State of California – Health and Human Services Agency

Department of Health Care Services
Licensing and Certification Division
Mental Health Licensing and Certification Branch
PO Box 997413, MS 2800
Sacramento, California 95899-7413
Email: LPSinfo@dhcs.ca.gov

APPLICATION FOR FACILITY DESIGNATION APPROVAL OR RENEWAL OF APPROVAL

A county shall submit this form to apply for approval or renewal of approval of a facility designation to provide treatment under the Lanterman-Petris-Short (LPS) Act.

INSTRUCTIONS FOR COMPLETING THIS FORM

Please read and follow these instructions carefully and complete each item. All requested items are mandatory. For additional information, please review the Facility Designation Interim Regulations (BHIN 25-XXX). Submit applications in electronic format by email to LPSinfo@dhcs.ca.gov.

You may attach additional documents if your response to a section in this form does not fit in the provided space. Label each additional document with a unique attachment name (for example, "Attachment A"), and identify that attachment in the appropriate section of the form. You must provide a response in all sections that request information. If a section does not apply, enter "N/A."

The application and all supporting documentation must be emailed as individual PDF files. Each file must be named according to the LPS designation process (e.g., "[Facility Name] Application Form," "[Facility Name] Program Statement," etc.). Documentation provided by a third party must be submitted unaltered and in the original format (size, font, color) that it was created.

SECTION A – FACILITY INFORMATION

1. Facility Name – Enter the name, telephone number, and email address (if applicable) of the designated facility.

2. Type of Facility – Enter the type of facility, as specified in subsection (b)(1) of Section 3.

3. Professional Person in Charge - Enter the name, qualifications, telephone number, and email address (if applicable) of the professional person in charge.

4. Total Number of designated beds – Enter the number of designated beds at the facility.

5. Facility Street Address – Enter the designated facility's street address.

6. Facility Mailing Address – Enter the facility's mailing address, if different from the street address listed in item **6.** If the address is different, the Department will send all official mail to this address.

7. **Operational Questions** – Check the box that describes the facility's designated operations.
8. **Age Range** – Enter the age range that will be treated by the designated facility.
9. **Behavioral Health Director -** Enter the name, telephone number, and email address of the County Behavioral Health Director.

SECTION B – ATTESTATION

This section must be completed by the county behavioral health director.

Read the attestation carefully before signing the application. The application must be signed by the county's behavioral health director.

SUPPORTING DOCUMENTS

Attach the following supporting documentation to this application:

1. A Designated Facility Program Statement, including all documents and information specified in Section 6 of the Facility Designation Interim Regulations.
2. A copy of the facility's licenses, accreditations, and/or certifications, as applicable, including the licensing, accreditation, and certifying agency, and the facility's license, accreditation, and certificate number.
3. A copy of the facility's fire clearance, issued by the county's Fire Marshal or other authorized governmental entity.
4. A sketch of the facility and its designated areas, including a floor plan depicting the designated areas of the facility and beds, including for minors and adults, if applicable.
5. A description of the behavioral health director's process for overseeing the designated facility and ensuring it complies with the LPS Act and the standards in Article 3 of the Facility Designation Interim Regulations.

If this is a renewal application, items (2) through (5) are not required unless any of the information changed since the last designation approval.

SECTION A – FACILITY INFORMATION

1. Facility Name:		
2. Facility Street Address:	City:	Zip Code:
Facility Type:		
4. Name of the Professional Person in Charge of the Facility (PPIC):	5. Phone Number PPIC:	
6. and Email Address PPIC:	City:	Zip Code:
7. Behavioral Health Director Name:	City:	Zip Code:
8. Total number of designated beds:_____		
9. Operational Questions:		
Which population(s) will receive evaluation and treatment services at the designated facility? ☐ Minor Only ☐ Adult Only ☐ Minor and Adult		

What credentials does the facility hold?

Please check all that apply

☐ Licensed ☐ Certified ☐ Accredited

Levels of treatment the facility is designated to provide (check all that apply):

☐ Evaluation and treatment pursuant to Article 1 (commencing with Section 5150).
☐ Intensive treatment pursuant to Article 4 (commencing with Section 5250).
☐ Additional intensive treatment pursuant to Article 4.5 (commencing with Section 5260).
☐ Additional intensive treatment pursuant to Article 4.7 (commencing with Section 5270.10).
☐ Postcertification treatment pursuant to Article 6 (commencing with Section 5300).

10. Minimum age of persons to be admitted:_____

SECTION B – ATTESTATION

I, _____, hereby attest that I will ensure the following, in accordance with the Facility Designation Interim Regulations:

(A) The designated facility will maintain compliance with all legal authorities governing its licensure, accreditation, or certification, as applicable. If the facility is a Jail Inpatient Unit, it will maintain compliance with the Board of State and Community Corrections' Minimum Standards for Local Detention Facilities (Subchapter 4 of Chapter 1 of Division 1 of Title 15 of the California Code of Regulations).

(B) I will monitor the designated facility to ensure compliance with the LPS Act and the standards set forth in Article 3 of the Facility Designation Interim Regulations. I will also require the facility to promptly correct any identified deficiencies.

(C) I, or my designees, will investigate all alleged patients' rights violations pursuant to Section 5326.9 of the Welfare and Institutions Code.

Behavioral Health Director Contact Information:

Name: _____

Mailing Address: _____

County: _____

Telephone Number: _____

Email Address: _____

Print Name:	Title:
Signature:	Date:

Please submit your completed application to:

Department of Health Care Services
Licensing and Certification Division
Mental Health Licensing and Certification Division
Email: LPSInfo@dhcs.ca.gov

PRIVACY NOTICE ON COLLECTION

The purpose of this form is to collect information for purposes of approving a county's designation of a facility to provide treatment pursuant to the LPS Act. The information collected in this form is required by the Department of Health Care Services (Department), Licensing and Certification Division, Mental Health Licensing and Certification Branch by the authority of Welfare and Institutions Code section 5404, and the Facility Designation Interim Regulations. The personal information collected in this form is confidential and protected by the Information Practices Act (California Civil Code section 1798 et seq.), Department policy, and state policy.

All information requested in this form is mandatory. The consequence of not supplying the information requested is that the application for facility designation approval or renewal may be denied. 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
1501 Capitol Avenue, MS 2601
Sacramento, CA 95814
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/formsandpubs/laws/priv/Pages/NoticeofPrivacyPractices.aspx) and the Privacy Policy Statement (https://www.dhcs.ca.gov/pages/privacy.aspx).