H9

# LASSEN COUNTY
## Health and Social Services Department


☒ **HSS Administration**
1345 Paul Bunyan Road, Ste B
Susanville, CA 96130
(530) 251 - 8128

☐ **Public Guardian/Administrator**
1345 Paul Bunyan Road, Ste B
Susanville, CA 96130
(530) 251 - 8337

☐ **Housing & Grants**
1445 Paul Bunyan Road, Ste B
Susanville, CA 96130
(530) 251 - 8309

☐ **Behavioral Health**
555 Hospital Lane
Susanville, CA 96130
(530) 251 - 8108

☐ **Public Health**
1445 Paul Bunyan Road, Ste B
Susanville, CA 96130
(530) 251 - 8183

☐ **Community Social Services**
1400 Chestnut Street, Ste A
Susanville, CA 96130

**LassenWORKS**
1616 Chestnut Street
Susanville, CA 96130
(530) 251 - 8152

**Child & Family Services**
1600 Chestnut Street
Susanville, CA 96130
(530) 251 - 8277

**Adult Services**
1400 Chestnut Street, Ste B
Susanville, CA 96130
(530) 251 - 8158

**Family Solutions/Wraparound**
1400 Chestnut Street, Ste C
Susanville, California 96130
(530) 251 - 8340

**Mailing Address:**
**PO Box 1180**
**Susanville, California 96130**


**Date:** December 17, 2024

**To:** Aaron Albaugh, Chairman
Lassen County Board of Supervisors

**From:** Barbara Longo, Agency Director
Health & Social Services Agency

**Subject:** Authorization for the Director of Behavioral Health to sign and submit the Application for Initial Treatment Provider with the State of California Health and Human Services Agency Department of Health Care Services Substance Use Disorder.

**Background:**

Prior to Assembly Bill (AB) 118, certification for both residential and outpatient Substance Use Disorder (SUD) treatment facilities or programs was voluntary. Certification was obtained if a facility/program met requirements as outlined in the Alcohol and/or Other Drug Program Certification Standards. Any SUD treatment facility not exempt from certification pursuant to HSC Section 11832.3 must submit an Initial Application for Certification by January 1, 2024, and obtain certification by January 01, 2025.
Submitting this application will help Lassen County Behavioral Health continue to provide SUD services for our residents. Not doing so would create hardship for clients needing these services.

**Fiscal Impact:**

The Application Fee will be paid out of Behavioral Health Fund/Budget 110/0751 and is included in the FY 2024/2025 budget.

**Action Requested:**

1) Authorize the Behavioral Health Director to sign and submit the Application.

Department of Health Care Services
Licensing and Certification Section, MS 2600
PO Box 997413
Sacramento, CA 95899-7413

# INITIAL TREATMENT PROVIDER APPLICATION

**STATE OF CALIFORNIA**

**HEALTH AND HUMAN SERVICES AGENCY**

**DEPARTMENT OF HEALTH CARE SERVICES**

**SUBSTANCE USE DISORDER COMPLIANCE DIVISION, MS 2600**

**LICENSING AND CERTIFICATION SECTION**

**PO Box 997413**

**SACRAMENTO, CA 95899-7413**

**(916) 322-2911**
**FAX (916) 322-2658**
**TTY (916) 445-1942**

Department of Health Care Services
Licensing and Certification Section, MS 2600
PO Box 997413
Sacramento, CA 95899-7413

The attached application is to be used by current and prospective providers that wish to apply for Substance Use Disorder (SUD) treatment program initial residential licensure, initial certification, merger with another legal entity or change of ownership of an existing facility. ***Current providers wishing to relocate, add or delete treatment services, increase/decrease treatment beds or change target population must complete the Supplemental Application DHCS 5255 - (Rev. 6/16)***. All items in blue underline throughout the application signifies a link to the specified website.

It is vital that you carefully read each component (including the regulations and/or standards) before beginning to fill out the application. Answer each question in the application, and submit only the documentation requested and required. An incomplete application results in a delay of the application process.

If you have any questions regarding the licensing or certification of SUD recovery or treatment facilities, please contact DHCS's SUD Compliance Division at (916) 322-2911.

## Public Information

Information provided by the applicant can be made available for public review, unless otherwise exempted by law (Inspection of Public Records, Chapter 3.5, Division 7, Government Code).

## Requirements for License

The California Code of Regulations (CCR), Title 9, Division 4, Chapter 5, §10505, states, in part, that no person, firm, partnership, association, corporation, or local government entity shall operate, establish, manage, conduct, or maintain an alcoholism or drug abuse recovery or treatment facility without obtaining a current, valid license pursuant to this chapter.

An alcoholism or drug abuse recovery, treatment, or detoxification facility is defined as any facility, place or building which provides 24-hour, residential, non-medical services in a group setting to adults. For the purpose of further defining whether licensure is required, alcoholism or drug abuse recovery or treatment services mean services which are designed to promote treatment and maintain recovery from substance use disorder problems which include one or more of the following: detoxification, group sessions, individual sessions, educational sessions, and recovery or treatment planning.

## Regulations

The regulations that govern the licensing of non-medical residential facilities covered by these application instructions are under CCR, Title 9, Division 4, Chapter 5. In order to assist applicants in supplying the detailed information needed in the licensing process, a copy of the regulations may be downloaded from the California Office of Administrative Law website. The pertinent regulations are listed under the Department and Alcohol and Drug Programs.

For information on purchasing the regulations, including the receipt of updates, please contact Legal Solutions Thomson Reuters online or by phone at 1-888-728-7677.

## Requirements for Certification

The Health and Safety Code, §11830, offers certification of residential and outpatient programs on a voluntary basis. Although certification is voluntary, programs wanting to ensure quality assurance, while expanding the availability of funding resources, will request certification. Many programs consider certification advantageous in gaining the confidence of potential clients, insurance companies, and other third-party payers, as it signifies that a program meets minimal levels of service quality. In addition, many counties require that programs under contract be SUD certified as a condition of receiving funds.

## Certification Standards

The standards that govern certified programs covered by these instructions are within the Alcohol and Other Drug Certification Standards, and may be downloaded from the DHCS website.

## Requirements for Drug Medi-Cal Certification (DMC)

CCR Title 22, offers DMC certification to programs that provide substance abuse services to Medi-Cal beneficiaries that are covered by the Medi-Cal program, when it is determined, by a physician, that alcohol and drug treatment is medically necessary.

If you intend to provide residential DMC services, you must first complete this application and be issued a residential license prior to submitting an application for DMC residential services.

The DMC certification requirements for substance abuse clinics are contained in the Drug Medi-Cal Certification Standards for Substance Abuse Clinics; the Alcohol and/or Other Program Certification Standards; and CCR Title 22, Sections § 51341.1, § 51490.1, and § 51516.1.

To assist applicants in supplying the detailed information needed in the DMC certification process, a copy of the regulations and standards can be downloaded from the Drug Medi-Cal Certification page. DMC applications must be submitted separately to:

PROVIDER ENROLLMENT DIVISION
MS 4704 PO Box 997412
Sacramento, CA 95899-7412
(800) 541-5555 or (916) 323-1945

Department of Health Care Services
Licensing and Certification Section, MS 2600
PO Box 997413
Sacramento, CA 95899-7413

## Treatment Provider Application Fees

DHCS assesses fees to all licensed and/or certified residential and certified outpatient SUD recovery and treatment facilities, regardless of the form of organization or ownership. Please see the Department's website for the current fee structure.

The application process is normally completed within 120 days. ***The 120 days begins when an application packet is determined to be complete.*** To prevent delays, be sure that all the required documentation is completed, properly signed, with original signatures, dated, and submitted in the proper format and sequence, with the appropriate fee. It is recommended that you retain a copy of the completed application packet for your records.

Once you have determined your application is complete, please mail the completed application, documentation, and a check or money order, made out to the Department of Health Care Services, to cover the appropriate initial application fee, to the following address:

Department of Health Care Services
Substance Use Disorder Compliance Division
Licensing and Certification Section
PO Box 997413, MS 2600
Sacramento, California 95899-7413

Department of Health Care Services
Licensing and Certification Section, MS 2600
PO Box 997413
Sacramento, CA 95899-7413

# APPLICATION INSTRUCTIONS

Please follow these instructions carefully and submit your application only after it has been properly completed, the required supportive documentation has been prepared, and the entire packet has been properly formatted.

