Initial Application for Certification

INSTRUCTIONS FOR COMPLETION OF THIS FORM

Return completed form to the address designated below:

Licensing and Certification Division
Licensing and Certification Section, MS 2600
PO Box 997413
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 10, which outlines the requirements for certification of an alcohol and other drug program certified under Chapter 7.1 (commencing with Section 11832), Part 2, Division 10.5 of the Health and Safety Code.

SECTION A – APPLICATION TYPE

This section must be completed by all applicants.

Check the appropriate box for the type of application being submitted:

- Initial Application for Outpatient Certification.
- Initial Application for Voluntary Certification.
- Initial Application for Voluntary Certification while application for licensure pursuant to Health & Safety Code section 11834.01 is pending.
- Change of Business Entity.
- Sale of the Facility.
- Transfer of Ownership of fifty-one (51%) percent or greater.
- For initial application for voluntary certification, enter the existing license number, and check the box to indicate the department the facility is licensed by.
- For change of business entity, sale of the facility, and transfer of ownership of fifty-one percent or greater, enter the existing program certificate number to be discontinued.

SECTION B – 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 government 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.

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.

Administrative/Corporate Office Address – Enter the physical address of the business entity's main office. This address may be the same as the program's street address if the business entity does not have a separate administrative/corporate office address. A post office box or commercial box is not acceptable.

Room/Suite – Enter the room or suite number of the administrative/corporate office. If not applicable, enter N/A.

City – Enter the city of the administrative/corporate office.

State – Enter the state of the administrative/corporate office.

Zip Code – Enter the zip code of the administrative/corporate office.

Business Entity Website Address – If the business entity has a website, enter the business entity's website address. If not applicable, enter N/A.

Program Website Address – If the program has a website (that is different from the business entity website), enter the program website address. If not applicable, enter N/A.

Program Email Address – Enter the program email address.

Administrative/Corporate Mailing Address – Enter the business entity's mailing address. A post office box or commercial box may be used as an administrative/corporate mailing address. If not applicable, enter N/A.

Room/Suite – Enter the room/suite number of the administrative/corporate mailing address. If not applicable, enter N/A.

City – Enter the city of the administrative/corporate mailing address.

State – Enter the state of the administrative/corporate mailing address.

Zip Code – Enter the zip code of the administrative/corporate mailing address.

Type of Organization

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

Licenses and Certifications

Does the applicant currently hold any licenses or certifications issued by the Department (such as an Alcoholism or Drug Abuse Recovery or Treatment Facility License, Alcohol and Other Drug (AOD) certification, or Drug Medi-Cal (DMC) certification)?

If yes, check "Yes." If not, check "No." If you check "Yes," provide the name of the facility, facility address including city, state and zip code, license or certification number, and the type (license or certification). If necessary, include additional sheets.

Has anyone associated with the business entity, including partners, owners, administrative/executive staff, board members, or stockholders, previously had a license or certification denied, terminated, suspended, or revoked by the Department, former Department of Alcohol and Drug Programs, or Department of Social Services?

If yes, check "Yes." If not, check "No." If you check "Yes," please provide the name of the individual, license or certification number associated with this individual, reason for denial, termination, suspension or revocation and relationship of individual to applicant. If necessary, include additional sheets.

Contact Person information

This section must be completed by all applicants.

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

Name – Enter the 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.

SECTION C – PROGRAM / BUILDING INFORMATION

This section must be completed by all applicants.

Program Street Address(es) – Enter the physical address(es) of the program. If more than two addresses, attach additional pages. All program addresses must be in the same county.

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.

County – Enter the county of the program.

City – Enter the city of the facility.

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.

Fax Number – Enter the fax number of the program. If not applicable, enter N/A.

Building Ownership Information – Check the box that best describes the relationship between you and the owner of the building.

SECTION D – CERTIFICATION INFORMATION

This section must be completed by all applicants.

Slot Count – Enter the maximum number of individuals who can receive AOD services at the program at any given time on any given day.

Services to be Provided – Check the box(es) that indicates what services you will provide to the clients at this program. An individual must be seeking treatment for a substance use disorder. Check all the boxes that apply.

