HEALTH FACILITY PROGRAM PLAN APPLICATION

DS 1852 (Rev.04/2022)

REQUEST FOR APPROVAL:

Initial Program Plan approval:
Conversion from CCF level ________ facility
Change of ownership
New facility
QIDP Approval: Attach copy of degree and resume

NOTIFICATION OF CHANGES:

Changes to existing Program Plan
Change of address or phone
Change of Administrator
Name: ____________________

Other: ____________________

LICENSE CATEGORY:
ICF/DD-H Program Plan
ICF/DD-N Program Plan
ICF/DD Program Plan: Annual Approval

FACILITY NAME: ____________________ Telephone: (____) ____________

***MEDI-CAL PROVIDER ID #**05G__________ **or** #55G ___________ Fax: (____) ____________
(* IF ASSIGNED)

Facility Address: ____________________ E-mail: ____________

____

Licensee/Corporation: ____________________ Telephone: (____) ____________

Licensee/Corporation Address: ____________________ Fax: (____)____________

____________________ E-mail: ____________

Corporate designee: ____________________

Mailing address: ____________________

____

Proposed/Actual Capacity: M ____ F ____

Licensed capacity of facility: ________ (beds) Age range: ________ Ambulatory status: ____________________ (AMB/NON-AMB)

QIDP:

ADMINISTRATOR:

Signature of Licensee/Corporate Designee	Title	Date

SUBMIT APPLICATION TO:	FOR DEPARTMENT USE ONLY
Department of Developmental Services Office of Statewide Clinical Services **Program and Policy Section** **1205 O Street, MS 7-10** **Sacramento, CA 95814** Phone: (916) 654-1965 Fax: (916) 654-2187 Email: HealthFacilities@dds.ca.gov	Date received: ____________ Date of program plan approval: ____________ Date of QIDP approval: ____________ Date of change acknowledged: ____________ Signed by: ____________

LICENSEE INFORMATION Identify any other facilities owned or operated by the licensee.		
Name of facility	**Regional Center**	**Capacity**
1.		
2.		
3.		
4.		

QIDP INFORMATION Identify any other facilities served by the QIDP.		
Name of facility	**Regional Center**	**Capacity**
1.		
2.		
3.		
4.		

ADMINISTRATOR INFORMATION Identify any other facilities administrated by the Administrator.		
Name of facility	**Regional Center**	**Capacity**
1.		
2.		
3.		

Attach additional pages if necessary.

Department of Public Health, Licensing & Certification District Office: ____________________

Address: ____________________

Telephone number: (   ) ____________________ **Contact person:** ____________________

Department of Health Care Services, Medi-Cal Field Office: ____________________

Address: ____________________

Telephone number: (   ) ____________________ **Contact person:** ____________________

Regional Center: ____________________

Address: ____________________

Telephone number: (   ) ____________________ **Contact person:** ____________________