MOBILE NARCOTIC TREATMENT PROGRAM APPLICATION

INSTRUCTIONS FOR COMPLETION OF THE INITIAL APPLICATION FOR MOBILE NARCOTIC TREATMENT FORM DHCS 1830

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.

Each page of the protocol, including any index, shall be numbered beginning with page one. NTPs shall not break the numerical order of the protocol when changing headings.

The NTP shall submit completed copies of all forms developed for a mobile NTP to the Department with the protocol. If an electronic service will be utilized to maintain electronic health records, sample pages of the electronic system including intake documents, dosing sheet, and treatment plan shall be submitted with the protocol.

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

This section must be completed by all applicants.

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#/.

Name of Legal Entity – Enter the legal entity name.

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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: https://www.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: https://www.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: https://www.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 Mobile NTP – 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 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:
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.

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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 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.

SECTION B	Mobile Narcotic Treatment Program

Mobile NTP Street Address – Enter the exact street address of the parking location of the mobile NTP when not in use. A post office box or commercial box is not acceptable.

City – Enter the city of the registered location.

County – Enter the county of the registered location.

Zip Code – Enter the zip code of the registered location.

An exact address can be verified at the United States Postal Service website:
https://tools.usps.com/go/ZipLookupAction_input

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

Operating Hours (M-F) – Enter the operating hours of the mobile NTP for Monday – Friday.

Dispensing Hours (M-F) – Enter the dispensing hours of the mobile NTP for Monday – Friday.

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Weekend Operating Hours – Enter the weekend operating hours of the mobile NTP.

Weekend Dispensing Hours – Enter the weekend dispensing hours of the mobile NTP.

Approximate Number of Patients – Enter the approximate number of patients to be served by the mobile NTP.

Geographical Area to be served – Describe the geographical area(s) to be served by the mobile NTP. Include specific address(es), or description of, of the dispensing location(s).

Population of the Area to be served – Describe the population of the area(s) to be served by the mobile NTP.

Diagram of Mobile NTP – Attach a diagram showing the dimensions of the mobile NTP, including the measurements of the safe for storing controlled substances, and an accompanying narrative that, at a minimum, describes patient flow, applicable waiting areas and the parking location of the mobile NTP when not in operation.

Vehicle Identification Number – Enter the Vehicle Identification Number.

Vehicle Registration for Vehicle – Attach a valid copy of the vehicle's registration.

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 the vehicle insurance policy.

Proof of Vehicle Insurance – Attach a copy showing proof insurance for the vehicle.

SECTION C	**Dispensing Route**

Dispensing Location – Enter the name of the first dispensing location.

Street Address – Enter the street address of dispensing location.

City – Enter the city of the dispensing location.

County – Enter the county of the dispensing location.

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Zip Code – Enter the zip code of the dispensing location.

Operational Hours – Enter the operation hours for the first dispensing location.

Additional dispensing locations – Enter the dispensing location, street address, city, county, zip code, and operational hours for each additional dispensing location. Attach a separate sheet of paper with additional dispensing locations if needed.

Map of Dispensing Route – Attach a map that depicts the standard dispensing route of the mobile NTP. The map must clearly identify the street, road, highway, or freeway names that the mobile NTP will traverse. The map must also label the starting location, each dispensing location, and mobile NTP parking location.

SECTION D	**Scheduled Mobile NTP Hours**

Scheduled Mobile NTP Hours for Medication – Complete the schedule identifying the days and hours for dispensing medications.

Scheduled Mobile NTP for Additional Services – Complete the schedule identifying the days and hours for any additional services provided by the mobile NTP.

Section E	**Additional Services**

Additional Services – 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

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Section F	Mobile NTP Staff Member

The Department must approve any mobile NTP staff member who will have access to the safe that stores medication. Only mobile NTP staff members who are licensed to dispense narcotic medication and authorized to administer such medication in accordance with Health and Safety Code section 11215 may be identified in this application for Departmental approval.

Staff Name – Enter the name of the mobile NTP staff member.

Job Title – Enter the job title of the mobile NTP staff member.

Staff License Information – Enter the license information of the mobile NTP staff member.

