

**NOTICE OF FORM CHANGE NO.**

DATE

**TO:**County Welfare Director  
Supply Clerk / Forms Coordinator**FROM:**Forms Management Unit  
(916) 657-1907 Community Care Licensing District Offices District Attorney Private and Public Adoption Agencies Other

Listed below is information regarding a form change. Only applicable information is shown.

This notice updates your Department of Social Services County Forms Catalog.

## FORM NUMBER AND TITLE

ORDER UNIT	<input type="checkbox"/> Free <input type="checkbox"/> Sold	ESTIMATED PRICE	INITIAL SUPPLY SENT <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> New <input type="checkbox"/> Revised	DATE OF FORM	REPLACES	<input type="checkbox"/> Obsolete
REQUIRED FORM- <input type="checkbox"/> No Change Permitted	REQUIRED FORM- <input type="checkbox"/> Substitute Permitted With Prior DSS Approval	<input type="checkbox"/> Recommended Form	
UNLESS OTHERWISE SPECIFIED STOCK MAINTAINED AT: <b>Department of Social Services Warehouse</b> <b>P.O. Box 980788</b> <b>West Sacramento, CA 95798-0788</b>		<input type="checkbox"/> OTHER:	

**FORMS DISPOSITION AND SPECIAL INSTRUCTIONS**

## DISPOSITION OF OLD SUPPLY

 Use until exhausted Destroy

## USE NEW FORM

 When supply available in DSS Warehouse Use new form effective \_\_\_\_\_

## USE FORM IN ACCORDANCE WITH

 All County Letter No. Other (specify)

## ADDITIONAL INFORMATION REGARDING FORM CHANGE

# STATEMENT OF FACTS SUMMARY SHEET

## A. To Be Completed by Regional Office/COB:

Legal Case #:	REGION: REG-___	
Appeal Rec'd:	Acknowledgment Letter Sent:	SOF Due:

## B. To Be Completed by D.O./County

FACILITY #:		CAPACITY:	OPERATING? YES / NO	FACILITY TYPE (Choose 1)	
Excluded Individual	Last, First MI		Phone ( )	400 AA 430 FFA 431FFAsub 433 CFFH	772 SRF 775 ADC
Address	#/Street/City		Zip	710 SFH 711 FFH	776 ADSC 810 FCCH
Cert Fam. Home			Phone ( )	730 GH 735 ARF	830 CCC-1 840 CCC-SA
Address	#/Street/City		Zip	736 RCFCI 740 RCFE	845 CCCIII 850 CCC
Licensee Name			Phone ( )	Telephone TSO	Attorney Name:
Address	#/Street/City		Zip	Date RM Approved	/ /
Facility Name			Phone ( )	Immediate Exclusion	Date Served: / /
Address			Zip	Attorney Consulted	Name:

Date First Licensed: / / # of other facilities: Attach additional summary sheets

VIOLATIONS (Choose all that pertain)				TYPE OF ACTION REQUESTED			
01	Physical Abuse	11	Food Service	01	Denied Application	15	NonImmed Exc - Admin
02	Sexual Abuse	12	False Statements	02	Telephone TSO	16	NonImmed Exc - Other
03	Other Persons Rights/Restraints	13	Medications	03	TSO	17	Denied Exemption Action
04	Unlicensed	14	Financial Abuse	04	Revocation	18	Admin Decert.
05	Fire Clearance	15	Level of Care	41	Expedited Revocation		
06	Crimes - no arrest	16	Qualifications	05	Inj/TRO		
61	Crimes-Conv Exemp Denied	17	Financial Issues	06	Attorney Review		
62	Crimes-Non Exemptible	18	Questionable Death	08	Revoke Prob		
63	Crimes-Arrest Only	19	Other	09	FFA Certified Family Action		
07	Physical Plant	21	Ritualistic Abuse	11	Immed. Exc-Employee		
08	Record Keeping	22	Physical Punishment	12	Immed. Exc-Administration		
09	License/Cap.	23	CAIC Match	13	Immed. Exc-Other		
10	Neglect/Lack of Sup	24	Conduct Inimical	14	NonImmed Exc-Employee		
		25	Failure To Pay Initial and/or Annual Fees				

**FOR STATE CASES ONLY**

RIS INVOLVED? YES / NO	CASE #:	CASE #:	CASE #:
TSP SERVICES? YES / NO	AUDITOR SERVICES? YES / NO	AUDITOR NAME:	CIVIL PENALTIES? YES / NO

