIS), OUT OF STATE DRIVERS LICENSE OR I.C.</small>	
EYE Color: BROWN	HAIR Color: BROWN	Home Address: (All applicants must complete)	
POB: FRESNO		123 Main St	
		<small>STREET OR PO BOX</small>	
SOC: 123-45-6789		FRESNO, CA 93706	
<small>(See Privacy Statement on Page 4)</small>		<small>CITY, STATE AND ZIP CODE</small>	
6. Facility/Organization Number: 123456789 Level of Service <input checked="" type="checkbox"/> DOJ <input checked="" type="checkbox"/> 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)			
HOME CARE AIDES, INC			
<small>Employer Name</small>			
123 A STREET			
<small>Street No.</small>	<small>Street or PO Box</small>	<small>Mail Code (five digit code assigned by DOJ)</small>	
FRESNO	CA	93706	
<small>City</small>	<small>State</small>	<small>Zip Code</small>	
<small>Agency Telephone No. (Optional)</small>			
8.			
Live Scan Transaction Completed By _____ Date _____			
<small>Name of Operator</small>			
<small>Transmitting Agency</small>	<small>LSID#</small>	<small>ATI No.</small>	<small>Amount Collected/Billed</small>

GUIDELINES FOR COMMUNITY CARE LICENSING (CCLD) APPLICANTS WHO USE A LIVE SCAN SITE (CCLD or DOJ SITE) FOR FINGERPRINTING

Instructions for the LIC 9163

- Originating Response Indicator (ORI):** Preprinted
- Working Title:** Check the appropriate box
- 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 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

Background Check Process - LIC 9163

REQUEST FOR LIVE SCAN SERVICE - COMMUNITY CARE LICENSING

Applicant Submission

1. ORI: A0448			
2. Working Title: (Check <input checked="" type="checkbox"/> one) <input type="checkbox"/> Adult Resident other than Client <input checked="" type="checkbox"/> Employee <input type="checkbox"/> License, Certification, Applicant <input type="checkbox"/> Volunteer <input type="checkbox"/> Home Care Aide			
3. Authorized Applicant Type - Enter from list on Page 2, "DOJ Abbreviated CCLD Facility/Organization Type." ADULT DAY / RESIDENT / REHAB			
4. Agency Address Set Contributing Agency: CA Dept of Social Services 03502 <small>Agency authorized to receive criminal history information Mail Code (five-digit code assigned by DOJ)</small>			
PO BOX 944243	Mail Station 9-15-62	N/A	
Street No.	Street or PO Box	Contact Name (Mandatory for all school submissions)	
Sacramento,	CA	94244-2430	() N/A
City	State	Zip Code	Contact Telephone No.
5. Applicant Information:			
Name of Applicant: (Please print) SMITH		JANE	H
		LAST	FIRST MI
AKA's: JOHNSON		JANE	CDL No. A1234567
		LAST	FIRST
DOB: 05/17/1974	SEX: <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	Misc. No. BL	<small>AGENCY BILLING NUMBER (IF APPLICABLE)</small>
HT: 5'6"	WT: 145	Misc. No.:	<small>PERMANENT RESIDENT (ISSUED BY CALIFORNIA DEPARTMENT OF SOCIAL SERVICES)</small>
EYE Color: BROWN	HAIR Color: BROWN	Home Address: (All applicants must complete)	
POB: FRESNO	123 Main St <small>STREET OR PO BOX</small>		
SOC:	FRESNO, CA 93706 <small>CITY, STATE AND ZIP CODE</small>		
<small>(See Privacy Statement on Page 4)</small>			
6. Facility/Organization Number: 123456789 Level of Service <input checked="" type="checkbox"/> DOJ <input checked="" type="checkbox"/> 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)			
HOME CARE AIDES, INC			
Employer Name			
123 A STREET			
Street No.	Street or PO Box	Mail Code (five digit code assigned by DOJ)	
FRESNO	CA	93706	
City	State	Zip Code	Agency Telephone No. (Optional)
8. Live Scan Transaction Completed By: _____ Date: _____ <small>Name of Operator</small>			
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

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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.**

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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 III Residential Care Facilities for the Elderly	Residential Care Facility Elderly
Small Family Home Transitional Housing Placement Program	Residential Child Care 6/less