Applications received by DHCS that do not meet the requirements described in these instructions will be returned to the applicant, minus any fees, without having been reviewed. The review process will not begin until the application meets submission requirements. *If your application is returned without having been reviewed, and you decide not to proceed with the application process, DHCS will refund all fees paid.*

Please complete all applicable sections of the application. If a line or question does not apply to you, fill the line or question with "N/A." If an entire section does not apply to your application, place a check mark in the "N/A" box located in the section heading.

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 must be complete or the entire packet will be returned to you without review and processing.**

The application and all supportive documentation must be printed single sided, with 12 point font on 8 1/2" by 11" white paper. Documentation provided by a third party, such as the lease agreement or fire clearance, must be submitted unaltered and in the original format (size, font, color) it was created. When applying for more than one type of service at a time, (i.e. residential licensure and SUD certification of the same facility, or SUD certification only), complete all the required sections of the application, prepare the supporting documentation (as listed on the following pages), and submit the entire packet at the same time.

**If you are applying for a license and certification at the same time, please complete one application and submit one set of supporting documentation.**

## SUPPORTING DOCUMENTATION AND DESCRIPTIONS

Due to DHCS's filing requirements, applications ***should not*** be doubled sided, bound, and **must not include** plastic sheet or page protectors. Each item, as listed below, must be numbered and separated by correspondingly numbered tabbed dividers.

***In order to expedite the application process for all applicants, packets not submitted in this order will be rejected without review.***

***Tab 1*** *(all applicants) – Initial Treatment Provider Application, Form DHCS 6002 (**Rev. 06/16**).*

***Tab 2*** *(all applicants) – Corporations, LLP's, or LLC's must attach their approved articles of incorporation; partnerships must attach the partnership agreement; non-profit organizations must attach a copy of the 501(c)(3) filing from the California Secretary of State; sole proprietors must attach the Sole Proprietor Supplement. A fictitious business name statement or business license is required if the sole proprietor name is different from the name of the facility (see Section H of instructions).*

Department of Health Care Services
Licensing and Certification Section, MS 2600
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***Tab 3*** *(all applicants – except governmental entities) – Lease agreement, donated space agreement, or letter from school approving use of space (see Section C of instructions).*

***Tab 4*** *(license applicants only) – Bacteriological Analysis of Water, if applicable (see Section D-3 of instructions).*

***Tab 5*** *(all outpatient applicants) – Fire Clearance (see Section E-5 of instructions).*

***Tab 6*** *(all outpatient applicants) – Zoning Clearance (see Section E-6 of instructions).*

***Tab 7*** *(all applicants) – Table of Administrative Organization – This document must include a chart that shows the governing board, advisory groups, including resident council when applicable, and both lines of authority (straight lines) and communication lines (broken lines) to all staff positions.*

***Tab 8*** *(all applicants) – Annual Line Item Budget – A line-item budget (projection of revenues and expenditures) for the current fiscal year that correlates with quarterly and annual written operation reports. If the applicant is a nonprofit corporation, the budget must be approved by the board of directors.*

***Tab 9*** *(all applicants) – Community Resources – This document shows the community resources to be utilized by the facility as part of its program. Provide a copy of this inventory which shall be used as a resource for assisting program participants in securing additional services to meet and maintain their personal well-being while continuing to enhance personal development.*

***Tab 10*** *(all applicants) – Outline of Activities and Services – A written statement listing the activities and services provided by the facility. This statement should include an outline for specific activities and services such as detoxification (if applicable), group and individual sessions, recovery or treatment planning, continuing recovery or treatment planning recreation, self-help activities (AA, NA, CA), and other activities/services being provided by the program.*

***Tab 11*** *(all applicants) – Program Description – A written statement that describes the program's alcohol and/or other drug services and settings that are offered according to the severity of alcohol and/or other drug involvement, and the program's approach to recovery or treatment, which shall include, but not be limited to, an alcohol and drug free environment.*

***Tab 12*** *(all applicants) – Statement of Program Goals and Objectives – A written statement that includes the program goals (intent or purpose of its existence) and objectives of the facility. The goals and objective should be time-limited, measurable, and outcome objectives that can be verified in terms of time and results, and that serve as indicators of program effectiveness.*

***Tab 13*** *(all applicants) – Program Evaluation Plan – A written evaluation plan for management decision making. Sufficient program data shall be collected to provide a meaningful assessment of the program's progress in meeting its objectives.*

***Tab 14*** *(all applicants) – Program Mission and Philosophy Statement – A written statement(s) describing the program's mission and philosophy.*

Department of Health Care Services
Licensing and Certification Section, MS 2600
PO Box 997413
Sacramento, CA 95899-7413

***Tab 15** – (all applicants) – Continuous Quality Management Plan – Written policies and procedures for continuous quality management, which shall include how the program monitors and/or ensures that participant files are reviewed, that services are provided to participants, the process for achieving objectives identified in the recovery or treatment plan, recovery or treatment plan reviews, and assurances that the participant's file contains all required documents.*

***Tab 16** (all applicants) – Job Descriptions – A narrative description of staff needs (i.e., briefly describe staff composition) for each position at the facility (both paid and volunteer), including minimum staff qualifications and lines of supervision for each position.*

***Tab 17** (all applicants) – Statement of Admission, Readmission and Intake Criteria – A written statement of admission, readmission, and intake policies, procedures and criteria for determining the participant's eligibility and suitability for services.*

***Tab 18** (all applicants) – Admission Agreement – A copy of the admission agreement that will be used by the program.*

*Minimum Requirements for Admission Agreements for License Applicants:*

1. *Services to be provided;*
2. *Payment provisions, including amount assessed and payment schedule;*
3. *Refund policy;*
4. *Those actions, circumstances or conditions which may result in resident eviction from the facility;*
5. *The consequences when a resident relapses and consumes alcohol and/or non-health sustaining drugs; and*
6. *Conditions under which the agreement may be terminated.*

*Minimum Requirements for Admission Agreements for Certification Applicants:*

1. *Fees assessed for services provided;*
2. *Activities expected of participant;*
3. *Program rules and regulations;*
4. *Participants' statutory rights to confidentiality;*
5. *Participants' grievance procedure; and*
6. *Reasons for termination.*

***The admission agreement must include all required elements for each application type if applying for multiple services, e.g. the admission agreement must include all licensure and certification elements if applying for a license and certification.***

Department of Health Care Services
Licensing and Certification Section, MS 2600
PO Box 997413
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## LICENSE APPLICANTS ONLY

***Tab 19*** – *Sketch of Building and Grounds – Submit a sketch, preferably on an 8½" x 11" sheet of paper, all building(s) to be occupied, including a floor plan of all rooms intended for resident's use. A sketch of the grounds must show all buildings, driveways, fences, storage areas, pools, gardens, recreational area and other spaces of the property. All sketches shall show dimensions of each area, but need not be to scale. The floorplan shall show the number and location of beds for all residents, dependent children and staff (if applicable), and other non-ambulatory persons.*

***Tab 20*** – *Sample Menu – The total daily diet for residents shall be of the quality and quantity necessary to meet their needs, and shall be made so that each resident has available at least three meals per day. The written menu(s) shall include times of food service, food provided for breakfast, lunch, and dinner for one week, including the type and availability of snacks.*

***Tab 21*** – *Safeguarding of Personal Property of Residents – Describe the process for safeguarding of resident's personal property accepted by the licensee for safekeeping, if it is the licensee's policy to accept such valuables.*

*As previously stated, please see the chart below to ensure you have submitted the appropriate documentation related to your application:*

| APPLICANT CONTENT GUIDE | | |
|---|---|---|
| **Tab Number** | **TYPE OF APPLICATION** | |
| | *Facility Licensing* | *Program Certification* |
| Tab 1 | **X** | **X** |
| Tab 2 | **X** | **X** |
| Tab 3 | **X*** | **X*** |
| Tab 4 | **X** | |
| Tab 5 | | **X** |
| Tab 6 | | **X** |
| Tab 7-18 | **X** | **X** |
| Tabs 19 - 21 | **X** | |

