LEVEL OF CARE DESIGNATION APPLICATION

STATE OF CALIFORNIA

HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF HEALTH CARE SERVICES
LICENSING AND CERTIFICATION DIVISION, MS 2602
P.O. BOX 997413
SACRAMENTO, CA 95899-7413

LCDLOCDesig@dhcs.ca.gov

APPLICATION INSTRUCTIONS

Pursuant to Health and Safety Code (HSC) Section 11834.015, the Department of Health Care Services (DHCS) adopted the American Society of Addiction Medicine (ASAM) treatment criteria as the minimum standard of care for all licensed adult alcoholism or drug abuse recovery or treatment (AOD) facilities. The Department has incorporated the ASAM treatment criteria into the DHCS Level of Care (LOC) Designations program and requires licensed AOD facilities to obtain a designation as a part of licensure.

To ensure that all licensed AOD facilities are capable of delivering care consistent with the ASAM treatment criteria and meet all of DHCS' requirements, DHCS developed the following DHCS LOC Designations:

- DHCS Level 3.1 – Clinically Managed Low-Intensity Residential Services,
- DHCS Level 3.2 – Clinically Managed Residential Withdrawal Management,
- DHCS Level 3.3 – Clinically Managed Population-Specific High-Intensity Residential Services,
- DHCS Level 3.5 – Clinically Managed High-Intensity Residential Services.

All licensed AOD facilities shall obtain at least one DHCS LOC Designation and/or at least one residential ASAM LOC Certification consistent with all its program services. If a facility chooses to obtain an ASAM LOC Certification, then that facility will not be required to obtain a DHCS LOC Designation. However, a facility may obtain both a DHCS LOC Designation and ASAM LOC Certification upon discretion. The DHCS LOC Designations are not equivalent to or affiliated with the ASAM LOC Certifications developed by ASAM, in partnership with Commission on Accreditation of Rehabilitation Facilities (CARF) International. An approval for a DHCS LOC Designation does not guarantee eligibility for an ASAM LOC Certification.

Applicants are required to submit a DHCS LOC Designation Application (DHCS 4022) and all supporting documentation. The application and supporting documentation shall demonstrate the licensed AOD facility's ability to comply with the requirements identified in Exhibit A of Behavioral Health Information Notice No.: 21-001. An application package that is incomplete or does not meet the requirements described in these instructions will be returned to the applicant.

Please complete all sections of the application. You may attach additional documentation if your information does not fit in the appropriate area; however, the spaces for the requested information must be completed. The application and all supportive documentation must be printed single sided with 12 point Arial font on 8 1/2" by 11" white paper. It is recommended that you retain a copy of the completed application packet for your records.

At this time, there is no fee for processing a DHCS LOC Designation Application. Please submit the completed application package to:

Department of Health Care Services
Licensing and Certification Division, MS 2602
P.O. Box 997413
Sacramento, California 95899-7413

If you are a new applicant applying for an initial residential licensure, the DHCS LOC Designation application must be submitted concurrently with an Initial Treatment Provider Application (DHCS 6002), including required fees and supporting documentation, to the Department.

If you are applying for a LOC designation for multiple facilities, you must submit an application package for each corresponding facility.

SUPPORTING DOCUMENTATION AND DESCRIPTIONS

In order to expedite the application process for all applicants, please submit all documents required. Incomplete packets will be rejected without review.

Facility Staffing Data (DHCS 5050) – All facility staff who provide direct client services and/or oversee the program must be included on the form. Enter all required staff information including, but not limited to, the date of hire, alcohol and drug treatment experience in years, last tested date for tuberculosis, last training date for first aid and cardiopulmonary resuscitation, and valid credentials.

Detailed Monthly Program Staff Schedule – Provide a copy of the monthly program staff schedule showing 24-hour staff coverage in the facility.

