State of California – Health and Human Services Agency
Department of Health Care Services
Licensing and Certification Division
Mental Health Licensing and Certification Branch
PO Box 997413, MS 2800
Sacramento, California 95899-7413
Email: PRTF@dhcs.ca.gov

APPLICATION FOR RENEWAL OF LICENSE FOR PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

A private nonprofit organization, county, county contracted nonprofit provider, city, public agency or other governmental entity shall use this application form to apply to the Department of Health Care Services (DHCS) for a Psychiatric Residential Treatment Facility (PRTF) license renewal.

"PRTF" means a health facility licensed by DHCS that is operated by a public agency or private nonprofit organization that provides inpatient psychiatric services for individuals under age twenty-one (21), as described in Subpart D (commencing with Section 441.150) of Title 42 of the Code of Federal Regulations, in a nonhospital setting.

APPLICATION INSTRUCTIONS

Please read and follow these instructions carefully, and complete each item requested. Submit your application only after it has been properly completed, the required supportive documentation has been prepared, and the entire packet has been properly formatted.

Applications received by DHCS that do not meet the requirements described in these instructions will be returned to the applicant, minus any fees, without having been reviewed. The review process will not begin until the application meets the submission requirements. *An applicant may withdraw their application in writing at any time. The fee for processing the application shall be forfeited upon withdrawal.*

For additional information, please review the PRTF Interim Regulations, which outline the requirements for licensure of a PRTF.

For hard-copy submissions:

The application and all supportive documentation must be printed single-sided, with 12-point font on 8½" x 11" white paper. Documentation provided by a third party must be submitted unaltered and in the original format (size, font, color) that it was created.

DO NOT LEAVE any questions, boxes, lines, or fields blank.

DO NOT USE staples on this form or on any attachments.

DO NOT SUBMIT double-sided or bound documents.

DO NOT USE plastic sheets or page protectors, correction tape, white out, or highlighter pens or ink of a similar type on this form or any supporting documentation. If you must make corrections, please line through, date, and initial in ink.

You may attach additional documents if your response to a section in this form does not fit in the provided space. Label each additional document with a unique attachment name (for example, "Attachment A"), and identify that attachment in the appropriate section of the form. You must provide a response in all sections that request information. If a section does not apply, enter "N/A."

SECTION A – FACILITY INFORMATION

This section must be completed by the licensee:

1. Facility Name – Enter the name of the licensed facility that the licensee is seeking renewal for.

2. Telephone and Email Address – Enter the facility's telephone number and email address (if applicable).

3. Facility Street Address – Enter the physical location of the facility. If the licensee is seeking renewal for more than one facility, the licensee shall complete a separate application for each facility.

4. Facility Mailing Address – Enter the facility's mailing address, if different from the street address listed in **3.** If the address is different, the Department will send all official mail to this address.

5. Type of Ownership – Check the box that describes the facility's tax status, i.e., a government entity or non-profit organization.

6. Total number of beds to be licensed – Enter the number of beds at the facility that the licensee is seeking to be licensed for.

7. Operational Questions – Check the box that describes the facility's secured status.

8. Minimum age to be admitted – Enter the minimum age that will be admitted to the facility.

SECTION B – ATTESTATION

This section must be completed by all licensees applying for renewal

Read the attestation carefully before signing the application. The application must be signed by the chief executive officer or an authorized representative.

If the licensee applying for renewal is a corporation of any type, submit a board of director's resolution or board minutes granting authorization to the person signing the application.

If the licensee applying for renewal is a public agency, submit authorization from the agency, department administrator, or the County Board of Supervisors, for the person signing the application.

If the licensee applying for renewal is a partnership, the application shall be signed by all partners.

SUPPORTING DOCUMENTATION AND DESCRIPTIONS

The supporting documentation as listed below shall be submitted as part of a completed application.

If you are submitting your application electronically, identify each supporting document using the below *titles*.

