Application for Certification Amendment(s)

Instructions for Completion of this Form

Return completed form to the address designated below:

Licensing and Certification Division
SUD Licensing and Certification Section
PO Box 997413, MS 2600
Sacramento, California 95899-7413

Email: LCDQuestions@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 ½" by 11" white paper.

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 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, please review the Alcohol and Other Drug Program Certification Standards commencing with Section 11, which outlines the requirements for all alcohol and other drug programs certified under Chapter 7.1 (commencing with Section 11832), Part 2, Division 10.5 of the Health and Safety Code.

Section A – Type of Amendment(s)

This section must be completed by all applicants.

Check the appropriate box for the type of certification amendment for which you are applying and complete the corresponding sections for each amendment type as described below:

Adding/Removing Outpatient Treatment or Recovery Services – Outpatient Service means a client shall be provided a maximum of nine (9) hours per week of counseling services.

Adding/Removing Intensive Outpatient Services – Intensive Outpatient Service means a client shall be provided a minimum of nine (9) hours per week with a maximum of nineteen (19) per week of counseling services. Services received by a client may exceed the maximum based on individual medical necessity.

Adding/Removing Outpatient Detoxification Services – Outpatient Detoxification Services means services designed to support and assist a client experiencing withdrawal from alcohol and other drugs in an outpatient setting.

Adding/Removing Outpatient Medications for Addiction Treatment (MAT) Services – MAT services mean the program shall either offer MAT directly to clients or have a MAT referral process in place.

Increasing/Decreasing Slot Count – "Slot" means the maximum number of individuals who can receive AOD services at the program at any given time on any given day.

Relocating Operation of a Program – A change in the location of a program.

Adding/Removing Program Address – The addition or removal of a building, room or suite number to an existing program address.

Changing the name of the Program – A change in the name of the program.

Changing the Name of the Business Entity – A change in the name of the business entity.

Section B – Program Information

This section must be completed by all applicants.

Program Name – Enter the name of the program. Do not include the business entity name in this box unless the 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 program's name.

Program Certification Number – Enter the program certification number.

Program Street Address – Enter the physical street address of the program.

Room/Suite – Enter the room or suite number of the program. If there are more than one, enter all rooms or suite numbers, if not applicable, enter N/A.

City – Enter the city of the program.

State – This field is pre-filled to California. The Department only certifies programs physically located in California.

Zip Code – Enter the zip code of the program.

Business Phone Number – Enter the business phone number for the program.

Type of Organization – Check the box that describes the tax status of your business entity.

Contact Person Information

Enter the contact information of the person you want the Department to contact regarding this application.

Name – Enter the first and last name of the contact person.

Title – Enter the title or position of the contact person (i.e., program director, executive director, etc.).

Salutation – Enter the salutation of the contact person (i.e., Mr., Mrs., Dr., etc.).

Business Phone Number – Enter the business phone number of the contact person, including an extension, if any.

Business Email Address – Enter the business email address of the contact person.

Program Director Information

Name – Enter the first and last name of the program director.

Business Phone Number – Enter the business phone number of the program director, including an extension, if any.

Business Email Address – Enter the business email address of the program director.

Section C – Outpatient Detoxification Services

This section must be completed to apply for the addition or removal of outpatient detoxification services.

Proposed effective date – Enter the proposed date outpatient detoxification services will be added or removed.

Check the appropriate box to add or remove outpatient detoxification services.

For the addition of outpatient detoxification services:

Attach a copy of the following supporting documentation reflecting the addition of outpatient detoxification services:

1. Staff and Health Care Practitioner (HCP) information form (DHCS 5050).
2. Program description.
3. Admission agreement.
4. Written policies and procedures for admission and readmission.
5. Written policies and procedures for MAT (if applicable).

For the removal of outpatient detoxification services:

Attach a copy of the following supporting documentation reflecting the removal of detoxification services:

1. Program description.
2. Admission agreement.
3. Written policies and procedures for admission and readmission.
4. Written policies and procedures for MAT (if applicable).

Section D – Outpatient Medications for Addiction Treatment (MAT) Services

This section must be completed to apply for the addition or removal of outpatient MAT services.

Proposed effective date – Enter the proposed date outpatient MAT services will be added or removed.

Check the appropriate box to add or remove outpatient MAT services.

For the addition of outpatient MAT services:

Attach a copy of the following supporting documentation reflecting the addition of outpatient MAT services:

1. Staff and Health Care Practitioner (HCP) information form (DHCS 5050).
2. Program description.
3. Admission agreement.
4. Written policies and procedures for admission and readmission.
5. Written policies and procedures for MAT.

