TRANSITIONAL HOUSING PROGRAM PLUS FOSTER CARE (THP+FC)

Non-Minor Dependent Rate Application

☐ NEW PROVIDER
☐ NEW PROGRAM
☐ BIENNIAL

1. CORPORATION NAME	5. CORPORATION'S FISCAL YEAR END (6/30, 12/31, etc.) ____ / ____ MONTH DAY
2. PROGRAM NAME (IF DIFFERENT FROM CORPORATION NAME)	6. CORPORATE IDENTIFICATION NUMBER
3. CORPORATION MAILING ADDRESS	7. EMPLOYER IDENTIFICATION NUMBER (EIN)
4. CITY, STATE, ZIP CODE	8. BOARD PRESIDENT'S NAME AND TELEPHONE NUMBER
9. EXECUTIVE DIRECTOR'S NAME (LAST NAME, FIRST NAME)	10. CONTACT PERSON'S NAME (LAST NAME, FIRST NAME)
9a. TELEPHONE NUMBER	10a. TELEPHONE NUMBER
9b. E-MAIL ADDRESS	10b. E-MAIL ADDRESS
9c. FAX NUMBER	10c. FAX NUMBER

11. IDENTIFY OTHER AFDC-FC PROGRAMS YOU OPERATE:

12. CHECK THE TYPE OF THP PLUS FOSTER CARE PROGRAM MODEL: (CHECK ALL THAT APPLY)

☐ REMOTE SITE ☐ STAFFED SITE ☐ HOST FAMILY

13. ☐ YES ☐ NO ☐ N/A HAS THERE BEEN ANY CHANGES TO YOUR PROGRAM STATEMENT? IF YES, SUBMIT CCL-APPROVED AMENDMENTS.

14. LIST COUNTY PLACEMENT AGENCIES USING THIS PROGRAM. LIST PRIMARY USER FIRST AND OTHERS IN DESCENDING ORDER OF USAGE:

I understand that the information contained in this document is correct to the best of my knowledge and that submission of false or misleading information may be prosecuted as a crime.

SIGNATURE OF PERSON PREPARING RATE REQUEST	TITLE	DATE
SIGNATURE OF EXECUTIVE DIRECTOR	TITLE	DATE

CDSS USE ONLY

PROGRAM IDENTIFIER	POSTMARK DATE	DATE RECEIVED	DATE ASSIGNED	COUNTY	CCL DIST.	ANALYST
___ . ___ . ___	___ - ___ - ___	___ - ___ - ___	___ - ___ - ___			

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PROGRAM NUMBER
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15. LIST CASE MANAGER NAMES AND DEGREES:

NO.	NAME	CASE MANAGER DEGREE	LICENSED
1.			☐ Yes ☐ No
2.			☐ Yes ☐ No
3.			☐ Yes ☐ No
4.			☐ Yes ☐ No
5.			☐ Yes ☐ No
6.			☐ Yes ☐ No
7.			☐ Yes ☐ No
8.			☐ Yes ☐ No
9.			☐ Yes ☐ No
10.			☐ Yes ☐ No

TRANSITIONAL HOUSING PROGRAM PLUS FOSTER CARE (THP+FC)
APPLICATION INSTRUCTIONS

PURPOSE

The THP Plus Foster Care application and instructions serve two purposes: 1) to gather identifying information about the provider, and 2) obtain certification as to the accuracy of the rate request

INSTRUCTIONS FOR COMPLETION

Each provider should complete one form for each program for which a rate is requested.

Line 1.	**Corporation Name:**	Enter the corporation's name listed on the THP Plus Foster Care license.
Line 2.	**Program Name:**	If the program name is different from the corporate name, enter it here.
Line 3,4.	**Corporate Mailing Address:**	Enter the mailing address (street or P.O.Box, city, state, zipcode) where mail is received.
Line 5.	**Corporation's Fiscal Year End:**	Enter the month and day that your corporation's fiscal year ends (e.g. 6/30, 12/31).
Line 6.	**Corporate Identification Number:**	Enter the corporation's identification number issued by the Secretary of State.
Line 7.	**Employer Identification Number:**	Enter the corporation's Employer Identification Number (EIN) which is a nine-digit number that IRS assigns in the following format: XX-XXXXXXX
Line 8.	**Board President's Name and telephone number**	Enter the name of the President of the Board of Directors for your corporation and his/her telephone number.
Line 9., 9a,b,c	**Executive Director's Information:**	Enter the Executive Director's Name, telephone number, e-mail address and fax number.
Line 10., 10a,b,c	**Contact Person's Information:**	Enter the name of the person who prepared the rate request and to whom questions may be directed. Enter his/her telehpone number, e-mail address, and fax number.
Line 11.	**Other AFDC-FC Programs:**	Enter other AFDC-FC programs you operate (e.g. group home, foster family agency)
LIne 12.	**Type of THP Plus Foster Care program model:**	Check the type of THP Plus Foster Care program model. *Remote Site* are apartments or rooms that are located in areas throughout a city and rented for a THP Plus Foster Care participant. *Staffed Site* are apartments or rooms that are located in the same building/site as other apartments/rooms rented for THP Plus Foster Care participants in which one or more adult employees of the THP Plus FC provider reside and provide supervision. *Host Family Model* is where participants live with a caring adult who has a commitment to establising a permanent connection.
Line 13.	**Program Statement Changes?:**	Check "yes", "no", or "not applicable" to the question "Has there been any changes to your program statement?" If checking "yes", submit CCL-approved amendments. New Providers will check "N/A."
Line 14.	**County Placing Agencies:**	List the county placing agencies using this program. (e.g. Fresno County Human Services System, Orange County Probation Department).
Line 15.	**Case Manager:**	List the name and type of degree of your case manager. Check "yes" or "no" if they are licensed.

After the rate request package has been prepared and examined, the person preparing the report and the Executive Director must sign on the lines provided. Enter their titles and date signed. Forward the original of this form to the Department with the completed rate request package.