MOBILE NARCOTIC TREATMENT PROGRAM APPLICATION

INSTRUCTIONS FOR COMPLETION OF THE APPLICATION FOR MOBILE NTP LICENSE RENEWAL FORM DHCS 1831

Return completed form to the address designated in the header above or submit electronically to dhcsntp@dhcs.ca.gov.

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 Health & Safety Code Section 11839.6.1, Behavioral Health Information Notice (BHIN) 23-039, and 21 Code of Federal Regulations Parts 1300, 1301, and 1304, which outline the requirements and standards for mobile Narcotic Treatment Programs.

Mobile Narcotic Treatment Program (MNTP) - narcotic treatment program operating from a motor vehicle that serves as a mobile component and is operating under a primary narcotic treatment program, and engages in treatment of opioid addiction, including maintenance or detoxification treatment, at a location or locations remote from the primary narcotic treatment program, but within California.

Section A	Applicant Information

A mobile NTP must fill out sections A and B. If you have more than one mobile NTP attach additional Section B information.

This section must be completed by all applicants.

Application for Fiscal Year – Enter the fiscal year for which you are applying for renewal.

Original Operational Date – Enter the initial date the Department authorized the mobile NTP to begin operation.

License Number – Enter the NTP license number.

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

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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: https://bizfileonline.sos.ca.gov/search/business

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: https://bizfileonline.sos.ca.gov/search/business

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: https://bizfileonline.sos.ca.gov/search/business

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 Mobile NTP – If different from legal entity name, enter the name of the mobile NTP.

Facility Street Address – Enter the exact address of the location that the mobile NTP will be parked at the end of each day of operation. 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 facility street address, enter the exact mailing address of the mobile 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

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extension if applicable.

Name of Program Sponsor – Enter the person or organization responsible for the operation of the mobile 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. 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 mobile 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 mobile NTP.

Vehicle Identification Number – Enter the Vehicle Identification Number.

Vehicle License Plate Number – Enter the vehicle's license plate number.

Vehicle Year – Enter the vehicle year.

Vehicle Make – Enter the vehicle make.

Vehicle Model – Enter the vehicle model.

Insurance Company – Enter the name of the insurance company issuing insurance for the vehicle.

Policy Number – Enter the policy number of vehicle insurance policy.

Additional Services Provided at the Mobile NTP – In addition to dispensing medications for opioid use disorder treatment, a mobile NTP may provide any of the following additional services, if approved by the Department: (1) collecting samples for drug testing or analysis; (2) dispensing take-home medications; (3) admission; (4) medical evaluation; and/or (5) counseling. Check the box(es) for each additional service being requested for approval by the Department

Operating Hours (M-S) – Enter the mobile NTP hours of operation from Monday through Sunday.

Dispensing Hours (M-S) – Enter the mobile NTP hours of dispensing medication from Monday through Sunday.

This section must be completed by all applicants.

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Maintenance Treatment – Enter the total number of patients in methadone maintenance treatment on January 31st of the current year.

Maintenance Treatment – Enter the total number of patients in buprenorphine maintenance treatment on January 31st of the current year.

Detoxification Treatment – Enter the total number of patients in methadone detoxification treatment on January 31st of the current year.

Detoxification Treatment – Enter the total number of patients in buprenorphine detoxification treatment on January 31st of the current year.

Annual Maintenance Dosage Level and Take-Home Privileges for Methadone – Complete all fields based on program census data on January 31st of the current year for the annual maintenance dosage level and step level of patients in methadone treatment.

Annual Maintenance Dosage Level and Take-Home Privileges for Buprenorphine – Complete all fields based on program census data on January 31st of the current year for the annual maintenance dosage level and step level of patients in buprenorphine treatment.

Patients in Methadone Detoxification Treatment – Complete all fields based on program census data on January 31st of the current year for dosage levels of patients in methadone detoxification treatment.

Patients in Buprenorphine Detoxification Treatment – Complete all fields based on program census data on January 31st of the current year for dosage levels of patients in buprenorphine detoxification treatment.

<u>This section must be completed by all applicants.</u>

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	Applicant Information	
Application for Fiscal Year:	Original Operational Date:	
License Number:	National Provider Identifier (NPI):	
Name of Legal Entity:		
Name of Mobile 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:		
Vehicle Identification Number:		
Vehicle License Plate Number:		
Vehicle Year:	Vehicle Make:	Vehicle Model:
Insurance Company:	Policy Number:	

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Additional Services Provided at the Mobile NTP (check all that apply):

- ☐ Collecting Samples for Drug Testing or Analysis
- ☐ Dispensing Take-Home Medications
- ☐ Admission
- ☐ Medical Evaluation
- ☐ Counseling

Operating Hours						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Dispensing Hours						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Section B Annual Maintenance Report

Maintenance Treatment

Total Number of Patients in Methadone Maintenance Treatment as of January 31:

Total Number of Patients in Buprenorphine Maintenance Treatment as of January 31:

Detoxification Treatment

Total Number of Patients in Methadone Detoxification Treatment as of January 31:

Total Number of Patients in Buprenorphine Detoxification Treatment as of January 31:

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

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Section B (Continued)					**Annual Maintenance Report**											
Annual Maintenance Dosage Level and Take-Home Privileges																
Methadone																
Dosage	Num.		Step Level		Step Level		Step Level		Step Level		Step Level		Step Level		TOTAL	
(mg.)	Take-Homes		1		2		3		4		5		6			
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
0															0	0
1-19															0	0
20-39															0	0
40-59															0	0
60-79															0	0
80-99															0	0
100-119															0	0
120-139															0	0
140-159															0	0
160-179															0	0
180-199															0	0
200-219															0	0
220-239															0	0
240-259															0	0
260-279															0	0
280-300+															0	0
TOTAL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

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													GRAND TOTAL: 0

Section B (Continued)	**Annual Maintenance Dosage Level and Take-Home Privileges**															
Buprenorphine																
Dosage	Num.		Admission – 89 days		90 days – 180 days		181 days – 270 days		271 days – 365 days		1 Year – 2 Years		2+ Years		TOTAL	
(mg.)	Take-Homes		Step 1		Step 2		Step 3		Step 4		Step 5		Step 6			
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
0															0	0
2-4															0	0
6-8															0	0
10-12															0	0
14-16															0	0
18-20															0	0
22-24															0	0
26-28															0	0
30-32															0	0
34-36															0	0
38-40															0	0
42+															0	0
TOTALS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
													GRAND TOTAL: 0			

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Section B (Continued)			**Patients in Detoxification Treatment**		
Patients in Methadone Detoxification Treatment			**Patients in Buprenorphine Detoxification Treatment**		
Dosage	Num.		Dosage	Num.	
(mg.)	Take-Homes		(mg.)	Take-Homes	
	M	F		M	F
0			0		
1-19			2-4		
20-39			6-8		
40-59			10-12		
60-79			14-16		
80-99			18-20		
100-119			22-24		
120-139			26-28		
140-159			30-32		
160-179			34-36		
180-199			38-40		
200-219			42+		
220-239			**TOTALS**	0	0
240-259				**GRAND TOTAL:**0	
260-279					
280-300+					
TOTALS:	0	0			
	GRAND TOTAL:0				

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Section C	**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 to collect information for mobile narcotic treatment program applications. The information collected in this form 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 BHIN 23-039. 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 the application shall be deemed incomplete and, if not corrected, review of the application may be terminated. 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).