

Supplemental Application Request for Additional Services

Please review the following information and note any changes. **This document must be COMPLETELY FILLED OUT, SIGNED BY AN AUTHORIZED REPRESENTATIVE(S), received and approved by the Department of Health Care Services (DHCS) prior to providing any additional treatment services.**

This form shall be returned with applicable fees payable to: Department of Health Care Services and mailed to the address listed above. **Please include your provider number on all correspondence.**

You must complete all fields on this application. Incomplete applications will be returned unprocessed and may delay approval of the requested change(s).

Provider Number (License/Certification Number):			
Legal Entity Name:			
Mailing Address:			
City:	State:	Zip Code:	Phone:
Facility Name:			
Facility Address:			
City:	State: CA	Zip Code:	Phone:
Website:	Fax:	Email:	
Contact Person:	Phone:	Email:	
Director's Name:	Phone:	Email:	
Type of Organization: <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Profit Corporation <input type="checkbox"/> Nonprofit Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Government Entity			
REQUESTED CHANGE (please check all that apply):		TARGET POPULATION:	
RESIDENTIAL <input type="checkbox"/> Incidental Medical Services <input type="checkbox"/> Detoxification <input type="checkbox"/> Increased Capacity <input type="checkbox"/> Decreased Capacity <input type="checkbox"/> Relocation <input type="checkbox"/> Co-ed <input type="checkbox"/> Discontinuance of a Treatment Service	CERTIFICATION <input type="checkbox"/> Day Treatment <input type="checkbox"/> Outpatient <input type="checkbox"/> Residential <input type="checkbox"/> Detoxification <input type="checkbox"/> Relocation <input type="checkbox"/> Discontinuance of a Treatment Service	<input type="checkbox"/> Co-Ed <input type="checkbox"/> Dual Diagnosis <input type="checkbox"/> Men Only <input type="checkbox"/> Families <input type="checkbox"/> Women Only <input type="checkbox"/> Other _____ <input type="checkbox"/> Youth/Adolescents <input type="checkbox"/> Parents/Children # of Children: _____ <input type="checkbox"/> Modification of Target Population	

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Additional Required Documentation

<p>Increased Capacity:</p> <p><input type="checkbox"/> Fire Clearance STD 850</p> <p><input type="checkbox"/> Floor plan</p> <p><input type="checkbox"/> Building/Local Use Permit (If applicable)</p> <p><input type="checkbox"/> Fees</p> <p><input type="checkbox"/> Facility Staffing Data Form - DHCS 5050</p>	<p>Day Treatment: (Outpatient Only)</p> <p><input type="checkbox"/> Weekly Activities Schedule DHCS 5086 Form</p> <p><input type="checkbox"/> Building/Local Use Permit (If applicable)</p> <p><input type="checkbox"/> Facility Staffing Data Form - DHCS 5050</p>
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<p>Co-Ed:</p> <p><input type="checkbox"/> Fire Clearance STD 850 Form</p> <p><input type="checkbox"/> Fees</p> <p><input type="checkbox"/> Facility Staffing Data Form - DHCS 5050</p> <p><input type="checkbox"/> Floor Plan</p> <p>Include a new floor plan that specifies which beds and restrooms will be designated for males and females</p>	<p>Detoxification:</p> <p><input type="checkbox"/> Fire Clearance STD 850</p> <p><input type="checkbox"/> Facility Staffing Data Form - DHCS 5050</p> <p><input type="checkbox"/> Revised program description that includes detox services</p> <p><input type="checkbox"/> Protocol's that state the procedures for accepting detox clients</p> <p><input type="checkbox"/> Floor Plan (specify which beds will be used for detox)</p>
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Incidental Medical Services:

Incidental Medical Protocols and Policies

Valid Health Care Practitioners License

Fire Clearance - STD 850

Health Care Practitioners Acknowledgement

Floor Plan

Facility Staffing Data Form - DHCS 5050

Fees

***Relocation:**

Fire Clearance STD 850

Lease Agreement (If applicable)

Facility Staffing Data Form DHCS 5050

Fees

Board Resolution Approving Relocation (If applicable)

Building/Local Use Permit (If applicable)

Floor Plan

***If you are requesting to relocate you must include a letter explaining why you are moving, anticipated move date and the new facility address.**

New Facility Address	City	Zip

Discontinue Treatment Services and/or Target Population:

Updated Policy and Procedures

Revised Floor Plan

Current Facility Staffing Data Form

CERTIFICATIONS AND ASSURANCES

I certify under penalty of perjury that I have read, understand, and will comply with the regulations and/or standards that govern the operation of the program for which I am applying. The information contained in this application is accurate, true and complete in all material aspects. All program policies and procedures required by the regulations and/or standards that govern the operation of this program have been developed, comply with the appropriate regulations and standards, and are available for review by DHCS upon request. Furthermore, the applicant does not discriminate in employment practices or provision of services on the basis of race, national origin, ethnic group, identification, religion, age, sex, sexual orientation, color or disability pursuant to the Title VI, Civil Rights Act of 1964, (42 U.S.C. Chapter 21), The Americans with Disabilities Act of 1990 (42 U.S.C. § 12132), California Government Code § 11135, The Rehabilitation Act of 1973 (29 U.S.C. § 794), and Title 9, California Code of Regulations, Commencing with § 10800.

If the applicant is a sole proprietor, the application shall be signed by the proprietor; If the applicant is a partnership, the application shall be signed by each partner, and if the applicant is a firm, association, corporation, county, city, public agency or other governmental entity, the application shall be signed by the chief executive officer or an individual authorized to represent the provider. Attach additional signature pages if necessary.

Signature of Authorized Individual	Print Name	Title	Date
Signature of Authorized Individual	Print Name	Title	Date