Weekly Activities Schedule (DHCS 5086) – Enter your full weekly schedule of treatment services. Although you may attach a separate schedule of your own design, please be very specific about the types of services you offer; do not enter codes, letters, numbers, or include a key to describe codes, letters, or numbers. Type the services you provide in the time slot you provide them. Time slots in which you are not providing treatment services should be left blank. For example, meals are not a treatment service, nor any other activity not directly related to the services for which you have applied to provide. Abbreviations of treatment services are acceptable to allow them to fit in the spaces provided. The allowed abbreviations for the treatment services are as follows:

Individual Counseling Sessions – IS Group Counseling Session – GS
Educational Sessions – ES Recovery or Treatment Planning – RP or TP

After you have entered the treatment services in the appropriate time slots, add up the total number of hours per day and enter the total hours per week at the bottom of the page.

Detailed Weekly Program Activities Schedule – Provide a copy of the weekly program activities schedule that must include detailed services, staff person facilitating each service, and activities listed for up to a month schedule.

Program's Level of Care Assessment – Provide a copy of the program's LOC Assessment used to determine the appropriate level of care for a resident. The LOC Assessment must incorporate *The ASAM Criteria©,* which includes a comprehensive biopsychosocial assessment addressing six dimensions and associated risks.

Section A – Application Information

This section must be completed by all applicants.

For new applicants who submitted an Initial Treatment Provider Application and under review by the Department, the information provided must match all the information listed on the initial application.

For current providers, the information provided must match all the information listed on the Department issued license and/or certification.

DHCS Provider Number – Enter the DHCS license and/or certification number associated with the facility or legal entity. Enter N/A if Not Applicable.

Provider Type – Select from the drop down box if the facility is licensed, certified, licensed and certified, or new applicant.

Program/Facility Name – Enter the name of the program/facility. Do not include the legal entity name in this box unless the program/facility name is the same as the legal entity name.

Facility Address – Enter the physical address of the program/facility.

City/State/Zip – Enter the city, state, and zip code of the program/facility.

Target Population – Select appropriate target population from the drop down box: Co-Ed, Male Only, Female Only, Women and Children, or Adolescent.

Treatment Capacity – Enter the number of treatment capacity for the facility. Treatment capacity is the total number of individuals residing in and receiving treatment services from the AOD facility.

Total Capacity – Enter the number of total capacity for the facility. Total capacity is the total number of beds in the facility, including any beds for staff and/or dependent children.

Contact Person Name, Title, Phone Number, and Email – Enter the name, title, phone number, and email of the primary contact person. This person must be an authorized individual with the facility. Include the Designation of Administrative Responsibility form (DHCS 5085), if necessary.

Section B – Application Designation

This section must be completed by all applicants.

Application Type – Check the appropriate box or boxes for the LOC designation you are applying for:

- 3.1: Clinically Managed Low-Intensity Residential Services
- 3.2: Clinically Managed Residential Withdrawal Management
- 3.3: Clinically Managed Population-Specific High-Intensity Residential Services
- 3.5: Clinically Managed High-Intensity Residential Services

Provisional Designation – Check the appropriate box if the program currently holds a Provisional DHCS LOC Designation and indicate the designation.

ASAM/CARF Certification – Check the appropriate box if the program currently holds or has applied for an ASAM/CARF Certification.

Sections C – G

This section must be completed by all applicants.

This portion of the application is a self-assessment of the residential facility. Please answer all questions regarding the program services, staffing, population served, support systems, and assessment/treatment plan review.

Glossary

IND – Individual Counseling Sessions
GRP – Group Counseling Sessions
EDU – Educational Sessions
CO/MH – Co-Occurring/Mental Health
COG – Cognitive/Functional Impairment

DHCS Level of Care Designation Application

Section A – Application Information		
DHCS Provider Number:	Provider Type: Choose an Item	
Program/Facility Name:		
Facility Address:		
City:	State:	Zip:
Target Population: Choose An Item	Treatment Capacity:	Total Capacity:
Contact Person Name:	Title:	
Phone Number:	Email:	

Section B – Application Designation			
Application Type – Check all boxes relevant to this application:			
Adult Residential:	☐ 3.1	☐ 3.3	☐ 3.5
Adult Withdrawal Management:	☐ 3.2		
DHCS Provisional LOC Designation – Does the program currently hold a DHCS Provisional LOC Designation?	◯ Yes	◯ No	
If yes, indicate which LOC:	☐ 3.1	☐ 3.3	☐ 3.5
ASAM LOC Certification – Does the program currently hold or has applied for an ASAM LOC Certification?	◯ Yes	◯ No	
If yes, indicate which residential LOC obtained:	☐ 3.1	☐ 3.5	☐ Other

