APPLICATION FOR LICENSURE
MENTAL HEALTH REHABILITATION CENTER (MHRC)

Name of Applicant/ Facility Name:	Program Director:	
Mailing Address (street):	City:	
Host County:	Zip Code:	Telephone: ( )

Type of Ownership:

☐ Government Entity ☐ Non-Profit Corp. ☐ Individual or Proprietary Corp. ☐ Partnership

☐ Other _____

Is the property owned by the applicant? If no, state the name, address, and affiliation of the property owner.

☐ Yes ☐ No

Capacity to be licensed:

Current Status of the Facility:

☐ To be constructed
☐ Existing Community Care Facility (to be remodeled: Yes or No)
☐ Existing Health Facility (to be remodeled: Yes or No)
☐ Other (to be remodeled: Yes or No) _____

Current Facility License Classification (if any):	Address (street, city, zip code):
Setting: ☐ Rural ☐ Urban	General Target Population:
Legal Classes to be Admitted:	Provisions for Physical Health Treatment: Transfer Agreement with:_____

The following must be submitted with this application:

A. A specific description of what makes the program innovative compared to existing licensed or certified mental health programs.
B. Those items required by Section 783.10, Title 9.
C. A description of the applicant's experience in mental health service delivery.
D. The number, description, and qualifications of staff, by class. (Show only staff time to be worked in the MHRC.)

Applicant's Signature:	Title:	
Organization:	Date:	
Approved - Mental Health Director Signature:	County of:	Date:

Please submit your completed application to:

Licensing & Certification Section
DHCS – Mental Health Services Division
1700 K Street, MS 2800
Sacramento, CA 95811