If you are submitting a hard-copy application, each supporting document shall be numbered and separated by correspondingly numbered tabbed dividers.

Application for Renewal of License For Psychiatric Residential Treatment Facility

In addition to the Application for Renewal of License For Psychiatric Residential Treatment Facility, this packet shall include the following:

(1) A copy of the current fire clearance from the city or county fire department, the district providing fire protection services, or the State Fire Marshal's Office;
(2) A written financial plan including an actual or proposed annual budget approved by the governing body;
(3) The license renewal fee; and
(4) The application renewal fee as required by **Section 15** of the PRTF Interim regulations.

SECTION A – FACILITY INFORMATION

1. Facility Name:	Administrator: Clinical Director:

2. Telephone:	Email Address (If applicable):

3. Facility Street Address:	City:	Zip Code:	County:
4. Facility Mailing Address: (if different from above)	City:	Zip Code:	County:

5. Type of Ownership:

☐ Government Entity ☐ Non-Profit Organization

6. Total number of beds to be licensed:

7. Operational Questions

Will the PRTF operate as a locked or unlocked (*staff-secured with delayed egress*) facility?

☐ Locked ☐ Unlocked (*staff-secured with delayed egress*) ☐ Both

8. Minimum age to be admitted:

SECTION B – ATTESTATION

I declare, under penalty of perjury under the laws of the State of California, that the foregoing information and any attachment is true, accurate and complete to the best of my knowledge and belief. I hereby further declare that I have read, understand, and will comply with the statutes, regulations and standards that govern the operation of the facility for which I am applying, including Subpart D of Part 441 and Subpart G of Part 483 of the Code of Federal Regulations. All program policies and procedures required by the regulations and/or standards that govern the operation of this facility have been developed and comply with the appropriate regulations and standards.

I HEREBY CERTIFY that I have read and understand all statutes, regulations, and interim regulations applicable to PRTFs. I FURTHER CERTIFY that the PRTF shall comply with all applicable laws and regulations, as well as the Plan of Operation.

I declare that I am authorized to sign this application on behalf of the licensee.

Print Name:	Title:
Signature:	Date:

Please submit your completed application to:

Department of Health Care Services
Licensing and Certification Division
ATTN: Mental Health Licensing and Certification Branch
P.O. Box 997413, (MS 2800)
Sacramento, CA 95899-7413
Main Line: (916) 323-1864
Fax: (916) 324-0993
Email: PRTF@dhcs.ca.gov

PRIVACY NOTICE ON COLLECTION

The purpose of this form is to collect information for licensure of PRTF. The information collected in this form is required by the Department of Health Care Services (Department), Licensing and Certification Division, Mental Health Licensing and Certification Branch by the authority of Health and Safety Code sections 1250.10 and 1254, Welfare and Institutions Code sections 4081 and 4082, and the PRTF Interim Regulations. The personal information collected in this form is confidential and protected by the Information Practices Act (California Civil Code section 1798 et seq.), Department policy, and state policy.

All information requested in this form is mandatory. The consequence of not supplying the mandatory information requested or supplying incomplete information is that review of the application shall be terminated. The Department may share provided information with other state agencies to perform its constitutional or statutory duties where the use is compatible with a purpose for which the information was collected. The Department may also share information with local, state, or federal government entities if required by state or federal law. Please do not provide any personal information other than the information that is specifically requested in this form.

In most cases, individuals have a right to access information about them that is in federal and state records. For more information or access to records containing your personal information maintained by the Department, contact the following:

Licensing and Certification Division
Section Officer of the Day
1501 Capitol Avenue, MS 2601
Sacramento, CA 95814
Tel: (916) 322-2911

The Department of Health Care Services' policies regarding personal information are available online in the Department's Notice of Privacy Practices (https://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/NoticeofPrivacyPractices.aspx) and the Privacy Policy Statement (https://www.dhcs.ca.gov/pages/privacy.aspx).