State of California — Health and Human Services Agency

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

ORGANIZATIONAL RESPONSIBILITY

INSTRUCTIONS FOR COMPLETION OF THE ORGANIZATIONAL RESPONSIBILITY FORM DHCS 5031 (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	Type of Organization

Tax Status – Check the box which applies to your organization's business structure for tax purposes.

Section B	Organizational 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 a NTP license issued by the Department, please enter "N/A".

Federal Tax ID Number – Enter the federal tax identification number assigned to the organization.

Name of Organization – Enter the name of the organization.

> **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/

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Partnership/Limited Partnership – For a partnership or limited partnership, enter the name of the partnership exactly as it is filled 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.

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

Section C	Individual Information

Name – Enter the name of the partner, officer, director or 10 percent or greater shareholder of the organization.

Title – Enter the title of the partner, officer, director or 10 percent or greater shareholder of the organization.

Address – Enter the address of the partner, officer, director or 10 percent or greater shareholder of the organization.

Telephone Number – Enter the telephone number of the partner, officer, director or 10 percent or greater shareholder of the organization.

Percentage of Ownership – If applicable, for a for-profit organization enter the percentage of the organization owned by the partner, officer, director or 10 percent or greater shareholder.

Term Began – If applicable, for a non-profit organization enter the date that the term of the partner, officer, director or 10 percent or greater shareholder of the organization began.

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Term Expire – If applicable, for a non-profit organization enter the date that the term of the partner, officer, director or 10 percent or greater shareholder of the organization will expire.

Section D	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 form is signed by the program sponsor.

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Section A	**Type of Organization**

Tax Status:

- ☐ Corporation
- ☐ Nonprofit Corporation
- ☐ Limited Liability Company
- ☐ Partnership/Limited Partnership
- ☐ Sole Proprietor
- ☐ Governmental Agency

Section B	**Organization Information**	
License Number (if applicable):		Federal Tax ID Number:
Name of Organization:		
Facility Street Address (if applicable Room/Suite/Unit):		
City:	County:	Zip Code:

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Section C		**Individual Information**				
Name	Title	Address	Telephone Number	Percentage of Ownership	Term Began	Term Expire

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Section D	**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.	
Print Name:	Title: Program Sponsor
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 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.