Outpatient Service means a client shall be provided a maximum of nine (9) hours per week of counseling services.

Intensive Outpatient Service 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 hours based on individual medical necessity.

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

Residential Detoxification Services means services designed to observe, support and assist a client experiencing withdrawal from alcohol and/or other drugs in a residential setting.

Recovery Services means any assistance provided to a client to maintain abstinence from the use of alcohol and/or other drugs, sobriety, or any goal achieved during treatment for a substance use disorder. Recovery services may include care coordination, counseling services, and education sessions.

Treatment Services means any assistance provided to a client to obtain any goal associated with recovery from a substance use disorder. Treatment services may include care coordination, counseling services, and education sessions.

Medications for Addiction Treatment (MAT) also known as “Medication Assisted Treatment” means the use of any drug approved by the United States Food and Drug Administration to treat substance use disorders.

If providing recovery and/or treatment services specify the level of service provided:

Outpatient Service means a client shall be provided a maximum of nine (9) hours per week of counseling services.

Intensive Outpatient Service 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 hours based on individual medical necessity.

Fire Authority Information – Please provide information for the local fire department and/or fire agency assigned to the program where you are requesting to provide alcohol or other drug services.

Name – Enter the name of the local fire authority for where the program is located.

Business Phone Number – Enter the business phone number of the local fire authority.

Fax Number – Enter the fax number of the local fire authority.

Address – Enter the address of the local fire authority.

City – Enter the city of the local fire authority.

State – Enter the state of the local fire authority.

Zip Code – Enter the zip code of the local fire authority.

SECTION E – PROOF OF LIABILITY COVERAGE

This section must be completed by all applicants.

Select all applicable types of liability coverage obtained by the applicant. Proof of insurance coverage must apply to the program address listed on the application.

Check the appropriate box for the type of liability coverage obtained:

Liability Insurance; or

Bond.

SECTION F – DECLARATION

This section must be completed by all applicants.

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 name of the individual signing the application.

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

Signature – Sign the application.

Date – Enter the date that the application is signed.

SUPPORTING DOCUMENTATION & DESCRIPTIONS – SECTION 1

The supporting documentation as listed below shall be submitted with the Initial Application for Certification form DHCS 6040 as part of a completed application for the **outpatient** mandatory certification. Each item shall be numbered and separated by correspondingly numbered tabbed dividers. **An application that is not submitted in the order specified below shall be considered incomplete.**

For licensed facilities applying for the voluntary certification, see Section 2 below.

Documentation provided by a third party, such as the lease agreement shall be submitted unaltered and in the original format (size, font, color) it was created.

Tab 1 – Business entity formation documents, if applicable – Submit documentation reflecting formation of the business entity including:

One of the following listed below as appropriate to your business entity type.

- Corporations – Articles of Incorporation and Statement of Information.
- Nonprofit Corporation – Articles of Incorporation, Statement of Information, and Bylaws.
- Partnerships – Statement of Partnership Authority.
- LPs – Certificate of Limited Partnership.
- LLCs – Articles of Organization.

For a business entity with a Board:

- Board minutes reflecting business entity formation.
- Board minutes and/or a board resolution reflecting authorization of an individual to sign on behalf of the business entity, the approval of a budget, or the authorization to apply for a change of business entity, sale of the facility, or a transfer of ownership, if applicable.

Tab 2 – Current business license, as required by the local jurisdiction. – Submit a copy of the business license.

Tab 3 – Fictitious business name statement, if applicable – Any business operating under a fictitious name shall submit a copy of the county filing setting forth that name.

Tab 4 – Property deed, lease or rental agreement or written authorization for use of the property.

Tab 5 – Administrative organizational chart of the business entity – This document shall include a chart that shows the governing board, advisory groups, including resident council if applicable, and both lines of authority (straight lines) and communication lines (broken lines) to all staff positions.

Tab 6 – Community resources – This document shows the community resources to be utilized by the program. This document shall be used as a resource for assisting clients in securing additional services to meet and maintain their personal well-being while continuing to enhance personal development.

