

**APPLICATION FOR CERTIFICATION
COMMUNITY TREATMENT FACILITY SERVICES**

Name of Applicant/ Facility Name:		Program Director:	
Facility Address (Street No., Street Name, P.O. Box, Apt. No.):		City:	
Mailing Address (if different from above):		City:	
County of Residence:		Zip Code:	Telephone: ()
Licensee:			
Mental Health Contract (MHP) Yes <input type="checkbox"/> No <input type="checkbox"/>		Medi-Cal Certification Yes <input type="checkbox"/> No <input type="checkbox"/>	
Age Groups to be admitted:		Bed capacity:	
Applicant's Printed Name:		Title:	
Applicant's Signature:		Phone Number:	
Organization:		Date:	

**Please submit your completed application which includes a Plan of Operation
that meets 9 CCR § 1919 to:**

DHCS at:

E-Mail

Attention: CTF Certification application
CMHC@DHCS.CA.GOV

*If e-mailing the application, please print, sign, scan and e-mail to mailbox.

Certified Mail

Department of Health Care Services
Continuum of Mental Health Care Section
1500 Capitol Av, MS 2633
Sacramento, CA 95814