Application for Existing Licensee to Obtain Initial Licensure for New Facility

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 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 licensee to apply for licensure of a new facility where all services will be identical to those of the existing licensed facility. Only an existing licensee with an active, current license, in good standing and in compliance with California Code of Regulations, Title 9, Division 4, Chapter 5 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 California Code of Regulations, Title 9, Division 4, Chapter 5, Subchapter 1, commencing with section 10500, which outlines the requirements for licensure of a residential alcoholism or drug abuse recovery or treatment facility. The Department shall terminate the review of this application (Application for Existing Licensee to Obtain Initial Licensure for New Facility (DHCS 6047)) if the services at the proposed new facility do not match those of the active facility license number provided in Section A.

SECTION A– ATTESTATION

This section must be completed by all applicants.

List the active license number of the existing facility from which the applicant intends to use the policies and procedures for the proposed new facility. An applicant shall not use a provisionally licensed facility as the existing facility for this application. Provide only one active facility license number.

By checking the first box, the applicant attests that all business entity information on file with the Department for the active facility license number is identical to the business entity listed in Section B of this form and that the services to be provided at the new facility are identical to those provided at the existing facility.

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

Any updated policies and procedures for the active facility license 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 facility license 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 facility and new facility.

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 licensee. **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.

Facility Name – Enter the name of the facility. Do not include the business entity name in this box unless the facility 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's name.

Administrative/Corporate Office Address (if different than existing address) – Enter the physical address of the business entity's main office. This address may be the same as the facility'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/cooperate office.

Facility Website Address – If the facility has a website (that is different from the business entity website), enter the facility website address. If not applicable, enter "N/A."

Facility Email Address – Enter the facility email address.

Administrative/Corporate Mailing Address (if different than existing 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, probation 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 business email address of the contact person.

SECTION C – FACILITY / BUILDING INFORMATION

This section must be completed by all applicants.

Facility Street Address(es) – Enter the physical address(es) of the facility. If more than two addresses, attach additional pages. All facility addresses must be in the same county.

Room/Suite – Enter the room or suite number of the facility. If there are more than one, enter all rooms or suite numbers. If not applicable, enter "N/A."

County – Enter the county of the facility.

City – Enter the city of the facility.

State – This field is pre-filled to California. The Department only licenses facilities physically located in California.

Zip Code – Enter the zip code of the facility.

Business Phone Number – Enter the business phone number for the facility.

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 addresses on the application. If necessary, include additional sheets. **If the business entity 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.

SECTION D – RESIDENTIAL LICENSE INFORMATION

This section must be completed by all applicants.

Target Population – Check the box(es) that describes the residents for whom you intend to provide alcoholism or drug abuse recovery or treatment services. Check all the boxes that apply.

Services to be Provided – Check the box(es) that indicates what services you will provide to the residents at this facility. Check all the boxes that apply. All services to be provided at the new facility shall be identical to the services of the active facility license number. Otherwise, this form cannot be used.

> **Detoxification Services** means services designed to observe, support and assist a resident experiencing withdrawal from alcohol and/or other drugs.
>
> **Recovery Services** means any assistance provided to a resident to maintain abstinence from the use of alcohol and/or other drugs, sobriety, or any goal achieved during treatment for a substance use disorder. Recovery services may include: care coordination, counseling services, education sessions, and medication oversight.
>
> **Treatment Services** means any assistance provided to a resident to obtain abstinence from the use of alcohol and/or other drugs, sobriety, or any goal associated with recovery from a substance use disorder. Treatment services may include: care coordination, counseling services, education sessions, and medication oversight.
>
> **Incidental Medical Services (IMS)** means optional services provided at a facility by a Health Care Practitioner (HCP) to address medical issues associated with detoxification services, recovery services, and/or treatment services.

Water Supply – Specify whether the water comes from a municipal water supply. If you mark “Yes,” provide us the name of the municipal water source.

If the water is not supplied by a municipal water source, you must check “No.” If you mark “No,” provide the water source. A bacteriological water analysis is required for a facility that receives water from a non-municipal source. This shall be conducted annually by your local health department, the State Department of Public Health, or a licensed commercial laboratory. Include the bacteriological water analysis.