HCA Paper Application Process

- ▶ A complete Home Care Aide Registry Application package includes all of the following:
 - ▶ Home Care Aide Registry Application (HCS 100)
 - ▶ Criminal Record Statement (LIC 508)
 - ▶ Check or Money Order for payment of HCA registration application fee of \$25

HCA Paper Application Process (cont'd)

The screenshot shows a web browser window with the address bar displaying <http://www.cdss.ca.gov/cdssweb/PG165.htm#h>. The browser has a menu bar with File, Edit, View, Favorites, Tools, and Help. Below the menu bar is a toolbar with icons for home, back, forward, print, and search. The main content area lists several forms with blue hyperlinks:

- > [FCR 2FFA \(5/09\) - Program Description Checklist](#)
- > [FCR 3FFA \(7/03\) - Days Of Care Schedule](#)
- > [FCR 12FFA \(2/05\) - Total Program Cost Display \(FCR 12 FFA\)](#)
- > [FCR 16 \(2/15\) - Group Home Shelter Costs, Self-Dealing Transactions Declaration And Survey](#)
- > [FSP 1 \(8/14\) - Family Stabilization Program Evaluation Request](#)
- > [FSP 2 \(8/14\) - Family Stabilization Program Denial Notice](#)
- > [FSP 3 \(8/14\) - Family Stabilization Program Notice of Change in Program Status](#)

Below the list is a [Top](#) link. The section is titled **G FORMS** and contains:

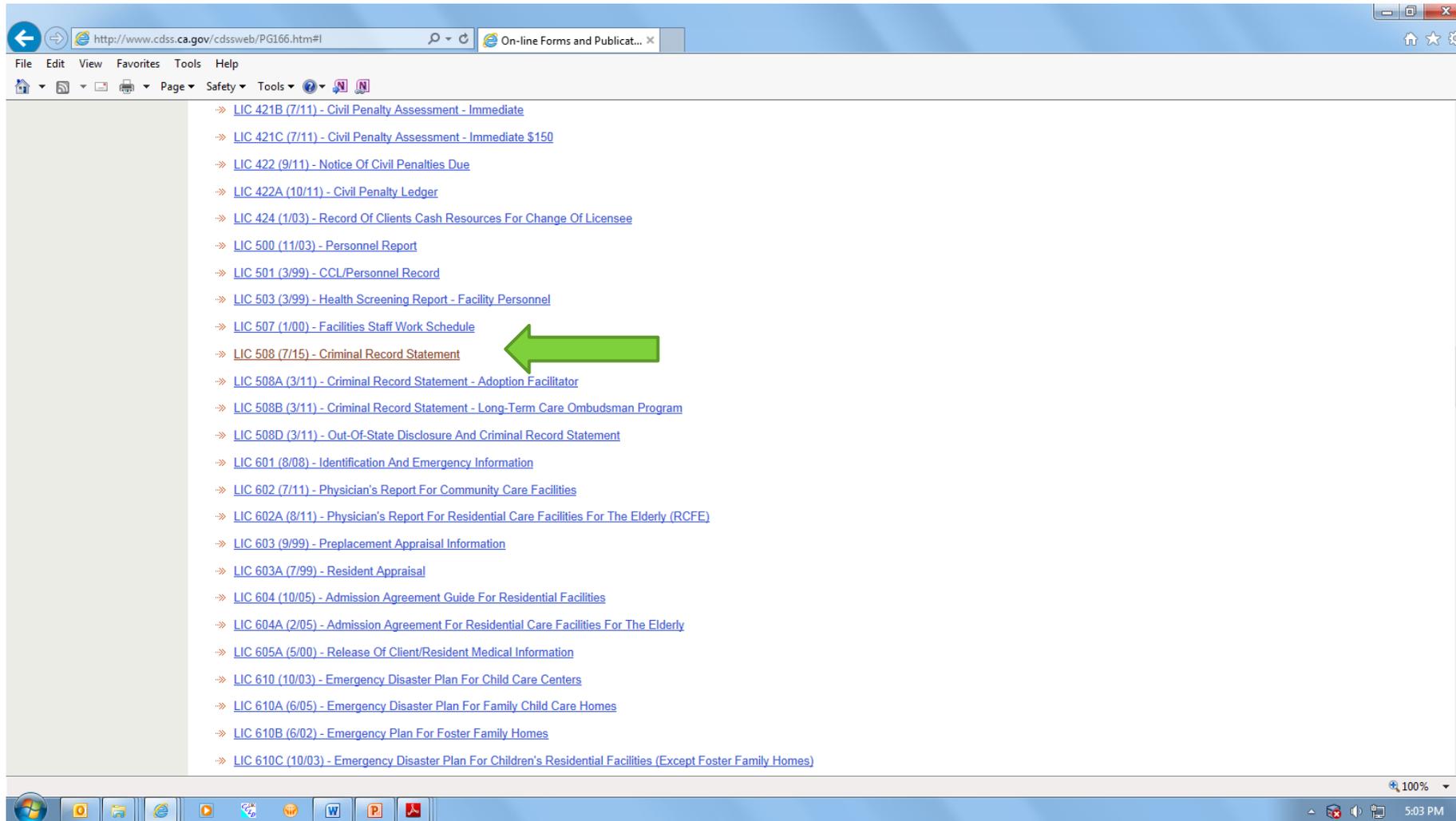
- > [GEN 727B \(7/12\) - County Forms Order, with Instructions](#) Do NOT download this file to your computer if you want to use it to order online - open the file within your web browser. You should have the latest version of [Adobe PDF Reader](#) installed on your computer to use this form online.
- > [GEN 1031 \(4/15\) - Annual County Training Plan](#)
- > [GEN 1179 \(9/12\) - Complaint of Discrimination](#)
- > [GEN 1321 \(3/00\) - CDSS System And Application Access Form](#)
- > [GEN 1321A \(11/03\) - HHSDC Teale Data Security Access Request](#)
- > [GEN 1388 \(9/15\) - Language Accessibility Services Complaint Form](#)

