



CDSS

WILL LIGHTBOURNE
DIRECTOR

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

744 P Street • Sacramento, CA 95814 • www.cdss.ca.gov



EDMUND G. BROWN JR.
GOVERNOR

January 22, 2014

ALL-COUNTY LETTER (ACL) NO. 14-03

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY FISCAL OFFICERS
ALL IHSS PROGRAM MANAGERS
PUBLIC AUTHORITY EXECUTIVE DIRECTORS

SUBJECT: COORDINATED CARE INITIATIVE (CCI) CONTRACTOR MODE
AGENCIES - AUTOMATICALLY CERTIFIED AS A QUALIFIED
AGENCY

REFERENCE: Welfare and Institutions Code (WIC) section 12302.6; Senate Bill (SB)
1008 (Chapter 33, Statutes of 2012); SB 1036 (Chapter 45, Statutes of
2012); and Assembly Bill (AB) 1471 (Chapter 439, Statutes of 2012)

This ACL provides direction for Agencies that have an existing contract with a county which are being automatically certified by the California Department of Social Services (CDSS) as a Qualified Agency under the Managed Care Health Plan (MCHP) for the provisions of In-Home Supportive Services (IHSS), pursuant to WIC section 12302.6. Specific information regarding certification, re-certification, other requirements and general information regarding the Contract Mode are provided in ACL No. 14-02.

BACKGROUND

As part of the Budget Act of 2012, Governor Brown signed SB 1008 which enacted the CCI. As a part of the CCI, SB 1036 (amended by AB 1471) added section 12302.6 to the WIC, authorizing MCHP to contract with certain agencies for the provision of IHSS in the CCI counties only. WIC section 12302.6 defines criteria upon which the MCHP may enter into such contracts, establishes rules as to how IHSS may be provided by the Agencies, and sets forth minimum requirements for such contracts. Pursuant to WIC section 12302.6(b)(1) "Agency" is defined as a city, county, city and county agency, local health district, proprietary agency, or an entity that has or seeks a contract to provide IHSS. In order for an Agency to enter such a contract, they must be

REASON FOR THIS TRANSMITTAL

- State Law Change
- Federal Law or Regulation Change
- Court Order
- Clarification Requested by One or More Counties
- Initiated by CDSS

certified as a Qualified Agency. The legislature tasked CDSS, in consultation with the Department of Health Care Services (DHCS), to create and manage the certification and re-certification process to become a Qualified Agency.

Agencies with Existing Contracts

Agencies that have an existing contract with a county for the provision of IHSS at the time MCHP assumes contracting authority in that county will be automatically certified as a Qualified Agency. The applicability of the automatic certification process outlined in this ACL includes Agencies that have existing contracts for emergency back-up services. The automatic certification will be limited to the geographical area and type(s) of services provided for under the existing contract. In order to be automatically certified, the Agency must submit an Application for Qualified Agency Certification (SOC 2250), a copy of the existing contract with the county, a processing fee of \$3,000, and a letter from the MCHP acknowledging that they are entering into a contract with the county to continue providing the services. The county must maintain its' existing contract with the Agency for the provision of IHSS until such time as that contract is due to expire.

Geographical Expansion and Service(s) Addition

Agencies that have an existing contract with a county that seek to expand the geographical area and/or type(s) of services provided for under the existing contract must submit a complete application for certification reflecting the proposed expansion. As indicated above, information regarding the specific certification and re-certification application and qualification requirements are provided in ACL No.14-02. In addition to the complete application, an Agency with an existing contract must submit a fee of \$10,000 for the first expansion of geographical area and/or type(s) of services beyond those provided for under the existing contract. The applicable fee is \$10,000 for the first expansion application regardless of whether the proposed expansion is geographical, service type(s), or both. All subsequent applications for expansion beyond the geographical area and/or type(s) of services provided for in the existing contract require a separate \$5,000 expansion fee.

For example: If the Agency seeks to expand the geographical area covered by the existing contract, the Agency must submit a complete application for the geographical expansion and an application fee of \$10,000. If at a later date, the Agency seeks to add an additional type(s) of service, a second complete application and \$5,000 fee would be required. Thus, the total fees for the two separate applications would be \$15,000. However, if the Agency applied for both the geographical expansion and the service

type(s) expansion in the same application, the total fee would be \$10,000 for the one application.

Re-Certification Process

Unless continuing to operate under an existing contract with the county, a Qualified Agency will be required to apply for re-certification with CDSS every three (3) years from the date of its initial certification. For the purposes of Agencies that are automatically certified, the date of initial certification is the date that the MCHP assumes contracting authority. The automatic certification of Agencies with existing county contracts will remain in effect until the triennial deadline that occurs no less than one (1) year after the contract in effect at the time that MCHP assume the contracting authority expires.

