State of California
Health and Human Services Agency

RESET FORM

Department of Health Care Services

APPLICATION FOR LICENSURE - PSYCHIATRIC HEALTH FACILITY (PHF)

Name of Applicant/Facility Name:

Mailing Address (street):		City:
County:	Zip Code:	Telephone:

Sponsorship:
☐ Government Entity ☐ Non-Profit Corp. ☐ Individual or Proprietary Corp. ☐ Partnership
☐ Other _____

Is the property owned by the applicant? ☐ Yes ☐ No
If no, state the name, address, and affiliation of the property owner:

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):	Location of Facility:

Setting:	Services, in addition to in-patient treatment, to be offered by the facility:
☐ Rural ☐ Urban	☐ Day treatment ☐ Out-patient ☐ None ☐ Other: _____

Age Groups to be admitted:
☐ Children ☐ Adolescent ☐ General ☐ Adult ☐ Geriatric

Legal Classes to be admitted:
☐ Voluntary ☐ Involuntary ☐ LPS Conservatee ☐ Judicially Committed

Provisions for treatment of patients requiring medical services for physical health conditions:
☐ Contractual Agreements Attached. If No, under development with: _____

Provision for referral of patient who are found to have psychiatric disorders, that the facility is not able to treat, including transportation arrangements:
☐ Statement of Provisions Attached
If No, under development with: _____

Provision for After-Care Services:

Anticipated Source of Funding for Care and Treatment:
☐ Short-Doyle ☐ Insurance ☐ Private ☐ Other _____

If Short-Doyle Funding is not sought, are comments by Board of Supervisors or evidence or consideration by the Board of Supervisors attached? ☐ Yes ☐ No

Date that Letter of Intent and supporting documents were submitted to the governing body: _____ (Thirty-day wait is required before submitting the form to the Department of Health Care Services, together with comments, if any, by the governing body. If no comments were forthcoming, a copy of the official noticing of the application on the governing body's agenda is sufficient.)

Clinical Director – Name: _____ Degree: _____

License type & #: _____ Phone: _____

Anticipated average per diem charge for in-patient services to a fully paid patient: $_____
Attach a complete list of any and all charges and costs for in-patient services.

The following must be submitted with this application:

A. A plan for quality assurance, including utilization review and medication monitoring.
B. A list of diagnoses proposed to be treated by the applicant's program.
C. A list of diagnostic and treatment services, including all personnel, equipment and modalities that will be used to treat the various diagnoses listed under 'B' above.
D. A schedule of weekly activities to be engaged in by each patient and a schedule of a patient's typical day. This should include the anticipated flexibility of the program activities to provide for the individual needs of each patient.
E. A list of the staff identified or hired to date, with a brief resume and copy of current licensure for each.
F. A description of applicant's previous experience in the provision of mental health services, including appropriate licenses and biographies of both the organization and individual administrators.
G. The number, description and qualifications of proposed staff; if actual staff members have been hired, submit a copy of their current resume and license.
H. If the treatment staff time is to be assigned to other than in-patient services, indicate the percent distribution.
I. A statement from administrators/staff stating whether their licenses have ever been suspended or revoked and whether they are under current indictment, as well as a listing of: their arrest record, if any; any convictions of a felony; and malpractice actions, if any, against them; any charged felonious activities; and any currently pending actions by any private individual, government body, hospital staff office, or hospital affiliation, involving their professional duties. A floor plan of the proposed program space, augmented by photographs if possible (Polaroid photos are acceptable).
J. A narrative description which explains the program. The summary of the planned program should explain how the programmatic space will be used, what treatments and activities will be available to patients and how they will be assured an appropriate, safe and therapeutic environment. The purpose of this section is to allow the Department of Health Care Services to understand both the elements and the overall program that they are reviewing. A detail program description is required.
K. A clearly written statement of an Admissions Policy by diagnosis which specifies the explicit exclusion of individuals whose primary presenting problems result from drug or alcohol abuse or who require detoxification.
L. P.H.F. application fee of one thousand dollars ($1000).

Applicant's Signature:	***Please submit your completed application with payment to:***
Applicant's Title:	***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***
Organization Name:	
Date:	