

State of California—Health and Human Services Agency Department of Health Care Services

APPLICATION FOR LICENSURE PSYCHIATRIC HEALTH FACILITY (P.H.F.) & PROGRAM

1. Name of Applicant: _____
Address: _____
City: _____
County: _____
Zip Code: _____
Telephone: () _____
2. Sponsorship:
Government Entity _____ Non-Profit Corp. _____
Individual or Proprietary Corp. _____ Partnership _____ Other _____
3. Is the property owned by the applicant? Yes _____ No _____
If no, state the name, address and affiliation of the property owner:

4. Current status of the facility:
To be constructed _____ Existing Community Care Facility _____ (to be remodeled: yes _____ no _____)
Existing Health Facility: _____ (to be remodeled: yes _____ no _____)
Other: _____ (to be remodeled: yes _____ no _____)
5. Current License Classification (if any): _____
6. Location of Facility: _____
7. Setting: Rural _____ Urban _____
8. Services, in addition to in-patient treatment, to be offered by the facility:
Day treatment _____ Out-patient _____ None _____ Other: _____
9. Age Groups to be admitted: Children _____ Adolescent _____ General Adult _____
Geriatric _____

10. Legal Classes to be admitted: Voluntary _____ Involuntary _____
LPS Conservatee _____ Judicially Committed _____
11. Provisions for treatment of patients requiring medical services for physical health conditions: Contractual Agreements Attached: _____ If No, under development with:

12. Provision for referral of patient who are found to have psychiatric disorders, that the facility is not able to treat, including transportation arrangements: Statement of Provisions attached: _____
If No, under development with:

13. Provision for After-Care Services:

14. Anticipated Source of Funding for Care and Treatment:
Short-Doyle _____ Insurance _____ Private _____ Other _____
15. If Short-Doyle Funding is not sought, are comments by Board of Supervisors or evidence or consideration by the Board of Supervisors attached? Yes No
Date that Letter of Intent and supporting documents were submitted to the governing body:
_____ (Thirty-day wait is required before submitting the form to the Department of Health Care Services, together with comments, if any, by the governing body. If no comments were forthcoming, a copy of the official noticing of the application on the governing body's agenda is sufficient.)
16. Clinical Director – Name: _____
Degree: _____ License type & #: _____
Phone: _____ () _____

Anticipated average per diem charge for in-patient services to a fully paid patient: \$ _____
Attach a complete list of any and all charges and costs for in-patient services.

The following must be submitted with this application:

- A. A plan for quality assurance, including utilization review and medication monitoring.
- B. A list of diagnoses proposed to be treated by the applicant's program.
- C. A list of diagnostic and treatment services, including all personnel, equipment and modalities that will be used to treat the various diagnoses listed under 'B' above.
- D. A schedule of weekly activities to be engaged in by each patient and a schedule of a patient's typical day. This should include the anticipated flexibility of the program activities to provide for the individual needs of each patient.
- E. A list of the staff identified or hired to date, with a brief resume and copy of current licensure for each.
- F. A description of applicant's previous experience in the provision of mental health services, including appropriate licenses and biographies of both the organization and individual administrators.
- G. The number, description and qualifications of proposed staff; if actual staff members have been hired, submit a copy of their current resume and license;
- H. If the treatment staff time is to be assigned to other than in-patient services, indicate the percent distribution.

- I. A statement from administrators/staff stating whether their licenses have ever been suspended or revoked and whether they are under current indictment, as well as a listing of: their arrest record, if any; any convictions of a felony; and malpractice actions, if any, against them; any charged felonious activities; and any currently pending actions by any private individual, government body, hospital staff office or hospital affiliation involving their professional duties.
- J. A floor plan of the proposed program space, augmented by photographs if possible (Polaroid photos are acceptable).
- K. A narrative description which explains the program. The summary of the planned program should explain how the programmatic space will be used, what treatments and activities will be available to patients and how they will be assured an appropriate, safe and therapeutic environment. The purpose of this section is to allow the Department of Health Care Services to understand both the elements and the overall program that they are reviewing. A detail program description is required.
- L. A clearly written statement of an Admissions Policy by diagnosis which specifies the explicit exclusion of individuals whose primary presenting problems result from drug or alcohol abuse or who require detoxification.
- M. P.H.F. application fee of one thousand dollars (\$1000).

Applicant's signature: _____

Applicant's title: _____

Organization name: _____

Date: _____

Please submit your completed application with payment to:

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

THIS PAGE FOR DEPARTMENT OF HEALTH CARE SERVICES/LICESNING AND CERTIFICAION SECTION ONLY:

CHECKLIST:

- | | | | |
|----------|-----------|------------|------------|
| 1. _____ | 9. _____ | 16. _____ | 18f. _____ |
| 2. _____ | 10. _____ | 17. _____ | 18g. _____ |
| 3. _____ | 11. _____ | 18a. _____ | 18h. _____ |
| 4. _____ | 12. _____ | 18b. _____ | 18i. _____ |
| 5. _____ | 13. _____ | 18c. _____ | 18j. _____ |
| 6. _____ | 14. _____ | 18f. _____ | 18k. _____ |
| 7. _____ | 15. _____ | 18e. _____ | 18l. _____ |
| 8. _____ | | | |

Reviewer: _____

Date reviewed: _____

Date application completed: _____

REVIEWER COMMENTS:

SITE REVIEW: date(s):

COMMENTS:

REVIEWER: _____ DATE APPROVED: _____