The section is titled **H FORMS** and contains:

- > [HCS 100 \(10/15\) - Home Care Aide Registry Application](#) ← **Green arrow pointing to this link**
- > [HCS 200 \(8/15\) - Application For A Home Care Organization License](#)
- > [HCS 215 \(8/15\) - Home Care Organization Licensee Applicant Information](#)
- > [HCS 281 \(8/15\) - Application Instructions For A Home Care Organization License](#)
- > [HCS 308 \(8/15\) - Designation Of Home Care Organization Responsibility](#)
- > [HCS 309 \(8/15\) - Partnership/Corporation/Limited Liability Company Organization Structure](#)
- > [HCS 402 \(8/15\) - Employee Dishonesty Bond](#)

The browser's status bar at the bottom shows the Windows taskbar with various application icons and the system clock displaying 5:06 PM.

HCA Paper Application Process (cont'd)



HCA Paper Application Process (cont'd)

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: Smith	FIRST: Jane	MIDDLE: H
----------------	----------------	--------------

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

Jane Johnson

3. RESIDENCE ADDRESS

STREET: 123 Main St	APT.:	CITY: Fresno	STATE: CA	ZIP: 93706	COUNTY: Fresno
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4. MAILING ADDRESS (IF DIFFERENT):

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

5. E-MAIL (Voluntary)

DATE OF BIRTH 05/17/1974	SEX female
-----------------------------	---------------

6a. SOCIAL SECURITY NUMBER (Voluntary)

123-45-6789	6b. DRIVERS LICENSE OR ID#/PERMANENT RESIDENT ID#/OUT-OF-STATE ID # A1234567
-------------	---

7. TELEPHONE NUMBERS

DAY: (559) 555-1234	EVENING: (559) 555-5678
------------------------	----------------------------

8. TRANSFER PROCESS

Are you currently registered on TrustLine, or licensed by, or working in a facility licensed by, the California Department of Social Services Community Care Licensing? Yes No
Please provide the personal ID number _____

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 # _____ (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 organization name and organization number.

ORGANIZATION NAME: Home Care Aides, Inc	ORGANIZATION #: 123456789
--	------------------------------

10. SIGNATURE

SIGNATURE (REQUIRED) 	DATE (REQUIRED) 10/29/2015
---	-------------------------------

11. FEES: Make a check or money order in the amount of \$25.00 payable to the California Department of Social Services.

12. SUBMISSION

Mail this application, fees, copy of Live Scan Form, and 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.*
- a) 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.
b) 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.*
- List a daytime and evening telephone number.
- TRANSFER PROCESS: If you are currently licensed by the Community Care Licensing Division, working in a facility 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 \$25.00, 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).**

HCA Paper Application Process (cont'd)

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. 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 (PL 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.