Section C – Program Services		
1.	Individualized Counseling Sessions – On average, how many hours per resident per week?	
2.	Group Counseling Sessions – On average, how many hours per resident per week?	
3.	Education Sessions – On average, how many hours per resident per week?	
4.	Co-Occurring (CO) and Mental Health (MH) Treatment Services – On average, how many hours per resident per week?	
5.	Cognitive or Functional Impairment Services – On average, how many hours per resident per week?	
6.	What services are made available to the resident to facilitate the application of recovery skills, sobriety maintenance, and emotional coping strategies?	
7.	What is the average length of stay in your facility?	
8.	Is the program approved by DHCS to provide detoxification services?	◯ Yes ◯ No ◯ Application in Process

9.	Is the program approved by DHCS to provide Incidental Medical Services (IMS)? If no or application in process, what are the current referral procedures for medical services?	◯ Yes ◯ No ◯ Application in Process
10.	Is the program providing medication assisted treatment (MAT) services? If no, what is the referral procedures for MAT services?	◯ Yes ◯ No

Section D – Staffing					
11. Indicate program staff conducting each service. Check all that apply.					
License or Certification/Registration	**IND**	**GRP**	**EDU**	**CO/MH**	**COG**
Licensed Clinical Psychologist	☐	☐	☐	☐	☐
Licensed Clinical Social Worker	☐	☐	☐	☐	☐
Licensed Marriage and Family Therapist	☐	☐	☐	☐	☐
Licensed Professional Clinical Counselor	☐	☐	☐	☐	☐
Registered Nurse, Nurse Practitioner, Nurse Practitioner Intern	☐	☐	☐	☐	☐
Physician/Physician Assistant	☐	☐	☐	☐	☐
Marriage and Family Intern	☐	☐	☐	☐	☐
Associate Social Worker	☐	☐	☐	☐	☐
Professional Clinical Counselor Intern	☐	☐	☐	☐	☐
Registered Psychologist/ Psychological Assistant	☐	☐	☐	☐	☐
Registered AOD Counselor	☐	☐	☐	☐	☐
Certified AOD Counselor	☐	☐	☐	☐	☐
Other (Please specify):	☐	☐	☐	☐	☐

12.	Is the facility staffed 24 hours a day, 7 days a week and at least one staff on-site trained in cardiopulmonary resuscitation and first aid at all times?	◯ Yes	◯ No
13.	Is there at least one individual who is a Licensed Professional trained in treatment of substance use disorder available on-site or by telephone 24 hours a day, 7 days a week?	◯ Yes	◯ No

14.	Does the program have a Medical Doctor on staff or on contract? If yes, please include a job description.	◯ Yes	◯ No
15.	Does the program have trained personnel documenting observations and face-to-face physical checks at least every 30 minutes during the first 72 hours following admission for each detoxification resident?	◯ Yes	◯ No

Section E – Population Served	
Identify the percentage of population served in each category. The total must equal 100%	
16.	What percentage of residents do you anticipate to treat for moderate to severe substance use disorder without a co-occurring mental health illness?
17.	What percentage of residents do you anticipate to treat for moderate to severe substance use disorder combined with a co-occurring mental health disorder?
18.	What percentage of residents do you anticipate to treat for moderate to severe substance use disorder combined with functional limitations that were primarily cognitive in nature (e.g., traumatic brain injury, amnesia, dementia, etc.)?
19.	How do you track the data compiled from questions 16, 17, and 18? Where is this information documented?

