NOTICE OF FORM CHANGE NO. 05-040

DATE: 05/11/2005

TO:
County Welfare Director
Supply Clerk / Forms Coordinator

FROM:
Forms Management Unit
(916) 657-1907

☒ Community Care Licensing District Offices
☐ Private and Public Adoption Agencies
☐ District Attorney
☐ 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: LIC 9011A - County Licensing Administrative Action - Personnel Flagging Attachment

ORDER UNIT		ESTIMATED PRICE	INITIAL SUPPLY SENT
MASTER ONLY	☒ Free ☐ Sold		☐ Yes ☐ No
☐ New ☒ Revised	DATE OF FORM: 4/05	REPLACES: 10/00	☐ Obsolete

REQUIRED FORM-
☒ No Change Permitted
REQUIRED FORM-
☐ Substitute Permitted With Prior DSS Approval
☐ Recommended Form

UNLESS OTHERWISE SPECIFIED STOCK MAINTAINED AT:
Department of Social Services Warehouse
P.O. Box 980788
West Sacramento, CA 95798-0788

☐ 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 4/05

USE FORM IN ACCORDANCE WITH
☐ All County Letter No.
☐ Other (specify)

ADDITIONAL INFORMATION REGARDING FORM CHANGE
Attached is a Reproducible Copy

Check on the internet to see if forms are available at www.dss.cahwnet.gov

For camera-ready copies of English and Spanish forms, please call the Forms Management Unit (FMU) at (916) 657-1907, or by electronic mail at: fmudss@dss.ca.gov. Contact Language Services for other languages at (916) 445-6778 or by electronic mail at LTS@dss.ca.gov.

COUNTY LICENSING ADMINISTRATIVE ACTION PERSONNEL FLAGGING ATTACHMENT

Reference Section

Facility Type : _____
Facility Name : _____
Facility Address : _____
_____
Facility Number : _____
Other Facility Nos.: _____
Licensing Office : _____
Address : _____
_____
Contact Person : _____
Telephone No. : _____

Data Summary Section

Individual's Name: _____
AKA: _____
Date of Birth: _____
CII No.: _____
SS No.: _____
DL No.: _____
Height: _____ Color of Eyes: _____
Place of Birth: _____

Individual's relationship to facility (check one):

Licensee/Applicant ☐ Employee ☐ Resident (Non-Client) ☐ Relative ☐ Other ☐ _____

DSS LEGAL DIVISION USE ONLY

Legal Case No.: _____ Attorney: _____

License to operate a facility was revoked:
No ☐ Yes ☐ Effective Date: _____

Application to operate a facility was denied:
No ☐ Yes ☐ Effective Date: _____

Client contact, presence and/or employment in a facility was denied:
No ☐ Yes ☐ Effective Date: _____

Employee Address: _____

Probation: _____ Term: _____

Beginning Date.: _____ Ending Date: _____

Comments: _____

_____

Closure Codes: _____ Closure Date: _____

INSTRUCTIONS FOR COMPLETION:

County Licensing Office: Complete only the Reference and Data summary sections. Submit this form as part of the Statement of Facts package to the California State Department of Social Services.