When applying for re-certification, Agencies that were automatically certified as a Qualified Agency due to an existing contract will be subject to the same re-certification requirements as all other Agencies seeking to renew their certification. As indicated above, information regarding the specific certification and re-certification application and qualification requirements are provided in ACL No. 14-02. As provided in ACL No. 14-02, re-certification applications must be submitted one hundred and twenty (120) calendar days prior to the re-certification deadline. Applications for re-certification submitted after the one hundred and twenty (120) day re-certification deadline will be charged a late fee of \$100 per calendar day past the one hundred and twenty (120) day deadline.

If an Agency is denied re-certification and appeals the denial, the Agency may continue to operate while the appeal is pending unless the Agency operations pose a health and/or safety risk as determined by CDSS. Complete instructions on how to submit an appeal are provided in ACL No. 14-02.

Applicable Fees

All applicable fees must be submitted in the form of a certified check payable to the CDSS. The application fees are as follows:

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|---|----------------|
| 1) Processing Fee for Automatically Certified | \$ 3,000 |
| 2) First Geographical Expansion or Service addition | \$10,000 |
| 3) Subsequent Geographical Expansion or Service additions | \$ 5,000 |
| 4) Re-certification Fee | \$10,000 |
| 5) Late Re-Certification Fee | \$ 100 per day |

ACL No. 14-03
Page Four

For camera-ready copies in English, contact the Forms Management Unit at fmudss@dss.ca.gov. If your office has internet access you may obtain this form from the CDSS webpage at http://www.dss.cahwnet.gov/cdssweb/FormsandPu_271.htm.

If you have any questions regarding this process, please call 1 (855) 729-2383 or visit www.cdss.ca.gov/ageblinddisabled/PG3413.htm or contact Ruben Romero, Chief, Systems and Administrative Branch at Ruben.Romero@dss.ca.gov.

Sincerely,

Original Document Signed By:

EILEEN CARROLL
Deputy Director
Adult Programs Division

Attachments



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

744 P Street • Sacramento, CA 95814 • www.cdss.ca.gov

QUALIFIED AGENCY CERTIFICATION APPLICATION CHECKLIST

**This checklist must accompany all application packages when returned to CDSS.*

- Verified Completed Application (Form SOC 2250) – (Signed, Dated, Notarized)
- Application Fee - \$10,000 (New), \$3,000 (Automatically Certified) or \$10,000 (Re-certification), \$10,000 (Automatically Certified **first time** Geographical Expansion or Service), \$5,000 (Subsequent Geographical Expansion or Service Additions), \$100 per calendar day past re-certification deadline
- Current geographical location(s) in which services are provided
- Provide a list of services available to recipients
- Provide Legal Name of Agency
 - o DBA or Business Name
 - o Federal Employer Identification Number (FEIN)
 - o Social Security Number (SSN) (individuals or sole proprietorships only)
 - o Attach Fictitious Name Statement
 - o Articles of Incorporation
- Organizational Chart, List of Directors, Officers and Owners
- Three (3) References or Letters of Recommendation
- Three (3) Most Recent Audited Financials – years 20____, 20____, 20____
(or other independently verified documentation showing liquid assets to cover 180 days of IHSS operating expenses. Public entities may submit a “letter of support” in lieu of financial statements)
- Business Plan and Budget Narrative
- W-9 Form (if applicable)
- Bank Account Statements (Past 12 months)
- Proof of Insurance
 - o General and Professional Liability (\$1 million per occurrence/\$3 million aggregate)
 - o Worker’s Compensation (\$1 million total compensation)
 - o Motor Vehicle Liability (\$1 million which includes uninsured motorist and medical)
- Provide copy of current contract with the county or Public Authority (if applicable)

COMMENTS:

You will be notified by CDSS confirming a Completed Application for Certification was received with an Official File Date Letter or a letter requesting further information. Please send completed package to:

**California Department of Social Services
Contract Mode and Certification Unit (CMCU)
Attn: CMCU, Manager
744 P Street, MS 9-9-04, Sacramento, California 95814**



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 ONE): <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 (CHECK ONE) <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. BANK STATEMENTS PAST 12 MONTHS
 B. BUSINESS PLAN AND BUDGET NARRATIVE D. LETTERS OF RECOMMENDATIONS/SUPPORT F. OTHER _____

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.

TO REQUEST APPEAL OF AGENCY CERTIFICATION DENIAL

- This request for appeal must be received within thirty (30) calendar days of the date of the notice informing your agency of its denial for certification.
- Complete and sign the second page of this form.
- Provide a copy of the denial notification.
- Make a copy of the front and back page for your records
- Send this page to:

**California Department of Social Services
Claims, Certification and Appeals Bureau
Appeals Unit, MS 9-9-04
Sacramento, CA 94244-2430**

- The California Department of Social Services (CDSS), Appeals Unit (AU), will review the information contained with the request to make the decision regarding your agency's certification. Upon completion of the review of all materials, the AU will make a determination of certification.
- If you have any questions, call the CDSS AU at 1 (855) 729-2383.