Referring D.O./County Name:

Evaluator Name:	Last, First	Phone: ( )
Supervisor Name:	Last, First	Phone: ( )
D.O./County Manager Signature:		Date:
Regional Manager Signature:		Date:

Comments:

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## C. CASE SUMMARY

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**D. SPECIAL ISSUES/PERTINENT INFORMATION**

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**E. INFORMAL CONFERENCE(S)/LICENSEE INTERVIEW**

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**F. WITNESSES**

1. NAME: \_\_\_\_\_ DRIVER LICENSE NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ NUMBER \_\_\_\_\_ STREET \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

WORK PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
( ) - ( ) -

RELATIONSHIP TO FACILITY: \_\_\_\_\_

2. NAME: \_\_\_\_\_ DRIVER LICENSE NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ NUMBER \_\_\_\_\_ STREET \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

WORK PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
( ) - ( ) -

RELATIONSHIP TO FACILITY: \_\_\_\_\_

3. NAME: \_\_\_\_\_ DRIVER LICENSE NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ NUMBER \_\_\_\_\_ STREET \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

WORK PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
( ) - ( ) -

RELATIONSHIP TO FACILITY: \_\_\_\_\_

4. NAME: \_\_\_\_\_ DRIVER LICENSE NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ NUMBER \_\_\_\_\_ STREET \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

WORK PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
( ) - ( ) -

RELATIONSHIP TO FACILITY: \_\_\_\_\_

5. NAME: \_\_\_\_\_ DRIVER LICENSE NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ NUMBER \_\_\_\_\_ STREET \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

WORK PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
( ) - ( ) -

RELATIONSHIP TO FACILITY: \_\_\_\_\_

6. NAME: \_\_\_\_\_ DRIVER LICENSE NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ NUMBER \_\_\_\_\_ STREET \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

WORK PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
( ) - ( ) -

RELATIONSHIP TO FACILITY: \_\_\_\_\_

**G. WITNESSES**

1. NAME:			DRIVER LICENSE NUMBER:		
ADDRESS:	NUMBER	STREET	CITY	ZIP	
WORK PHONE ( ) -	HOME PHONE ( ) -		DATE OF BIRTH: - -		
RELATIONSHIP TO FACILITY:					

2. NAME:			DRIVER LICENSE NUMBER:		
ADDRESS:	NUMBER	STREET	CITY	ZIP	
WORK PHONE ( ) -	HOME PHONE ( ) -		DATE OF BIRTH: - -		
RELATIONSHIP TO FACILITY:					

3. NAME:			DRIVER LICENSE NUMBER:		
ADDRESS:	NUMBER	STREET	CITY	ZIP	
WORK PHONE ( ) -	HOME PHONE ( ) -		DATE OF BIRTH: - -		
RELATIONSHIP TO FACILITY:					

4. NAME:			DRIVER LICENSE NUMBER:		
ADDRESS:	NUMBER	STREET	CITY	ZIP	
WORK PHONE ( ) -	HOME PHONE ( ) -		DATE OF BIRTH: - -		
RELATIONSHIP TO FACILITY:					

5. NAME:			DRIVER LICENSE NUMBER:		
ADDRESS:	NUMBER	STREET	CITY	ZIP	
WORK PHONE ( ) -	HOME PHONE ( ) -		DATE OF BIRTH: - -		
RELATIONSHIP TO FACILITY:					

6. NAME:			DRIVER LICENSE NUMBER:		
ADDRESS:	NUMBER	STREET	CITY	ZIP	
WORK PHONE ( ) -	HOME PHONE ( ) -		DATE OF BIRTH: - -		
RELATIONSHIP TO FACILITY:					

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## STATEMENT OF FACTS (SOF) SUMMARY SHEET INSTRUCTIONS

THE SOF SUMMARY SHEET PROVIDES BASIC INFORMATION TO BE ENTERED INTO THE LEGAL CASE TRACKING SYSTEM (LCTS). THE LCTS PROVIDES A MECHANISM FOR TRACKING LEGAL CASES THROUGHOUT THE PROCESS.

### TO BE COMPLETED BY REGIONAL OFFICE/COB:

**Legal Case Number:** Enter a 9 to 11 digit case number, which remains with case throughout legal action.

**REGION:** Enter appropriate region number - 1 = NRO; 2 = CRO, 3 = LARO; 4 = SRO

**Appeal Rec'd:** Enter date Regional Office/COB received appeal for: exclusion, de-certification, denial of application, or denial of exemption.

