

REQUEST FOR DESIGNATION AS A RURAL ALTERNATIVE ADULT DAY HEALTH CARE (ADHC) CENTER

*If form is completed as part of a licensing application, submit with the application.
If form is completed separately, forward to County ADHC Planning Council Chair. Planning Council
will make determination and forward to ADHC Section, Department of Aging, for final determination.*

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|---|-------------|-----------------|
| APPLICANT NAME | CENTER NAME | CONTACT PERSON |
| ADDRESS | ADDRESS | CONTACT PHONE # |
| Service Area Number as specified by County ADHC Plan. | | |

DESCRIPTION OF RURAL SERVICE AREA

Does the service area have 200 or less estimated ADHC eligible persons? Yes No
If no, STOP HERE, request will be denied.

IF YES, COMPLETE THE FOLLOWING

"Rural Service Area" means any identified service area in an approved County ADHC Plan with 200 or less estimated ADHC eligible population and with two or more of the following characteristics. Please describe the rural service area below.

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|---|------------------------------|-----------------------------|
| What is the number of eligible person? | | Source of Information _____ |
| Is the service area more than one-half hour driving time from an urban area of 50,000 population or more? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If yes, what is the closest urban area of 50,000 population or more? | | |
| Is there another ADHC center within one-half hour direct driving time of the service area? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If yes, name of center: _____ | | |
| Are there geographic or climatic barriers (including, but not limited to snow , fog, ice, mountains, inadequate highways, or weather) in the service area which makes transportation to another ADHC impractical? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If yes, describe. | | |
| Is the service area located in a county with an overall population density of less than 100 persons per square mile? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If yes, specify the population density. | | Source of Information _____ |
| Does a shortage of qualified professionals exist in the county or service area? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

If yes, Describe this shortage with specific information on disciplines and number of professionals involved.

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|------------------------------------|------|
| SIGNATURE OF BOARD CHAIR/PRESIDENT | DATE |
| ➤ | |

| FOR COUNCIL USE ONLY | FOR DEPARTMENT USE ONLY |
|---|--|
| Approved: Yes <input type="checkbox"/> No <input type="checkbox"/> | Approved: Yes <input type="checkbox"/> No <input type="checkbox"/> DATE |
| CHAIR, ADHC PLANNING COUNCIL | CHIEF, MEDI-CAL SERVICES BRANCH |
| ➤ | ➤ |
| If denied, reason: | If denied, reason: |