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

ADULT NONMEDICAL ALCOHOLISM OR DRUG ABUSE RECOVERY OR TREATMENT FACILITY

INITIAL LICENSING APPLICATION BOOKLET

STATE OF CALIFORNIA

HEALTH AND HUMAN SERVICES AGENCY

DEPARTMENT OF HEALTH CARE SERVICES

SUBSTANCE USE DISORDER COMPLIANCE DIVISION

PO Box 997413 MS 2600
SACRAMENTO, CA 95899-7413

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

Department of Health Care Services
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INITIAL LICENSING APPLICATION

Requirements for License

Chapter 7.5, Part 2, Division 10.5 of the California Health and Safety Code states 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 in this state without obtaining a current, valid license pursuant to this chapter".

The code defines an alcoholism or drug abuse recovery, treatment, or detoxification facility as any facility, place or building which provides 24-hour residential nonmedical 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 alcohol or drug problems which include one or more of the following: detoxification, group sessions, individual sessions, educational sessions, and recovery or treatment planning. If you have questions regarding the need for your facility to be licensed or regarding the requirements for licensure, please call the Department of Health Care Services (DHCS) at **(916) 322-2911** and request to speak with a licensing analyst.

Procedure for Obtaining a License

The Initial Licensing Application Section A and B documents must be completed and submitted to DHCS with a check or money order, made out to the Department of Health Care Services, to cover the $2,773 initial application fee. **The application fee is non-refundable.** The review of the application cannot begin until all the necessary documents and fees have been received by DHCS. In addition, applicants must demonstrate a capability to meet the goals and objectives of an alcoholism or drug abuse recovery or treatment facility, **obtain a valid and appropriate fire clearance**, and pass an on-site inspection by a DHCS licensing analyst. Once an applicant has passed the on-site inspection, a biennial residential licensure fee, in the amount of $147 per each treatment bed, will be assessed. When the appropriate biennial fee has been submitted, DHCS will issue a license, which will be valid for two (2) years.

This booklet details the requirements in three sections.

Section A – Contains the application forms which must be completed and submitted to the Division.

Section B – Identifies documents the applicant must develop or secure and submit to the Division as a part of the license application.

Section C – Identifies those areas that will be reviewed at the time the Division conducts its on-site review of the applicant's facility. Documents identified are not to be submitted to the Division prior to the review of the facility but must be readily available for review at all times.

License Application Processing

The Section A and B documents must be submitted in the same sequence as they are in the application booklet. Do not bind the application documents or place them in a protective covering. **If the application packet is incomplete, in the wrong format or sequence, or submitted without the appropriate fee, DHCS will return the entire packet to you.** 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.

The licensing process normally is completed within 120 days. ***The 120 days begins when an application packet is determined to be complete.***

Please mail a check or money order, made out to the Department of Health Care Services, to cover the appropriate initial application fee, the completed application forms contained in Section A and the documents required in Section B in one complete packet to:

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

Regulations

The regulations that govern the licensing of the facility category covered by these application instructions are under the California Code of Regulations (CCR), Title 9, Division 4, Chapter 5. To assist applicants in supplying the detailed information needed in the licensing process, a copy of the regulations and amendments can be downloaded at http://www.DHCS.ca.gov/Licensing/laws.shtml

For information on purchasing regulations with an update service, contact:

Barclays West Group
1-800-888-3600

Public Information

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

Application Fees

On August 24, 2007, Chapter 177, Statutes of 2007, (Senate Bill 84), was enacted mandating the assessment of fees to all licensed and/or certified residential and certified outpatient Alcohol and Other Drug (AOD) recovery and treatment facilities regardless of the form of organization or ownership. For more information please refer to ADP Bulletin Number 07-11, entitled Assessment of Fees for Licensure and Certification of Residential and Outpatient Recovery and/or Treatment Facilities, issued on October 11, 2007, and posted on DHCS's website at www.DHCS.ca.gov

The following Residential Licensure Fees will be assessed by DHCS.

Residential Licensure Fees	
Initial Residential Licensure Application Fee	$ 2,773
Initial Biennial Residential Licensure Fee	$ 147 (per bed)

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Licensing and Certification Division
MS 2600
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SECTION A – Checklist and Sequence for Submission

Application Forms
(Link to Forms Here)

Applicant check off and initial when submitting	YES	NO	INC	N/A
	For Internal Use Only			
☐ 1. Application for License (A-1)				
☐ 2. Administrator/Director Information (A-2)				
☐ 3. Administrative organization, Corporations (A-3A) Public Agency, Partnership, Sole Proprietor, or Other Association (A-3B)				
☐ 4. Designation of Administrative Responsibility (A-4)				
☐ 5. Weekly Activities Schedule (A-6)				

Explanation of Section A

Forms to be submitted to the Department of Health Care Services to initiate the request for licensing.
(Link to Forms Here)

Facilities that have more than one property address may require completion of additional Section A portions of the application. If you have any questions regarding this issue call the Department of Health Care Services at (916) 322-2911 and ask to speak with a licensing analyst.

1. Application for License (A-l) - identifies the applicant(s), facility, and other required information for licensure. [Regulations Section 10516]

2. Administrator and/or Director Information (A-2) - identifies the Administrator and/or Director of the facility applying for licensure and verifies qualifications to operate a facility. [Regulations Section 10564]

3. Administrative Organization - identifies the entity applying for licensure, Corporation (A-3A) or Public Agency, Partnership, Sole Proprietor, or Other Association (A-3B). [Regulations Section 10516(a)(2)]

4. Designation of Administrative Responsibility (A-4) - identifies the person(s) authorized by the applicant to accept responsibility of facility in his/her absence. [Regulations Section 10564(a)(2)]

5. Weekly Activity Schedule (A-6) - indicates the weekly schedule for specific activities and recovery or treatment services such as detoxification, group sessions, education, problem solving, counseling sessions, recreation, individual and family sessions, recovery or treatment planning, or other

activities the facility is providing for the residents. [Regulations Sections 10501(a)(5) and 10574]

Department of Health Care Services
Licensing and Certification Division
MS 2600
PO Box 997413
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SECTION B – Checklist and Sequence for Submission