**Acknowledgment Letter Sent:** Enter date acknowledgment letter was sent to appellant.

**SOF Due:** Enter date SOF is due from D.O., CRCB, or County staff.

### TO BE COMPLETED BY D.O./CRCB/COUNTY:

**Facility number:** Enter facility number that D.O./County has assigned to facility.

**Capacity:** Enter capacity for which facility is licensed.

**Operating?:** Circle yes if facility is currently operating. Circle no if facility is not currently operating.

**Facility type:** Check appropriate facility type.

**Excluded Individual:** Enter last name/first name, address, and phone number of excluded individual.

**FFA Certified Family Home:** Enter the name, address, and phone number of the Certified Family Home (last name/first name) when an FFA decertification action is being taken.

**Licensee Name:** Enter licensee's last name/first name, (or corporate name as shown on license), mailing address, and phone number.

**Facility Name:** Enter facility's name (**as shown on license**), address, and phone number.

**Telephone TSO:** Enter assigned attorney's name and date approved by Regional Manager.

**Immediate Exclusion:** Enter date letter was sent to individual and the name of attorney that was consulted.

**Date first licensed:** Enter date the first license was issued.

**# of other facilities:** If licensee operates more than one facility, enter the number of additional facilities and attach an additional summary sheet and LIS profile for each facility. Enter "0" if there are no other facilities.

### VIOLATIONS:

**01 Physical Abuse:** Subject kicking, punching, slapping, hitting, hitting with an object, squeezing, pushing, with intent to do physical harm to victim.

**02 Sexual Abuse:** Inappropriate sexual activity between a client and non-client including rape, molestation, sodomy, voyeurism, pornography or sexual harassment.

**03 Other Personal Rights/Restraint:** Verbal or emotional abuse (excluding #22 Physical Punishment below), intimidation, interference with daily living such as eating or sleeping, locking clients in or out or using other restraints.

**04 Unlicensed:** Providing unlicensed care.

**05 Fire Clearance:** Operating a facility without an appropriate fire clearance.

**06 Crimes - no arrest:** Criminal conduct which did not result in an arrest or conviction.

**61 Crimes - Conv Exempt Denied:** Denial of exemption due to conviction.

**62 Crimes - Non Exemptible:** Denial of exemption due to non-exemptible crime.

**63 Crimes - Arrest Only:** Action taken as a result of the arrest only investigation.

**07 Physical Plant:** Unsafe or unsanitary buildings or grounds including unfenced pool, poor repair, heating, lighting, cooling, or lack of phone or signal system.

**08 Record Keeping:** Inadequate client or staff records including medical, staff qualifications, admission agreement, or other required records.

**09 License/Capacity:** Operating beyond terms of license including overcapacity. Excludes Level of care.

**10 Neglect/Lack of Supervisor:** Lack of adequate staff to provide aid with daily living including dressing, bathing, feeding, transportation, or medical needs. Failure to protect clients from harm.

**11 Food Service:** Failure to provide adequate food service including poor food, special diets, menu planning, etc.

**12 False Statements:** Providing false information on application, lying about facility incidents or submitting false reports about clients.

**13 Medications:** Mishandling of medications including poor storage, dispensing, labeling or record keeping.



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## SOF SUMMARY SHEET INSTRUCTIONS

(Continued)

- 14 Financial Abuse:** Misuse of client cash resources such as P&I, gifts, SSI/SSP checks or failure to protect client's personal property.
- 15 Level of Care:** Accepting/retaining clients requiring higher level of care than allowed in a non-medical facility or by the license.
- 16 Qualifications:** Persons providing services not meeting required qualifications.
- 17 Financial Issues:** Lack of resources to operate facility within licensing requirements or other non-client financial issues.
- 18 Questionable Death:** Client's death where it appears the facility could have been responsible or could have done more to prevent death.
- 19 Other:** All violations which do not fit into other categories.
- 21 Ritualistic Abuse:** Physical, emotional, psychological, sexual abuse in a ritualistic manner.
- 22 Physical Punishment:** Spanking on bottom, slapping on back of hand, etc. (not rising to the level of #01 Physical Abuse above).
- 23 CAIC Match:** Actions taken as a result of a CAIC match and subsequent substantiated violation.
- 24 Conduct Inimical:** Conduct which is inimical to the health, morals, welfare, or safety of either an individual in, or receiving services from, the facility or the people of the State of California.
- 25. Failure To Pay Initial and/or Annual Fees.**