**X* - excludes governmental agencies**

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**The following information matches, in order, the information, sections and numbers on the "Initial Treatment Provider Application" that must be completed. Incomplete applications will be returned without review.**

## SECTION A – APPLICATION INFORMATION

***This section must be completed by all applicants***

1. ***Application Type*** *– Check the appropriate box(es) for the service(s) which you are applying for with this application. If you are applying for more than one type of service at the same location check all the boxes that apply.*
2. ***Application Purpose*** *– Check all box(es) best describing the purpose of this application. If you are changing ownership of an existing facility, please list the license and/or certification number of the program that is being abolished. If you are merging this program with another program, please list the license and/or certification number of that program. You must include the change of ownership documents and board resolution documents authorizing the merge and/or sale under Tab #2.*

## SECTION B – LEGAL ENTITY INFORMATION

***This section must be completed by applicants***

1. ***Legal Entity Name*** *– Enter the legal entity name.*
   *Below are specified instructions for:*

   ***Corporation only:*** *For a corporation or Limited Liability Company (LLC) of any type this box must match exactly the name of the corporation (or LLC) as filed with the Secretary of State (SOS) and on the entities articles of incorporation.*

   ***Partnership only:*** *For a partnership that has filed a certification of limited partnership with the SOS, this box must match exactly the name filed. For a partnership of any type that has not filed a certification of limited partnership with the SOS, this box must contain the surnames of the partners.*

   ***Sole Proprietor only:*** *For a sole proprietorship, this box must be the full legal name of the sole proprietor and include the Sole Proprietor Supplement. A fictious business name statement or business license is required if the sole proprietor name is different from the name of the facility.*

   *If the entity has filed any of the above mentioned documents with the SOS, you can look up your entities legal name at the SOS website. The entities status with the SOS must remain valid and active during the licensing or certification period.*

2. ***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. Do not include the words or abbreviation for "Doing Business As" unless you actually intend to use those words or the abbreviation in the program's name.*

   *Below are specified instructions for:*

   ***Sole proprietors only:*** *Must submit a copy of the fictitious business name statement if different from their full legal name.*

3. ***Administrative/Corporate Address*** *– This box must contain the physical address of the legal entities main office. This address may match the programs address if the entity does not have a separate Administrative/Corporate address. P.O. Boxes or other mail receipt addresses will not be accepted as an administrative address; however, a P.O. Box may be used as a mailing address, as identified in instruction #5 below.*

   ***3a. Room/Suite*** *– If applicable, enter the room or suite number of the administrative/ corporate address.*
   ***3b. City*** *– Enter the city of the administrative/corporate address.*
   ***3c. State*** *– Enter the state of the administrative/corporate address.*
   ***3d. Zip code (zip)*** *– Enter the zip code of the administrative/cooperate address.*

4. ***Entity/Program Website Address*** *– If the legal entity has a website, the website must be entered in this box. If the entity has a website and has a separate website specifically for the program, please enter both website addresses. If the entity/program has no website, enter "None" in this box.*

5. ***Mailing Address*** *– Enter the facility's mailing address. P.O. Box maybe used as a mailing address. Note: The department will use this address to send all official mail.*

   ***5a. Room/Suite*** *– If applicable, enter the room/suite number of the mailing address.*
   ***5b. City*** *– Enter the city of the mailing address.*
   ***5c. State*** *– Enter the state of the mailing address*
   ***5d. Zip code (zip)*** *– Enter the zip code of the mailing address.*

6. ***Entity Type*** *– Check the box that describes the type of legal entity in which yourorganization operates. Below are specified instructions for:*

   ***Corporation, LLC, or Limited Liability Partnership (LLP)*** *– For a corporation of any type, LLC, or LLP include the articles of incorporation under Tab #2.*
   ***Partnerships or General Partnership*** *– For a partnership of any type include the partnership agreement under Tab #2. If the entity is registered with the SOS, include the articles of incorporation under Tab #2.*
   ***Sole Proprietor only*** *– Submit a copy of the fictitious business name statement or business license if different from your full legal name.*
   ***Governmental Entities only*** *– Governmental entities do not need to provide documentation.*

7. ***Type of Organization*** *– Check the box that describes the tax status of your entity. If you check 'other', please give a detailed description, including the government entity that granted the status. Below are specified instructions for:*

   ***Non-profit organizations only*** *– must include a copy of the 501(c)(3) filing from the California Secretary of State under Tab #2.*

8. ***Does the applicant currently hold any licenses or certifications issued by DHCS*** *(or the former Department of Alcohol and Drug Programs) or the Department of Social Services (DSS)? – Check 'Yes' if your legal entity has any other programs currently licensed and/or certified by the listed departments; check 'No' if not. If you check 'Yes' enter the license, certification and/or DMC billing number of all of your other facilities and select the type of facility from the drop down list. For entities with more facilities than the form allows, please attach a separate list of all licensed and/or certified facilities, their license number(s), certification(s) and/or DMC billing numbers, including the type of license and/or certification that has been issued under Tab #1.*

9. ***Has the applicant ever held a license issued by DHCS or Department of Alcohol and Drug Programs (ADP) other than those listed in question 8?*** *– Check 'Yes' if the legal entity has previously been issued a DHCS or ADP license or certification; check 'No' if not. If you check 'Yes' enter the program name(s), license number(s) and address(es) in the boxes provided.*

10. ***Has anyone associated with the legal entity, including employees, partnership, ownership structure, administrative/executive staff, board members, or stock holders, previously had a ADP, DHCS, or DSS license or certification denied, terminated, suspended, or revoked?*** *– If yes check 'Yes'; if not check 'No'. If you check 'Yes', please provide the applicant/employee name, license and/or certification number, reason for denial, termination, suspension or revocation and the individual's relationship to the program. If necessary, include additional sheets under Tab #3.*

11. ***Contact Person Information*** *– Enter the contact information of the person you want the DHCS to contact regarding this application.*
    - ***11a. Name –*** *Enter the name of the contact person.*
    - ***11b. Title*** *– Enter the position title of the contact person, i.e. program director, executive director, etc.*
    - ***11c. Salutation*** *– Enter the salutation of the contact person, i.e. Mr., Mrs., Dr., etc.*
    - ***11d. Phone Number*** *– Enter the contact person's phone number, including an extension if any.*
    - ***11 e. Email Address*** *– Enter the contact person's email address.*

## SECTION C – FACILITY/BUILDING INFORMATION

***<u>This section must be completed by all applicants.</u>***

1. ***Facility/Building Address*** *– Enter the address where the treatment services will be provided.*
    - ***1a. County*** *– Enter the county where the facility is located.*
    - ***1b. City*** *– Enter the city where the facility is located.*
    - ***1c. State*** *– Must be California – this field cannot be changed. The Department does not license or certify programs not physically located in California.*
    - ***1d. Zip code (zip)*** *– Enter the zip code of the facility.*
    - ***1e. Phone Number*** *– Each licensed and/or certified facility must have a physical phone number, not including a cellular phone. Do not enter your corporate phone number unless your corporate facility address is the same as the facility address.*
    - ***1f. Fax Number*** *– Enter the fax number assigned to the facility, if applicable.*
    - ***1g. Room/Suite*** *– Enter the room or suite number of the facility if there is one; if there is more than one, enter all rooms or suite numbers.*

2. ***Is this facility Drug Medi-Cal Certified?*** *– If the facility currently holds a DMC Certification check 'Yes'; if not check 'No'.*

3. ***If yes, enter the 6 digit DMC Provider ID number*** *– If you answered yes to #2, enter the six digit Provider ID number of your DMC certification.*

4. ***Site specific National Provider Identification (NPI) number, if any*** *– If you answered yes to #2 above, you must enter your NPI number. Enter the 10 digit NPI number for the facility. NPI numbers must be site specific and have an address that matches the facility address on this application. If you need additional information on the requirements for obtaining an NPI number, please contact the National Plan & Provider Enumeration System.*

