INSTRUCTIONS FOR COMPLETION OF THE INTERIM TREATMENT PATIENT NOTIFICATION DHCS 4032

Submit completed form electronically to DHCSNTP@DHCS.CA.GOV or return completed form to the following address:

Department of Health Care Services
Counselor & Medication Assisted Treatment Section, MS2603
PO BOX 997413
Sacramento, CA 95899-7513

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 Behavioral Health Information Notice (BHIN) 25-008, and CCR, Title 9, Section 10023 (Attachment 1 to the BHIN), which outline the requirements and standards for interim treatment.

Interim Treatment – Means that on a temporary basis, not to exceed 180 days in any 12-month period, a patient may receive medication for opioid use disorder from a Narcotic Treatment Program (NTP) while awaiting access to comprehensive treatment. The NTP must be compliant with the requirements specified in California Code of Regulations, Title 9, Chapter 4, Section 10023:

- A NTP may not provide interim treatment unless it has prior approval from both SAMHSA and DHCS.
- A NTP may admit a person into interim treatment only if comprehensive treatment is unavailable to that person within a reasonable geographic distance within 14 days of the date on which they sought admission.
- The maximum amount of time a patient can remain in interim treatment is 180 days, and a NTP is not permitted to involuntarily discharge a patient from interim treatment except as provided by Section 10415 of Title 9. A NTP is responsible for transferring a patient into comprehensive treatment before the patient's 180-day period of interim treatment ends.
- A NTP must notify DHCS of a patient's admission into interim treatment by submitting this form within 30 days of admission.
- A NTP must notify DHCS of a patient's transfer into comprehensive treatment, or a patient's discharge from interim treatment, by submitting this form within 30 days of transfer or discharge.
- A NTP must notify DHCS that a patient will be in interim treatment for 120 days or more by submitting this form at least 60 days before the end of the patient's interim treatment period (no later than day 120). This notice must include the NTP's plan for transferring the patient into comprehensive treatment by the end of the patient's 180-day interim treatment period.

This form notifies DHCS of the following events: (1) when a patient is admitted into interim treatment, (2) when a patient is transferred from interim treatment into comprehensive treatment or discharged from interim treatment, and (3) when a patient will be in interim treatment for 120 days or more. A NTP must report events (1) and (2) within 30 days of the event, and event (3) at least 60 days before the end of a patient's 180-day interim treatment period (no later than day 120). The data collected ensures compliance with California Code of Regulations Title 9 and Department of Health Care Services (DHCS) policies.

Section A	NTP Information

This section must be completed.

License Number – Enter the NTP license number.

National Provider Identifier (NPI) – Enter the 10-digit NPI number associated with the NTP. 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#/.

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.

Facility Street Address – Enter the NTP's street address. A post office box or commercial box is not acceptable.

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 at:
https://tools.usps.com/go/ZipLookupAction_input

Mailing Address – If different from the facility's street address, enter the exact mailing address of the NTP. 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

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

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 or behavioral health 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.

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.

Section B	Patient Admissions into Interim Treatment

This section must be completed for each patient admitted into interim treatment.

Record information about patients admitted into interim treatment.

Section C	Patient Transfer into Comprehensive Treatment or Discharge

This section must be completed for each patient transferred from interim treatment into comprehensive treatment or discharged from interim treatment.

For patients transferred from interim treatment into comprehensive treatment or discharged from interim treatment, provide details including the patient's name, patient ID, receiving NTP's name and license number, transfer or discharge date, and reason for discharge (if applicable).

Section D	Patients Remaining in Interim Treatment 120 Days or More

This section must be completed for each patient who will remain in interim treatment for 120 days or more.

For patients who will remain in interim treatment for 120 days or more, record the patient's name, patient ID, end date of interim treatment, and provide the NTP's plan for transferring the patient to comprehensive treatment by the end of the 180-day period.

Section E	Declaration

This section must be completed.

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.

Section A	**NTP Information**	
License Number:	National Provider Identifier (NPI):	
Name of Legal Entity:		
Name of Narcotic Treatment Program (if different than name of legal entity):		
Facility Street Address:		
City:	County:	Zip Code:
Mailing Address (if applicable Room/Suite/Unit)/(if different than facility street address):		
City:	County:	Zip Code:
Business Telephone Number:		
Name of Program Sponsor:		
Name of Program Director:		
Name of Medical Director:		

INTERIM TREATMENT PATIENT NOTIFICATION

Section B	Admissions into Interim Treatment			
First Name	Last Name	Patient ID	Date of Admission	Last Day of 180 Day Period

INTERIM TREATMENT PATIENT NOTIFICATION

Section C	**Patient Transfer into Comprehensive Treatment or Patient Discharge from Interim Treatment**			
Patient Name (first and last name)	Patient ID	NTP Name (if transferred to another NTP) or Reason for Discharge	NTP License Number (if transferred to another NTP)	Date of Transfer or Discharge

INTERIM TREATMENT PATIENT NOTIFICATION

Attach additional sheets if necessary.

Section D	**Patients Remaining in Interim Treatment 120 Days or More**		
Patient Name (first and last name)	Patient ID	End Date of Interim Treatment (last day)	Plan for Transferring Patient into Comprehensive Treatment by Day 180

INTERIM TREATMENT PATIENT NOTIFICATION

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. 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 Notice on Collection

The purpose of this form is for licensed Narcotic Treatment Programs to notify the Department of Health Care Services (Department) of certain events related to patients in interim treatment. The information collected in this form is required by the Substance Use Disorder Compliance Division, Counselor & Medication Assisted Treatment Section, by the authority of Health and Safety Code, Section 11839.01 and BHIN 25-008. The personal information collected in this form is confidential and protected by the Information Practices Act (California Civil Code 1798, et seq.), Department policy, and state policy. All information requested in this form is mandatory. The consequence of not supplying the mandatory information is that a Narcotic Treatment Program's authorization to provide interim treatment may be impacted. The Department may share provided information with other state agencies to perform its constitutional or statutory duties where the use is compatible with a purpose for which the information was collected. The Department may also share information with local, state, or federal government entities if required by state or federal law. Please do not provide any personal information other than the information that is specifically requested in this form. In most cases, individuals have a right to access information about them that is in federal and state records. For more information or access to records containing your personal information maintained by the Department, contact the following:

Counselor & Medication Assisted Treatment Section
Officer of the Day
PO BOX 997413
Sacramento, CA 95899-7413
Tel: (916) 322-6682

The Department of Health Care Services' policies regarding personal information are available online in the Department's Notice of Privacy Practices (https://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/NoticeofPrivacyPractices.aspx) and the Privacy Policy Statement (https://www.dhcs.ca.gov/pages/privacy.aspx).