



California Access to Recovery Effort

(CARE)

Form 12

ORGANIZATION INFORMATION CHANGE

Section 1 (Required for all changes)	
Organization Name	CARE Provider Number:
Reason for submitting form: <input type="checkbox"/> Organizational change <input type="checkbox"/> Address, phone or email change <input type="checkbox"/> Delete a service type <input type="checkbox"/> New or additional staff (assessors or family therapists)	
Section 2 (Required for organizational changes)	
<input type="checkbox"/> Organization Name Change: Old name: New name:	
<input type="checkbox"/> Change in Administrator or Director Old name: New name:	
<input type="checkbox"/> Organizational Status Change Old status: <input type="checkbox"/> sole proprietor <input type="checkbox"/> partnership <input type="checkbox"/> for-profit corp <input type="checkbox"/> nonprofit corp New status: <input type="checkbox"/> sole proprietor <input type="checkbox"/> partnership <input type="checkbox"/> for-profit corp <input type="checkbox"/> nonprofit corp	
Section 3 (Required for address, phone, or email changes)	
<input type="checkbox"/> Administrative Address Change Old address: _____ Old phone no: _____ New address: _____ New phone no: _____	
<input type="checkbox"/> Mailing Address Change Old address: _____ Old phone no: _____ New address: _____ New phone no: _____	
<input type="checkbox"/> Service Address Change (Provider Number: _____) Old address: _____ Old phone no: _____ New address: _____ New phone no: _____	
<input type="checkbox"/> Email change Old email address: _____ New email address: _____	
Section 4 (Required to delete a service type)	
Service Type Deleted (Provider number: _____) <input type="checkbox"/> Assessment <input type="checkbox"/> Outpatient treatment <input type="checkbox"/> Residential treatment <input type="checkbox"/> Recovery support	
Section 5 (Required for approval of new staff—assessors or family therapists)	
<input type="checkbox"/> New Assessor(s): Attach a list of each name, their license number and type of license, or certification number and the name of the certifying organization	
<input type="checkbox"/> New Family Therapist(s): Attach a list of each name, their license number and type of license	
Section 6 (required for all changes)	
Completed by: _____	Date: _____

Return to Department of Alcohol and Drug Programs (ADP), 1700 K Street, Sacramento, CA 95811 or fax to (916) 445-0846. For CARE services to be allowable, the changes must be approved by ADP in advance of program implementation.