5. ***Does this application include more than 1 building?*** *– If there is more than one building being used to provide the services for which you are applying, check ' yes'; if not, check 'no'. If you answer 'yes', enter the total number of buildings and put all addresses on the application (Section C, Box #1).*

   ***5a. Are the buildings on the same property/parcel of land?*** *– If the buildings that make up this facility are on the same piece of property or parcel of land check 'yes'. If you do not know, please contact your County Assessor's Office.*

   ***5b. If 'No', are the services provided in each building integral components of the same treatment program?*** *– If you answer 'no' to whether or not the buildings are on the same piece of property or parcel of land, tell us whether or not the services you are providing in each building are integral to each other. Integral means that the services provided in each different building are essential to make a complete treatment program. If the services are integral check 'yes'; if not, check 'no'.* ***DHCS makes the final determination during the onsite visit whether or not the locations are integral components of each other.***

6. ***Ownership Information*** *– Check the box that best describes the relationship between you and the owner of the building. If you lease the building, include a copy of the lease agreement under Tab #3.*

   *If the building or a space in the building has been donated to you, include a copy (under Tab #3) of the written agreement allowing use of the donated space.*

   *If the space is entirely located on public school grounds, include a letter, on official letterhead (under Tab #3), from the school superintendence or school district official detailing their approval of your use of the space.*

## SECTION D – RESIDENTIAL LICENSE

***<u>This section must be completed only by applicants for residential licensure</u>***

1. ***Target Population*** *– Check the box that describes the residents for whom you intend to provide alcohol and/or drug services. Check all boxes that apply.*

2. ***Services to be Provided*** *– Check the box that indicates what services you will provide to the residents at this facility. Alcohol and/or drug treatment must be the primary criteria for client admission. Check all the boxes that apply.*

*"Detoxification Services" is defined as a service designed to support and to assist an individual in the alcohol and/or drug withdrawal process and to explore plans for continued service.*

*"Educational Session" is defined as a planned, structured, didactic presentation of information related to alcoholism and alcohol or drug abuse.*

*"Group Session" is defined as group interaction that encourages residents to identify and resolve alcohol- and/or drug-related problems, to examine personal attitudes and behavior, and provides support for positive changes in life style and recovery from alcoholism and/or drug abuse.*

*"Individual Session" means a private interaction between a resident and program staff which focuses on identification and resolution of alcohol and/or drug-related problems, to examine personal attitudes and behavior and other barriers to recovery.*

*"Recovery or Treatment Planning" is defined, as follows:*

1. *Statement of problems to be addressed;*
2. *Statement of objectives to be reached that addresses each problem;*
3. *Action steps that will be taken by the program and/or participant to accomplish the identified objectives; and*
4. *Target dates for accomplishment of action steps and objectives.*

*"Incidental Medical Services" (IMS) is defined as services provided during detoxification and during the provision of alcoholism or drug abuse recovery or treatment services to assist in the enhancement of treatment. IMS services must be related to the patient's process of moving into long-term recovery. IMS does not include the provision of general primary medical care and are limited to services that are not required to be performed in a licensed clinic or licensed health facility as defined in Section 1200 or 1250 and can safely be provided in compliance with the community standard of practice at the licensed alcoholism or drug abuse recovery or treatment facility. Assembly bill 848 authorizes adult alcoholism or drug abuse recovery or treatment facilities that are licensed by the Department of Health Care Services (DHCS) to allow a licensed physician, surgeon or other health care practitioner to provide incidental medical services (IMS) to a patient of the facility at the facility premises under specified limited circumstances. These circumstances include, but are not limited to an admission agreement signed by the patient and approval from a physician, surgeon or health care practitioner that these services are appropriate for the patient.* ***DHCS Form 5256 (Health Care Practitioner IMS Acknowledgement* and *DHCS Form 4026 (IMS Certification)* must be completed if the facility will be providing IMS.***

*IMS provides six service categories:*

- *Obtaining medical histories;*
- *Monitoring health status to determine whether the health status warrants transfer of the patient in order to receive urgent or emergent care;*
- *Testing associated with detoxification from alcohol or drugs;*
- *Providing alcoholism or drug abuse recovery or treatment services;*
- *Overseeing patient self-administered medications; and*
- *Treating substance abuse disorders, including detoxification.*

***Facilities are not permitted to conduct any form of surgical procedures at a residential facility.***

***Facilities are not permitted to order or stock prescription bulk medications for utilization during detoxification or treatment.***

3. ***Water Supply*** *– Tell us whether or not your water comes from a municipal water supply. If you mark 'yes', tell us the name of the municipal water source.*

   *If your water is not supplied by a municipal water source, you must check 'no'. A bacteriological water analysis is required for alcoholism or drug abuse recovery or treatment facilities that receive water from a non-municipal source. This shall be conducted by your local health department, the State Department of Public Health, or a licensed commercial laboratory. This analysis shall be done on an annual basis. Include the bacteriological analysis under Tab #4.*

4. ***Occupancy*** *– This information is to be used by DHCS to complete and submit a request to your local fire authority for a fire/safety inspection.* ***DO NOT SUBMIT A FIRE CLEARANCE WITH YOUR APPLICATION; DHCS must receive the clearance directly from the fire authority.***

   *Provide the number of beds in which you want the facility to be licensed. 'Ambulatory' means the total number of residents that will be living in the facility that are able to walk; 'non-ambulatory' means the total number of residents that will be living in the facility who are unable to walk; 'bedridden' means the number of residents that will be living in the facility that are confined to a bed for medical reasons.*

   *Total capacity is the total number of beds in the facility; the total must include any staff beds and/or any beds for dependent children, if applicable. The total number of beds for ambulatory, non-ambulatory, bedridden, staff and dependent children beds cannot exceed the total capacity approved by the local fire authority.*

5. ***Fire Authority information –*** *Please provide the name, address (including city and zip code), fax, and phone number of the fire department and/or fire agency assigned to the facility where you are requesting to provide alcohol and/or drug services. You may need to consult the government section of your local white pages of the phone book for this information.*

   *The fire clearance will include a determination of the number of beds for ambulatory residents and for non-ambulatory residents in the facility, and any restrictions regarding non-ambulatory clearances.* ***The fire clearance must include the number and age range of dependent children allowed to reside in the facility****. If no number of dependent children is indicated on the fire clearance, no dependent children are allowed to reside in the facility.*

## SECTION E – SUBSTANCE USE DISORDER (SUD) CERTIFICATION

***This section must be completed only by applicants for SUD certification (residential &outpatient).***

1. ***Type of Services to be Certified*** *– Check the box(es) that describe the services you propose to provide. Check all the boxes that apply. An applicant requesting to provide residential and nonresidential services must complete two applications, as the certification of the residential treatment is separate from the certification of the nonresidential treatment. In extremely rare cases, approval of an outpatient and residential certification at the same address 'may' be approved on a case-by-case basis.*

*"Day Treatment (Intensive Outpatient)" is defined as a non-residential alcohol and/or other drug service that is provided to participants at least three hours per day and at least three days per week.*

*"Detoxification Service" is defined as a service designed to support and to assist an individual in the alcohol and/or drug withdrawal process and to explore plans for continued service.*

*"Educational Session" is defined as a planned, structured, didactic presentation of information related to alcoholism and alcohol or drug abuse.*

*"Group Session" is defined as group interaction that encourages residents to identify and resolve alcohol-and/or drug-related problems, to examine personal attitudes and behavior, and provides support for positive changes in life style and recovery from alcoholism and/or drug abuse.*

*"Individual Session" is defined as a private interaction between a resident and program staff which focuses on identification and resolution of alcohol-and/or drug-related problems, to examine personal attitudes and behavior and other barriers to recovery.*

*"Outpatient Service" is defined as a non-residential alcohol and/or other drug service in which a participant is provided a minimum of two counseling sessions per 30-day period.*

