

Office of Statewide Health Planning and Development - Extension Request
Long-Term Care Integrated Disclosure & Medi-Cal Cost Report

Health Facility Name (D.B.A.):	Date:
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OSHPD Facility No:	Report Period Ending	Check One: ___ Initial ___ Additional
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Street Address:	City:	State:	Zip Code:
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Mailing Address: (If Different)	City:	State:	Zip Code:
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Number of Days Requested (Up to 30 per request – with a maximum of 90 days allowed):

Reason(s) Which Prevent(s) Completion by Deadline (Justification for Extension):

Actions Needed to Complete Report Within The Extended Time:

I hereby certify that I am authorized to request this extension:

Requestor's Name:	Signature:	Phone No:
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Mailing Address:	City	State	Zip Code:
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Mail to: Office of Statewide Health Planning & Development
Accounting & Reporting Systems Section, Attn: Patricia Burritt
818 K Street, Room 400, Sacramento, CA 95814

or **FAX to: (916) 323-7675**
or E-Mail as an attachment to Pburritt@OSHPD.state.ca.us

If you have questions call: Patricia Burritt at (916) 323-0875