APPLICATION FOR SUPPLEMENTAL SERVICES APPROVAL

Reply to:

Hospital Name

Address **City** **County** **Zip Code** **Telephone Number**

Total Licensed Bed Capacity: _____

Check the services which the hospital provides, list the number of beds where requested, and provide the additional information requested on subsequent pages. Re-application for service approval is not necessary for services which have received department approval since July 1975.

	Check Services Provided	Name of Service	Number of Beds
CDPH 241	_____	CARDIOVASCULAR SURGERY SERVICE	_____
CDPH 242	_____	*CHRONIC DIALYSIS SERVICE	_____
CDPH 243	_____	DENTAL SERVICE	_____
CDPH 245	_____	NUCLEAR MEDICINE SERVICE	_____
CDPH 246	_____	OUTPATIENT SERVICE	_____
CDPH 247	_____	PEDIATRIC SERVICE (NOTE: Include cribs, bassinets & beds)	_____
CDPH 248	_____	PERINATAL UNIT (NOTE: List adult beds only)	_____
CDPH 249	_____	PODIATRIC SERVICE	_____
CDPH 250	_____	PSYCHIATRIC UNIT	_____
CDPH 251	_____	RADIATION THERAPY SERVICE	_____
CDPH 252	_____	*RENAL TRANSPLANT CENTER	_____
CDPH 253	_____	RESPIRATORY CARE SERVICE	_____
CDPH 255	_____	SOCIAL SERVICE	_____
EMERGENCY MEDICAL SERVICES:			
CDPH 256	_____	STANDBY EMS, PHYSICIAN ON CALL	_____
CDPH 257	_____	BASIC EMS, PHYSICIAN ON DUTY	_____

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	Check Services Provided	Name of Service	Number of Beds
CDPH 258	_____	COMPREHENSIVE EMS	_____
***REHABILITATION SERVICES:**			
CDPH 259	_____	REHABILITATION CENTER	_____
CDPH 260	_____	OCCUPATIONAL THERAPY SERVICE	_____
CDPH 261	_____	PHYSICAL THERAPY SERVICE	_____
CDPH 262	_____	SPEECH PATHOLOGY AND/OR AUDIOLOGY SERVICE	_____
SPECIAL CARE UNITS:			
CDPH 263	_____	ACUTE RESPIRATORY CARE SERVICE	_____
CDPH 264	_____	BURN CENTER	_____
CDPH 265	_____	CORONARY CARE SERVICE	_____
CDPH 266	_____	INTENSIVE CARE NEWBORN NURSERY SERVICE	_____
CDPH 267	_____	INTENSIVE CARE SERVICE	_____

TOTAL SUPPLEMENTAL SERVICE BEDS _____

TOTAL REMAINING MEDICAL SURGICAL BEDS _____

TOTAL BEDS _____

_____ _____

Administrator's Signature Date

Name and phone number of person to be contacted if further information is needed:

_____

_____

*If the hospital also wishes certification of these services in the Medi-Cal Program and has not already done so, please make separate application. Medi-Cal certification for rehabilitation services applies to **Out-Patient** services only. Medi-Cal certification for dialysis applies to chronic dialysis only.