*"Recovery or Treatment Planning" is defined, as follows:*

1. *Statement of problems to be addressed;*
2. *Statement of objectives to be reached that addresses each problem;*
3. *Action steps that will be taken by the program and/or participant to accomplish the identified objectives; and*
4. *Target dates for accomplishment of action steps and objectives.*

2. ***Target Population*** *– Check the box(es) that best describe the population you intend to treat. Check all that apply.*

3. ***Hours of Operation*** *– Enter the time you open and close the program being certified. If your program is open 24 hours a day, 7 days a week, please enter '24' in the box for each day.*

4. ***Are services other than substance use disorder (SUD) treatment services provided at this location?*** *– Check 'yes' if you provide or intend to provide any services at the location that are not alcohol and/or drug treatment services. Check 'no' if the only services that will be provided at this location are alcohol and/or drug treatment services.*

5. **An Outpatient/Day Treatment** (DHCS 5104) **fire clearance sample or equivalent on fire authority letterhead is required for all outpatient facilities** – The DHCS 5104 can be used by your local fire authority if they do not customarily provide a written fire clearance (If you are applying for residential certification, please see 'Fire Authority Information' in Section D for fire clearance requirements). DHCS may accept a written fire clearance that is provided on your local fire authority letter head and dated no more than 12 months from the date the application is received by DHCS. **The entity and/or program name and the program address on the fire clearance must match the name and address on the application. Please include under Tab #5.**

Department of Health Care Services
Licensing and Certification Section, MS 2600
PO Box 997413
Sacramento, CA 95899-7413

6. **A Zoning Approval** (DHCS 5115) **from the local zoning authority with jurisdiction over the facilities location is required (outpatient facilities only). The entity and/or program name and the program address on the zoning clearance must match the name and address on this application.** The DHCS 5115 provides a sample format that can be used by your local zoning authority if they do not customarily provide a written zoning clearance. DHCS may accept a written zoning clearance that is provided on your local zoning authority letterhead and dated no more than 12 months from the date the application is received by DHCS. Please include under Tab #6.

## SECTION F – WEEKLY SCHEDULE

***This section must be completed by all applicants***

*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 abbreviations for the treatment services are as follows:*

*Detoxification - DX*
*Education Sessions - ES*
*Group Sessions - GS*
*Individual Sessions - IS*
*Recovery or Treatment Planning - RP OR TP*
*Incidental Medical Services - IMS*

*After you have entered the treatment services you intend to provide in the appropriate time slots, add up the total number of hours and enter that total at the bottom of the page.*

Department of Health Care Services
Licensing and Certification Section, MS 2600
PO Box 997413
Sacramento, CA 95899-7413

## SECTION G – ADMINISTRATIVE ORGANIZATION – CORPORATIONS, LLC/LLP

***This section must be completed by all corporate or LLC/LLP applicants***

1. ***Corporation Name*** *– (as listed with the Secretary of State) – This box must match Section B-1 of the application and your articles of incorporation. To verify the exact wording of your legal name, please check the information at the SOS website.*

2. ***Chief Executive Officer*** *– This box must contain the first and last name of the corporation or LLC/LLP Chief Executive Officer.*

3. ***Entity Number*** *– This box must match the entity number provided by the Secretary of State, as indicated on your articles of incorporation. You can verify this number at the SOS website.*

4. ***Incorporation Date*** *– This box must contain the corporation or LLC/LLP date of incorporation.*

5. ***Place of Incorporation*** *– This box must contain the corporation or LLC/LLP location of incorporation.*

6. ***Stockholder Information*** *– Include names and addresses (city, state, zip) of all person(s) who own ten percent (10%) or more of stock in the corporation.*

7. ***Governing Board of Directors***

   ***7a. Numbers of Board Members*** *– Please enter the total number of members of your board of directors. Non-profit corporations are required to have a minimum of five board members.*

   ***7b. Term of Office*** *– Please list the length of the term of office in years.*

   ***7c. Frequency of Meetings*** *– Please enter the frequency of board meetings (weekly, monthly and quarterly). Note: Meetings must be held at least quarterly.*

   ***7d. Method of Selection*** *– Please enter the method of board member selection (appointment, election, etc.)*

8. ***Board Officers and Members –*** *List the name, title, address (city, zip code), telephone number and term of expiration of all board members and officers of the legal entity.*

***The majority of the information requested in Sections H, I, J, and K is considered self-explanatory; enter the requested information for each box as completely and accurately as possible. The following instructions are for specific items contained in those sections that may need clarification.***

Department of Health Care Services
Licensing and Certification Section, MS 2600
PO Box 997413
Sacramento, CA 95899-7413

## SECTION H – ADMINISTRATIVE ORGANIZATION

***This section must be completed by all public agencies, partnerships, or sole proprietors***

***Public Agency –*** *This section must be completed by all public agencies (state, county, city or other governmental agencies).*

***Partnerships*** *– This section must be completed by all partnerships.*

1. *If registered with California Secretary of State, please enter the Entity Number. This must match the entity number provided by the Secretary of State; you can look this number up at the SOS Website.*

***Sole Proprietor/ Other Associations*** *– This section must be completed by all sole proprietors. Sole proprietors/other organizations must provide a list of all person(s) legally responsible for the organization, the contact person and appropriate legal documents (fictitious name statement, business license) which set forth the legal responsibility of the organization/sole proprietor and accountability for opening the program.*

1. *Organization's Employers Identification Number or sole proprietor's social security number – Enter your Employer Identification Number (EIN) as issued by the Internal Revenue Service. If you do not have an EIN, enter the social security number of the sole proprietor.* ***Only sole proprietor applicants are required to submit social security numbers and complete the Sole Proprietor Supplement.***

2. *Enter the name and business address of the owner or owners of the organization/sole proprietor.*

## SECTION I – ADMINISTRATOR, PROGRAM DIRECTOR, CLINIC DIRECTOR INFORMATION

***This section must be completed by all applicants***

*Complete the information for your program administrator, program director or clinic director, as it applies to your organizational structure.*

*Applicants for residential licensure should have a program administrator and applicants for SUD certification should have program director (as defined in AOD Certification Standards, § 18010). Programs applying for more than one type of license or certification at the same time should have each of the above positions; however, one person can serve multiple roles and hold multiple titles.*

Department of Health Care Services
Licensing and Certification Section, MS 2600
PO Box 997413
Sacramento, CA 95899-7413

## SECTION J – PROGRAM STAFF

***This section must be completed by all applicants***

1. ***Total number of staff (employed by the applicant) at this facility*** *– Enter the total number of staff, including volunteers and/or interns, who will work at this facility location – do not list staff who works for the legal entity who will not work at this particular site.*

2. ***Total number of staff at this facility who performs counseling duties*** *– Enter the total number of staff including, volunteers and/or interns, who will work at this facility and perform any counseling duties.*

3. ***Total number of staff employed at this facility who is currently licensed, certified or registered counselors*** *– Enter the total number of staff, including volunteers and/or interns, who will work at this facility and currently holds a license that meets counselor certification requirements, or who are certified/registered counselors with a DHCS approved counselor certifying organization. Title 9, California Code of Regulations, Chapter 8, §13010(a), mandates at least 30% of staff providing counseling services shall be licensed or certified; all other counseling staff shall be registered.*

4. ***Staff/Employee Information*** *– Enter all required information including but not limited to date of hire, alcohol and drug treatment experience in years and the date the employee was last tested for tuberculosis. All employees and/or volunteers having contact with clients must be tested for TB annually.*

***Counselor Qualifications*** **–** *For each counselor listed, please answer the licensed, certified, registered questions yes, no, or N/A. Please input the counselor's license number (if licensed by the Department of Consumer Affairs), certification, or registration number, their certifying organization or licensing department, and the effective date and expiration date of their certification or license.*

***Health Care Practitioners*** *– Health Care Practitioner means a person duly licensed and regulated under Division 2 (commencing with Section 500) of the Business and Professions Code, who is acting within the scope of practice of his or her license or certificate to provide IMS services as outlined in Health and Safety Code Section 11834.026(a). All health care practitioners must be included and listed as part of the staff.* ***DHCS Form 5256 and DHCS Form 4026 must be completed for each patient, if the facility will be providing IMS.***

***License applicants only – Expiration Date of CPR Certification & Date of First Aid Training*** *– During the provision of alcoholism or drug abuse recovery or treatment services, there shall be at least one person in the facility who is capable of performing first aid/CPR.* Documented proof must be in the personnel file for each certified employee.