Resume – Attach a resume for each staff member identified in this section of the application.

Name of Person Handling Medication – Enter the name of any person employed by the NTP who will handle medication.

Title and Function of Person Handling Medication – Enter the title and function of the person employed by the NTP who will handle medication.

Section G	Required Written Statements and Policies

Written Statements and Policies - Attach the required written statements and policies to the initial application.

Section H	Declaration

<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**
License Number:	National Provider Identifier (NPI):
Name of Legal Entity:	
Name of Mobile NTP (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:		
City:	County:	Zip Code:
Mailing Address (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:		

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Section B	**Mobile Narcotic Treatment Program**
Mobile NTP Street Address of Parking Location:	
City:	
County:	
Zip Code:	
Mobile NTP Business Telephone Number:	
Operating Hours – Monday – Friday:	
Dispensing Hours – Monday – Friday:	
Operating Hours – Saturday – Sunday:	
Dispensing Hours – Saturday – Sunday:	
Approximate Number of Patients to be Served:	
Written Statement Explaining Geographical Area to be Served (attach separate sheet if needed):	
Written Statement Explaining the Population of Area to be Served (attach separate sheet if needed):	
Attach a diagram showing the dimensions of the mobile NTP. Include the measurements of the safe and an accompanying narrative that, at a minimum, describes patient flow and applicable waiting areas and the parking location of the mobile NTP when not in operation.	

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Vehicle Identification Number:	
Valid Registration for Vehicle:	
Vehicle License Plate Number:	Vehicle Year:
Vehicle Make:	Vehicle Model:
Insurance Company:	Policy Number:
Proof of Vehicle Insurance (attach a copy):	

Section C	**Dispensing Route**
Dispensing Location (first stop):	
Street Address:	
City:	
County:	
Zip Code:	
Operational Hours at this location:	
Dispensing Location (second stop):	
Street Address:	
City:	
County:	
Zip Code:	
Operational Hours at this location:	
For additional stops, please attach a separate sheet of paper with the dispensing location, street address, city, county, zip code and operational hours for each location.	
Attach a map that depicts the dispensing route of the mobile NTP. The map must clearly identify the street, road, highway, or freeway names that the mobile NTP will traverse. The map must also label the starting location, each dispensing location, and the mobile NTP overnight parking location.	

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Section D Scheduled Moblie NTP Hours

Complete the schedule below identifying the days and hours for dispensing medications.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Complete the schedule below identifying the days and hours for additional services.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Section E Additional Services

Check the box(es) for any additional service to be provided by the mobile NTP:

- ☐ Collecting samples for drug testing or analysis
- ☐ Dispensing take-home medications
- ☐ Admission
- ☐ Medical evaluation
- ☐ Counseling

Section F Mobile NTP Staff

Identify the name, job title, and license information for every mobile NTP staff member who will access the safe that stores medication in the mobile NTP.

Staff Name:	Job Title:	Staff License Information:

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Attach a resume for every mobile NTP staff member identified above.		
Identify the name, title, and function of any other person employed by the NTP who will handle medication		
Name:		Title and Function:

Section G	**Required Written Statements and Policies**

Attach the following required written statements and policies:

1. Statement describing the approximate number of patients and how patients utilizing services provided by the mobile NTP will participate in regular treatment provided by the NTP.
2. Statement explaining how the NTP will track and account for all controlled substances on the mobile NTP.
3. Statement describing the method used to transfer medications from the NTP to the mobile NTP.
4. Statement describing the mobile NTP safe's alarm system and its direct connection to a central protection company or a local State policy agency.
5. Statement describing the standard route(s) to and from dispensing location(s).
6. Statement describing how patients utilizing services provided by the mobile NTP will participate in regular treatment provided by the NTP.
7. Policies and procedures to be followed in the event of an unforeseen circumstance, emergency or disaster, including the standard operating procedure to: Ensure all controlled substances on a mobile NTP are accounted for, removed from the mobile NTP, and secured at the registered location; and to notify all NTP patients regarding the mobile NTP's delay or inability to provide services and the instructions for how NTP patients may obtain their dosing.

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Section H	**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/formsandpubs/laws/priv/Pages/default.aspx).