Initial Application for an Existing Certified Program to Obtain Initial Certification for New Program

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 application 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 sheet 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: This form can only be used by an existing certified program to apply for certification of a new program where all services will be identical to those of the existing certified program. Only an existing certified program with an active, current certification, in good standing, and in compliance with the Department of Health Care Services Certification for Alcohol and Other Drug Programs 2.0 may use this application form. This form cannot be used if there have been any changes to the business entity that have not been reported to the Department of Health Care Services. Read all the instructions included on this form carefully and complete each item requested. For additional information, please review the Department of Health Care Services Certification for Alcohol and Other Drug Programs 2.0 commencing with section 10, which outlines the requirements for certification of an alcohol or other drug program. The Department shall terminate the review of this application (Initial Application for an Existing Certified Provider to Obtain Initial Certification for New Program (DHCS 6041)) if the services at the proposed new program do not match those of the active program certification number provided in Section A.

SECTION A – Attestation

This section must be completed by all applicants.

List the active program certification number of the existing program from which the applicant intends to use the policies and procedures for the proposed new program. Provide only one active program certification number.

By checking the first box, the applicant attests that all business entity information on file with the Department for the active program certification number is identical to the business entity listed in

Section B of this form and that the services to be provided at the new program are identical to those provided at the existing program.

By checking the second box, the applicant attests that they understand the following:

1. In addition to the policies and procedures submitted and approved as part of this application, the applicant shall comply with all other policies and procedures approved by the Department for the active program certification number at the new program.
2. In addition to those policies and procedures submitted as part of this application, all other policies and procedures for the active program certification number will be used by the Department for conducting site visits prior to initial certification of the new program.
3. Upon certification, the policies and procedures submitted as part of this application, and all other policies and procedures for the active program certification number, shall become the new program's policies and procedures.
4. Upon certification, the Department will use the new program's policies and procedures to determine compliance and take administrative action.
5. Any updates made to the active program certification number's policies and procedures after this application is approved shall not impact the new program's policies and procedures.

Any updated policies and procedures for the active program certification number shall be approved by the Department before they may be submitted as part of this application. Any subsequent changes to a policy and procedure for the active program certification number referenced in this form prior to approval of this application shall be submitted to the Department for approval prior to implementation at both the existing program and new program.

SECTION B – BUSINESS ENTITY INFORMATION

This section must be completed by all applicants.

Business Entity Name - Enter the business entity name. The name shall be the legal entity name as filed with the Secretary of State (SOS) as specified below. The name shall also match the legal entity name of the existing certified program. **If the legal entity name has changed, this form cannot be used.**

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.

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.

Has the business entity or anyone associated with the business entity, including partners, owner, administrative/executive staff, board members, or stockholders, previously had a license or certification denied, terminated, suspended, placed on probation, 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 and/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 - 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 position title of the contact person, (i.e., program director, executive director, etc.).

Business Phone Number - Enter the contact person's phone number, including an extension, if any.

Business Email Address - Enter the contact person's email address.

SECTION C – PROGRAM LOCATION/BUILDING INFORMATION

This section must be completed by all applicants.

Program Street Address(es) - Enter the physical address(es) of the program location.

Room/Suite – Enter the room or suite number of the program location. 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 location.

City - Enter the city of the program location.

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 location.

Business Phone Number - Each program must have a landline connected to the program location, not including a cellular phone. Do not enter your administrative/corporate office phone number unless your administrative/corporate office address is the same as the program address.

Does this application include more than one (1) building?

If there is more than one building being used to provide the services for which you are applying, check "Yes", if not, check "No". If you answer "Yes", enter the total number of buildings and list all building numbers on the application. If necessary, include additional sheets. All buildings must be located at the same street address. **If the entity-specific information has changed, this form cannot be used.**

Building ownership information - Check the box that best describes the relationship between you and the owner of the building. If you lease the building, include a copy of the lease agreement.

If the building or a space in the building has been donated to you, include a copy of the written authorization for use of the donated space.

