State of California – Health and Human Services Agency

Department of Developmental Services

HEALTH FACILITY PROGRAM PLAN APPLICATION

DS 1852 (Rev.04/2022)

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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:

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

FOR DEPARTMENT USE ONLY

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:** _____