NEW PROVIDER LEVEL OF CARE ATTESTATION STATEMENT
(Opting for ASAM Level of Care Certification Only)

Provider Information	
Program / Facility Name:	
Facility Address:	
Contact Person Name:	Title:
Phone Number:	Email:

ASAM Level of Care Certification		
Check the appropriate box(es) for the ASAM Level of Care Certification(s) which the program currently holds or has applied for:		
Adult Residential	☐ 3.1	☐ 3.5

I certify that I am authorized by the licensed alcohol or drug abuse recovery or treatment facility (hereinafter “facility”) indicated above, to provide information to the Department of Health Care Services (DHCS) for licensing purposes.

By this declaration, I attest the American Society of Addiction Medicine (ASAM) Level of Care (LOC) Certification indicated above accurately reflects the proposed status of facility and will not request DHCS LOC Designation(s) at this time.

I do hereby attest that I have attached a true and correct copy of the facility’s ASAM LOC Certification application.

I do hereby attest that if at any time the facility makes changes to its application for an ASAM LOC Certification, then I, or another facility representative, shall notify DHCS of that change within 10 working days of submission to ASAM by providing DHCS with a copy of the facility’s updated application for ASAM LOC Certification.

I do hereby attest that the facility maintains and will continue to maintain compliance with applicable level of care requirements set forth in Behavioral Health Information Notice No.: 21-001. I do hereby attest that the facility complies with, and will continue to comply with, all applicable statutes, regulations, and standards that govern the operation of the facility.

I do hereby attest that this information is true, accurate, and complete to the best of my knowledge.

Legal Disclaimer: The DHCS LOC Designations are not equivalent to, or affiliated with the ASAM LOC Certifications developed by ASAM©, in partnership with CARF International.

Signature of Authorized Individual: ______________________________

Print Name: ______________________________

Title: ____________________ Date: ____________________

DHCS Internal Use Only
Provider Number:

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ASAM Documents Provided
☐ Yes ☐ No
Initials and Date: __________

Licensing Branch 2, MS 2602
P.O. Box 997413
Sacramento, CA 95899-7413
LCDLOCDesig@dhcs.ca.gov