State of California - Health and Human Services Agency

Department of Health Care Services
Substance Use Disorder Compliance Division
Licensing and Certification Section, MS 2600
PO Box 997413
Sacramento, CA 95899-7413
(916) 322-2911

Supplemental Application
Request for Additional Services

Please review the following information and note any changes. **This document must be COMPLETELY FILLED OUT, SIGNED BY AN AUTHORIZED REPRESENTATIVE(S), received and approved by the Department of Health Care Services (DHCS) prior to providing any additional treatment services.**

This form shall be returned with applicable fees payable to: Department of Health Care Services and mailed to the address listed above. **Please include your provider number on all correspondence.**

You must complete all fields on this application. Incomplete applications will be returned unprocessed and may delay approval of the requested change(s).

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: ☐ Sole Proprietor ☐ Profit Corporation ☐ Nonprofit Corporation ☐ Partnership ☐ Government Entity

REQUESTED CHANGE (please check all that apply):

RESIDENTIAL
- ☐ Incidental Medical Services
- ☐ Detoxification
- ☐ Increased Capacity
- ☐ Decreased Capacity
- ☐ Relocation
- ☐ Co-ed
- ☐ Discontinuance of a Treatment Service
- ☐ Adding Address

CERTIFICATION
- ☐ Day Treatment
- ☐ Outpatient
- ☐ Residential
- ☐ Detoxification
- ☐ Relocation
- ☐ Discontinuance of a Treatment Service
- ☐ Adding Address/Suites

TARGET POPULATION:
- ☐ Co-Ed
- ☐ Men Only
- ☐ Women Only
- ☐ Dual Diagnosis
- ☐ Families
- ☐ Other _____
- ☐ Youth/Adolescents
- ☐ Parents/Children # of Children: _____
- ☐ Modification of Target Population

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Additional Required Documentation

Increased Capacity:

- ☐ Fire Clearance STD 850 Form
- ☐ Floor plan Specify location of added beds
- ☐ Building/Local Use Permit (If applicable)
- ☐ Fees
- ☐ Facility Staffing Data Form - DHCS 5050

Day Treatment: (Outpatient Only)

- ☐ Weekly Activities Schedule Form - DHCS 5086
- ☐ Facility Staffing Data Form - DHCS 5050
- ☐ Protocols and Procedures for Providing Day Treatment Services
- ☐ Program Description for Day Treatment Services

Co-Ed:

- ☐ Facility Staffing Data Form - DHCS 5050
- ☐ Fees
- ☐ Floor Plan

Include a new floor plan that specifies which beds and restrooms will be designated for males and females

Detoxification:

- ☐ Facility Staffing Data Form - DHCS 5050
- ☐ Revised program description that includes detox services
- ☐ Protocols that state the procedures for accepting detox clients
- ☐ Floor Plan (specify which beds will be used for detox)
- ☐ Fees

Incidental Medical Services:

- ☐ Incidental Medical Protocols and Policies
- ☐ Valid Health Care Practitioners License
- ☐ Job Description for Health Care Practitioner
- ☐ Revised Admission Agreement Specifying Services Provided
- ☐ Health Care Practitioners Acknowledgement
- ☐ Facility Staffing Data Form – DHCS 5050
- ☐ Fire Clearance - STD 850 Form
- ☐ Fees
- ☐ Floor Plan

Relocation or Adding Address/Suites:

- ☐ Fire Clearance STD 850 Form
- ☐ Facility Staffing Data Form DHCS 5050
- ☐ Fees
- ☐ Building/Local Use Permit (If applicable)
- ☐ Floor Plan (Residential Only)
- ☐ Lease Agreement (If applicable)
- ☐ Board Approval (If applicable)

If you are requesting to relocate, you must include a letter explaining why you are moving, anticipated move date and the new facility address.

New or Added Facility Address:	City	Zip

Discontinue Treatment Services and/or Target Population:

- ☐ Updated Policy and Procedures
- ☐ Current Facility Staffing Data Form
- ☐ Revised Floor Plan

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.

Signature of Authorized Individual	Print Name	Title	Date

Signature of Authorized Individual	Print Name	Title	Date