INSTRUCTIONS FOR COMPLETION OF THE AFFILIATED AND ASSOCIATED ACKNOWLEDGMENT FORM DHCS 5134 (04/2025)

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 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 Narcotic Treatment Program (NTP) Information

License Number – Enter the NTP license number issued by the Department.

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/#/contactUs
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: Business Programs :: California Secretary of State

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: Business Programs :: California Secretary of State

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: Business Programs :: California Secretary of State.

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

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

Fax Number – Enter the fax number assigned to the facility.

SECTION B	**Office-Based Narcotic Treatment Network (OBNTN) / Medication Unit (MU) Information**

Name of Provider – Enter the name of the provider that will be affiliated and associated with the primary NTP.

Professional License or Certification Number – If applicable, enter the professional license or certification number of the affiliated NTP provider.

NPI – Enter the 10 digit NPI number associated with the provider. 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/#/contactUs

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 of the provider.

Describe Services – Provide a description of the services that the provider affiliated and associated with the primary NTP will offer. If necessary, attach additional pages to this form.

A medication unit may provide any services that are provided by the primary NTP, provided that the medication unit has adequate space to provide the services to patients in a confidential manner.

SECTION C Acknowledgment of Agreement

This section must be read and agreed upon by the primary NTP and affiliated and associated OBNTN/MU.

SECTION D Declaration

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 this form is signed by the program sponsor.

Print Name – Enter the name of the legal representative for the provider.

Title – *This field has been pre-filled by the Department to reflect that the form must be signed by the legal representative for the provider.*

Signature – Legal representative's signature.

Date – Enter the date that this form is signed by the legal representative for the provider.

Section A	**Narcotic Treatment Program (NTP) Information**	
License Number:		National Provider Identifier (NPI):
Name of Legal Entity:		
Name of NTP (if different than name of legal entity):		
Facility Street Address (if applicable Room/Suite/Unit):		
City:	County:	Zip Code:
Mailing Address (if different than facility street address)/(if applicable Room/Suite/Unit):		
City:	County:	Zip Code:
Telephone Number:		Fax Number:
Section B	**Office-Based Narcotic Treatment Network (OBNTN)/ Medication Unit (MU) Information**	
Name of Provider:		
Professional License or Certification Number (if applicable):		
NPI:		
Facility Street Address (if applicable Room/Suite/Unit):		
City:	County:	Zip Code:
Mailing Address (if different than facility street address)/(if applicable Room/Suite/Unit):		
City:	County:	Zip Code:
Telephone Number:		Fax Number:
Describe services the OBNTN or MU will provide:		

Section C	Acknowledgment of Agreement

NTP named in Section A, hereinafter “NTP”, and provider named in Section B, hereinafter “Provider”, hereby acknowledge that the named parties have entered into a formal, documented agreement whereby the Provider shall render services described in Section B to patients enrolled at the NTP. This agreement shall be made available for verification by the Department upon written request.

NTP and Provider agree as follows:

1. Provider is affiliated and associated with the NTP.
2. Provider shall operate under the license of the NTP.
3. Provider shall adhere to the protocol of the NTP and the supplemental written protocol approved by the Department.
4. Provider shall immediately cease the provision of services in the event the license of the NTP is suspended or revoked.
5. NTP shall notify the Department in writing if the Provider intends to discontinue any service(s) described in Section B. Written notice shall be given at least 30 days prior to cessation of service(s) and shall be mailed to the Department.
6. This Affiliated and Associated Acknowledgment form DHCS 5134 (04/25) shall become effective on the date the Department approves the supplemental written protocol for the Provider. It shall remain effective until:
    a. Service(s) are discontinued pursuant to paragraph 5 of this Agreement; or
    b. The license of the NTP is revoked or expires.

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. By signing below, each party warrants that he/she has read this document and understands its content.

I declare that I have the authority to legally bind the NTP.

Print Name:	Title: Program Sponsor
Signature:	Date:
I declare that I have the authority to legally bind the Provider.	
Print Name:	Title: Legal Representative
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.