Department of Health Care Services
Counselor & Medication Assisted
Treatment Section, MS 2603
PO Box 997413
Sacramento, CA 95899-7413

GUARANTOR AGREEMENT

INSTRUCTIONS FOR COMPLETION OF THE GUARANTOR AGREEMENT FORM DHCS 5020 (04/16)

Return completed form to the address designated in the header above.

DO NOT USE staples on this form or on any attachments.
DO NOT USE correction tape, white out, or highlighter pen or ink of a similar type on this form. If you must make corrections, please line through, date, and initial in ink.
DO NOT LEAVE any questions, boxes, lines, or fields blank. Enter N/A if not applicable to you.

PLEASE NOTE: Read all the instructions included on this form carefully and complete each item requested. For additional information, please review the California Code of Regulations (CCR), Title 9, Division 4, Chapter 4, Subchapter 1 commencing with Section 10000, which outlines the requirements and standards for Narcotic Treatment Programs.

SECTION A	Applicant Information

License Number – If the applicant currently holds an active Narcotic Treatment Program (NTP) license issued by the Department, enter the license number. If the applicant does not currently hold an NTP license issued by the Department, please enter "N/A".

National Provider Identifier (NPI) – Enter the 10 digit NPI number associated with the facility. If you need additional information or do not know the NPI number, please contact the National Plan and Provider Enumeration System at https://nppes.cms.hhs.gov/NPPES/Welcome.do

Name of Legal Entity – Enter the legal entity name.

PLEASE NOTE: Any business operation under a fictitious name shall submit a copy of the county filing setting forth that name.

Corporation – For a corporation, enter the name exactly as it is filed with the Secretary of State (SOS) and as it appears on the entity's Articles of Incorporation. If you need additional information, please contact the SOS at: http://kepler.sos.ca.gov/

Limited Liability Company (LLC) – For a LLC, enter the name exactly as it is filed with the SOS and as it appears on the entity's Articles of Organization. If you need additional information, please contact the SOS at: http://kepler.sos.ca.gov/

GUARANTOR AGREEMENT

Partnership/Limited Partnership – For a partnership or limited partnership, enter the name of the partnership exactly as it is filed with the SOS on the Statement of Partnership Authority or Certificate of Limited Partnership respectively. If you need additional information, please contact the SOS at: http://kepler.sos.ca.gov/

Sole Proprietor – For a sole proprietor, enter the full legal name of the sole proprietor.

Governmental Agency – Enter the name of the governmental agency.

Name of Narcotic Treatment Program – If different from legal entity name, enter the name of the facility.

Facility Street Address – Enter the exact address of the facility. A post office box or a commercial box is not acceptable. If applicable, enter the room/suite/unit number of the facility.

City – Enter the city of the facility.

County – Enter the county of the facility.

Zip Code – Enter the zip code of the facility.

An exact address can be verified at the United States Postal Service website:
https://tools.usps.com/go/ZipLookupAction_input

Mailing Address – If different from facility street address, enter the exact mailing address. If applicable, enter the room/suite/unit number of the mailing address.

City – Enter the city of the mailing address.

County – Enter the county of the mailing address.

Zip Code – Enter the zip code of the mailing address.

An exact address can be verified at the United States Postal Service website:
https://tools.usps.com/go/ZipLookupAction_input

SECTION B	Guarantor Selection

PLEASE NOTE: Pursuant to CCR, Title 9, §10095(b)(1)(A)-(B), programs offering treatment shall provide a guarantee that treatment will continue at the existing location for up to 90 days following receipt by the Department of the program's notice of intent to close the program or shall guarantee that treatment will be provided through the transfer of patients at another program.

GUARANTOR AGREEMENT

Check the appropriate box for the continued operation of the program as required by this section.

SECTION C Guarantor Information

Name of Guarantor – Enter the name of the individual or entity who will guarantee that treatment will continue at the existing location for up to 90 days following receipt by the Department of the program's notice of intent to close the program.

Mailing Address – Enter the mailing address of the Guarantor. If applicable, enter the room/suite/unit number of the Guarantor.

City – Enter the city of the mailing address of the Guarantor.

County – Enter the county of the mailing address of the Guarantor.

Zip Code – Enter the zip code of the mailing address of the Guarantor.

An exact address can be verified at the United States Postal Service website:
https://tools.usps.com/go/ZipLookupAction_input

Telephone Number – Enter the Guarantor's telephone number, including an extension if applicable.

Fax Number – Enter the Guarantor's fax number.

SECTION D Guarantor Program Information

License Number – Enter the license number of the NTP that will guarantee that treatment will be provided through the transfer of patients to the NTP location.

NPI – Enter the 10 digit NPI number associated with the facility. If you need additional information or do not know the NPI number, please contact the National Plan and Provider Enumeration System at https://nppes.cms.hhs.gov/NPPES/Welcome.do

Name of Legal Entity – Enter the legal entity name.

> **PLEASE NOTE:** Any business operation under a fictitious name shall submit a copy of the county filing setting forth that name.