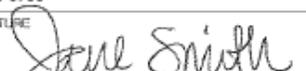
In order to be licensed, work at, or be present at, a licensed facility/organization, the law requires that you complete a criminal background check. (Health and Safety Code sections 1522, 1568.09, 1569.17, 1596.871, and 1796.19). The Department will create a file concerning your criminal background 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.

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 Home Care Aides, Inc		FACILITY/ORGANIZATION NUMBER 123456789	
YOUR NAME (PRINT CLEARLY) Jane H Smith	YOUR ADDRESS 123 Main St	CITY Fresno	ZIP 93706
SOCIAL SECURITY NUMBER (SEE PRIVACY STATEMENT ON REVERSE SIDE) 123-45-6789	DATE OF BIRTH 05/17/1974	DMV LICENSE NUMBER A1234567	
SIGNATURE 	DATE 10/29/2015		

Clearance Transfer Process

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

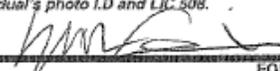
CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

CRIMINAL BACKGROUND CLEARANCE TRANSFER REQUEST

Active criminal record clearances may be transferred from one state licensed facility/organization 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/organization 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 provide a LIC 508, and 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 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/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
		02/05/2016
PLEASE TRANSFER THE CRIMINAL RECORD CLEARANCE FOR THE FOLLOWING INDIVIDUAL:		
LAST NAME	FIRST NAME	MIDDLE INITIAL
SMITH	JANE	H
CA DRIVER'S LICENSE OR ID #/PERMANENT RESIDENT ID# (I-551):		DOB:
A1234567		05/17/1974
LICENSING INFORMATION SYSTEM ID#:		SSN (OPTIONAL)
999999999		123-45-6789
FROM THE FOLLOWING FACILITY/ORGANIZATIONS:		
NAME OF FACILITY/ORGANIZATION:		FACILITY/ORGANIZATION NUMBER:
Home Care Aides, Inc		123456789
STREET ADDRESS:		
123 A STREET		
CITY	STATE	ZIP CODE:
FRESNO	CA	93706
TO THE FOLLOWING FACILITY/ORGANIZATION: <input type="checkbox"/> PLEASE ALSO KEEP THIS INDIVIDUAL ASSOCIATED WITH ABOVE FACILITY/ORGANIZATION.		
NAME OF FACILITY/ORGANIZATION:		Transferee Association Type
AIDES, LLC		<input type="checkbox"/> Facility Administrator
FACILITY/ORGANIZATION NUMBER:		<input type="checkbox"/> Corporation Board Member
987654321		<input type="checkbox"/> Employee
DATE OF EMPLOYMENT:		<input type="checkbox"/> Certified Home
02/05/2016		<input type="checkbox"/> Licensee/Applicant
STREET ADDRESS:		<input type="checkbox"/> Non-client Adult Resident
123 FIRST STREET		<input type="checkbox"/> Partnership Member
CITY	STATE	ZIP CODE:
FRESNO	CA	93706
I certify I have verified the above individual's identity and have enclosed a copy of the individual's photo I.D and LIC 508.		Title (licensee, administrator, director)
Signature 		LICENSEE
FOR DISTRICT OFFICE USE ONLY		
DATE OF TRANSFER ENTRY:		INITIAL OF PERSON ENTERING TRANSFER:

Exemption Transfer Process

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

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 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 made 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/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:
		02/05/2016
PLEASE TRANSFER THE CRIMINAL RECORD EXEMPTION FOR:		
LAST NAME	FIRST NAME	MIDDLE INITIAL
SMITH	JANE	H
CA DRIVER'S LICENSE or ID #/PERMANENT RESIDENT ID (I-551):		DOB:
A1234567		05/17/1974
LICENSING INFORMATION SYSTEM ID #:		SSN: (OPTIONAL)
999999999		123 — 45 — 6789
FROM THE FOLLOWING FACILITY/ORGANIZATION:		
NAME OF FACILITY/ORGANIZATION:		FACILITY/ORGANIZATION NUMBER:
HOME CARE AIDES, INC		123456789
STREET ADDRESS:		
123 A STREET		
CITY	STATE	ZIP CODE
FRESNO	CA	93706
TO THE FOLLOWING FACILITY/ORGANIZATION:		
NAME OF FACILITY/ORGANIZATION:		Transfer Association Type <input type="checkbox"/> Facility Administrator <input type="checkbox"/> Corporation Board Member <input type="checkbox"/> Employee <input type="checkbox"/> Certified Home <input type="checkbox"/> Licensee/Applicant <input type="checkbox"/> Non-client Adult Resident <input type="checkbox"/> Partnership Member <input type="checkbox"/> Spouse of Licensee <input checked="" type="checkbox"/> Affiliated Home Care Aide
AIDES, LLC		
FACILITY/ORGANIZATION NUMBER:	DATE OF EMPLOYMENT:	
987654321	02/05/2016	
STREET ADDRESS:		
123 FIRST STREET		
CITY	STATE	ZIP CODE
FRESNO	CA	93706
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.		Title (licensee, administrator, director)
Signature		LICENSEE
FOR DISTRICT OFFICE USE ONLY		
DATE OF EXEMPTION TRANSFER ENTRY:		INITIAL OF PERSON ENTERING TRANSFER:

HCA Paper Application with CDSS Clearance

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

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: Smith	FIRST: Jane	MIDDLE: H
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2. LIST ALL OTHER NAMES YOU HAVE EVER USED, SUCH AS MAIDEN OR ALIASES (AKAs)

Jane Johnson

3. RESIDENCE ADDRESS

STREET: 123 Main St	APT.:	CITY: Fresno	STATE: CA	ZIP: 93706	COUNTY: Fresno
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4. MAILING ADDRESS (IF DIFFERENT):

PO BOX/STREET:	APT.:	CITY:	STATE:	ZIP:	COUNTY:
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5. E-MAIL (Voluntary)

DATE OF BIRTH

SEX

	05/17/1974	female
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6a. SOCIAL SECURITY NUMBER (Voluntary)

6b. DRIVERS LICENSE OR ID#/PERMANENT RESIDENT ID#/OUT-OF-STATE ID

123-45-6789	A1234567
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7. TELEPHONE NUMBERS

DW: (559) 555-1234	EVERING: (559) 555-5678
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8. TRANSFER PROCESS

Are you currently registered on TrustLine, or licensed by, or working in a facility licensed by, the California Department of Social Services Community Care Licensing?
Please provide the personnel ID number 999999999

Yes No

Do you want to transfer your background clearances from TrustLine or Community Care Licensing to the Home Care Aide Registry? (If yes, fingerprints are not required.)
Enter the Facility # 987654321 (include photocopy of ID)

Yes No

9. AFFILIATED HOME CARE ORGANIZATION

Are you currently affiliated to or applying to become affiliated with a Home Care Organization?
If yes, please list organization name and organization number.

Yes No

ORGANIZATION NAME Home Care Aides, Inc	ORGANIZATION # 123456789
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10. SIGNATURE

SIGNATURE (REQUIRED) 	DATE (REQUIRED) 10/29/2015
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11. FEES: Make a check or money order in the amount of \$25.00 payable to the California Department of Social Services.

12. SUBMISSION

Mall this application, fees, copy of Live Scan Form, and 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 ...

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

HCO Application Intent Process

HCO Application Intent Process

- ▶ The application intent form ([HCS 200A](#)) can be found on the CDSS Forms Page:
<http://www.cdss.ca.gov/cdssweb/PG165.htm>
- ▶ HCO applicants must submit the HCS 200A on or before December 31, 2015.
 - ▶ Email to: HCSBApplications@dss.ca.gov; or
 - ▶ Mail to: California Department of Social Services
Home Care Services Bureau
744 P Street, M.S. T8-3-90
Sacramento, CA 95814
- ▶ The \$5,165 license application fee is not required with the HCS 200A.