Tab 7 – Outline of activities and services – A written statement listing the activities and services provided by the program. This statement should include an outline for specific activities and services such as detoxification (if applicable), group and individual sessions, recovery or treatment services, recreation, self-help activities (Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Cocaine Anonymous (CA)), and other activities/services being provided by the program.

Tab 8 – Program description – A written statement that describes the program's alcohol and other drug services that are offered according to the severity of alcohol and/or other drug involvement, and the program's approach to recovery or treatment, which shall include, but not be limited to, an alcohol and drug free environment.

Tab 9 – Continuous quality management plan – Written policies and procedures for continuous quality management, which shall include how the program monitors and/or ensures that client files are reviewed and contain all required documents and that services are provided to clients.

Tab 10 – Job Descriptions – A narrative description for each position at the program (both paid and volunteer), including minimum staff qualifications and lines of supervision for each position. The job descriptions should match the positions listed on the Staff and Health Care Practitioner (HCP) Information form (DHCS 5050).

Tab 11 - Policies and procedures for admission and readmission – Written admission and readmission policies and procedures for determining an individual's suitability for services.

Tab 12 – Admission agreement – A copy of the admission agreement that will be used by the program that includes the physical address(es) where the services will be provided.

Tab 13 – Policy for establishing and collecting fees.

Tab 14 – Policies and procedures in the event of an emergency or a disaster – Written policies and procedures to be followed in the event of an emergency or a disaster.

Tab 15 – Policies and procedures for medications – Written policies and procedures for medications.

Tab 16 – Policies and procedures for a medication audit to track and account for client medications – Written policies and procedures for the control of medications at the program.

Tab 17 – Policies and procedures for when a client returns to use or appears to be under the influence – Written policies and procedures to follow if a person on the premises appears to be under the influence.

Tab 18 – Policies and procedures for MAT – Written policies and procedures for MAT.

Tab 19 – Written policy that prohibits guns, knives (other than kitchen utensils), or other weapons (except for law enforcement officers or security guards acting in the line of duty) at the program.

Tab 20 – The following forms:

- Disclosure to Department of Health Care Services (DHCS) (DHCS 5140).
- Staff and Health Care Practitioner (HCP) Information (DHCS 5050).
- Program Director Information (DHCS 5082).
- Administrative Organization – Corporation, Nonprofit Corporation, Limited Liability Company, Partnership or Limited Partnership (DHCS 5083), if applicable.
- Administrative Organization – Public Agency or Sole Proprietor (DHCS 5084), if applicable.
- Designation of Administrative Responsibility (DHCS 5085), if applicable.
- Schedule of Recovery and Treatment Services (DHCS 5086).

Tab 21 – HCP documentation, if applicable – Include a Health Care Practitioner Incidental Medical Services Acknowledgement form (DHCS 5256) and documentation of a current license in good standing with the appropriate licensing board for each HCP.

Tab 22 – Management services/professional services agreement(s), if applicable.

Tab 23 – Proof of liability insurance for program or proof of bond.

SUPPORTING DOCUMENTATION & DESCRIPTIONS – SECTION 2

Licensed facilities, including facilities with pending license applications, applying for voluntary certification shall submit the supporting documentation listed below as part of a complete application. Each item shall be numbered and separated by correspondingly numbered tabbed dividers. **An application that is not submitted in the order specified below shall be considered incomplete.**

Tab 1 – Program mission and philosophy statement – A written statement describing the program's mission and philosophy.

Tab 2 – Program goals and objectives – A written statement that includes the program goals (intent or purpose of its existence) and objectives. The goals and objectives should be time-limited, measurable, and include outcome objectives that can be verified in terms of time and results, and that serve as indicators of program effectiveness.

Tab 3 – Program evaluation plan – A written evaluation plan for management decision making. Sufficient program data shall be collected to provide a meaningful assessment of the program's progress in meeting its objectives.

Tab 4 – Recreational Activities – A description of planned recreational activities that are offered in addition to treatment or recovery services.

Tab 5 – Fiscal Practices – Develop a reporting mechanism that indicates the relation of the budget to actual income and expenses to date. Have an accounting system, based on accepted accounting principles.

