Application For Mental Health Program Approval Short-Term Residential Therapeutic Programs

Legal Name of Applicant/ Facility Name**:**	Head of Service:	
Facility Address (Street No., Street Name, Apt. Num.):	City:	
Mailing Address (if different from above):	City:	
County Mental Health Plan:	Zip Code:	Telephone:

Type of Ownership:

☐ Government Entity ☐ Non-Profit Corporation

Total number of beds to be certified: _____

Number of beds to be certified per facility/house/cottage:_____

CDSS License Number: _____

CDSS License date: _____

Age Groups to be admitted:	Mental Health Contract (MHP) Yes ☐ No ☐
	Medi-Cal Certification Yes ☐ No ☐

The following information must be submitted along with this application form. Please check each box to indicate information has been submitted. Note: The Sections listed for each item below refer to the corresponding Section in STRTP Regulations Version III.

1. **Section 3(d):** Copy of signed county mental health plan contract(s). ☐
2. **Section 3(e):** Evidence of Medi-Cal mental health certification. ☐
3. **Section 3(f):** Copy of a valid license issued by California Department of Social Services. ☐
4. **Section 5(a)**: Mental Health Program Statement inclusive of: ☐
5. **Section 5(a)(1)(A-E):** Description on the mental health program statement. ☐
6. **Section 5(a)(2)(A-E):** Staffing policies. ☐
7. **Section 5(a)(3)(A-R):** Written, specific, and detailed policies and procedures that demonstrate how the mental health program will comply with every requirement of this subsection. ☐

Applicant's Signature:	Title:
Organization:	Date:

Please submit your completed application to:

Delegate County MHP
And to DHCS at:

E-Mail
Attention: STRTP MHPA Application
CHILDRENSMHPA@DHCS.CA.GOV