Required Supportive Documents
(Link to Forms Here)

Applicant check off and initial when submitting	YES	NO	INC	N/A
☐ 1. Approved Fire Safety Inspection Request (Standard Form 850)				
☐ 2. Licensing Fees				
☐ 3. Plan of Operation				
☐ a. Statement of program goals and objectives				
☐ b. Outline of activities and services				
☐ c. Admission policies and procedures				
☐ d. Assurance of nondiscrimination in employment practices and provisions of benefits and services				
☐ e. A copy of the facility's residential admission agreement				
☐ f. Table of administrative organization of the facility				
☐ g. Staffing plan, job descriptions, and minimum staff qualifications				
☐ h. A sketch of the grounds, showing buildings, driveways, fences, storage areas, pools, gardens, recreation areas, and other space used by residents				
☐ i. Floor plans which describe the dwelling capacity, intended use, and dimensions of the rooms				
☐ j. Sample menus and schedule for one calendar week, indicating the times of day that meals are to be served				
☐ k. Consultant and community resources to be utilized by the facility as part of its program				
☐ 4. Provisions for Safeguarding Residents Property				
☐ 5. Bacteriological Analysis of Private Water Supply				

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MS 2600
PO Box 997413
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Explanation of Section B

Supportive Documents to be submitted to the Department of Health Care Services (Link to Forms Here)

1. Fire Safety Inspection Request (Standard Form 850) – A valid and appropriate fire clearance issued from the fire authority having jurisdiction for the area in which the facility is located. The fire clearance shall 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. [Regulations Section 10517(a)(1)] The fire clearance shall include the number of dependent children allowed in the total capacity and the age range of the dependent children. If no number of dependent children is indicated, no dependent children are allowed.

2. Licensing Fees – All applicants for licensure are required to a pay a licensing fee regardless of the form of organization or ownership. [Chapter 177, Statues of 2007, (Senate Bill 84)]

3. Plan of Operation – Shall include, but not be limited to the following items [NOTE: Items a, b, and c should clearly demonstrate a relevance to the type of submitted application—alcohol , drug and/or combined alcohol and drug facility]:

    a. Statement of program goals and objectives – written statement to include program goals (intent or the purpose of its existence) and objectives of the facility. [Regulations Section 10517(a)(2)(A)]

    b. Outline of activities and services – written statement listing the activities and services being provided by the facility. [Regulations Section 10517(a)(2)(B)]

    c. Admission policies and procedures – written statement of admission policies and procedures regarding acceptance of residents. [Regulations Section 10517 (a)(2)(C)]

    d. Assurance of nondiscrimination in employment practices and provision of benefits and services – written assurance of nondiscrimination in employment practices, provision of benefits and services. [Regulations Section 10517(a)(2)(D)]

    e. A copy of the facility's residential admission agreement – a copy of the most current admission agreement used by the facility. [Regulations Section 10517(a)(2)(E)]. Pursuant to Title 9, California Code of Regulations, Section 10566, the admission agreement shall specify all of the following:

        - Services to be provided,
        - Payment provisions including (amount assessed and payment schedule),
        - Refund policy,
        - Those actions, circumstances or conditions which may result in resident eviction from the facility,
        - The consequences when a resident relapses and consumes alcohol and/or non-health sustaining drugs, and

- Conditions under which the agreement may be terminated.

f. Table of administrative organization of the facility – a chart that shows the governing board, advisory groups, including resident council when applicable, and both lines of authority (straight lines) and communications lines (broken lines) to all staff positions. [Regulations Section 10517(a)(2)(F)]

g. Staffing plan, job descriptions, and minimum staff qualifications – narrative description of staff needs (i.e., briefly describe staff composition, job description) for each position at facility (both paid and volunteer) which includes minimum staff qualifications for each position. [Regulations Section 10517(a)(2)(G)]

h. Sketch of Buildings and Grounds – sketch 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 showing buildings, driveways, fences, storage areas, pools, gardens, recreational area and other space to be used by residents. All sketches shall show dimensions but need not be to scale. The number of residents per bedroom, and the location and the number of beds for all residents, including the location of beds for infants and other non-ambulatory persons, must be identified. [Regulations Section 10517(a)(2)(H)&(I)]

i. Sample menus and schedule for one calendar week – menu(s) shall include times of food service, food provided for breakfast, lunch, and dinner for one week, and type and availability of snacks. [Regulations Section 10517(a)(2)(J)]

j. Consultant and 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 participants in securing additional services to meet and maintain their person well-being while continuing to enhance personal development. [Regulations Section 10517(a)(2)(K)]

4. Provisions for Safeguarding Resident's Property – 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. [Regulations Section 10516(a)(8)]

5. Bacteriological Analysis of Private Water Supply – 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 the local health department, the State Department of Health Services, or a licensed commercial laboratory. This analysis shall be done on an annual basis. [Regulations Section 10517(b)]

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Licensing and Certification Division
MS 2600
PO Box 997413
Sacramento, CA 95899-7413

SECTION C – SUPPORTIVE DOCUMENTS

Explanation of Section C

At the time of the on-site review the following items need to be ready and available for review by the licensing analyst.

(Link to Forms Here)

1. Plan of Operation A written plan of operation must be maintained which includes, at minimum, all requirements listed in Regulation Section 10517(a)(2).

2. Personnel Records of all Paid and/or Volunteer Staff
Personnel records must, at minimum, contain all of the requirements listed in Regulations Sections 10564, 10565 and 10572. The attached form Health Screening Report – Facility Personnel (C-3) may be used for Sections 10564(c) and 10565(b).

3. Resident Records
Resident records must, at minimum, contain all requirements listed in regulations Sections 10566, 10567, 10568 10569 and 10572.

4. Telephones and Transportation
Telephones, not including a cellular telephone, must be provided for emergency use to comply with Regulations Section 10570. Vehicles used to transport residents must comply with Regulation Section 10571.