Tab 6 – Confidentiality – A written statement regarding confidentiality when answering the telephone and confidentiality regarding files shall be included in the facility's operation manual. Resident files shall be accessible only to authorized personnel.

Tab 7 – Community Relations – A written description of the program's services and admission criteria and procedures shall be provided to the clients, to the general public, and to cooperating referral sources that may include emergency room personnel, law enforcement agencies, and self-help groups such as Alcoholics Anonymous. Continuing efforts shall be made to guarantee coordination and cooperation with other service providers and enhance relations with neighbors through a good neighbor policy.

Tab 8 – Continuous Quality Improvement – Written policies and procedures for continuous quality improvement.

Tab 9 – Code of Conduct – A written code of conduct for staff.

Tab 10 – The following forms:

- Disclosure to Department of Health Care Services (DHCS) (DHCS 5140).
- Staff and Health Care Practitioner (HCP) Information (DHCS 5050), if applicable.
    - Only required if adding voluntary certification to an existing DHCS licensed residential facility, and changes need to be reported.
- Program Director Information (DHCS 5082), if applicable.
    - Only required if adding voluntary certification to an existing DHCS licensed residential facility, and changes need to be reported.

- Administrative Organization – Corporation, Nonprofit Corporation, Limited Liability Company, Partnership or Limited Partnership (DHCS 5083), if applicable.
    - Only required if adding voluntary certification to an existing DHCS licensed residential facility, and changes to the organization of less than 51% need to be reported. A change of 51% or more to the organization requires the applicant to submit an initial application for licensure DHCS 6002.
- Administrative Organization – Public Agency or Sole Proprietor (DHCS 5084), if applicable.
    - Only required if adding voluntary certification to an existing DHCS licensed residential facility, and changes need to be reported (does not apply to Sole Proprietors).
- Designation of Administrative Responsibility (DHCS 5085), if applicable.
    - Only required if adding voluntary certification to an existing DHCS licensed residential facility, and changes need to be reported.
- Schedule of Recovery and Treatment Services (DHCS 5086), if applicable.
    - Only required if adding voluntary certification to an existing DHCS licensed residential facility, and changes need to be reported.

Tab 11 – HCP documentation, if applicable – Include a Health Care Practitioner Incidental Medical Services Acknowledgement form (DHCS 5256) and documentation of a current license in good standing with the appropriate licensing board for each HCP.

Facilities licensed by the Department of Social Services (DSS) or the Department of Public Health Care (DPH), shall submit the following additional documentation:

Tab 12 – Fire Clearance – Submit a copy of the valid Fire Clearance as issued by the local fire authority.

Tab 13 – Outline of activities and services – A written statement listing the activities and services provided by the program. This statement should include an outline for specific activities and services such as detoxification (if applicable), group and individual sessions, recovery or treatment services, recreation, self-help activities (Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Cocaine Anonymous (CA)), and other activities/services being provided by the program.

Tab 14 – Program description – A written statement that describes the program's alcohol and other drug services that are offered according to the severity of alcohol and/or other drug involvement, and the program's approach to recovery or treatment, which shall include, but not be limited to, an alcohol and drug free environment.

Tab 15 – Admission agreement – A copy of the admission agreement that will be used by the program that includes the physical address(es) where the services will be provided.

Tab 16 – Policies and procedures for admission and readmission – Written admission and readmission policies and procedures for determining an individual's suitability for services.

Tab 17 – Policies and procedures for Medications – Written policies and procedures for medications.

Tab 18 – Policies and procedures for a medication audit to track and account for client medications – Written policies and procedures for the control of medications at the program.

Tab 19 – Policies and procedures for when a client returns to use or appears to be under the influence – Written policies and procedures to follow if a person on the premises appears to be under the influence.

Tab 20 – Policies and procedures for MAT – Written policies and procedures for MAT.

Tab 21 – Proof of liability insurance for program or proof of bond.

Tab 22 – Copy of valid license.

