State of California
Health and Human Services Agency

RESET FORM

Department of Health Care Services

APPLICATION FOR LICENSURE - MENTAL HEALTH REHABILITATION CENTER (MHRC)

Name of Applicant/Facility Name:		Program Director:
Mailing Address (street):		City:
Host County:	Zip Code:	Telephone:

Type of Ownership:

Government Entity Non-Profit Corp. Individual or Proprietary Corp. Partnership

Other _____

Is the property owned by the applicant? If no, state the name, address, and affiliation of the property owner.

Yes No _____

Capacity to be licensed: _____

Current Status of the Facility:

To be constructed

Existing Community Care Facility (to be remodeled: ☐ Yes or ☐ No)

Existing Health Facility (to be remodeled: ☐ Yes or ☐ No)

Other (to be remodeled: ☐ Yes or ☐ No) _____

Current Facility License Classification (if any):	Address (street, city, zip code):
Setting: Rural Urban	General Target Population:
Legal Classes to be Admitted:	Provisions for Physical Health Treatment: Transfer Agreement with: _____

The following must be submitted with this application:

A. A specific description of what makes the program innovative compared to existing licensed or certified mental health programs.
B. Those items required by Section 783.10, Title 9.
C. A description of the applicant's experience in mental health service delivery.
D. The number, description, and qualifications of staff, by class. (Show only staff time to be worked in the MHRC.)

Applicant's Signature:	Title:
Organization:	Date:

Approved - Mental Health Director Signature:	County of:	Date:

Please submit your completed application to:

Email Address: ***MHLC@dhcs.ca.gov***

Mailing address: ***DEPARTMENT OF HEALTH CARE SERVICES***
Mental Health Licensing Section, Licensing Branch 2
Licensing and Certification Division
P.O. Box 997413, MS 2800
Sacramento, CA 95899-7413
Main Line: (916) 323-1864 Fax: (916) 324-0993