5. Health Related Documents and Policies
Health related documents and policies must contain all requirements listed in regulations Section 10572. The Centrally Stored Medication and Destruction Record (C-6A) may be used by the facility and Unusual Incident/Injury/Death Report (C-6B) shall be used by the facility. In addition, there shall be written rules and policies to prevent persons (except in detoxification programs) who have consumed alcohol or other drugs from being on the premises [Section 10572(e)].

6. Food Service – Documents and Storage
Food Service department, food preparation areas, and storage areas will be reviewed to ensure compliance with Regulations Section 10573.

7. Physical Service – Documents and Storage
The building will be inspected to ensure compliance with Regulations Section 10580 through 10584.

8. Federal Requirements
A copy of the Code of Federal Regulations regarding confidentiality, (42 CFR) and the Code of Federal Regulations regarding nondiscrimination, (45 CFR), must be maintained at the facility and available for review in accordance with Regulations Sections 10517(a)(2)(D), 10564, 10568, and 10569. The attached form Personal Rights (C-9) may be used by the facility for convenience.

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

State of California - Health and Human Services Agency
Department of Health Care Services

APPLICATION FOR INITIAL LICENSE A-1

DIRECTIONS TO FACILITY (applicant may include map)	FOR DEPARTMENTAL USE ONLY
	COUNTY:
	DATE:
	REVIEWED BY:
	ID NUMBER:

INITIAL APPLICATION

1. **APPLICANT INFORMATION:**

_____
Name of Applicant (if Corporation, legal name of Corporation)

_____
(Mailing Address of Applicant) (City/State) (Zip)

_____
(Contact Person) (Title) (Telephone) (Fax) (E-mail Address)

TYPE OF ORGANIZATION:

☐ For Profit ☐ Nonprofit

☐ Other, please explain _____

Partnerships, corporations, sole proprietors and other associations must complete form A-3A or A-3B.

APPLICANT:

Has the applicant ever been a licensee or co-licensee of an alcoholism or drug abuse recovery or treatment facility licensed by the Department of Alcohol and Drug Programs or a facility licensed by Department of Social Services – Community Care Licensing?

☐ Yes ☐ No

If yes, name of facility:_____

License Number:_____

Licensing Agency:_____

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

Has the applicant ever voluntarily surrendered, had a denial, suspension, or revocation of a residential license for an alcoholism or drug abuse recovery or treatment facility licensed by the Department of Alcohol and Drug Programs or a facility licensed by the Department of Social Services – Community Care Licensing?

☐ Yes ☐ No

If yes, the date license was surrendered, denied, suspended, or revoked:_____

2. FACILITY/PROGRAM INFORMATION:

_____
(Name of Facility/Program)

_____
(Street Address of Facility/Program) (City/State) (Zip)

_____ (___) _____ (___) _____
(County) (Telephone) (Fax) (Facility E-mail Address)

Proposed facility/program located within: ☐ Incorporated city limits **OR** ☐ Unincorporated portion of the county

_____
Mailing Address - (if different from above)

_____ (___) _____
(Name of Facility Administrator) (Title) (Telephone) (Administrator E-mail Address)

A. TYPE OF ALCOHOL AND/OR OTHER DRUG RECOVERY OR TREATMENT SERVICES PROVIDED: (Check all that apply)

☐ Detoxification* ☐ Group Sessions

☐ Individual Sessions ☐ Educational Sessions

☐ Recovery or Treatment Planning ☐ Other_____

***Additional regulatory requirements must be met to provide detoxification services. Refer to Title 9, CCR, Section 10572(b)(1).**

B. TOTAL OCCUPANCY OF FACILITY (FOR FIRE CLEARANCE PURPOSES) AS DETERMINED BY THE FIRE INSPECTOR.

(This is the maximum number of individuals who **live** at the facility and are approved by the fire safety inspector.) These individuals **include** the residents receiving recovery, treatment or detoxification services, children of the residents, and staff. **It is important to note that staff includes individuals who work for the applicant in exchange for either monetary or in-kind compensation (e.g., room and board).**
Total occupancy cannot be exceeded for any reason. _____

C. MAXIMUM REQUESTED ADULT RESIDENT CAPACITY OF THE FACILITY

(The number of adult residents that **receive recovery, treatment or detoxification services at any one time**, which cannot be greater than the total occupancy shown in B above): _____

D. MAXIMUM NUMBER AND AGE RANGE OF DEPENDENT CHILDREN WHO ARE SUPERVISED BY THEIR PARENT(S) IN THE FACILITY. This includes temporary residing (i.e., overnight, weekend visits) of dependent children. (Since there must always be at least one adult being served, the maximum number of dependent children housed must be at least one less than the total occupancy, determined by the fire inspector, as shown in B above): _____

E. DURATION OF USUAL RECOVERY OR TREATMENT PROGRAM IN FACILITY TO BE LICENSED (in days): _____

F. IS THE FACILITY/PROGRAM ACCESSIBLE TO INDIVIDUALS IN WHEELCHAIRS OR OTHER NONAMBULATORY CONDITIONS?

☐ **Yes** ☐ **No**

NOTE: The Americans with Disabilities Act of 1990 (ADA) - Public Law 101-336, C42 U.S.C., Chapter 126 is a comprehensive federal anti-discrimination law for people with disabilities. The Department of Health Care Services reminds all providers of alcoholism or drug abuse recovery or treatment services that discrimination against persons with disabilities is prohibited. Further, the Department of Health Care Services encourages you to become familiar and comply with the ADA guidelines. Local governmental entities should be contacted for specific ADA requirements for your area.

G. IS FACILITY/PROGRAM APPLYING FOR A WAIVER TO SERVE ADOLESCENTS?

☐ Yes ☐ No

If yes, a proposal to serve adolescents must be submitted with the application (in accordance with Title 9, CCR, Subchapter 4, Article 1, commencing with Section 10598.

