

**APPLICATION FOR MENTAL HEALTH PROGRAM APPROVAL
SHORT-TERM RESIDENTIAL THERAPEUTIC PROGRAMS (STRTP)**

Name of Applicant/ Facility Name:		Head of Service:	
Mailing Address (<i>Street #, Street Name, P.O. Box, Apt. #</i>):		City:	
Delegate County Mental Health Plan:		Zip Code:	Telephone: ()
Type of Ownership: <input type="checkbox"/> Government Entity <input type="checkbox"/> Non-Profit Corp.			
Number of beds to be certified:			
Age Groups to be admitted:		Children _____	Youth _____

The following information must be submitted along with this application form. Note: the Sections listed for each item below refer to the sections in the STRTP Mental Health Program Approval Protocol:

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1) Mental Health Program statement that meets the requirements of Section 3 . | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Policies and procedures the facility will utilize to meet the notification requirements in Section 4 ; | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Policies and procedures the facility will utilize to meet the program record documentation and retention requirements in Section 5 ; | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Policies and procedures the facility will utilize to meet the intake summary requirements in Section 6 . | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) Policies and procedures the facility will utilize to meet the mental health assessment requirements in Section 7 ; | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) Policies and procedures the facility will utilize to meet the requirements for the needs and services plan in Section 8 ; | <input type="checkbox"/> | <input type="checkbox"/> |
| 7) Policies and procedures the facility will utilize to meet the progress note documentation requirements in Section 9 ; | <input type="checkbox"/> | <input type="checkbox"/> |
| 8) Policies and procedures the facility will utilize to meet the transition determination plan requirements in Section 10 ; | <input type="checkbox"/> | <input type="checkbox"/> |
| 9) Policies and procedures the facility will utilize to meet the medication control and monitoring requirements in Section 11 ; | <input type="checkbox"/> | <input type="checkbox"/> |

	Yes	No
10) Provide a detailed description of the specific treatment modalities the facility will utilize to meet mental health treatment services requirements in Section 12 . This description shall include policies and procedures for ensuring that children receive medically necessary services that the facility does not provide directly, including Specialty Mental Health Services for Medi-Cal beneficiaries;	<input type="checkbox"/>	<input type="checkbox"/>
11) Policies and procedures the facility will utilize to meet the clinical review report and transition determination requirements in Section 13 ;	<input type="checkbox"/>	<input type="checkbox"/>
12) Provide documentation indicating that the proposed head of service meets the qualifications and experience required in Section 14 and will be employed forty hours per week.	<input type="checkbox"/>	<input type="checkbox"/>
13) Provide staffing patterns. Include an organizational chart, which lists job descriptions, staff-to-child ratios, functions, and professional licenses, if applicable, of the direct service program staff. Include information regarding contractors that will be available to provide mental health treatment services to children during their stay in the STRTP. Demonstrate through these documents that the applicant will provide at least one full time equivalent (FTE) direct service program staff for each 6 children residing in the STRTP which includes at least one half-time equivalent licensed mental health professional for each 6 children residing in the STRTP. Include the staff qualifications, training, and experience for each position type required in Section 15 ;	<input type="checkbox"/>	<input type="checkbox"/>
14) Policies and procedures the facility will utilize to meet the requirement in Section 15 that the facility has a psychiatrist on the premises or available 24 hours per day.	<input type="checkbox"/>	<input type="checkbox"/>
15) A detailed staff training plan, describing staff orientation procedures and in-service education required in Section 16 ;	<input type="checkbox"/>	<input type="checkbox"/>
16) Policies and procedures the facility will utilize to meet the personnel record requirements in Section 17 ;	<input type="checkbox"/>	<input type="checkbox"/>
17) Policies and procedures regarding the utilization of community resources as adjunct to the facility's mental health program, if applicable.		<input type="checkbox"/>
Applicant's Signature:	Title:	
Organization:	Date:	

**Please submit your completed
application to:**

**Delegate County MHP
and to DHCS at:**

Licensing & Certification Section
DHCS – Mental Health Services Division
P.O. Box 997413, MS 2800
Sacramento, CA 95899-7413