*The remainder of the information requested on the program staff form is considered to be self-explanatory. All information requested in this section of the application must be completed for all staff employed to work at this facility. Attach additional copies of this page, as needed, under Tab #16.*

Department of Health Care Services
Licensing and Certification Section, MS 2600
PO Box 997413
Sacramento, CA 95899-7413

## SECTION K – CERTIFICATIONS AND ASSURANCES

***This section must be completed by all applicants***

*Read the certifications and assurances carefully before signing the application. The application must be signed by an authorized individual.*

*If the applicant applying is a corporation of any type, include immediately after this page, a board of director's resolution or board minutes granting authorization to the person signing the application.*

*If the applicant applying is a public agency, include, immediately after this page, authorization from the agency, department administrator, or the County Board of Supervisors, for the person signing the application.*

*If the applicant applying is a partnership of any type, the application must be signed by all partners.*

*If the applicant applying is a sole proprietor, the application must be signed by the sole proprietor.*

*As stated on previous application pages, please see the chart below to ensure you have submitted the appropriate sets and required documentation related to your application:*

| APPLICANT CONTENT GUIDE | | |
|---|---|---|
| Tab Number | TYPE OF APPLICATION | |
| | Facility Licensing | Program Certification |
| Tab 1 | X | X |
| Tab 2 | X | X |
| Tab 3 | X* | X* |
| Tab 4 | X | |
| Tab 5 | | X |
| Tab 6 | | X |
| Tab 7-18 | X | X |
| Tabs 19 - 21 | X | |

**X* excludes governmental agencies**

Department of Health Care Services
Licensing and Certification Section, MS 2600
PO Box 997413
Sacramento, CA 95899-7413

**For DHCS use only**

**Program ID:** _

***(Read instructions fully before completing application)***

## SECTION A APPLICATION INFORMATION
***(must be completed by all applicants)***

**1. Application Type**

Check the appropriate box(es) for the service or services which you are applying for with this application.

☐ Residential License *(complete Sections A, B, C, D, F, G **or** H, I, J, and K)*

☑ Alcohol and/or Other Drug Certification *(complete Sections A, B, C, E, F, G **or** H, I, J, and K)*

**Drug Medi-Cal Certification applicants must *complete DHCS 6001 (Rev. 10/13). See page 3 of instructions.***

**2. Application Purpose**

Check the box best describing the purpose of this application:

☐ Open a new facility

☐ Change of ownership. Abolished program license/certification number: _

☐ Merging two or more existing legal entities. Merging program license/certification number:

## SECTION B LEGAL ENTITY INFORMATION
***(must be completed by all applicants)***

| | | |
|---|---|---|
| **1.** Legal Entity Name: Lassen County Behavioral Health | | |
| **2.**. Program/Facility Name: Lassen County Behavioral Health | | |
| **3.** Administrative/Corporate Address: 555 Hospital Ln | | **3a.** Room/Suite: |
| **3b.** City: Susanville | **3c.** State: Ca | **3d.** Zip: 96130 |
| **4.** Entity/Program Website Address: www.lassencounty.org/dept/behavioral-health/behavioral-health | | |
| **5.** Mailing Address: 555 Hospital Ln | **5a.** Room/Suite: | |
| **5b.** City: Susanville | **5c.** State: Ca | **5d.** Zip: 96130 |

**6.** Entity Type:

☐ Corporation ☐ Limited Liability Company ☑ Government Entity

☐ Partnership ☐ General Partnership ☐ Limited Liability Partnership

☐ Sole Proprietorship ☐ Other (describe) _____

***Include the Articles of Incorporation, partnership agreement, or sole proprietor documents as applicable under Tab #2.***

**7.** Type of Organization:

☐ For Profit ☐ Nonprofit ☑ Government ☐ Other (describe) _____

**8.** Does the applicant **currently** hold any licenses or certifications issued by DHCS (ADP) or DSS? ☑ Yes ☐ No

If yes, list below all license/certification numbers and indicate the type of license or certificate. For DMC certifications include 6 digit Provider ID number and 4 digit billing number.

| License/Certification Number | Type |
|---|---|
| 181828 | Drug Medi-Cal Certification |
| | |
| | |

***Include additional sheets, if necessary, under Tab #1***

**9. Has the applicant ever held a license issued by DHCS (ADP) other than those listed in question 8?** ☐ Yes ☑ No

If yes, complete the boxes below:

**A.** Program Name: _____ License Number: _____ Zip: _____

Address: _____ City: _____

**B.** Program Name: _____ License Number: _____ Zip: _____

Address: _____ City: _____

***Include additional sheets, if necessary, under Tab #3***

**10. Has anyone associated with the legal entity, including employees, partnership, ownership structure, administrative/executive staff, board officers/members or stockholders previously had an ADP, DHCS, or DSS license denied, terminated, suspended, or revoked?** ☐ Yes ☑ No

If yes complete the boxes below:

| Applicant/Employee Name | License/Certification Number | Reason for Denial, Termination, Suspension, or Revocation | Relationship to Denied, Terminated, Suspended or Revoked Program |
|---|---|---|---|
| | | | |
| | | | |

***Include additional sheets, if necessary, under Tab #3***

**11. Contact Person Information**

| | | |
|---|---|---|
| **11a.** Name: Tiffany Armstrong | **11b.** Title: Director | **11c.** Salutation: Mrs. |
| **11d.** Phone Number: (530) 251-8108 | **11e.** Email Address: TArmstrong@co.lassen.ca.us | |

## SECTION C FACILITY/BUILDING INFORMATION

***(must be completed by all applicants)***

| | | |
|---|---|---|
| **1.** Address(es): 545 Hospital Ln, 555 Hospital Ln, 557 Hospital Ln | **1a.** County: Lassen | |
| **1b.** City: Susanville | **1c.** State CALIFORNIA | **1d.** Zip: |
| **1e.** Phone Number: (530) 251-8108 | **1f.** Fax Number: (530) 251-8394 | **1g.** Room/Suite: |

**2.** Is this Facility Drug Medi-Cal Certified? ☑ Yes ☐ No If yes complete item #3.

**3.** DMC six digit Provider ID number: 181828

**4.** Site specific National Provider Identifier (NPI) Number: 1881720415

**5.** Does this application include more than one building? ☑ Yes ☐ No If Yes, Total number of buildings 3

**5a.** Are the buildings on the same property/parcel of land? ☑ Yes ☐ No

**5b.** If no, are the services provided in each building integral components of the same treatment program? ☐ Yes ☐ No

**6. Ownership Information** This building(s) is (are): ☐ Owned by the entity applying ☑ Owned or leased by the county*

☐ Leased (submit a fully executed lease agreement under Tab #3)

☐ Donated (submit the written agreement allowing use of the space under Tab #3)

☐ Entirely located on school grounds (submit written agreement on official letter head under Tab #3)

*Applies to county operated programs only, not including programs with a county contract.

Department of Health Care Services
Licensing and Certification Section, MS 2600
PO Box 997413
Sacramento, CA 95899-7413

## SECTION D — RESIDENTIAL LICENSE — N/A ☑

***(must be completed by applicants for residential licensure)***

**1. Target Population (check all that apply)**

- ☐ General Population (co-ed)
- ☐ Co-Ed/Children
- ☐ Co-Ed/Child/Dual Diagnosis
- ☐ Dual Diagnosis
- ☐ Women Only
- ☐ Women/Children
- ☐ Families
- ☐ Elderly
- ☐ Men Only
- ☐ Women/Child/Dual Diagnosis
- ☐ Other (describe): _____

**2. Services to Be Provided (check all that apply)**

- ☐ Detoxification (DX)
- ☐ Group Sessions (GS)
- ☐ Individual Sessions (IS)
- ☐ Educational Sessions (ES)
- ☐ Recovery or Treatment Planning (RP or TP)
- ☐ Incidental Medical Services (IMS)

**3. Water Supply**

Is water used for human consumption supplied by municipality? ☐ Yes ☐ No

If yes, give the name of the municipality _____

If no, give the source of water _____

A bacteriological analysis is required for non-municipal water (include under Tab #4)

**4. Occupancy**

Indicate the bed capacity for which you are applying.