H. POPULATION DEMOGRAPHICS

Describe and check the demographics of the resident population to be served (age, race/ethnicity, and sex). [Title 9, CCR, Section 10516 (a)(5)]

☐	1.1	General Population (co-ed)*	☐	1.4	Dependent Children of Residents**
☐	1.2	Men Only	☐	1.5	Adolescents (14-17)*
☐	1.3	Women Only	☐	1.8	Dual Diagnosis***

* **The applicant prior to serving this population must meet additional regulatory requirements. (Co-ed refer to Title 9, CCR, Section 10581(f)(1-3)) (Adolescents refer to Title 9, CCR Sections 10598-19631)**

** **The approved fire clearance must address any dependent children of residents residing at the facility. This includes temporary residency (i.e., overnight weekend visits of dependent children).**

*** **Serving this population may require the applicant to obtain a license from another state agency. For example, the Department of Health Care Services does not have licensing**

authority over facilities in which staff provides assistance to residents with activities of daily living. This includes, but is not limited to, assistance in dressing, grooming, bathing, and other personal hygiene. CONTACT THE DEPARTMENT OF SOCIAL SERVICES - COMMUNITY CARE LICENSING at (916) 324-4031 or a regional office (identified in the government pages of a local phone book) if you have questions regarding the proper licensing department.

I. FACILITY DESCRIPTION:

1. Was the building currently under consideration previously licensed as a residential facility by the Department of Alcohol and Drug Programs, Department of Health Care Services, Department of Social Services or Department of Health Services?

   ☐ Yes ☐ No ☐ Unknown

   If yes, give former facility name, name of licensing agency, and license number:

   _____
   (Name)

   _____
   (Licensing Agency)

2. Total number of buildings to be included in the license _____

3. Are all buildings located on the same property or integral components of the same facility?

   ☐ Yes ☐ No

4. Is major construction anticipated? ☐ Yes ☐ No

   If yes, give construction initiation and completion dates:

   _____ _____
   (Initiation Date) (Anticipated Completion Date)

   Please note: New construction and major renovations need to comply with ADA regulations.

5. Is water used for human consumption from a municipal water source?

   ☐ Yes ☐ No

   (a) If yes, give the name of the municipality_____

   (b) If no, give source of water_____

NOTE: A bacteriological analysis is required for non-municipal water (Chapter 5, Division 4, of Title 9, Section 10517(b), California Code of Regulations). The local health department, the State Department of Health Services, or a licensed commercial laboratory may conduct this. A copy of the analysis is to be submitted with the application and shall be updated annually and maintained at the facility.

J. NONPROFIT APPLICANTS ONLY (any change to the information below must be reported to the Department of Health Care Services):

Have you obtained tax-exempt status from the Internal Revenue Service under Internal Revenue Code 501(c)(3) **and** from the California Franchise Tax Board under Revenue and Taxation Code 23701d?

☐ YES ☐ NO

IF YES: What is your primary purpose (check one)?

☐ Charitable ☐ Religious ☐ Educational

☐ Other - Please Specify:_____

IF NO: Are you nonprofit based on another provision of the law? ☐ YES ☐ NO

IF YES: Specify the provision:_____

K. RELIGIOUS ACTIVITIES:

1. Do you **mandate** religious study or activities as part of your recovery, treatment, or detoxification services? ☐YES ☐NO

   IF YES: The religious studies or activities must be reflected on the Weekly Activities Schedule and in the Admission Agreement.

2. Do you offer, on a voluntary basis, religious study or activities as part of your recovery, treatment, or detoxification services? ☐YES ☐NO

   IF YES: Religious study or activities and distinct nonreligious activities for those not choosing the religious studies or activities must be reflected on the Weekly Activities Schedule and the Admission Agreement.

IT IS IMPORTANT TO NOTE: PUBLIC FUNDS CANNOT BE USED TO SUPPORT RELIGIOUS STUDY OR ACTIVITIES.

L. PUBLIC FUNDING:

(1) Do you have a county contract? ☐Yes ☐No

(2) Do you receive perinatal funds? ☐Yes ☐No

(3) Do you receive any funds from the Department of Corrections? ☐Yes ☐No

If yes, please provide source:

☐_____

(4) Other public funding: _____

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MS 2600
PO Box 997413
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M. PROPERTY OWNERSHIP:

☐Own ☐Rent ☐Lease ☐Other (specify) _____

If renting or leasing, name, address and telephone number of property owner:

_____ ( ) _____
(Name) (Telephone)

_____
(Address) (City/State) (Zip)

N. RECORDS: (Regulations Section 10568(a) requires resident records to be maintained at the facility site. However, Regulations Section 10565(c) allows personnel records to be maintained in a central location provided that they are readily available to the department at the facility site upon request). Are your personnel records maintained at the facility site?

☐YES ☐NO

If no, address where personnel records are maintained:

_____

_____

O. EMPLOYEES:

Total number of employees at facility to be licensed _____

Total number of employees of provider _____

3. APPLICANT RESPONSIBILITIES:

A. In addition to complying with the Health and Safety Code and regulations and the Alcohol and/or Other Drug Program Certification Standards concerning licensing, certification and fire safety, I/we understand that there is also an obligation to meet other state, federal, and/or local codes and regulations, such as *zoning, building, sanitation, labor, nondiscrimination, confidentiality, and Americans with Disabilities Act.*

B. Permission shall be obtained by the applicant from the Department of Health Care Services prior to making any changes that affect the terms of the license and/or certification.

C. The applicant may withdraw its application by submitting a written request to do so. Such withdrawal shall not constitute denial of the application. However, withdrawal does not prohibit the Department of Health Care Services from taking action to deny an application.

Department of Health Care Services
Licensing and Certification Division
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PO Box 997413
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4. AUTHORIZED SIGNATURE(S) OF APPLICANT:

THE UNDERSIGNED ASSURES THAT THE APPLICANT DOES NOT DISCRIMINATE IN EMPLOYMENT PRACTICES AND PROVISION OF SERVICES ON THE BASIS OF ETHNIC GROUP IDENTIFICATION, RELIGION, AGE, SEX, COLOR, OR DISABILITY PURSUANT TO TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 (SECTION 2000d, TITLE 42, UNITED STATES CODE); THE AMERICANS WITH DISABILITIES ACT OF 1990 (SECTION 12132, TITLE 42, UNITED STATES CODE); SECTION 11135 OF CALIFORNIA GOVERNMENT CODE; AND FOR RECIPIENTS OF FINANCIAL ASSISTANCE, THE REHABILITATION ACT OF 1973 (SECTION 794, TITLE 29, UNITED STATES CODE), AND CHAPTER 6 (COMMENCING WITH SECTION 10800) DIVISION 4, TITLE 9 OF THE CALIFORNIA CODE OF REGULATIONS.