Section F – Support System					
20.	Does the program offer telephone, in person consultation, or referrals to physicians [1] and emergency services 24 hours a day, 7 days a week?			◯ Yes	◯ No
21.	Does the program have a direct affiliation [2] with other levels of care, or coordination through referral to more or less intensive levels of care and other services? Check all that apply.				
	☐ 0.5	☐ 1.0	☐ 2.1	☐ 2.5	
	☐ 3.1	☐ 3.3	☐ 3.5	☐ 3.7	☐ 4.0
	☐ Opioid Treatment Program		☐ Office-based Buprenorphine Treatment		
22.	Check the services offered on site and/or co-located:				
	☐ Medical Services				
	☐ Psychiatric Services				
	☐ Mental Health Services [3]				
	☐ MAT Services				
	☐ Laboratory Services [4]				
	☐ Toxicology Services [5]				

1 Includes hospital/emergency room (ER) coverage
2 Includes memorandum of understanding (MOU), contract, or referral arrangement
3 Includes mental health counseling
4 Includes phlebotomy
5 Includes point-of-service urine drug screening

23.	Check the services offered through referrals: ☐ Medical Services ☐ Psychiatric Services ☐ Mental Health Services ☐ MAT Services ☐ Laboratory Services ☐ Toxicology Services

Section G – Assessment/Treatment Plan Review			
Does the program's assessment and treatment plan review include:			
24.	An individualized, comprehensive bio-psychosocial assessment of the resident's substance use disorder, which is conducted or updated by qualified [6] staff?	◯ Yes	◯ No
25.	An individualized treatment plan, which involves problems, needs, strengths, skills, short-term measurable goals, preferences and activities designed to achieve those goals?	◯ Yes	◯ No
26.	A completed physical examination?	◯ Yes	◯ No
27.	A completed health questionnaire?	◯ Yes	◯ No
28.	Ongoing transition/continuing care planning?	◯ Yes	◯ No
29.	Before enrollment, is an LOC Assessment completed in person, by telephone, or conducted by a third party agency? What is the job title of the person(s) responsible for conducting the assessment and determining the LOC for a resident? What are the time frames in which the assessment and LOC determination are made?		
30.	After assessment, what would promote a referral to another level of care, and who makes the decision for the referral?		
31.	Who is included in the Care Management Team? Provide details of how the Care Management Team completes and updates the Clinical Assessment including the LOC Assessment.		
32.	What is the job title of the person(s) creating the treatment plan? When is it completed and how often is it updated?		

6 At minimum, a registered alcohol and other drug counselor adhering to all requirements in the California Code of Regulations (CCR), Title 9, Chapter 8.

Section H – Certifications and Assurances

I certify under penalty of perjury that I have read, understand, and will comply with the regulations and/or standards that govern the operation of the program for which I am applying. The information contained in this application is accurate, true and complete in all material aspects. All program policies and procedures required by the regulations and/or standards that govern the operation of this program have been developed, comply with the appropriate regulations and standards, and are available for review by DHCS upon request. Furthermore, the applicant does not discriminate in employment practices or provision of services on the basis of race, national origin, ethnic group, identification, religion, age, sex, sexual orientation, color or disability pursuant to the Title VI, Civil Rights Act of 1964, (42 U.S.C. Chapter 21), The Americans with Disabilities Act of 1990 (42 U.S.C. § 12132), California Government Code § 11135, The Rehabilitation Act of 1973 (29 U.S.C. § 794), and Title 9, California Code of Regulations, Commencing with § 10800.

If the applicant is a sole proprietor, the application shall be signed by the proprietor; if the applicant is a partnership, the application shall be signed by each partner, and if the applicant is a firm, association, corporation, county, city, public agency or other governmental entity, the application shall be signed by the chief executive officer or an individual authorized to represent the provider. Attach additional signature pages if necessary.

CIVIL CODE § 1798.17 AND THE PRIVACY ACT OF 1974, 5 U.S.C. 552a, PROVIDES PROTECTION TO INDIVIDUALS BY ENSURING THAT PERSONAL INFORMATION COLLECTED BY STATE AGENCIES IS LIMITED TO THAT WHICH IS LEGALLY AUTHORIZED AND NECESSARY AND IS MAINTAINED IN A MANNER WHICH PRECLUDES UNWARRANTED INTRUSIONS UPON INDIVIDUAL PRIVACY.
Legal Disclaimer: The DHCS LOC Designations are not equivalent to, or affiliated with the ASAM Level of Care Certifications developed by ASAM©, in partnership with CARF International.

Printed Name: _____ Title: _____
Signature: _____ Date: _____
Email: _____ Contact Number: _____