SECTION D – PROGRAM INFORMATION

This section must be completed by all applicants.

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

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 location address listed on the application.

Check the appropriate box(es) 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 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 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 is a partnership, the application shall be signed by all partners.

If the applicant is a sole proprietor, the application shall be signed by the sole proprietor.

Print Name – Enter the name of the individual signing.

Title – Enter the title of the individual signing.

Signature – Sign the application.

Date – Enter the date that the application is signed.

SUPPORTING DOCUMENTATION & DESCRIPTIONS

The supporting documentation as listed below shall be submitted with the Initial Application for an Existing Certified Program to Obtain Initial Certification for New Program (DHCS 6041) as part of a completed 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.**

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 – Location specific management services/professional services agreement(s).

Tab 2 - Property deed, lease or rental agreement, or written authorization for use of property.

Tab 3 – Bacteriological analysis of water, if applicable.

Tab 4 – Outpatient/Intensive Outpatient fire clearance or equivalent on fire authority letter is required for all outpatient facilities (DHCS 5104).

Tab 5 – Business License as required by the local jurisdiction.

Tab 6 - 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 7 – 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 Practitioner (HCP) Information form (DHCS 5050).

Tab 8 – 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 9 – 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 10 – Policies and procedures for MAT – Written policies and procedures for MAT.

Tab 11 – 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).
- Designation of Administrative Responsibility (DHCS 5085).
- Schedule of Recovery and Treatment Services (DHCS 5086).

(Read instructions fully before completing application)

SECTION A - ATTESTATION
Active program certification number:
☐ By checking this box, I attest that all business entity information for the new program listed in Section B below is identical to the information on file with the Department for the existing certification number listed above and that all services to be provided at the new program will be identical to those of the certification number listed above. ☐ By checking this box, I understand and attest that: 1. In addition to the policies and procedures submitted and approved as part of this application, the applicant shall comply with all other policies and procedures approved by the Department for the active program certification number at the new program. 2. In addition to those policies and procedures submitted as part of this application, all other policies and procedures for the active program certification number will be used by the Department for conducting site visits prior to initial certification of the new program. 3. Upon certification, the policies and procedures submitted as part of this application, and all other policies and procedures for the active program certification number, shall become the new program's policies and procedures. 4. Upon certification, the Department will use the new program's policies and procedures to determine compliance and take administrative action. 5. Any updates made to the active program certification number's policies and procedures after this application is approved shall not impact the new program's policies and procedures.

SECTION B - BUSINESS ENTITY INFORMATION		
Business Entity Name:		
Program Name:		
Administrative/Corporate Office Address (if different than existing 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:
Contact Person Name:	Title:	
Phone Number:	Email Address:	

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

- ☐ Yes. If you check "Yes", please provide the name of the individual, license and/or certification number associated with this individual, reason for denial, termination, suspension, probation or revocation, and relationship of individual to applicant. If necessary, include additional sheets.
- ☐ No.

SECTION C – PROGRAM LOCATION/BUILDING INFORMATION	
Program Street Address:	Room/Suite:
County:	City:
State: California	Zip Code:
Business Phone Number:	
Program Street Address (Building 2):	Room/Suite:
County:	City:
State: California	Zip Code:
Business Phone Number:	
Does this application include more than one building? ☐ Yes ☐ No If "Yes", total number of buildings:	
Building Ownership Information	
☐ Owned by the business entity applying	☐ Owned or leased by the county*
☐ Leased or rented	☐ Donated
	*Applies to county operated programs only, not including programs with a county contract.

SECTION D - CERTIFICATION INFORMATION						
***SLOT COUNT:**						
Hours of Operation: Indication hours of operation below:						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

SECTION E - PROOF OF INSURANCE

Check the appropriate box 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 have read, understand, and will comply with the statutes and regulations that govern the operation of the program for which I am applying. All program policies and procedures required by the regulations and/or standards that govern the operation of this program have been developed and comply with the appropriate regulations and standards.

I declare that I am authorized to sign this application on behalf of the applicant.

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 11832et 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).