



# APPLICATION FOR LICENSED CARE FACILITY

## SAN BERNARDINO COUNTY FIRE PROTECTION DISTRICT COMMUNITY SAFETY DIVISION

**San Bernardino Office**  
385 N. Arrowhead Ave., 1<sup>st</sup> Floor  
San Bernardino, CA 92415-0187  
Phone (909) 386-8400  
Fax (909) 387-3249  
Hours: 8:00 am – 5:00 pm M-F

**North Desert Office**  
15900 Smoke Tree St. Suite 131  
Hesperia, CA 92345-3222  
Phone (760) 995-8190  
Fax (760) 995-8205  
Hours: 8:00 am – 5:00 pm M-F

**East Valley Office**  
200 East Third Street  
San Bernardino, CA 92410  
Phone (909) 918-2201  
Fax (909) 381-0071  
Hours: 8:00 am – 5:00 pm M-Th

**South Desert Office**  
58928 Business Center Dr.  
Yucca Valley, CA 92284  
Phone (760) 995-8190  
Fax (760) 995-8205  
Hours: 9:00 am to 12:00 pm Wed

WEBSITE: [www.sbcfire.org](http://www.sbcfire.org)

### FACILITY INFORMATION

Licensed care uses may have specific zoning, building and Fire Code requirements. These requirements provide a minimum level of safety for this sensitive type of use. Licensed care providers are urged to contact the appropriate County or City agencies, including the Planning and Building and Safety offices to obtain all information needed to convert your property into a Licensed Care facility.

|               |  |                         |                 |                     |                |          |  |
|---------------|--|-------------------------|-----------------|---------------------|----------------|----------|--|
| FACILITY NAME |  | FACILITY ADDRESS        |                 | CITY / COMMUNITY    |                | ZIP CODE |  |
| FACILITY TYPE |  | PROPOSED TOTAL CAPACITY | # OF AMBULATORY | # OF NON-AMBULATORY | # OF BEDRIDDEN |          |  |

### CONTACT INFORMATION

|                      |  |                    |  |                        |  |       |          |
|----------------------|--|--------------------|--|------------------------|--|-------|----------|
| CONTACT NAME         |  | CONTACT ADDRESS    |  | CITY                   |  | STATE | ZIP CODE |
| CONTACT PHONE NUMBER |  | CONTACT FAX NUMBER |  | CONTACT E-MAIL ADDRESS |  |       |          |

- Prior to a required FIRE CLEARANCE inspection, a completed California Fire Safety Inspection Request (Form STD 850) must be received by this office from the agency. EXCEPTION: Applicants for facilities licensed by Alcohol & Drug programs may download the STD 850 form from [www.adp.ca.gov](http://www.adp.ca.gov) and submit the completed form directly to us. (NOTE: The STD 850 form is NOT required for a Pre-Application Inspection).
- Dimensional site plan showing all buildings on site, access driveways, setbacks from property lines, and distances between buildings. Include fenced areas and exits to the street.
- Floor plan showing all rooms, interior and exterior doors, windows, bedrooms, common use areas, attached garages, etc. Indicate the use of each room on the plan.
- Number and location of client bedrooms. Please specify how many clients are ambulatory vs. non-ambulatory and the location of their respective bedrooms. (Residential Care Facility only)
- Location of any ramps for all interior and exterior changes in elevation for all exit paths, including slope, handrails, guardrails. (Residential Care Facility only)
- Information and location of all smoke and carbon monoxide alarms, fire extinguishers, fire alarms, fire protection systems, water tanks and hydrants, as applicable.

### FIRE CLEARANCE AND ANNUAL FEES

| OCC. CLASS                     | PERMIT TYPE (Fees are for first habitable 25,000 square feet)        | Fee                            |
|--------------------------------|--|--------------------------------|
| <input type="checkbox"/> N/A   | Pre-License Clearance Inspection                                     | \$ 464.00                      |
| <input type="checkbox"/> N/A   | Initial Fire Clearance (Form 850 or Agency Request) (≤ 6clients)     | \$ 0.00                        |
| <input type="checkbox"/> N/A   | Initial Fire Clearance (Form 850 or Agency Request) (Over 6 clients) | \$ 204.00/hr x ____ = \$ _____ |
| <input type="checkbox"/> E     | Annual - Day Care Facility (≥7 Clients NOT requiring assistance)     | \$ 505.00                      |
| <input type="checkbox"/> I-2   | Annual - Hospitals/Nursing Homes/Detox. Facilities                   | \$ 505.00                      |
| <input type="checkbox"/> I-4   | Annual - Day Care Facilities (≥7 Clients requiring assistance)       | \$ 505.00                      |
| <input type="checkbox"/> R-2.1 | Annual – Residential Care Facility                                   | \$ 674.00                      |
| <input type="checkbox"/> R-3.1 | Annual – Residential Care Facility                                   | \$ 447.00                      |
| <input type="checkbox"/> R-4   | Annual - Residential Care Facility                                   | \$ 571.00                      |
| <input type="checkbox"/> N/A   | All Facilities – Each Additional Habitable 25,000 Square Feet        | \$ 166.00 x ____ = \$ _____    |
| <b>TOTAL FEE = \$</b>          |  | <input type="text"/>           |

|                             |                      |                      |
|-----------------------------|----------------------|----------------------|
| SUBMITTED BY (please print) | SIGNATURE            | DATE                 |
| <input type="text"/>        | <input type="text"/> | <input type="text"/> |

### FOR SBCFD USE ONLY

|                  |   |                      |                      |
|------------------|---|----------------------|----------------------|
| PAYMENT RECEIVED | PAYMENT TYPE  | DATE RECEIVED        | RECEIVED BY          |
| \$               | <input type="checkbox"/> CHECK <input type="checkbox"/> CASH <input type="checkbox"/> CREDIT CARD | <input type="text"/> | <input type="text"/> |