

Additional Required Documentation

<p>Increased Capacity:</p> <p><input type="checkbox"/> Fire Clearance Form 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 Form DHCS 5086</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 Form STD 850</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 Form 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 Form STD 850

Health Care Practitioners Acknowledgment

Floor Plan

Facility Staffing Data Form DHCS 5050

Fees

***Relocation:**

Fire Clearance Form 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