Enclosure 2: Rate Change Form

DATE: **Fiscal Year:**

FACILITY NAME: **COUNTY:** Make a Selection

FACILITY ADDRESS:

CITY: **STATE:** **ZIP CODE:**

FACILITY PAY-TO ADDRESS:

CITY: **STATE:** **ZIP CODE:**

CURRENT PSYCHIATRIC INPATIENT HOSPITAL PROVIDER NUMBER:

ACCOMODATION/ REVENUE CODE		DESCRIPTION		Max Age	RATE	EFFECTIVE DATE
00114	PA	Rm/Brd - Private Psych	Adolesc.	18		
00114	PB		Adult			
00124	PA	Rm/Brd - Semi Private, 2 Bed Psych	Adolesc.	18		
00124	PB		Adult			
00134	PA	Rm/Brd - Semi Private, 3 or 4 Bed Psych	Adolesc.	18		
00134	PB		Adult			
00154	PA	Rm/Brd - Ward (Med. Or Gen). Psych.	Adolesc.	18		
00154	PB		Adult			
00169		Administrative Day				
00204	PA	Intensive Care, Psychiatric	Adolesc.	18		
00204	PB		Adult			

For optimal use, use the desktop version of Adobe Acrobat to complete this form.
Please submit this form and any questions to SDMCRates@dhcs.ca.gov.

I hereby certify that I am the duly authorized person to execute this request.

Name:

Title