

**APPLICATION FOR CHANGE IN CERTIFIED SOCIAL REHABILITATION PROGRAM**

INSTRUCTIONS: Fill out Sections 1 and 6 for all Application for Change in SRP types. For a change in facility/program name, fill out Section 2. For a change in facility/program ownership, fill out Section 3. For a change in facility/program bed count, fill out Section 4. For a change in facility/program location, fill out Section 5. When completed, please email the application to: [CSDTRPU@dhcs.ca.gov](mailto:CSDTRPU@dhcs.ca.gov)

For more information on the Continuum of Mental Health Care Section, visit our webpage at <https://www.dhcs.ca.gov/services/MH/Pages/Community-support-branch1.aspx>

<b>SECTION 1 – FACILITY/PROGRAM INFORMATION</b>	
<b>FACILITY/PROGRAM NAME</b>	<b>PROGRAM DIRECTOR</b>
<b>FACILITY/PROGRAM WEBSITE URL</b>	

<b>SECTION 2 – CHANGE IN FACILITY/PROGRAM NAME</b>	
<b>CURRENT NAME</b>	<b>PROPOSED NAME</b>

<b>SECTION 3 – CHANGE IN FACILITY/PROGRAM OWNERSHIP</b>	
<b>CURRENT OWNERSHIP NAME</b>	<b>PROPOSED OWNERSHIP NAME</b>

<b>SECTION 4 – CHANGE IN FACILITY/PROGRAM BED COUNT</b>	
<b>CURRENT NUMBER OF BEDS</b>	<b>PROPOSED NUMBER OF BEDS</b>

<b>SECTION 5 – CHANGE IN FACILITY/PROGRAM LOCATION</b>	
<b>CURRENT LOCATION</b>	<b>PROPOSED LOCATION</b>

<b>SECTION 6 – APPLICANT INFORMATION</b>	
<i>My signature below confirms that there are no other changes to the programmatic aspects of the SRP. I understand if there are changes, I will need to submit a DHCS 1734 application packet.</i>	
<b>PERSON COMPLETING APPLICATION</b>	<b>TITLE</b>
<b>TELEPHONE NUMBER</b>	<b>EMAIL</b>
<b>SIGNATURE</b>	<b>DATE</b>