HEALTH FACILITY PROGRAM PLAN APPLICATION
DS 1852 (Rev.06/2015)

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
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: _____   Age range: _____   Ambulatory status: _____
                        (beds)   (AMB/NON-AMB)

QIDP: **ADMINISTRATOR:**

Signature of Licensee/Corporate Designee	Title	Date

SUBMIT APPLICATION TO:	**FOR DEPARTMENT USE ONLY**
Department of Developmental Services Community Living Section 1600 Ninth Street, Room 320, MS 3-9 Sacramento, CA 95814 Phone: (916) 654-1965 Fax: (916) 654-2187 E-Mail: ddscls@dds.ca.gov	Date received: _____ Date of program plan approval: _____ Date of QIDP 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.		

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: _____