A. If the applicant is a sole proprietor, the application shall be signed by the proprietor [Title 9, CCR, Section 10516(b)]

B. If the applicant is a partnership, the application shall be signed by each partner. [Title 9, CCR, Section 10516(b)(1)] [Standards Section 3030 a. 2. A.]

C. 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 the individual legally responsible for representing the agency. [Title 9, CCR, Section 10516(b)(2)]

D. The applicant(s) affirms that the facts contained in this application and supporting documents are true and correct.

(Signature)	(Title)	(Date)
(Signature)	(Title)	(Date)
(Signature)	(Title)	(Date)
(Signature)	(Title)	(Date)

APPLICATION FOR A COMMUNITY CARE FACILITY OR RESIDENTIAL CARE FACILITY FOR THE ELDERLY LICENSE *(See Instructions on next page)*

FOR DEPARTMENT USE ONLY

DISTRICT:

COUNTY: FACILITY NUMBER:

DATE: ACTION TYPE:

REVIEWED BY: FACILITY TYPE:

REPLY TO:

1. APPLICANT(S) NAME(S) (PLEASE PRINT)

2. REQUESTED ACTION *(CHECK ONE)*:
- ☐ A. INITIAL APPLICATION
- ☐ B. CHANGE OF CAPACITY
- ☐ C. CHANGE OF LOCATION
- ☐ D. CHANGE OF FACILITY TYPE
- ☐ E. CHANGE OF AMB/NON-AMB BEDRIDDEN STATUS
- ☐ F. CHANGE WITHIN CORPORATION
- ☐ G. OTHER (Specify)

3. APPLICANT MAILING ADDRESS	CITY	STATE	ZIP CODE	AREA CODE/TELEPHONE
				( )

4. TYPE OF AGENCY OR FACILITY

- ☐ ADULT RESIDENTIAL FACILITIES
- ☐ FOSTER FAMILY AGENCIES
- ☐ ADULT DAY PROGRAMS
- ☐ TRANSITIONAL HOUSING PLACEMENT PROGRAMS
- ☐ SOCIAL REHABILITATION FACILITIES
- ☐ ADOPTION AGENCIES
- ☐ GROUP HOMES
- ☐ CRISIS NURSERIES
- ☐ RESIDENTIAL FACILITIES--ELDERLY
- ☐ RESIDENTIAL FACILITIES--CHRONICALLY ILL
- ☐ SMALL FAMILY HOMES
- ☐ OTHER(SPECIFY)

5. **APPLICATION FILED BY:**
- ☐ A. INDIVIDUAL
- ☐ B. PARTNERSHIP
- ☐ C. NON PROFIT CORP.
- ☐ D. PROFIT CORP
- ☐ E. COUNTY
- ☐ F. OTHER PUBLIC AGENCY
- ☐ G. LIMITED LIABILITY CORPORATION

6. FACILITY OR AGENCY NAME	EMAIL ADDRESS (NOT REQUIRED)	AREA CODE/TELEPHONE
		( )

7. FACILITY STREET ADDRESS	CITY	COUNTY	ZIP CODE	ALTERNATIVE PUBLIC TELEPHONE
				( )

8. FACILITY MAILING ADDRESS	CITY	STATE	ZIP CODE

9. ADMINISTRATOR OR PERSON IN CHARGE OF FACILITY	TITLE

10. TOTAL REQUESTED CAPACITY	10A. NUMBER OF NON-AMBULATORY (IF ANY)	10B. NUMBER OF BEDRIDDEN UNABLE TO TURN OR REPOSITION IN BED (IF ANY)

11. FOR CHILDREN'S FACILITY ONLY:

NUMBER OF INFANTS (AGES 0 THROUGH 2) CHILDREN (AGES 3 THROUGH 17)

12. DAYS AND HOURS OF OPERATION:	13. PROPERTY OWNERSHIP: ☐ OWN ☐ RENT ☐ OTHER (SPECIFY)

13A. NAME, ADDRESS AND PHONE NUMBER OF PROPERTY OWNER, IF RENTING OR LEASING:

14. WAS FACILITY PREVIOUSLY LICENSED? ☐ YES ☐ NO	IF YES, FACILITY NAME AND NUMBER:	LICENSING AGENCY NAME:

15. IS MAJOR CONSTRUCTION REQUIRED? ☐ YES ☐ NO	DATE CONSTRUCTION TO BEGIN: DATE TO BE COMPLETED:	16. SOURCE OF WATER FOR HUMAN CONSUMPTION ☐ PUBLIC ☐ PRIVATE

17. ENTER THE INFORMATION BELOW FOR ANY RESIDENTIAL CARE OR HEALTH CARE FACILITY PREVIOUSLY OR CURRENTLY OPERATED. REFER TO INSTRUCTIONS.

FACILITY NAME AND NUMBER	LICENSING AGENCY NAME
A.	
B.	

18. *APPLICANT(S)/LICENSEE(S) RESPONSIBILITIES:*

A. *I/WE UNDERSTAND THAT THERE MAY BE OTHER STATE, FEDERAL AND/OR LOCAL LAWS, WHICH ARE NOT ENFORCED BY THIS AGENCY, THAT MAY NEED TO BE MET SUCH AS: ZONING, BUILDING, SANITATION AND LABOR REQUIREMENTS.*

B. *I/WE HAVE READ AND UNDERSTAND THE STATUTES AND REGULATIONS WHICH PERTAIN TO MY/OUR LICENSING CATEGORY PRIOR TO THE ISSUANCE OF MY/OUR LICENSE.*

C. *I/WE SHALL ENSURE THAT ALL PERSONS SUBJECT TO FINGERPRINT REQUIREMENTS SHALL HAVE A DEPARTMENT OF JUSTICE CLEARANCE OR A CRIMINAL RECORD EXEMPTION PRIOR TO EMPLOYMENT, RESIDENCE OR INITIAL PRESENCE IN THE FACILITY AS REQUIRED.*

