

**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 the services which the hospital provides, list the number of beds or stations where requested, and provide the additional information requested on subsequent pages.

	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.