Administrative Organization - Public Agency or Sole Proprietor

INSTRUCTIONS FOR COMPLETION OF THIS FORM

Return completed form to the address 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 1/2" by 11" white paper.

DO NOT USE staples on this form or on any attachments.
DO NOT SUBMIT doubled 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 regarding licensure of a residential alcoholism or drug abuse recovery or treatment facility providing alcoholism or drug abuse treatment or recovery services, please review Health and Safety Code section 11834.01 *et seq.* For additional information regarding the certification of an alcohol and other drug program providing alcohol and other drug (AOD) services, please review Health and Safety Code section 11832 *et seq.* This form can be used for licensure of a residential alcoholism or drug abuse recovery or treatment facility and/or certification of an alcohol and other drug program. Accordingly, terminology applicable for licensure (including “resident” and “facility”) and terminology applicable for certification (including “client” and “program”) are both referenced within this form.

PUBLIC AGENCY INFORMATION

This section must be completed by all public agencies (state, county, city or other governmental agencies).

Type of Public Agency – Check the appropriate box for the type of public agency.

Facility/Program Name – Enter the name of the facility or program. Do not include the business entity name in this box unless the facility or 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 facility or program’s name.

Facility/Program Street Address – Enter the physical street address of the facility or program.

City – Enter the city of the facility or program.

State – This field is pre-filled to California. The Department only licenses facilities and/or certifies programs physically located in California.

Zip Code – Enter the zip code of the facility or program.

Contact Person Information

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

Name – Enter the first and last 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.

SOLE PROPRIETOR INFORMATION

Sole Proprietor Name – Enter the full legal name of the sole proprietor.

Employer ID Number – Enter the federal tax identification number used to identify the business.

Facility/Program Name – Enter the name of the facility or program. Do not include the business entity name in this box unless the facility or 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 facility or program’s name.

Facility/Program Street Address – Enter the physical address of the facility or program.

City – Enter the city of the facility or program.

State – This field is pre-filled to California. The Department only licenses facilities and/or certifies programs physically located in California.

Zip Code – Enter the zip code of the facility or program.

Business Phone Number – Enter the business phone number of the sole proprietor, including an extension, if any.

Business Email Address - Enter the business email address of the sole proprietor.

DECLARATION

Print Name – Enter the first and last name of the individual signing the form.

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

Signature – Sign the form.

Date – Enter the date that the form is signed.

PUBLIC AGENCY INFORMATION		
Type of Public Agency: ☐ County ☐ City ☐ Other Governmental Agency		
Facility/Program Name:		
Facility/Program Street Address:		
City:	State: CALIFORNIA	Zip Code:
Contact Person Information		
Name:	Title:	Salutation:
Business Phone Number:	Business Email address:	

SOLE PROPRIETOR INFORMATION		
Sole Proprietor Name:	Employer ID Number:	
Facility/Program Name:		
Facility/Program Street Address:		
City:	State: CALIFORNIA	Zip Code:
Business Phone Number:	Business Email address:	

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, regulations and standards 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 licensure and/or certification of residential alcoholism and drug abuse recovery or treatment facilities, or 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, Sections 11832 *et seq.* and 11834.01 *et seq.* 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/formsandpubs/laws/priv/Pages/NoticeofPrivacyPractices.aspx) and the Privacy Policy Statement (https://www.dhcs.ca.gov/pages/privacy.aspx).