D. *IF I/WE OPERATE A FACILITY WHICH PROVIDES CARE AND SUPERVISION TO CHILDREN. I/WE SHALL ENSURE THAT A CHILD ABUSE INDEX CHECK FORM FOR EACH PERSON SUBJECT TO FINGERPRINT REQUIREMENTS IS SUBMITTED TO THE DEPARTMENT OF JUSTICE AS REQUIRED.*

E. *I/WE SHALL OBTAIN APPROVAL FROM THE LICENSING AGENCY PRIOR TO MAKING ANY CHANGE(S) THAT AFFECT THE TERMS OF THE LICENSE.*

19. *I/WE UNDERSTAND THAT I/WE HAVE THE RIGHT TO APPEAL ANY DECISION REGARDING THE DISPOSITION OF THIS APPLICATION.*

20. *I/WE DECLARE UNDER PENALTY OF PERJURY THAT THE STATEMENTS ON THIS APPLICATION AND ON THE ACCOMPANYING ATTACHMENTS ARE CORRECT TO THE BEST OF MY/OUR KNOWLEDGE.*

21. *I/WE AM/ARE AUTHORIZED TO SIGN THIS APPLICATION ON BEHALF OF THE NAMED APPLICANT.*

SIGNED TITLE COUNTY WHERE SIGNED DATE

SIGNED TITLE COUNTY WHERE SIGNED DATE

INSTRUCTIONS FOR APPLICATION FOR FACILITY LICENSE

Type or print clearly. Prepare application in duplicate. Return original and maintain a copy for your records. Attach to this application form, a copy of all requested forms and documents including those underlined below.

1. Applicant(s): Enter the names of the person(s) or organization legally responsible for the facility. Enter full names. Individuals enter first, middle and last name. If joint application, all applicants must sign this application. Individuals, each general partner, and chief executive officer or authorized representative of a firm, association, corporation, county, city, public agency or governmental entity must complete Applicant Information (LIC 215). Corporations and other organizations also complete Administrative Organization, (LIC 309).

2. Requested Action: Check appropriate box.

3. Applicant Mailing Address: Enter legal home mailing address of individual(s) and headquarters mailing address of corporations. Major partner enters principal business mailing address. Other partner(s) enter principal business mailing address(es) on Applicant Information (LIC 215). Enter area code with telephone number.

4. Type of Agency or Facility: Check the appropriate box for type of facility as defined in California Code of Regulations, Title 22. If unknown, enter the name commonly used to identify such a facility in space marked "other".

5. Application Filed By: Check appropriate box.

6. Facility or Agency Name: Enter the name used to designate the single facility under application. If an agency, fill in the name of the agency which provides the services.

7. Facility Street Address: Enter the physical location of the facility. If applicant has more than one facility, a separate application must be completed for each facility. Enter area code with telephone number.

8. Facility Mailing Address: Enter the address where all mail for the facility from the department/licensing agency should be sent.

9. Administrator or Person in Charge of Facility: Enter the name and title of person who will directly supervise the facility. If not yet employed enter "unknown".

10. Total Requested Capacity: Enter the total number of persons for whom care will be provided in any 24 hour period.

10A. If applicable, enter the number of beds available for non-ambulatory, unable to independently transfer but who do not need assistance in turning and repositioning in bed.

10B. If applicable, enter the number of beds available for bedridden, unable to independently turn or reposition in bed.

11. For Children's Facilities Only: Applicants for children's residential facilities enter the number of infants and the number of children to be served.

12. Days and Hours of Operation: Enter days and hours of facility operation.

13. Property Ownership: Check the appropriate box.

13a. Control of Property: If applicant(s) is leasing or renting, enter name, address and phone number of owner of facility premises.

14. Was Facility Previously Licensed?: Check YES or NO. If yes, enter facility name, number and name of agency that issued license(s).

15. Is Major Construction Required?: Indicate whether or not the facility is to be constructed or requires major structural improvements. If yes, enter dates construction is to begin and be completed.

16. Source of Water for Human Consumption?: Check *PUBLIC* or *PRIVATE* water source.

17. Other Facilities: H & S Code Section 1520(d), 1568.04(b) and 1569.15(d) require that an applicant disclose, prior or present service as an administrator, general partner,corporate officer or director of, or as a person who has held or holds a beneficial ownership of 10 percent or more in any community care, residential care facility for chronically ill, residential care facility for the elderly, or health care facility (attach separate sheet of paper for additional facilities).

18., 19, and 20. Statement of applicant(s)/licensee(s) responsibilities of compliance with all applicable laws and regulations.

21. SIGNATURES OF ALL APPLICANTS OR AUTHORIZED PERSON(S) (I.E., GENERAL PARTNERS OF A PARTNERSHIP AND CHIEF EXECUTIVE OFFICER OR DULY AUTHORIZED REPRESENTATIVE FOR ALL CORPORATIONS, PUBLIC AGENCIES, ETC.)

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

A-2 – ADMINISTRATOR/DIRECTOR INFORMATION

IDENTIFYING INFORMATION

NAME

TITLE	TELEPHONE NUMBER ( )	E-MAIL ADDRESS

ADDRESS

OTHER NAME(S) USED BY ADMINISTRATOR/DIRECTOR

EDUCATION

EDUCATION CIRCLE THE HIGHEST GRADE YOU COMPLETED 1 2 3 4 5 6 7 8 9 10 11 12 HIGH SCHOOL GRADUATE YES ☐ NO ☐ PASSED HIGH SCHOOL EQUIVALENCY TESTS YES ☐

NAME AND LOCATION OF COLLEGE OR UNIVERSITY	COURSE OF STUDY	COMPLETED SEMESTER UNITS	COMPLETED QUARTER UNITS	DEGREE OBTAINED	DATE COMPLETED

MANAGEMENT EXPERIENCE

Type	Title	Date Started	Date Ended	Reason for Leaving

DO YOU HAVE A PROFESSIONAL LICENSE OR CERTIFICATE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING

Type	Period Held	Issuing Agency

WORK EXPERIENCE. BEGIN WITH YOUR MOST RECENT WORK EXPERIENCE. LIST ALL EXPERIENCE WHICH INDICATES COMPLIANCE WITH LICENSING REGULATIONS AND/OR CERTIFICATION STANDARDS.

