State of California - Health and Human Services Agency
Department of Health Care Services
Licensing and Certification Division
Licensing Branch 1, MS 2600
PO Box 997413
Sacramento, CA 95899-7413
(916) 322-2911

Request for License and/or Certification Extension

Please review the following information and note any changes. **This document must be COMPLETELY FILLED OUT, SIGNED BY AN AUTHORIZED REPRESENTATIVE(S) and received by Department of Health Care Services (DHCS).** Please submit the Request for License and/or Certification Extension DHCS Form 5999 (12/18) with all supporting documentation, renewal fees and any civil penalties to the department.

In accordance with the Alcohol and/or other Drug Program Certification Standards, Section 3000(b), the program shall submit the Request for License and/or Certification Extension DHCS Form 5999 (12/18) with all supporting documentation and renewal fees to the department **120 days** prior to the expiration date reflected on the certificate. Failure to provide all necessary documentation shall result in the **termination of the certification** in accordance with Section 3000(d).

Have there been any changes since your current license/certification was issued? ☐ Yes ☐ No
If you answered yes to the above question please contact your analyst at (916) 322-2911. Please have your provider number (license/certification number) ready. Failure to do so may result in a delay or termination of your request for extension.

This form shall be returned with fees payable to: DHCS (i.e. license fees, civil penalties, etc.), via mail. **Please include your provider number (license or certification number) on all correspondence. You must complete all fields on this application. Incomplete applications will be returned unprocessed and may delay the extension of your licensure/certification.**

Provider Number (License/Certification Number):			
Legal Entity Name:			
Mailing Address:			
City:	State:	Zip Code:	Phone:
Facility Name:			
Facility Address:			
City:	State: CA	Zip Code:	Phone:
Website:	Fax:		Email:
Contact Person:	Phone:		Email:
Director's Name:	Phone:		Email:
Type of Organization: ☐ Profit Corporation ☐ Nonprofit Corporation			
☐ Sole Proprietor ☐ Partnership ☐ Government Entity			

TYPE OF SERVICE(S) PROVIDED:		TARGET POPULATION:
RESIDENTIAL	**CERTIFICATION**	☐ Co-Ed ☐ Men Only
☐ Detoxification	☐ Day Treatment	☐ Women Only
☐ Educational Sessions	☐ Detoxification	☐ Men Only or Women Only
☐ Group Sessions	☐ Outpatient	☐ Youth/Adolescents
☐ Individual Sessions	☐ Residential	☐ Parents/Children # of Children: _____
☐ Recovery/Treatment Sessions		

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ADDITIONAL ITEMS: (Required of all applicants)	**RESIDENTIAL FACILITIES ONLY:** (Required)
1) DHCS 5050 - Facility Staffing Data 3) A Valid Fire Clearance 2) DHCS 5086 - Weekly Activities Schedule 4) A Line Item Budget	Treatment/Recovery Capacity:_____ Total Building Capacity:_____ Date of Current Fire Clearance:_____

California Health and Safety Code § 11834.01(a) and the Alcohol and/or Other Drug Program Certification Standards § 3000 require all licensed and/or certified providers of alcohol and other drug services, respectively, to request extension of the license and/or certification every two years. Chapter 5, Title 9 California Code of Regulations § 10529(a) (2) and Alcohol and/or Other Drug Program Certification Standards § 3010 specifies the items to be provided in order to have the license and/or certification extended. Civil Code, § 1798.17 and the Privacy Act of 1974, 5 USC 552a, provide 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.

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. I further certify, under penalty of perjury, that the information contained in this application is accurate, true and complete in all material aspects.

I certify under penalty of perjury that 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 the DHCS upon request.

I certify under penalty of perjury that 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.

a. If the applicant is a sole proprietor, the application shall be signed by the proprietor.
b. If the applicant is a partnership, the application shall be signed by each partner.
c. 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.

Please print, sign in blue ink, and send this completed form and the additional items required (from page one) to DHCS. Attach additional signature pages if necessary.

Signature of Authorized Individual	Print Name	Title	Date
Signature of Authorized Individual	Print Name	Title	Date
Signature of Authorized Individual	Print Name	Title	Date