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

INITIAL APPLICATION COVERSHEET

INSTRUCTIONS FOR COMPLETION OF THE INITIAL APPLICATION COVERSHEET FORM DHCS 5014 (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	Application Type

This section must be completed by all applicants.

Check the appropriate box(es) for the type of facility for which you are applying. If applying for a narcotic treatment program, please check the appropriate box(es) for services that will be provided.

Narcotic Treatment Program (NTP) – A licensed opioid addiction treatment program, whether inpatient or outpatient, which offers all of the following: evaluation, maintenance treatment and/or detoxification treatment, and other services in conjunction with replacement narcotic therapy.

> **Detoxification Treatment –** The treatment modality whereby replacement narcotic therapy is used in decreasing, medically determined dosage levels for a period not more than 21 days, to reduce or eliminate opioid addiction, while the patient is provided treatment services.
>
> **Maintenance Treatment –** The treatment modality whereby replacement narcotic therapy is used in sustained, stable, medically determined dosage levels for a period in excess of 21 days, to reduce or eliminate chronic opioid addiction, while the patient is provided a comprehensive range of treatment services.

Medication Unit (MU) – A facility established as part of, but geographically separate from an NTP, from which licensed private practitioners or community pharmacists dispense or administer an opioid agonist treatment medication and/or collect samples for drug testing or analysis.

INITIAL APPLICATION COVERSHEET

Office-Based Narcotic Treatment Network (OBNTN) – A network of providers, that are affiliated and associated with a primary NTP, offering one or more of the following: evaluation of medical, employment, alcohol, criminal, and psychological problems; screening for diseases that are disproportionately represented in the opioid-abusing population; counseling by addiction counselors that are evaluated through ongoing supervision; and professional medical, social work, and mental health services, on-site or by referral.

Section B	Applicant Information

This section must be completed by all applicants.

License Number – If the applicant currently holds an active 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/

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.

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

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

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.

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 assigned to the facility.

Name of Program Sponsor – Enter the person or organization responsible for the operation of the NTP and who assumes responsibility for all its employees, including any practitioners, agents, or other persons providing medical, rehabilitative, or counseling services at the program or any of its medication units and OBNTNs. The program sponsor need not be a licensed physician but shall employ a licensed physician for the position of medical director.

Name of Program Director – Enter the name of the person who has primary administrative responsibility for operation of the NTP.

INITIAL APPLICATION COVERSHEET

Name of Medical Director – Enter the name of the physician licensed to practice medicine in California who is responsible for medical services provided by the NTP.

Proposed Capacity – Enter the proposed patient capacity for the NTP.

Section C	MU/OBNTN

This section must be completed by MU and OBNTN applicants only.

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 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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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 MU or OBNTN – If different from legal entity name, enter the name of the facility or provider.

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

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/unite number of the facility.

City – Enter the city of the facility.

INITIAL APPLICATION COVERSHEET

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

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

Fax Number – Enter the fax number of the facility.

Name of Program Director – Enter the name of the person who has primary administrative responsibility for operation of the facility.

Section D	**Declaration**

This section must be completed by all applicants.

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.

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Section A	**Application Type**

☐ Narcotic Treatment Program (NTP) CCR, Title 9, §10030 (Complete Sections B & D)

☐ Detoxification Treatment ☐ Maintenance Treatment

☐ Medication Unit (MU) CCR, Title 9, §10020 (Complete Sections B, C, & D)

☐ Office-Based Narcotic Treatment Network (OBNTN) CCR, Title 9, §10021 (Complete Sections B, C, & D)

License Number (if applicable):

National Provider Identifier (NPI):

Name of Legal Entity:

Name of Narcotic Treatment Program (if different than name of legal entity):

Tax Status:

☐ Corporation

☐ Nonprofit Corporation

☐ Limited Liability Company

☐ Partnership/Limited Partnership

☐ Sole Proprietor

☐ Governmental Agency

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):

INITIAL APPLICATION COVERSHEET

City:	County:	Zip Code:
Section B (Continued) Applicant Information		
Telephone Number:	Fax Number:	
Name of Program Sponsor:		
Name of Program Director:		
Name of Medical Director:		
Proposed Capacity:		
Section C MU/OBNTN (Complete section C only if application is for MU or OBNTN)		
NPI:		
Name of Legal Entity:		
Name of MU or OBNTN (if different than name of legal entity):		
Tax Status: ☐ Corporation ☐ Nonprofit Corporation ☐ Limited Liability Company ☐ Partnership/Limited Partnership ☐ Sole Proprietor ☐ Governmental Agency		
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):		
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Name of Program Director:	
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. I hereby further declare that I will abide by all State and federal laws and regulations governing narcotic treatment programs. I declare that I am authorized to sign this application.	
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.