**NOTE: License capacity shall never exceed total capacity approved by the fire authority or the DHCS.**

| Ambulatory: | Non-Ambulatory: | Bedridden: | ***TOTAL CAPACITY**: |
|---|---|---|---|
| Indicate number of staff beds if any: | | Number of dependent children if any: | |

*** TOTAL CAPACITY** includes treatment, dependent children of residents, and staff beds and shall not exceed total capacity approved by the fire authority.

**5. Fire Authority Information**

**LOCAL FIRE INSPECTION AUTHORITY INFORMATION**

**REQUIRED BY THE DEPARTMENT OF HEALTH CARE SERVICES**

**PLEASE FULLY COMPLETE THIS SECTION**

**FAILURE TO DO SO WILL RESULT IN YOUR APPLICATION BEING RETURNED WITHOUT PROCESSING**

As part of the application process, the licensing agency is responsible for obtaining a fire safety inspection from the local fire inspection authority having jurisdiction in the area where your facility is located. To help us expedite this process, we are requiring that you identify the local fire inspection authority that is responsible to inspect your facility and issue a fire clearance. DHCS will submit the fire clearance (STD 850) directly to your local fire authority.

**FIRE AUTHORITY INFORMATION**

| Susanville Fire Department | (530) 257-5152 | (999) 999-9999 |
|---|---|---|
| LOCAL FIRE INSPECTION AUTHORITY | PHONE | FAX NUMBER |
| 1505 Main St | Susanville | 96130 |
| ADDRESS | CITY | ZIP CODE |

Department of Health Care Services
Licensing and Certification Section, MS 2600
PO Box 997413
Sacramento, CA 95899-7413

## SECTION E SUBSTANCE USE DISORDER (SUD) CERTIFICATION N/A ☐

***(Must be completed by applicants for SUD certification. This section does not include DMC certification)***

**1. Type of Services to be Certified (Check all that apply ON ONE SIDE ONLY)**

| Residential | Nonresidential |
|---|---|
| ☐ Detoxification | ☐ Detoxification |
| ☐ Group Sessions | ☑ Group Sessions |
| ☐ Individual Sessions | ☑ Individual Sessions |
| ☐ Educational Sessions | ☑ Educational Sessions |
| ☐ Recovery or Treatment Planning | ☑ Recovery or Treatment Planning |
| ☐ Incidental Medical Services | ☑ Day Treatment |
| | ☑ Outpatient |

**2. Target Population (check all that apply)**

- ☑ 1.1 - General Population (co-ed)
- ☐ 1.2 - Men Only
- ☐ 1.3 - Women Only
- ☑ 1.4 - Women/Children
- ☑ 1.5 - Youth/Adolescents
- ☑ 1.7 - Families
- ☑ 1.8 - Dual Diagnosis
- ☑ 1.9 - Co-Ed/Children
- ☑ 1.10 - Co-Ed/Youth
- ☑ 1.11 - Men/Youth
- ☑ 1.12 - Women/Youth
- ☐ 1.13 - Co-Ed/Child/Dual Diagnosis
- ☐ 1.14 - Women/Child/Dual Diagnosis

**3. Hours of Operation**

Indicate hours of operation below:

| Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|
| 8:00am - 5:00pm | 8:00am - 5:00pm | 8:00am - 5:00pm | 8:00am - 5:00pm | 8:00am - 5:00pm | | |

**4. Are Services Other Than SUD Treatment Services Provided at this Location?** ☑ Yes ☐ No

If yes, describe services: Specialty Mental Health services

**5. An Outpatient/Day Treatment** (DHCS 5104) fire clearance or equivalent on fire authority letter head is required for all outpatient facilities (see application instructions).

***Include the fire clearance under Tab #5.***

**6. A Zoning Approval** (DHCS 5115 Rev. 7/14) or equivalent from zoning authority is required for all outpatient facilities (see application instructions).

***Include the zoning clearance under Tab #6.***

Department of Health Care Services
Licensing and Certification Section, MS 2600
PO Box 997413
Sacramento, CA 95899-7413

## SECTION F — WEEKLY SCHEDULE

***(must be completed by all applicants)***

### WEEKLY SCHEDULE OF ALCOHOL AND/OR DRUG RECOVERY, TREATMENT, OR DETOXIFICATION SERVICES

**Include only: Detoxification (DX), Group Sessions (GS), Individual Sessions (IS), Educational Sessions (ES), and/or alcoholism or drug abuse Recovery Planning (RP) or Treatment Planning (TP) and Incidental Medical Services (IMS)**

| Time | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|
| 6-7 am | | | | | | | |
| 7-8 am | | | | | | | |
| 8-9 am | IS,TP,GS,ES,RP | IS,TP,ES, RP | IS, TP,GS,ES,RP | IS,TP,GS,ES,RP | IS,TP, ES, RP | | |
| 9-10 am | IS,TP,GS,ES,RP | IS,TP,ES,RP | IS,TP,GS,ES, RP | IS,TP,GS,ES, RP | IS,TP,ES, RP | | |
| 10-11 am | IS,TP,GS,ES, RP | IS,TP,ES,RP | IS,TP,GS,ES,RP | IS,TP,GS, ES, RP | IS,TP,ES, RP | | |
| 11 am-12 | IS,TP,GS,ES, RP | IS,TP,ES, RP | IS,TP,GS,ES,RP | IS,TP,GS, ES, RP | IS,TP,ES, RP | | |
| 12-1 pm | | | | | | | |
| 1-2 pm | IS,TP,ES,RP | IS,TP,GS,ES,RP | IS,TP,ES,RP | IS,TP,ES,RP | IS,TP,ES, RP | | |
| 2-3 pm | IS,TP,ES,RP | IS,TP,GS,ES,RP | IS,TP,ES,RP | IS,TP,ES, RP | IS,TP,ES, RP | | |
| 3-4 pm | IS,TP,ES, RP | IS,TP,ES,RP | IS,GS,TP,ES,RP | IS,TP, ES, RP | IS, TP, ES, RP | | |
| 4-5 pm | IS,TP,ES,RP | IS,TP,ES,RP | IS,GS,TP,ES,RP | IS,TP, ES, RP | IS, TP,ES, RP | | |
| 5-6 pm | | | | | | | |
| 6-7 pm | | | | | | | |
| 7-8 pm | | | | | | | |
| ***Daily total hours of services:*** | 8 | 8 | 8 | 8 | 8 | | |
| | | | | | ***Total hours per week of services provided:*** | | 40 |

Department of Health Care Services
Licensing and Certification Section, MS 2600
PO Box 997413
Sacramento, CA 95899-7413

## SECTION G ADMINISTRATIVE ORGANIZATION -- CORPORATIONS, LLC N/A ☑

**(must be completed by all applicants)**

***1. Corporation Name (as listed with the Secretary of State):*** _

***2. Chief Executive Officer:*** _____

***3. Entity Number:*** _____

***4. Incorporation Date:*** _____

***5. Place of Incorporation:***

**6. Stockholder information: Names and addresses of all persons who own ten percent (10%) or more of stock in corporation.**

| Name | Address | City | State | Zip |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

***Attach additional pages, if necessary, under Tab#2.***

### *7. Governing Board of Directors*

7a. Number of Board Members: _____ 7b. Term of Office: _____

7c. Frequency of Meetings: _____ 7d. Method of Selection : _____

### *8. Board Officers and Members*

***Attach additional pages, if necessary, under Tab #2.***

| Office/Title | Name (Last, First) | Business Address, City, Zip Code | Telephone Number | Term Expiration |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

Department of Health Care Services
Licensing and Certification Section, MS 2600
PO Box 997413
Sacramento, CA 95899-7413