(Read instructions fully before completing application)

SECTION A – APPLICATION TYPE	
☐ Initial Application for Outpatient Certification	
☐ Initial Application for Voluntary Certification	License Number:
Please indicate which department you are licensed by: ☐ Department of Health Care Services (DHCS) ☐ Department of Social Services (DSS) ☐ Department of Public Health (DPH)	
☐ Initial Application for Voluntary Certification while application for licensure pursuant to Health & Safety Code section 11834.01 is pending.	
☐ Change of Business Entity	Existing program certificate number:
☐ Sale of the Program	Existing program certificate number:
☐ Transfer of Ownership of fifty-one (51%) percent or greater	Existing program certificate number:

SECTION B – BUSINESS ENTITY INFORMATION		
Business Entity Name:		
Program Name:		
Administrative/Corporate Office Address:		Room/Suite:
City:	State:	Zip Code:
Business Entity Website Address:		
Program Website Address:	Program Email Address:	
Administrative/Corporate Mailing Address:		Room/Suite:
City:	State:	Zip Code:

Type of Organization

☐ Corporation
☐ Nonprofit Corporation
☐ Partnership
☐ Limited Partnership
☐ Limited Liability Company
☐ Sole Proprietorship
☐ Government Agency

Licenses and Certifications

Does the applicant currently hold any licenses or certifications issued by the Department (such as an Alcoholism or Drug Abuse Recovery or Treatment License, Alcohol and Other Drug (AOD) certification, or Drug Medi-Cal (DMC) certification)?

☐ **Yes** ☐ **No**

If "Yes," provide the information below for each facility. *Include additional sheets if necessary.*

Name:			
Facility/Program Address:	City:	State:	Zip Code:
License/Certification Number:	Type: ☐ License ☐ Certification		
Name:			
Facility/Program Address:	City:	State:	Zip Code:
License/Certification Number:	Type: ☐ License ☐ Certification		
Name:			
Facility/Program Address:	City:	State:	Zip Code:
License/Certification Number:	Type: ☐ License ☐ Certification		

Has anyone associated with the business entity, including partners, owners, administrative/executive staff, board members, or stockholders, previously had a license or certification denied, terminated, suspended, or revoked by the Department, former Department of Alcohol and Drug Programs, or Department of Social Services?

☐ **Yes** ☐ **No**

If "Yes," provide the information below for each individual. *Include additional sheets if necessary.*

Name	License/Certification Number	Reason for Denial, Termination, Suspension, or Revocation	Relationship to Applicant

Contact Person Information		
Name:	Title:	Salutation:
Business Phone Number:	Business Email Address:	

SECTION C – PROGRAM / BUILDING INFORMATION			
Program Street Address:			Room/Suite:
County:	City:	State: California	Zip Code:
Business Phone Number:	Fax Number:		
Include additional sheets, if necessary.			

Building Ownership Information

☐ Owned by the business entity applying ☐ Leased or rented ☐ Donated

☐ Owned or leased by the county*

*Applies to county operated programs only, not including programs with a county contract.

SECTION D – CERTIFICATION INFORMATION	
Slot Count:	
AOD Services to Be Provided (check all that apply) ☐ Outpatient Detoxification Services ☐ Recovery Services ☐ Treatment Services ☐ Medications for Addiction Treatment (MAT) **If providing recovery and/or treatment services specify the level of service provided:** ☐ Outpatient Services ☐ Intensive Outpatient Services	**Licensed Facility Services to Be Provided (check all that apply)** ☐ Residential Detoxification Services ☐ Recovery Services ☐ Treatment Services

Fire Authority Information			
Name:	Business Phone Number:		Fax Number:
Address:	City:	State:	Zip Code:

SECTION E - PROOF OF LIABILITY COVERAGE

Check the appropriate box(es) for the type of liability coverage:

☐ Liability insurance

☐ Bond

SECTION F – 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 and regulations 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 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, Licensing and Certification Section by the authority of Health and Safety Code, Section 11832 et seq. and the Alcohol and Other Drug Program Certification Standards. 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
Section Officer of the Day
Licensing and Certification Section, MS 2600
PO Box 997413
Sacramento, California 95899-7413
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/formsandbubs/laws/priv/Pages/NoticeofPrivacyPractices.aspx) and the Privacy Statement (https://www.dhcs.ca.gov/pages/privacy.aspx).