Dates	Name and Address of Employer	Duties	Reason for Leaving
FROM TO			
FROM TO			
FROM TO			

Signature: _____ **Date:** _____

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

A-5 – FACILITY STAFFING DATA - Page 1

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

Facility Name:			**Provider #:**		**Counselor Information** (A minimum of 30% of all staff who provide counseling services shall be licensed or certified.)				
Employee Information:	**Date Hired**	**Last TB Test Date**	**First Aid and CPR required for licensed facilities only.** First Aid: Date of last Training	CPR: Date of last Training	**Licensed?**	**Certified?**	**Registered?**	*** Certified/Registered By:** (Provide certification/registration # and organization (list below) **OR** **** Licensed As:** A. Psychologist B. MFT C. Physician D. LCSW E. Registered Intern	**Effective and expiration dates of:** Licensure, Certification, or Registration
1. _____					Yes	Yes	Yes	_____ Certification/registration #	_____ Effective date
Title: _____					No	No	No		
Scheduled hours per week:_____					N/A	N/A	N/A	_____ Lic/Cert/Reg organization	_____ Expiration date
2. _____					Yes	Yes	Yes	_____ Certification/registration #	_____ Effective date
Title: _____					No	No	No		
Scheduled hours per week:_____					N/A	N/A	N/A	_____ Lic/Cert/Reg organization	_____ Expiration date
3. _____					Yes	Yes	Yes	_____ Certification/registration #	_____ Effective date
Title: _____					No	No	No		
Scheduled hours per week:_____					N/A	N/A	N/A	_____ Lic/Cert/Reg organization	_____ Expiration date
4. _____					Yes	Yes	Yes	_____ Certification/registration #	_____ Effective date
Title: _____					No	No	No		
Scheduled hours per week:_____					N/A	N/A	N/A	_____ Lic/Cert/Reg organization	_____ Expiration date
5. _____					Yes	Yes	Yes	_____ Certification/registration #	_____ Effective date
Title: _____					No	No	No		
Scheduled hours per week:_____					N/A	N/A	N/A	_____ Lic/Cert/Reg organization	_____ Expiration date

DHCS 5050 (7/13)

*** APPROVED CERTIFYING ORGANIZATIONS**

1. Board for Certification of Addiction Specialists (CAARR)
2. California Certification Board of Alcohol and Drug Counselors (CAADAC)
3. California Association of Alcohol/Drug Educators (CAADE)
4. Breining Institute
5. California Association of Drinking Driver Treatment Programs (CADDTP)
6. American Academy of Health Care Providers in the Addictive Disorder (AAHCPAD)

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

Licensed professional means a physician licensed by the 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.

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

A-5 – FACILITY STAFFING DATA – Page 2

Facility Name:			**Provider #:**		**Counselor Information** (A minimum of 30% of all staff who provide counseling services shall be licensed or certified.)				
Employee Information:	**Date Hired**	**Last TB Test Date**	**First Aid and CPR required for licensed facilities only.** First Aid: Date of last Training	CPR: Date of last Training	**Licensed?**	**Certified?**	**Registered?**	*** Certified/Registered By:** (Provide certification/registration # and organization (list below) **OR** **** Licensed As:** A. Psychologist B. MFT C. Physician D. LCSW E. Registered Intern	**Effective and expiration dates of:** Licensure, Certification, or Registration
6. _____ Title: _____ Scheduled hours per week:_____					Yes / No / N/A	Yes / No / N/A	Yes / No / N/A	_____ Certification/registration # _____ Lic/Cert/Reg organization	_____ Effective date _____ Expiration date
7. _____ Title: _____ Scheduled hours per week:_____					Yes / No / N/A	Yes / No / N/A	Yes / No / N/A	_____ Certification/registration # _____ Lic/Cert/Reg organization	_____ Effective date _____ Expiration date
8. _____ Title: _____ Scheduled hours per week:_____					Yes / No / N/A	Yes / No / N/A	Yes / No / N/A	_____ Certification/registration # _____ Lic/Cert/Reg organization	_____ Effective date _____ Expiration date
9. _____ Title: _____ Scheduled hours per week:_____					Yes / No / N/A	Yes / No / N/A	Yes / No / N/A	_____ Certification/registration # _____ Lic/Cert/Reg organization	_____ Effective date _____ Expiration date
10. _____ Title: _____ Scheduled hours per week:_____					Yes / No / N/A	Yes / No / N/A	Yes / No / N/A	_____ Certification/registration # _____ Lic/Cert/Reg organization	_____ Effective date _____ Expiration date

DHCS 5050 (7/13)

*** APPROVED CERTIFYING ORGANIZATIONS**

1. Board for Certification of Addiction Specialists (CAARR)
2. California Certification Board of Alcohol and Drug Counselors (CAADAC)
3. California Association of Alcohol/Drug Educators (CAADE)
4. Breining Institute
5. California Association of Drinking Driver Treatment Programs (CADDTP)
6. American Academy of Health Care Providers in the Addictive Disorder (AAHCPAD)

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

Licensed professional means a physician licensed by the 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.

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

A-6 – WEEKLY ACTIVITIES SCHEDULE

WEEKLY SCHEDULE OF RECOVERY, TREATMENT, OR DETOXIFICATION SERVICES

(Include individual/group education sessions, recovery or treatment planning)

ARE DETOXIFICATION SERVICES PROVIDED AT THE FACILITY (please check): ☐ **YES** ☐ **NO**

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
6-7 a.m.							
7-8 a.m.							
8-9 a.m.							
9-10 a.m.							
10-11 a.m.							
11 a.m.-12							
12-1 p.m.							
1-2 p.m.							
2-3 p.m.							
3-4 p.m.							
4-5 p.m.							
5-6 p.m.							
6-7 p.m.							
7-8 p.m.							

