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

PATIENT DEATH REPORT

INSTRUCTIONS FOR COMPLETION OF THE PATIENT DEATH REPORT FORM DHCS 5048 (04/16)

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 — Regulation Authority

PLEASE NOTE: Pursuant to CCR, Title 9, §10195, a program shall notify the Department of a patient's death within one (1) working day from the date the program is notified, if a patient of the program dies at the program site, or if ingestion of medication used in replacement narcotic therapy may have been the cause of the patient's death; and within ninety (90) calendar days from the date of death for all other patients.

Patient Death Report Form DHCS 5048 (04/16) should be mailed to:

Department of Health Care Services
Counselor & Medication Assisted Treatment Section, Unit 2 MS 2603
PO Box 997413
Sacramento, CA 95899-7413

Sent via email to: DHCSNTP@dhcs.ca.gov **Sent via Fax to:** (916) 440-5230

Please confirm receipt by calling: (916) 322-6682

SECTION B — Program Information

License Number – Enter the Narcotic Treatment Program (NTP) license number issued by the Department.

PATIENT DEATH REPORT

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/

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 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.

PATIENT DEATH REPORT

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

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

Fax Number – Enter the fax number of the facility.

SECTION C	Patient Information

Name – Enter the first and last name of the patient.

Patient Record Number – Enter the record number assigned to the patient by the NTP.

Gender – Enter the patient's gender.

Dose level – Enter the patient's dose level at the time of the patient's death.

Take-home Status – Enter the patient's take-home status at the time of the patient's death.

Date of Patient Death – Enter the date of the patient's death.

Age of Patient at Death – Enter the patient's age at the time of the patient's death.

Date Death Information was Received by Program – Enter the date that the program was notified of the patient's death.

Cause of Death – Enter the cause of the patient's death. Please be sure to include all relevant details known about the cause of the patient's death.

SECTION D	Declaration

Print Name – Enter the name of the authorized program representative.

Title – Enter the title of the authorized program representative.

Signature – Authorized program representative signature.

Date – Enter the date that the form is signed by the authorized program representative.

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Section A	**Regulation Authority**

Pursuant to CCR, Title 9, §10195, a program shall notify the Department of a patient's death within one (1) working day from the date the program is notified, if a patient of the program dies at the program site; or if ingestion of the medication used in replacement narcotic therapy may have been the cause of the patient's death; and within ninety (90) calendar days from the date of death for all other patients.

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Section B	**Program Information**	
License Number:		National Provider Identifier (NPI):
Name of Legal Entity:		
Name of Narcotic Treatment Program (If different than legal entity name):		
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 C	**Patient Information**
Name:	
Patient Record Number:	Gender:
Dose Level:	Take-home Status:
Date of Patient Death:	Age of Patient at Death:
Date Death Information was Received by Program:	

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Section C (Continued)	**Patient Information**
Cause of Death (describe the cause of death and all relevant details known about the death of the patient):	

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:
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), Substance Use Disorder Compliance Division, Counselor & Medication Assisted Treatment Section by the authority of Health and Safety Code, Section 11839.3 and California Code of Regulations, Title 9, Section 10195. The consequences of not supplying the mandatory information requested could include rejection of the document, a finding of deficiency, and the imposition of fines or other corrective action, including license revocation. 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.