State of California – Health and Human Services Agency   Department of Health Care Services

Application For Renewal of Special
Treatment Program Approval

INSTRUCTIONS: Complete pages 1-4 and email the complete application and/or any questions related to the application to: AdultMHCertification@dhcs.ca.gov. Please include a copy of your most current California Department of Public Health (CDPH) Skilled Nursing Facility (SNF) license with this application.

This renewal application is due between January 1st and January 31st of each year. This renewal application will capture information for the previous full year.

For more information on the Mental Health Program Certification Section, visit our webpage at https://www.dhcs.ca.gov/services/MH/Pages/Mental-Health-Program-Certification-Section.aspx

FACILITY/PROGRAM NAME		LICENSEE NAME
FACILITY/PROGRAM WEBSITE URL		
ADDRESS		**COUNTY**
CITY	**ZIP**	**FACILITY/PROGRAM PHONE NUMBER**
ADMINISTRATOR'S NAME		**PROGRAM DIRECTOR'S NAME**
ADMINISTRATOR'S EMAIL		**PROGRAM DIRECTOR'S EMAIL**
NUMBER OF LICENSED SNF BEDS		**NUMBER OF APPROVED STP BEDS**

NAME OF PERSON COMPLETING APPLICATION	TITLE
PHONE NUMBER	**EMAIL**
SIGNATURE	**DATE**

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WRITTEN DESCRIPTION OF SPECIAL TREATMENT PROGRAM

INSTRUCTIONS: Fill out the table below with information pertaining to patient type, age range of patients, and a written description of the STP. Additional pages may be submitted if more space is needed.

PATIENT TYPE	AGE RANGE OF PATIENTS	AVERAGE LENGTH OF STAY

WRITTEN DESCRIPTION OF SPECIAL TREATMENT PROGRAM *(Include relevant information on demographics of patients served, services provided, etc.)*

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SPECIAL TREATMENT PROGRAM ANNUAL DATA

INSTRUCTIONS: Fill out the table below with information pertaining to the number of patient admissions, patient discharges, patient restraint incidents, patient seclusion incidents, and patient denial of rights incidents occurring in the previous full year.

MONTH	NUMBER OF ADMISSIONS	NUMBER OF DISCHARGES	NUMBER OF RESTRAINT INCIDENTS	NUMBER OF SECLUSION INCIDENTS	NUMBER OF DENIAL OF RIGHTS
JANUARY					
FEBRUARY					
MARCH					
APRIL					
MAY					
JUNE					
JULY					
AUGUST					
SEPTEMBER					
OCTOBER					
NOVEMBER					
DECEMBER					

LIST OF INTERDISCIPLINARY PROFESSIONAL STAFF

INSTRUCTIONS: Fill out the table below with the name, title/discipline, number of hours of professional staff time the individual will provide per week, and the individual's date of hire. For each name below that has not previously been approved by DHCS, please provide the individual's resume and/or application providing evidence that the individual meets the requirements in §72465(f).

NAME	TITLE/ DISCIPLINE	LICENSE NUMBER	NUMBER OF HOURS PER WEEK	NUMBER OF YEARS EXPERIENCE/ TRAINING IN A MENTAL HEALTH SETTING