

Chemical Dependency Recovery Hospital (CDRH) Report of Change Application Checklist for Change of Bed

The following is a list of application forms and supporting documents required for a complete application packet. Failure to include each of the forms and documents will delay processing.

Check all that apply: **Add/Reactivate** **Suspend/Remove**

CHECKLIST AND INSTRUCTIONS - *Please submit your documents in this order.*

REQUIRED DOCUMENTS TO ADD/REACTIVATE A BED(S)

<i>Use this space to check if included</i>	Forms and supporting documents	Additional Instructions (Each form listed also has instructions on the form)
	Cover Letter	<p>COVER LETTER</p> <p>Letter on company letterhead with the following information:</p> <ul style="list-style-type: none"> • License number • Facility name and ID number (if known) • Brief description of request • Requested bed count • Contact information (name, title, phone number, and e-mail address) • Emergency Contact Information (name, email, alternate email, phone, fax, and phone number that will receive text messages). The Department will use this information to contact the provider in the event of an emergency using the California Health Alert Network (CAHAN). All information provided must allow CAHAN to contact the provider on a 24/7/365 basis for distribution of health alerts. For additional information: CAHAN (https://www.calhospitalprepare.org/cahan) • Signature

<i>Use this space to check if included</i>	Forms and supporting documents	Additional Instructions (Each form listed also has instructions on the form)
	HS 200	<p>LICENSURE & CERTIFICATION APPLICATION [Title 22 California Code of Regulations (CCR) section 79101(b)(2)]</p> <p>Tips</p> <ul style="list-style-type: none"> • Page 2, section B, item 6 — An organization must own 100 percent of the licensee to be considered a parent company. This parent company will have its own Employer Identification Number (EIN) • Page 3, section C, item 7 — When listing the names of individuals with direct or indirect ownership of the facility in section C, provide the EIN (do not enter a Social Security number in this field)
	CDPH 609	<p>BED OR SERVICE REQUEST</p> <p>Top of page:</p> <ul style="list-style-type: none"> • Under the “Existing Beds” category: <ul style="list-style-type: none"> ○ Include the bed count next to the applicable bed type • Under the "Requested Beds" category: <ul style="list-style-type: none"> ○ Include the new total bed count(s) ○ The "Approved Capacity" field should be left blank
	CDPH 709	<p>CLIENT ACCOMMODATION ANALYSIS</p> <ul style="list-style-type: none"> • Complete this form in its entirety • Must be signed
	Supporting Documents	<p>FLOOR PLAN</p> <p>Submit a floor plan that describes the requested change including a schematic of the room(s) on CDPH 709</p>

<i>Use this space to check if included</i>	Forms and supporting documents	Additional Instructions (Each form listed also has instructions on the form)
	STD 850	<p>FIRE SAFETY INSPECTION REQUEST [22 CCR section 79105]</p> <p>The STD 850 form must be submitted or a similar form from the fire authority that contains equivalent information as the STD 850 form. The OSHPD Fire Life & Safety (FLS) Inspection approval does not replace this form</p>

REQUIRED DOCUMENTS TO SUSPEND/ REMOVE A BED(S)

<i>Use this space to check if included</i>	Forms and supporting documents	Additional Instructions (Each form listed also has instructions on the form)
	Cover Letter	<p>COVER LETTER [22 CCR section 79101(c)]</p> <p>Letter on company letterhead with the following information:</p> <ul style="list-style-type: none"> • License number • Facility name and ID number (if known) • Brief description of request • Requested bed type and bed count • Reason for suspension • Requested dates of suspension must be one year or less (e.g., 03/08/19-03/07/20) • Ability to reactivate beds within 24-hours • Contact information (name, title, phone number, and e-mail address) • Emergency Contact Information (name, email, alternate email, phone, fax, and phone number that will receive text messages). The Department will use this information to contact the provider in the event of an emergency using the California Health Alert Network (CAHAN). All information provided must allow CAHAN to contact the provider on a 24/7/365 basis for distribution of health alerts. For additional information: CAHAN (https://www.calhospitalprepare.org/cahan) • Signature