## SECTION H ADMINISTRATIVE ORGANIZATION N/A ☐

***(must be completed by all public agencies, partnerships, sole proprietors/other associations)***

### PUBLIC AGENCY

**1.** Check type of public agency: ☑ County ☐ City ☐ Other (specify) _____

**2.** Agency providing service:

Name: Lassen County Behavioral Health Address: 555 Hospital Ln

City: Susanville Zip Code: 96130 Contact Person: Tiffany Armstong

Title: Director Telephone: (530) 251-8108

### PARTNERSHIPS N/A ☑

**1.** If registered with California Secretary of State, Entity Number:

**2.** Type of Partnership:

| Partner's Name | Type | Business Address | City | Zip Code |
|---|---|---|---|---|
| | ☐ General ☐ Limited | | | |
| | ☐ General ☐ Limited | | | |
| | ☐ General ☐ Limited | | | |
| | ☐ General ☐ Limited | | | |

### SOLE PROPRIETOR/OTHER ASSOCIATIONS N/A ☑

**1.** Organization's EIN or sole proprietor's SSN: _____

**2.** Sole Proprietors/other associations must also provide a list of all person(s) legally responsible for the organization, the contact person, and appropriate legal documents (fictitious name statement, business license) which set forth legal responsibility of the organization and accountability for opening the program. Use the following space.

| Name | Address | City | State | Zip Code |
|---|---|---|---|---|
| | | | | |
| | | | | |
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## SECTION I ADMINISTRATOR, PROGRAM DIRECTOR, CLINIC DIRECTOR INFORMATION

***(must be completed by all applicants)***

### IDENTIFYING INFORMATION

| | | |
|---|---|---|
| Name: Tiffany Armstrong | | |
| Title: Director | Telephone: (530) 251-8108 | Email address: TArmstrong@co.lassen.ca.us |
| Address: 555 Hospital Ln, Susanville CA 96130 | | |
| Other names(s) used by administrator/director: | | |

### MANAGEMENT EXPERIENCE

| Type | Title | Date Started | Date Ended | Reason for Leaving |
|---|---|---|---|---|
| Behavioral Health Director | BH Director | 07/01/2017 | | Not applicable |
| | | | | |

Do you have a professional license or certificate? [✔] Yes [ ] No If yes, complete the following:

| Type | Period Held | Issuing Agency |
|---|---|---|
| LCSW #66443 | January 2006-Expires 3/2025 | Board of Behavioral Sciences |
| | | |

### WORK EXPERIENCE

Begin with your most recent work experience. List all experience which indicates compliance with licensing regulations and/or certification standards.

| Dates FROM | Dates TO | Name and Address of Employer | Duties | Reason for Leaving |
|---|---|---|---|---|
| 07/01/2017 | 02/26/2024 | Lassen County Behavioral Health<br>555 Hospital lane Susanville, Ca 96130 | Behavioral Health Director | Not applicable-Still currently employed |
| 11/01/2009 | 07/01/2017 | Lassen County Behavioral Health<br>555 Hospital lane Susanville, Ca 96130 | Mental Health Services Act Program manager | Promotion |
| 06/01/2005 | 10/01/2009 | Lassen County Behavioral Health<br>555 Hospital lane Susanville, Ca 96130 | Health and Social Services program Manager | Promotion |
| 08/18/1998 | 06/01/2005 | Lassen County Behavioral Health<br>555 Hospital lane Susanville, Ca 96130 | Case Manager<br>Rehabilitation Specialist | Promotion |

Department of Health Care Services
Licensing and Certification Section, MS 2600
PO Box 997413
Sacramento, CA 95899-7413

## Section J — PROGRAM STAFF

***(must be completed by all applicants)***

Personnel files must match information on application. List the staff that will provide direct treatment services at this location on pages 29 including staff under contract. Attach a separate piece of paper if necessary.

**1.** Total number of staff employed **at this facility**: 4

**2.** Total number of staff **at this facility** who perform alcohol and drug counseling duties: 4

**3.** Total number of staff employed at this facility who are currently licensed, certified or registered counselors: 4

***** The following link allows programs to verify the Department's list of Approved Certifying Organizations

****LICENSED PROFESSIONALS AND INTERN QUALIFICATION REQUIREMENTS**

Licensed professional means a physician licensed by the Medical Board of California or by the Osteopathic Medical Board of California; a psychologist licensed by the Board of Psychology; or a clinical social worker or MFT licensed by the California Board of Behavioral Sciences or an intern registered with the California Board of Behavioral Sciences or with the Board of Psychology.

**Personnel files must match information on application. List the staff that will provide direct treatment services at this location on pages 29, including staff under contract. Attach a separate piece of paper if necessary.**

Department of Health Care Service
Licensing and Certification Section, MS
2600 PO Box 997413
Sacramento, CA 95899-7412

## 4. Staff/Employee Information

Pursuant to the CCR, Title 9, § 13010, at least thirty percent (30%) of staff providing counseling services in all SUD programs licensed and/or certified by DHCS shall be licensed or certified pursuant to the requirements of this chapter. All other counseling staff shall be registered pursuant to § 13035(f). Licensed professionals may include LCSW, MFT, Licensed Psychologist, Physician, or registered Intern, as specified in § 13015. This form must include licensed physicians and surgeon or other health care practitioners associated with the licensed residential facility, if incidental medical services will be provided.

INSTRUCTIONS: Use this form to identify all staff of the facility. Designate volunteers by placing a "V" after their names. Use additional sheets as needed.

| Employee Information: | Date Hired | Alcohol & Drug Treatment Exp. - in Years | Last TB Test Date | First Aid and CPR required for license applicants only. | | Licensed? Yes/No/N/A | Certified? Yes/No/N/A | Registered? Yes/No/N/A | *Certified/Registered By: (Provide Lic/Cert/Reg number and organization (listed on page 28) OR ** Licensed As: A. Psychologist B. MFT C. Physician D. LCSW E. Registered Intern F. Physician | Effective and expiration dates of: Licensure, Certification, or Registration. |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | First Aid: Date of last Training | CPR: Date of last Training | | | | | |
| **Name:** Alexandra Smith<br>**Title:** CADC-CAS<br>**Scheduled hours per week:** 40 | 06/18/2001 | 22 | 04/04/2024 | | | N/A | Yes | No | C3751214 Lic/Cert/Reg number<br>CCAPP Lic/Cert/Reg organization | 05/01/2023 Effective date<br>05/01/2025 Expiration date |
| **Name:** Sherry Mathers<br>**Title:** CADC-CAS<br>**Scheduled hours per week:** 40 | 01/01/2007 | 17 | 05/13/2024 | | | N/A | Yes | No | C20531214 Lic/Cert/Reg number<br>CCAPP Lic/Cert/Reg organization | 06/17/2023 Effective date<br>06/17/2025 Expiration date |
| **Name:** Samantha Sam<br>**Title:** CADC-CAS<br>**Scheduled hours per week:** 40 | 06/14/2001 | 23 | 04/05/2( | | | N/A | | | C12111214 Lic/Cert/Reg number<br>CCAPP Lic/Cert/Reg organization | 05/02/2023 Effective date<br>05/02/2025 Expiration date |
| **Name:** Nichole Bond<br>**Title:** SUDCC 3-CS<br>**Scheduled hours per week:** 40 | 08/08/2017 | 13 | 04/05/2024 | | | N/A | Yes | No | 5020 Lic/Cert/Reg number<br>CADTP Lic/Cert/Reg organization | 09/02/2022 Effective date<br>09/06/2024 Expiration date |

Department of Health Care Services
Licensing and Certification Section, MS 2600
PO Box 997413
Sacramento, CA 95899-7413

## Section K — CERTIFICATIONS AND ASSURANCES
**(must be completed by all applicants)**

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.

***Only one signature is required unless applicant is a partnership.***

| Signature of Authorized Individual | Print Name | Title | Date of Birth | Gender | Driver's License/ I.D. Number | Expiration Date |
|---|---|---|---|---|---|---|
| | | | | | | |
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