For the removal of outpatient MAT services:

Attach a copy of the following supporting documentation reflecting the removal of detoxification services:

1. Program description.
2. Admission agreement.
3. Written policies and procedures for admission and readmission.
4. Written policies and procedures for MAT.

Section E – Slot Count

This section must be completed to apply for an increase or decrease of slot capacity.

Proposed Effective Date – Enter the proposed date of the increase or decrease in slot capacity.

Current Slot Count – Enter the previous slot count for the program.

Requested Slot Count – Enter the requested slot count for the program.

Attach a copy of the following supporting documentation for an increase or decrease in capacity:

1. Staff and Health Care Practitioner (HCP) Information form (DHCS 5050).
2. Fire authority information.
3. Current business license, as required by the local jurisdiction, if applicable.
4. Proof of required liability insurance coverage or proof of bond, in accordance with Alcohol and Other Drug Program Certification Standards, Section 40 if applicable.

Section F – Relocating Operation of a Program

This section must be completed to apply for relocating the operation of a program

Proposed Effective Date – Enter the proposed date of the relocation.

Proposed County – Enter the county of the proposed program.

Proposed Program Street Address – Enter the physical address of the proposed program.

Proposed Room/Suite – Enter the room or suite number of the proposed program. If not applicable, enter N/A.

Proposed City – Enter the city of the proposed program.

State – This field is pre-filled to California. The Department only certifies programs physically located in California.

Proposed Zip Code – Enter the zip code of the proposed program.

Proposed Business Phone Number – Enter the business phone number for the proposed program.

Attach a copy of the following supporting documentation for relocating the operation of a program:

1. Staff and Health Care Practitioner (HCP) Information form (DHCS 5050).
2. Fire authority information.
3. Current business license, as required by local jurisdiction.
4. Property deed, lease or rental agreement, or written authorization for use of property.
5. Board minutes approving relocation, if applicable.
6. Proof of required liability insurance coverage or proof of bond, in accordance with Health and Safety Code section 11834.10, Alcohol and Other Drug Program Certification Standards, Section 40.
7. Admission agreement (if applicable).
8. Any other documentation updated to reflect the relocation of the program.

Section G – Adding Program Address

This section must be completed to apply to add a program address.

Proposed Effective Date – Enter the proposed date of the addition of a program address.

County – Enter the county of the program.

Program Street Address – Enter the physical address of the program.

Proposed Building/Room/Suite – Enter the building, room or suite number of the proposed addition to the program.

City – Enter the city of the program.

State – This field is pre-filled to California. The Department only certifies programs physically located in California.

Zip Code – Enter the zip code of the program.

Proposed Business Phone Number – Enter the business phone number for the proposed addition to the program.

Attach a copy of the following supporting documentation for adding a program address:

1. Staff and Health Care Practitioner (HCP) Information form (DHCS 5050).
2. Fire authority information.
3. Admission agreement.
4. Current business license, as required by the local jurisdiction, if applicable.
5. Property deed, lease or rental agreement, or written authorization for use of property.
6. Board minutes approving the new program address, if applicable.
7. Proof of required liability insurance coverage or proof of bond, in accordance with Health and Safety Code section 11834.10, Alcohol and Other Drug Program Certification Standards, Section 40.

Section H – Removing a Program Address

This section must be completed to apply to remove a program address.

Proposed Effective Date – Enter the proposed date of the removal of a program address.

County – Enter the county of the program being removed.

Program Street Address – Enter the physical address of the program being removed.
Proposed Building/Room/Suite – Enter the building, room or suite number of the program being removed.

City – Enter the city of the program being removed.

State – This field is pre-filled to California. The Department only certifies programs physically located in California.

Zip Code – Enter the zip code of the program being removed.

Business Phone Number – Enter the business phone number for the program being removed.

Attach a copy of the following supporting documentation for removing a program address:

1. Staff and Health Care Practitioner (HCP) Information form (DHCS 5050), if applicable.
2. Admission agreement.
3. Board minutes approving the removal of the program address, if applicable.

Section I – Changing the Name of the Program

This section must be completed to apply to change the name of the program.

Proposed Effective Date – Enter the proposed date of the name change of the program.

Proposed Program Name – Enter the proposed name of the program.

Attach a copy of the following supporting documentation for the name change of the program.

1. Fictitious business name statement.
2. All policies and procedures updated to reflect the program name change.
3. Admission agreement.
4. Any other documentation updated to reflect the program name change.
5. Proof of required liability insurance coverage or proof of bond, in accordance with Health and Safety Code section 11834.10, Alcohol and Other Drug Program Certification Standards, Section 40, if applicable.