GUARANTOR AGREEMENT

Corporation – For a corporation, enter the name exactly as it is filed with the SOS and as it appears on the entity's Articles of Incorporation. If you need additional information, please contact the SOS at: http://kepler.sos.ca.gov/

Limited Liability Company (LLC) – For a LLC, enter the name exactly as it is filed with the SOS and as it appears on the entity's Articles of Organization. If you need additional information, please contact the SOS at: http://kepler.sos.ca.gov/

Partnership/Limited Partnership – For a partnership or limited partnership, enter the name of the partnership exactly as it is filed with the SOS on the Statement of Partnership Authority or Certificate of Limited Partnership respectively. If you need additional information, please contact the SOS at: http://kepler.sos.ca.gov/

Sole Proprietor – For a sole proprietor, enter the full legal name of the sole proprietor.

Governmental Agency – Enter the name of the governmental agency.

Name of NTP – If different from legal entity name, enter the name of the NTP that will guarantee that treatment will be provided through the transfer of patients to the NTP location.

Facility Street Address – Enter the exact address of the facility. A post office box or commercial box is not acceptable. If applicable, enter the room/suite/unit number of the facility.

City – Enter the city of the facility.

County – Enter the county of the facility.

Zip Code – Enter the zip code of the facility.

An exact address can be verified at the United States Postal Service website:
https://tools.usps.com/go/ZipLookupAction_input

Mailing Address – If different from facility street address, enter the exact mailing address. If applicable, enter the room/suite/unit number of the mailing address.

City – Enter the city of the mailing address.

County – Enter the county of the mailing address.

Zip Code – Enter the zip code of the mailing address.

GUARANTOR AGREEMENT

An exact address can be verified at the United States Postal Service website:
https://tools.usps.com/go/ZipLookupAction_input

Telephone Number – Enter the contact person's telephone number, including an extension if applicable.

Fax Number – Enter the fax number of the NTP.

Section E	**Declaration**

Print Name – Enter the name of the program sponsor.

Title – *This field has been pre-filled by the Department to reflect that the form must be signed by the program sponsor.*

Signature – Program sponsor's signature.

Date – Enter the date that the application is signed by the program sponsor.

Print Name – Enter the name of the legal representative for the Guarantor.

Title – This field has been pre-filled by the Department to reflect that the form must be signed by the legal representative for the Guarantor.

Signature – Legal representative's signature.

Date – Enter the date that the application is signed by the legal representative for the Guarantor.

Department of Health Care Services
Counselor & Medication Assisted
Treatment Section, MS 2603
PO Box 997413
Sacramento, CA 95899-7413

GUARANTOR AGREEMENT

Section A	**Applicant Information**	
License Number (if applicable):	National Provider Identifier (NPI):	
Name of Legal Entity:		
Name of Narcotic Treatment Program (if different than name of legal entity):		
Facility Street Address (if applicable Room/Suite/Unit):		
City:	County:	Zip Code:
Mailing Address (if applicable Room/Suite/Unit)/(if different than above):		
City:	County:	Zip Code:

Section B — **Guarantor Selection** (Check one box)

Pursuant to CCR, Title 9, §10095 the Guarantor agrees as follows:

☐ Treatment will continue at the NTP location specified in Section A for up to 90 days following receipt by the Department of the program's notice of intent to close the program. CCR, Title 9, §10095(b)(1)(A) (complete Sections C & E)

☐ Treatment will be provided through the transfer of patients at another program. CCR, Title 9, §10095(b)(1)(B) (complete Sections D & E)

Section C	**Guarantor Information**	
Name of Guarantor:		
Mailing Address (if applicable Room/Suite/Unit):		
City:	County:	Zip Code:
Telephone Number:	Fax Number:	

Section D	**Guarantor Program Information**
License Number:	NPI:
Name of Legal Entity:	
Name of Narcotic Treatment Program:	

Department of Health Care Services
Counselor & Medication Assisted
Treatment Section, MS 2603
PO Box 997413
Sacramento, CA 95899-7413

GUARANTOR AGREEMENT

Section D (Continued)	**Guarantor Program Information**	
Facility Street Address (if applicable Room/Suite/Unit):		
City:	County:	Zip Code:
Mailing Address (if applicable Room/Suite/Unit)/(if different than facility street address):		
City:	County:	Zip Code:
Telephone Number:	Fax Number:	

Section E	**Declaration**
I declare under penalty of perjury under the laws of the State of California that the foregoing information and any attachment is true, accurate, and complete to the best of my knowledge and belief. By signing below, each party warrants that he/she has read this document and understands its content.	
I declare that I have the authority to legally bind the NTP.	
Print Name:	Title: Program Sponsor
Signature:	Date:
I declare that I have the authority to legally bind the guarantor.	
Print Name:	Title: Legal Representative
Signature:	Date:

PRIVACY STATEMENT

PRIVACY STATEMENT (Civil Code Section 1798 et seq.)

All information requested in this form is mandatory. This information is required by the Department of Health Care Services (Department) by the authority of Health and Safety Code, Section 11839.3 and California Code of Regulations, Title 9, Section 10055. The consequences of not supplying the mandatory information requested is that review of the application shall be terminated, which may result in lapse of licensure and/or imposition of fines. The Department may share or provide any of the information provided in or with this form to the California Health and Human Services Agency, the California State Controller's Office, the California Department of

GUARANTOR AGREEMENT

PRIVACY STATEMENT (Continued)
Justice, the California Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, the Federal Bureau of Investigation, the Internal Revenue Service, the U.S. Justice Department, the United States Drug Enforcement Administration, the United States Department of Health and Human Services, and the United States Substance Abuse and Mental Health Services Administration. For more information or access to records containing your personal information maintained by the Department, contact the Counselor & Medication Assisted Treatment Section Officer of the Day at (916) 322-6682.