

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

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