HCO Application Intent Process (cont'd)

- ▶ After you submit your HCS 200A, you will receive a notice with information regarding:
 - ▶ Your HCO number which you should use in all future communication;
 - ▶ How to commence with the fingerprinting process; and
 - ▶ The online orientation.
- ▶ A completed application package with the \$5,165 license application fee must be submitted (via mail) by March 1, 2016.

HCA Intent Spreadsheet

HCA Intent Spreadsheet

- ▶ The HCA application intent spreadsheet ([HCS 500A](#)) is in process of being posted.
- ▶ HCO applicants, who employ HCA applicants, must email the HCS 500A to the HCSB on or before December 31, 2015.
 - ▶ Email to: HCSBApplications@dss.ca.gov
- ▶ The \$25 HCA registration application fee is not required with the HCS 500A.
- ▶ The HCAs listed on the HCS 500A, must apply online, pay the \$25 HCA registration application fee, and submit LiveScan fingerprints within 30 days from the date the Registry becomes available.

HCA Intent Spreadsheet

HOME CARE AIDE REPORT

California Health and Safety Code Section 1796.61(b) allows Home Care Aide applicants who submit applications prior to January 1, 2016, to continue providing services while going through the application process. Home Care Organization applicants who employ Home Care Aide applicants shall use this form to meet the requirements of this section. This form must be submitted to the Home Care Services Bureau electronically, by the Home Care Organization, on or before December 31, 2015. Please submit any revisions to this forms (i.e., additional Home Care Aides, name changes, etc.) to the email address listed below in the instructions section. In addition, Home Care Aides must apply online, pay the \$25 application fee, and submit LiveScan fingerprints within 30 days from the date the Registry becomes available. Notice of the Registry becoming available will be posted on the Home Care Services Bureau website at: <http://www.cdld.ca.gov/PG3654.htm>. Please note that the \$25 application fee is not required with this intent form. Please see instructions below.

INSTRUCTIONS:

- Please ensure that the form is filled out completely and save the file with your Home Care Organization Name and the date in MM-DD-YY format as the filename. (For example: Apple Home Care 12-20-15.xls)
- The spreadsheet only allows 100 Home Care Aides to be listed. If your Home Care Organization has more than 100 Home Care Aides, please complete multiple spreadsheets for each 100 Home Care Aides. Please save each spreadsheet with your Home Care Organization Name, the date in MM-DD-YY format, and the corresponding numbers with parenthesis as the filename. (For example: Apple Home Care 12-15-15 (1-100).xls; Apple Home Care 12-15-15 (101-200).xls; etc.)
- Please email to HCSBapplications@dss.ca.gov on or before December 31, 2015.
- **Home Care Organization (HCO) Name:** Enter the name used to designate the Home Care Organization under the application or the intent to apply form.
- **Date:** Enter the date the form is completed.
- **Home Care Organization Number:** Enter the number given to the Home Care Organization on the HCS 415A after submission of the intent to apply or HCS 415B after submission of the application. If you have not received the HCS 415A or HCS 415B, please leave blank.
- **Prepared By:** Enter the name and title of the person who completed this form.
- **Name of Home Care Aide (HCA):** Enter the first name and last name of the Home Care Aide in the appropriate column.
- **Date of Hire:** Enter the date the Home Care Aide was first hired by the Home Care Organization.
- **Tuberculosis (TB) Test:** If the Home Care Aide has already completed a TB test, please enter the date of the TB test.
- **Training Hours To Date:** Enter the total training hours the Home Care Aide has completed within the last two (2) years.

HOME CARE ORGANIZATION NAME				
HOME CARE ORGANIZATION NUMBER			PREPARED BY (Name and Title)	
NAME OF HOME CARE AIDE		DATE FIRST HIRED BY HCO	DATE OF TB TEST (if completed)	HCA TRAINING HOURS
FIRST NAME	LAST NAME			
1				
2				
3				
4				

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

Acronyms

Acronym	Term
AB	Assembly Bill
CBCB	Caregiver Background Check Bureau
CCLD	Community Care Licensing Division
CDPH	California Department of Public Health
CDSS	California Department of Social Services
DDS	Department of Developmental Services (California)
DOJ	Department of Justice (California)
DRA	Domestic Referral Agency
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
IHSS	In Home Supportive Services
LPA	Licensing Program Analyst
RO	Regional Office
SB	Senate Bill
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 or by telephone at (916) 657-3570.