### TYPE OF ACTION REQUESTED:

- 01 Denied Application:** Denial of an application. OK to include Attorney Review (06) if necessary. However, for any other actions taken against the same licensee (i.e., revoking additional licenses), a SOF Summary Sheet must be completed for each action.
- 02 Telephone TSO:** Imminent danger has been established and an attorney is assigned prior to receiving case. Note above reference to Telephone TSO. Must include Revocation (04).
- 03 TSO:** Imminent danger has been established. Must include Revocation (04); Ok to include Attorney Review (06).
- 04 Revocation:** License is to be revoked. OK to include Attorney Review (06). However, for any other actions taken against the same license (i.e., revoking additional licenses or excluding an employee, etc.), an additional SOF Summary Sheet must be completed for each action.
- 41 Expedited Revocation:** Use to request priority action on an accusation.
- 05 Injunction/TRO:** Request to legal to request the court to enjoin or temporarily restrain a facility from operating without a license.
- 06 Attorney Review:** Use when requesting attorney review. Most often is used in conjunction with another action type.
- 08 Revoke Probl.:** Probation is to be revoked. OK to include Attorney Review (06).
- 09 FFA Certified Family Home Action:** Use when de-certifying or requesting that a home not be certified.
- 11 Immediate Exclusion - Employee:** Use when an employee has been or will be immediately excluded. Must complete date served and attorney consulted. OK to include Attorney Review (06) when letter has not been served.
- 12 Immediate Exclusion - Administrator:** Use when an Administrator has been or will be immediately excluded. Must complete date served and attorney consulted. OK to include Attorney Review (06) when letter has not been served.
- 13 Immediate Exclusion - Other:** Use when a family member or non-client adult has been or will be immediately excluded. Must complete date served and attorney consulted. OK to include Attorney Review (06) when letter has not been served.
- 14 Non-Immediate Exclusion - Employee:** Use to request non-immediate exclusion of an employee. OK to include Attorney Review (06).
- 15 Non-Immediate Exclusion - Administrator:** Use to request non-immediate exclusion of an Administrator. OK to include Attorney Review (06).
- 16 Non-Immediate Exclusion - Other:** Use to request non-immediate exclusion of a licensee, board member, family member or non-client adult. Ok to include Attorney Review (06).
- 17 Denied Exemption Action:** To be used by CRCB when a criminal record exemption has been denied. Could be used in conjunction with immediate or non-immediate exclusion.
- 18 Administrator Decertification:** Not currently being used. Reserve for future use.

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## SOF SUMMARY SHEET INSTRUCTIONS

(Continued)

### FOR STATE CASES ONLY:

**RIS Involved:** Circle Yes or No. If yes, enter all investigation report numbers. If more than 3, include in comment section.

**TSP Services:** Circle Yes or No. If yes, include all documents in case.

**Audit Services:** Circle Yes or No. If yes, enter auditor's name, if known.

**Civil Penalties:** Circle Yes or No.

### FOR ALL CASES:

**Referring D.O. or County:** Enter D.O. or county name.

**Evaluator Name:** Enter Evaluator's last name/first name and phone number.

**Supervisor Name:** Enter Supervisor's last name/first name and phone number.

**D.O./CRCB/County Manager Signature:** D.O., CRCB or County Manager signs and dates document.

**Regional/COB Manager Signature:** Regional or COB Manager signs and dates document.

**Comments:** Enter any additional comments necessary.

### FACILITY TYPES:

**400 - AA** Adoption Agency

**430 - FFA** Foster Family Agency

**431 - FFAsub** Foster Family Agency Suboffice

**433 - CFFH** Certified Foster Family Home

**710 - SFH** Small Family Home

**711 - FFH** Foster Family Home

**730 - GH** Group Home

**735 - ARF** Adult Residential Facility

**736 - RCF-C1** Residential Care Facility for the Chronically Ill

**740 - RCFE** Residential Care Facility for the Elderly

**772 - SRF** Social Rehabilitation Facility

**775 - ADC** Adult Day Care

**776 - ADSC** Adult Day Support Center

**810 - FCCH** Family Child Care Home

**830 - CCC-I** Child Care Center - Infant

**840 - CCC-SA** Child Care Center - School Age

**845 - CCC-III** Child Care Center - Ill Children

**850 - CCC** Child Care Center