HEALTH FACILITY PROGRAM PLAN APPLICATION

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DS 1852 (Rev.12/2007) (Electronic Version)

REQUEST FOR APPROVAL:

- ○ Initial Program Plan approval:
  - ○ Conversion from CCF level _____ facility
  - ○ Change of ownership
  - ○ New facility
- ○ QMRP Approval: Attach copy of degree and resume

NOTIFICATION OF CHANGES:

- ○ Changes to existing Program Plan
- ○ Change of address or phone
- ○ 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)

QMRP: **ADMINISTRATOR:**

Signature of Licensee/Corporate Designee	Title	Date

SUBMIT APPLICATION TO:	FOR DEPARTMENT USE ONLY
Department of Developmental Services Health Facilities Program Section 1600 Ninth Street, Room 320, MS 3-9 Sacramento, CA 95814 Phone: (916) 654-1965 Fax: (916) 654-2187 E-Mail: ddshfps@dds.ca.gov	Date received: _____ Date of program plan approval: _____ Date of QMRP approval: _____ Signed by: _____

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

QMRP INFORMATION Identify any other facilities served by the QMRP.		
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:** _____