Capacity (Occupancy) – Indicate the capacity for which you are applying. This information is to be used by the Department to complete and submit a request to your local fire authority for a fire/safety inspection. **DO NOT SUBMIT A FIRE CLEARANCE WITH YOUR APPLICATION; the Department must receive the clearance directly from the fire authority.**

For each type of resident, indicate the number of beds for which you are applying and include the sum for “Total Treatment Capacity.”

- “Ambulatory” means residents that will be living in the facility that are able to walk. Enter the number of beds requested for residents who are able to walk. If not applicable, enter “N/A.”
- “Non-ambulatory” means residents that will be living in the facility who are unable to walk. Enter the number of beds requested for residents who are unable to walk. If not applicable, enter “N/A.”

- "Bedridden" means residents that will be living in the facility that are confined to a bed for medical reasons. Enter the number of beds requested for residents who are confined to a bed for medical reasons. If not applicable, enter "N/A."
- Dependent Children of Residents – Enter the number of beds requested for dependent children of residents. If not applicable, enter "N/A."
- Staff – Enter the number of beds requested for staff or HCPs who work at the facility. If not applicable, enter "N/A."

Total capacity – Enter the total number of beds for which you are applying. The total capacity should equal the sum of beds requested for all ambulatory, non-ambulatory, and bedridden residents, dependent children of residents, and staff, and cannot exceed the total capacity approved by the local fire authority.

Fire Authority Information –. Please provide information for the local fire department and/or fire agency assigned to the facility where you are requesting to provide alcoholism or drug abuse recovery or treatment services.

Name – Enter the name of the local fire authority for where the facility is located.

Business Phone Number – Enter the business phone number of the local fire authority.

Fax Number – Enter the fax number of the local fire authority.

Address – Enter the address of the local fire authority.

City – Enter the city of the local fire authority.

Zip Code – Enter the zip code of the local fire authority.

The fire clearance will include a determination of the number of beds for ambulatory and non-ambulatory residents, as well as any restrictions regarding non-ambulatory clearances. **The fire clearance shall include the number and age range of dependent children allowed to reside in the facility.** If the fire clearance does not include a number of dependent children, no dependent children are allowed to reside in the facility.

SECTION E – PROOF OF INSURANCE

This section must be completed by all applicants.

Select all applicable types of insurance obtained by the applicant. Proof of insurance coverage must apply to the facility address listed on the application in the amounts of coverage specified:

Check the appropriate box(es) for the type of insurance required:

General liability insurance for facilities with six or fewer residents.

Commercial general liability insurance for facilities with more than six residents, that includes coverage for premises liability, products and completed operations, contractual liability, personal injury and advertising liability, abuse, molestation, sexual actions, and assault and battery, with minimum coverage amounts for bodily injury or property damage of not less than one million dollars ($1,000,000) per occurrence.

Commercial or business automobile liability insurance for facilities with more than six residents, covering all owned vehicles, hired or leased vehicles, non-owned vehicles, and borrowed and permissive uses, with minimum coverage amounts for bodily injury or property damage of not less than one million dollars ($1,000,000) per occurrence.

Workers' compensation insurance for facilities with more than six residents as required by law. Notwithstanding subdivision (b) of Section 3700 of the Labor Code, a certificate of self-insurance obtained pursuant to that subdivision does not satisfy this requirement.

Employer's liability insurance for facilities with more than six residents, with minimum coverage amounts for bodily injury or disease of not less than one hundred thousand dollars ($100,000) per occurrence.

Professional liability and errors and omissions insurance for facilities with more than six residents, that includes an endorsement for contractual liability, with minimum coverage amounts of one million dollars ($1,000,000) per occurrence and two million dollars ($2,000,000) aggregate. If applicable, the contract shall include an endorsement for defense and indemnification of any government entity with which the licensee has contracted.

If Professional Liability applies, the applicant must submit copies of the professional liability coverage for each individual.

SECTION F – DECLARATION

<u>This section must be completed by all applicants.</u>

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

Print Name – Enter the name of the individual signing the application.

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

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 Application for Existing Licensee to Obtain Initial Licensure for New Facility (DHCS 6047) 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 – Management services/professional services agreement(s) specific to the new facility, if applicable.

