

## APPLICATION FOR CERTIFICATION OF SPECIAL TREATMENT PROGRAM SERVICES

- INITIAL
- RENEWAL

**INSTRUCTIONS:** Attach this form with the facility’s written program plan

Please send application to: Department of Health Care Services  
 Mental Health Services Division  
 Program Certification Unit  
 1500 Capitol Ave. MS 2703  
 Sacramento, CA 95814

<b>APPLICANT (s) NAME AND ADDRESS</b>		<b>TELEPHONE</b>	<b>FACILITY NAME AND ADDRESS</b>		<b>TELEPHONE</b>
<b>FACILITY MAILING ADDRESS ( if different )</b>			<b>Person in Charge of Facility (include title)</b>		<b>Maximum bed Capacity</b>
<b>PATIENT TYPE</b>		<b>AGE RANGE OF CLIENTS</b>		<b>Number of Certified STP Beds</b>	
<b>NAME OF PROGRAM DIRECTOR</b>		<b>DISCIPLINE</b>	<b>DEGREE</b>		<b>YEARS WORKED WITH MENALLY DISABLED</b>
<b>INTERDISCIPLINARY PROFESSIONAL STAFF</b>					
<b>ADMINISTRATOR’S SIGNATURE:</b>					<b>DATE</b>
<b>FACILITY FAX:</b>		<b>EMAIL ADDRESS:</b>			