Section J – Changing the Name of the Business Entity

This section must be completed to apply to change the name of the business entity.

Proposed Effective Date – Enter the proposed date of the name change of the business entity.

Proposed Business Entity Name – Enter the proposed name of the business entity.

Attach a copy of the following supporting documentation for the name change of the business entity:

1. Secretary of State verification of business entity name change.
2. Policies and procedures, if applicable.
3. Admission agreement, if applicable.
4. Any other documentation updated to reflect the business entity name change.
5. Proof of required liability insurance coverage or proof of bond, in accordance with Health and Safety Code section 11834.10, Alcohol and Other Drug Program Certification Standards, Section 40.

Section K – Other Written Policies and Procedures

This section must be completed by all applicants.

Are there additional or updated written policies and procedures not related to the requested amendment that you would like to submit for Department review in accordance with Alcohol and Other Drug Program Certification Standards, Section 34.5?

If yes, check “Yes”, if not, check “No”. If you check “Yes”, please list the additional or updated written policies and procedures being submitted. If necessary, include additional sheet.

Declaration

Read the declaration carefully before signing the application. The application must be signed by an authorized individual.

If the applicant applying 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 applicant applying 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 applicant applying is a partnership, the application must be signed by all partners.

If the applicant applying is a sole proprietor, the application must be signed by the sole proprietor.

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.

Section A – Type of Amendment
☐ Adding/Removing Treatment or Recovery Outpatient Services ☐ Adding/Removing Intensive Outpatient Services ☐ Adding/Removing Outpatient Detoxification Services ☐ Adding/Removing Medications for Addiction Treatment Services ☐ Changing the Slot Count ☐ Relocating Operation of a Program ☐ Adding/Removing a Program Address ☐ Changing the Name of the Program ☐ Changing the Name of the Business Entity

Section B – Program Information			
Program Name:			Program Certificate Number:
Program Street Address:			Room/Suite:
City:	State: CALIFORNIA	Zip Code:	Business Phone Number:
Type of Organization ☐ Corporation ☐ Nonprofit Corporation ☐ Limited Liability Company ☐ Sole Proprietorship ☐ Limited Partnership ☐ Partnership ☐ Governmental Agency			
Contact Person Information			
Name:	Title:		Salutation:
Business Phone Number:	Business Email Address:		
Program Director Information			
Name:			
Business Phone Number:	Business Email Address:		

Section C – Outpatient Detoxification Services	
Proposed Effective Date:	☐ Addition of Detoxification Services ☐ Removal of Detoxification Services

Section D – Outpatient MAT Services	
Proposed Effective Date:	☐ Addition of MAT Services ☐ Removal of MAT Services

Section E – Slot Count		
Proposed Effective Date:	Current Slot Count:	Requested Slot Count:

Section F – Relocating Operation of a Program		
Proposed Effective Date:	Proposed County:	
Proposed Program Street Address:		Proposed Room/Suite:
Proposed City:	State: CALIFORNIA	Proposed Zip Code:
Proposed Business Phone Number:		

Section G – Adding a Program Address			
Proposed Effective Date:		County:	
Program Street Address:		Proposed Building/Room/Suite:	
City:	State: CALIFORNIA	Zip Code:	Business Phone Number:

Section H – Removing a Program Address			
Proposed Effective Date:		County:	
Program Street Address:		Proposed Building/Room/Suite:	
City:	State: CALIFORNIA	Zip Code:	Business Phone Number:

Section I – Changing the Name of the Program	
Proposed Effective Date:	Proposed Program Name:

Section J – Changing the Name of the Business Entity	
Proposed Effective Date:	Proposed Business Entity Name:

Section K – Other Written Policies and Procedures
Are there additional or updated written policies and procedures not related to the requested amendment that you would like to submit for Department review in accordance with Alcohol and Other Drug Program Certification Standards, Section 34.5? ☐ Yes ☐ No
If "Yes," please list the additional or updated written policies and procedures being submitted:

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.	
Print Name:	Title:
Signature:	Date:

Privacy Notice on Collection

The purpose of this form is to collect information for licensure or certification of residential alcoholism and drug abuse recovery or treatment facilities or treatment program. The information collected in this form is required by the Department of Health Care Services (Department), Licensing and Certification Division, Licensing and Certification Section by the authority of Health and Safety Code, Section 11834.01 et seq. and California Code of Regulations, Title 9, Division 4, Chapter 5 and the Alcohol and Other Drug Program Certification Standards 2.0. 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
Email: LCDQuestions@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/NoticeofPrivacyPractices.aspx) and the Privacy Policy Statement (https://www.dhcs.ca.gov/pages/privacy.aspx).