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 – Fire authority information.

Tab 5 – Program description – A written statement that describes the program's alcoholism or drug abuse recovery or treatment services and settings 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 6 – Job Descriptions – A narrative description for each position at the facility (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 7 – Policies and procedures for admission and readmission – Written admission and readmission policies and procedures for determining an individual's suitability for services.

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 – Sketch of building and grounds – Submit a sketch on an 8½" x 11" sheet of paper of all building(s) to be occupied. A sketch of the grounds must show all buildings, driveways, fences,

storage areas, pools, gardens, recreational areas, and other spaces of the property. All sketches shall show dimensions of each area but need not be to scale.

Tab 10 – Floor plan of facility – Submit a sketch on an 8½" x 11" sheet of paper of the floor plan of the building identifying all rooms intended for use by residents, including location of detoxification beds, if applicable. The floorplan shall show the number and location of beds for all residents, including ambulatory, non-ambulatory, and bedridden residents; dependent children of residents; and staff (if applicable). Where female and male residents are housed in the same facility, separate toilet, hand washing, bathing facilities, and sleeping areas shall be identified. All sketches shall show dimensions of each area but need not be to scale.

Tab 11 – 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 12 – Policies and procedures for MAT – Written policies and procedures for MAT.

Tab 13 – 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).

Tab 14 – Proof of required insurance coverage in accordance with Health and Safety Code section 11834.10 –Submit copies of required insurance documents for general liability, commercial general liability, commercial or business automobile liability, workers compensation, employer's liability, and professional liability and errors and omissions insurance, as applicable.

Tab 15 – HCP documentation, if applicable – Include a Health Care Practitioner Incidental Medical Services Acknowledgement (DHCS 5256) and documentation of a current license in good standing with the appropriate licensing board for each HCP.

(Read instructions fully before completing application)

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

SECTION B – BUSINESS ENTITY INFORMATION		
Business Entity Name:		
Facility Name:		
Administrative/Corporate Office Address (if different than existing address):		Room/Suite:
City:	State:	Zip Code:
Facility Website Address:	Facility 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 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 - FACILITY/BUILDING INFORMATION	
Facility Street Address (Building 1):	Room/Suite:
County:	City:
State: CALIFORNIA	Zip Code:
Business Phone Number:	
Facility Address (Building 2):	Room/Suite:
County:	City:
Business Phone Number:	
Does this application include more than one (1) building? ☐ Yes ☐ No	
If "Yes", enter 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 - RESIDENTIAL LICENSE INFORMATION

Target Population (check all that apply)

☐ General Population (co-ed)
☐ Co-Ed with Dependent Children
☐ Women Only
☐ Men Only
☐ Perinatal

Services to Be Provided (check all that apply)

☐ Detoxification Services
☐ Recovery Services
☐ Treatment Services
☐ Incidental Medical Services (IMS)

Water Supply

Is water used for human consumption supplied by a municipal water source? ☐ Yes ☐ No

If "Yes", provide the name of the municipal water source:

If "No", provide the source of water:

Capacity (Occupancy): Indicate the bed capacity for which you are applying.			
Ambulatory:	Non-Ambulatory:	Bedridden:	***TOTAL TREATMENT CAPACITY:**
Dependent Children of Residents:		**Staff:**	
***TOTAL CAPACITY:**			
Includes all residents, dependent children of residents, and staff and shall not exceed the capacity approved by the fire authority.			
FIRE AUTHORITY INFORMATION			
Name:			
Business Phone Number:		Fax Number:	
Address:		City:	Zip Code

SECTION E - PROOF OF INSURANCE

- ☐ General liability insurance (for six or fewer residents)
- ☐ Commercial general liability insurance (for more than six residents)
- ☐ Commercial or business automobile liability insurance (for more than six residents)
- ☐ Employer's liability insurance (for more than six residents)
- ☐ Professional liability and errors and omissions insurance (for more than six residents)

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 licensure of residential alcoholism and drug abuse recovery or treatment facilities. 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 11834.01 et seq. and California Code of Regulations, Title 9, Division 4, Chapter 5. 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
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).