TOTAL HOURS PER WEEK OF INDIVIDUAL/GROUP/EDUCATION SESIONS, RECOVERY OR TREATMENT PLANNING, AND DETOXIFICATION SERVICES (IF PROVIDED):_____

Comments:

STATE OF CALIFORNIA – FORESTRY AND FIRE PROTECTION

FIRE SAFETY INSPECTION REQUEST

STD. 850 (REV. 4-2000)

See instructions on reverse.

AGENCY CONTACT'S NAME	TELEPHONE NUMBER	REQUEST DATE	PROGRAM
EVALUATOR'S NAME	**REQUESTING AGENCY FACILITY NUMBER**		**REQUEST CODE**

LICENSING AGENCY NAME AND ADDRESS

CODES

1. ORIGINAL A. FIRE CLEARANCE
2. RENEWAL B. LIFE SAFETY
3. CAPACITY CHANGE
4. OWNERSHIP CHANGE
5. ADDRESS CHANGE
6. NAME CHANGE
7. OTHER

AMBULATORY		NONAMBULATORY		BEDRIDDEN		TOTAL CAPACITY
CAPACITY	PREVIOUS CAPACITY	CAPACITY	PREVIOUS CAPACITY	CAPACITY	PREVIOUS CAPACITY	

FACILITY NAME		LICENSE CATEGORY
STREET ADDRESS *(Actual Location)*		NUMBER OF BUILDINGS
CITY		RESTRAINT
FACILITY CONTACT PERSON'S NAME	FACILITY CONTACT PERSON'S TELEPHONE NUMBER	HOURS

SPECIAL CONDITIONS

TO BE COMPLETED BY INSPECTING AUTHORITY

CLEARANCE /DENIAL CODE

FIRE AUTHORITY NAME AND ADDRESS

CODES

1. FIRE CLEARANCE GRANTED
2. FIRE CLEARANCE DENIED
   - A. EXITS
   - B. CONSTRUCTION
   - C. FIRE ALARM
   - D. SPRINKLERS
   - E. HOUSEKEEPING
   - F. SPECIAL HAZARD
   - G. OTHER

INSPECTOR'S NAME *(Typed or Printed)*	TELEPHONE NUMBER	CFIRS NUMBER	OCCUPANCY CLASS

INSPECTION DATE	INSPECTOR'S SIGNATURE *(Typed or Printed)*

EXPLAIN DENIAL OR LIST SPECIAL CONDITIONS

STATE OF CALIFORNIA – FORESTRY AND FIRE PROTECTION

FIRE SAFETY INSPECTION REQUEST

STD. 850 (REV. 4-2000) (REVERSE)

INSTRUCTIONS

This form is designed for use with a window envelope

Licensing or Requesting Agencies--Complete the following 19 sections on this form before submitting it to the fire authority having jurisdiction.

1. **AGENCY CONTACT, 2. TELEPHONE NUMBER, 5. EVALUATOR.** Enter the name and telephone number of agency contact person.
3. **PROGRAM.** Licensing agency use.
4. **REQUEST DATE.** Enter date request was prepared.
6. **REQUESTING AGENCY FACILITY NUMBER.** This is the file number assigned by the licensing agency.
7. **REQUEST CODE.** Use the seven codes shown and insert the appropriate number in the box following "Request Code". If NAME CHANGE, please list previous name. Insert date of original request is other than an original.
8. **AGENCY NAME AND ADDRESS.** Enter the name and address of the licensing facility requesting the inspection.
9. **AMBULATORY--NONAMBULATORY--BEDRIDDEN.**

   Capacity: Insert in the appropriate section, the capacity of licensed ambulatory or nonambulatory occupants covered by this request.

   Previous Capacity: If request is for renewal or capacity change, insert capacity of previous clearance.

   Total Capacity: Show total licensed capacity. If the facility is intended to house part ambulatory, nonambulatory, and part bedridden, show the total of the three types of occupants.

10. **FACILITY NAME.** Insert the name of the facility as it will appear on the license. List identifying sub name if known (i.e., Hacienda Corp/Medina Lodge).
11. **LICENSE CATEGORY.** Insert the category of license being sought as it will appear on the license certificate.
12. **ADDRESS.** Insert street address and city only. A post office box is not acceptable as only location.
13. **NUMBER OF BUILDINGS.** Insert the total number of buildings to be used for housing of the occupants covered by the license.
14. **RESTRAINT.** Indicate if physical restraint (locked in a room or the building) is to be used in the housing of the occupants.
15. **FACILITY CONTACT PERSON--TELEPHONE NUMBER.** Indicate the name and telephone number of the responsible individual at the facility to be contacted by the fire authority.
16. **HOURS.** Indicate the number of hours the occupants are housed at the facility (less than 24 or 24+).
17. **SPECIAL CONDITIONS.** Indicate any conditions unique to this request. As an example, if the inspection request is for one building in a multi-building facility.

FIRE AUTHORITY CONDUCTING THE INSPECTION--COMPLETE THE FOLLOWING:

18. **FIRE AUTHORITY, NAME AND ADDRESS.** Insert the name and address of the fire authority where the facility is located.
19. **CLEARANCE/DENIAL CODE.** Use the two codes: 1 for clearance granted, and 2 for clearance denied. If denied, also include the appropriate letter code. As an example, Denial based upon exiting would be coded 2A.
20. **INSPECTOR'S NAME.** Print the initial of the inspector's first name and full last name; insert the telephone number where the inspector may be contacted.
21. **CFIRS I.D. NUMBER.** Insert the fire department's number assigned by California Fire Incident Reporting System.
22. **OCCUPANCY CLASSIFICATION.** Use California Building Code occupancy classifications and insert the occupancy determined by the inspector.
23. **INSPECTION DATE.** Enter the actual date of the inspection.
24. **INSPECTOR'S SIGNATURE.** To be signed by the inspector conducting the inspection.
25. **EXPLAIN DENIALOR SPECIAL CONDITIONS.** If clearance code #2 is used, briefly explain reason. This space is also to be used to specify any additional limitations placed by the fire authority, such as the use of certain floors or sleeping rooms approved for nonambulatory clients.