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

COUNTY CERTIFICATION

INSTRUCTIONS FOR COMPLETION OF THE COUNTY CERTIFICATION FORM DHCS 5027 (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	Program Information

This section must be completed by applicant.

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/

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

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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.

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	Type of Program Request

This section must be completed by applicant.

Check the appropriate box for the type of program request.

Initial Application – If requesting county certification for initial licensure, enter the maximum number of patients that will be served at the facility.

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License Renewal – Enter the Department approved licensed patient capacity for maintenance and detoxification services.

Relocation – A change of location of a facility or of any portion of the facility.

SECTION C	Regulation Authority

PLEASE NOTE: Pursuant to CCR, Title 9, §10040 a complete protocol must include a statement from the County Alcohol and Drug Program Administrator certifying that:

1) There is need for the NTP services described in the program's protocol in the community in which it is located, and
2) All local ordinances, fire regulations, and local planning agency requirements have been complied with.

Pursuant to CCR, Title 9, §10055(b)(2), the renewal of a NTP license requires the County Alcohol and Drug Program Administrators to submit to the Department a certification for continued services of the NTP and a recommendation for renewal of the license.

SECTION D	County Information

This section must be completed by the County Alcohol and Drug Program Administrator.

County – Enter the county.

Address – Enter the business address of the County Alcohol and Drug Program Administrator.

Telephone Number – Enter the telephone number of the County Alcohol and Drug Program Administrator.

Fax Number – Enter the fax number of the County Alcohol and Drug Program Administrator.

SECTION E	County Recommendation

This section must be completed by the County Alcohol and Drug Program Administrator.

Check the appropriate box for recommendation.
PLEASE NOTE: A county's recommendation for denial may not be based on funding. If the county does not recommend initial program licensure, renewal or relocation additional documentation to support the recommendation must be attached to the County Certification Form DHCS 5027 (04/16) such as:

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- Evidence of a substantial decline in medically qualified NTP patients,
- Program compliance issues, and/or
- Evidence showing other licensees within the area that can provide more efficient, cost effective NTP services.

SECTION F	Declaration

This section must be completed by the County Alcohol and Drug Program Administrator.

Print Name – Enter the name of the County Alcohol and Drug Program Administrator.

Title – *This field has been pre-filled by the Department to reflect that the form must be signed by the County Alcohol and Drug Program Administrator.*

Signature – County Alcohol and Drug Program Administrator's signature.

Date – Enter the date that this form is signed by the County Alcohol and Drug Program Administrator.

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Section A	**Program Information**	
License Number (if applicable):	National Provider Identifier (NPI):	
Name of Legal Entity:		
Name of Narcotic Treatment Program (if different from 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:

Section B **Type of Program Request**

Check one box:

- ☐ Initial Application – Proposed Capacity: _____
- ☐ License Renewal – Current Licensed Capacity: _____
- ☐ Relocation

Section C **Regulation Authority**

Pursuant to CCR, Title 9, § 10040 a complete protocol must include a statement from the County Alcohol and Drug Program Administrator certifying that:

1) There is need for the narcotic treatment program services described in the program's protocol in the community in which it is located, and
2) All local ordinances, fire regulations, and local planning agency requirements have been complied with.

Pursuant to CCR, Title 9, § 10055(b)(2), the renewal of a narcotic treatment program license requires the County Alcohol and Drug Program Administrator to submit to the Department a certification for continued treatment services of the narcotic treatment program and a recommendation for renewal of the license.

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Section D	**County Information**
County:	
Address:	
Telephone Number:	Fax Number:

Section E	**County Recommendation**

Check one box:

☐ County recommends the program's initial licensure, renewal or relocation.

☐ County **does not** recommend initial program licensure, renewal or relocation.
Documentation attached to support the county's recommendation.

Section F	**Declaration**

I declare that I am the County Alcohol and Drug Program Administrator responsible for issuing the county recommendation.

Print Name:	Title: County Alcohol and Drug Program Administrator
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.