

Disclosure to the Department of Healthcare Services (DHCS)

Pursuant to Health and Safety Code (HSC) Section 11833.05(a), applicants, programs certified or facilities licensed by DHCS are required to disclose specified information to DHCS. This information includes:

1. Any ownership, control of, or financial interest in a recovery residence as defined in HSC Section 11833.05(f);
2. Any contractual relationship with an entity that provides professional services, addiction treatment, or recovery services to clients of facilities licensed and/or programs certified by DHCS, if the entity is not part of the facility licensed and/or program certified by DHCS.

Disclosures must be made at the time of:

1. Application for initial licensure or certification;
2. Application for extension of licensure or certification; **AND**
3. Whenever a licensed facility or certified program acquires or starts a relationship that meets the requirements of HSC Section 11833.05(a).

The disclosure form shall be completed, signed, and dated by an authorized individual. DHCS may suspend or revoke the certification of a program or license of a facility for failure to submit this disclosure.

INSTRUCTIONS FOR COMPLETION OF THIS FORM**Return completed form to the address below:**

Licensing and Certification Division
Licensing and Certification Section, MS 2600
PO Box 997413
Sacramento, California 95899-7413
Email: LCDSUDApplication@dhcs.ca.gov

DO NOT LEAVE any questions, boxes, lines, or fields blank. Enter N/A if not applicable to you.

For hard-copy submissions:

The form and all supportive documentation must be printed single sided, with 12-point font on 8 1/2" by 11" white paper.

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

DO NOT SUBMIT doubled sided or bound documents.

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

PLEASE NOTE: Read all the instructions included on this form carefully and complete each item requested. For additional information regarding licensure of a residential alcoholism or drug abuse recovery or treatment facility providing alcoholism or drug abuse treatment or recovery services, please review Health and Safety Code section 11834.01 *et seq.* For additional information regarding the certification of an alcohol and other drug program providing alcohol and other drug (AOD) services, please review Health and Safety Code section 11832 *et seq.* This form can be used for licensure of a residential alcoholism or drug abuse recovery or treatment facility and/or certification of an alcohol and other drug program. Accordingly, terminology applicable for licensure (including “resident” and “facility”) and terminology applicable for certification (including “client” and “program”) are both referenced within this form.

BUSINESS ENTITY INFORMATION

This section must be completed by all applicants.

Business Entity Name - Enter the business entity name. This should be the legal entity name as filed with the Secretary of State (SOS) as specified below:

Corporation - For a corporation, enter the name exactly as it is filed with the SOS and as it appears on the entity's Articles of Incorporation.

Nonprofit Corporation - For a nonprofit corporation, enter the name exactly as it is filed with the SOS and as it appears on the entity's Articles of Incorporation.

Partnership or Limited Partnership (LP) - For a partnership or LP, enter the name of the partnership exactly as it is filed with the SOS on the Statement of Partnership Authority or Certificate of Limited Partnership, respectively.

Limited Liability Company (LLC) - For a LLC, enter the name exactly as it is filed with the SOS and as it appears on the entity's Articles of Organization.

Sole Proprietor - For a sole proprietor, enter the full legal name of the sole proprietor.

Governmental Agency - For a governmental agency, enter the name of the governmental agency.

If the business entity has filed any of the above-mentioned documents with the SOS, you can look up your business entity's name on the SOS website at: <https://www.sos.ca.gov/>. The business entity's status with the SOS must remain valid and active.

Facility/Program Name(s) - Enter the name of the facility(ies) or program(s). Do not include the business entity name in this box unless the facility or program name is the same as the business entity name. Do not include the words or abbreviation for "Doing Business As," unless you intend to use those words or the abbreviation in the facility or program's name.

Facility License and/or Program Certification Number(s) - Enter the facility license and/or program certification number(s), if applicable.

DISCLOSED BUSINESS ENTITY INFORMATION

This section must be completed by all applicants.

Use this section to report information on the business entity being disclosed to the Department.

DHCS License, Certification and Provider Number(s) - Enter all DHCS issued facility license numbers, facility certification numbers, and provider numbers associated with the business entity being disclosed. If not applicable, enter N/A.

Disclosed Business Entity Name (include Doing Business As (DBA) Name) - Enter the name of the business entity being disclosed.

Physical Address of Disclosed Business Entity - Enter the physical address, including city, state and zip code of the recovery residence or program that provides professional, addiction, or recovery services to residents/clients.

Business Type - Enter the business type of the business entity being disclosed (e.g., hospital, clinic, counseling center, transportation, outpatient or recovery residence).

Relationship with Disclosed Business Entity (include all that apply): Enter the relationship between the applicant, licensed, or certified program and the business entity being disclosed. Include all that apply.

- ☐ Ownership
- ☐ Control of
- ☐ Financial Interest
- ☐ Contractual Relationship

DECLARATION

Print Name – Enter the first and last name of the individual signing the form.

Title – Enter the title of the individual signing the form.

Signature – Sign the form.

Date – Enter the date that the form is signed.

BUSINESS ENTITY INFORMATION

Business Entity Name:

Facility/Program Name(s):

Facility License and/or Program Certification Number(s), if applicable:

DISCLOSED BUSINESS ENTITY INFORMATION*(Include additional sheets, if necessary)***Use this Section to report the information on Disclosed Business Entities**

DHCS License, Certification and Provider Number(s):

Business Type:

Disclosed Business Entity Name (Include Doing Business As (DBA) Name):

Street Address of Disclosed Business Entity:

City:

State:

Zip Code:

Relationship with Disclosed Business Entity (Include all that apply):

DHCS License, Certification and Provider Number(s):

Business Type:

Disclosed Business Entity Name (Include Doing Business As (DBA) Name):

Street Address of Disclosed Business Entity:

City:

State:

Zip Code:

Relationship with Disclosed Business Entity (Include all that apply):

DHCS License, Certification and Provider Number(s):

Business Type:

Disclosed Business Entity Name (Include Doing Business As (DBA) Name):

Street Address of Disclosed Business Entity:

City:

State:

Zip Code:

Relationship with Disclosed Business Entity (Include all that apply):

DECLARATION

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 will comply with the statutes, regulations and standards that govern the operation of this facility or program.

I declare that I am authorized to sign this form.

Only one signature is required unless applicant is a partnership.

Print Name:	Title:
Signature:	Date:
Print Name:	Title:
Signature:	Date:
Print Name:	Title:
Signature:	Date:

PRIVACY NOTICE ON COLLECTION

The purpose of this form is to collect information for licensure and/or certification of residential alcoholism and drug abuse recovery or treatment facilities, or certification of alcohol and other drug programs. The information collected in this form is required by the Department of Health Care Services (Department), Licensing and Certification Division, by the authority of Health and Safety Code, Sections 11832 *et seq.* and 11834.01 *et seq.* The personal information collected in this form is confidential and protected by the Information Practices Act (California Civil Code 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
SUD Licensing and Certification Section
PO Box 997413, MS 2600
Sacramento, California 95899-7413
Tel: (916) 322-2911

Return completed form to email address: LCDSUDApplication@dhcs.ca.gov.

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>).