MOBILE NARCOTIC TREATMENT PROGRAM APPLICATION

INSTRUCTIONS FOR COMPLETION OF THE APPLICATION FOR PROTOCOL AMENDMENT MOBILE NTP FORM DHCS 1832

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 Type of Amendment

This section must be completed by all applicants. Check the appropriate box(es) for the type(s) of protocol amendment for which you are applying and complete the corresponding sections for each protocol amendment.

The following changes in a mobile NTP's protocol and supplemental written protocol require the prior approval of the Department. A mobile NTP shall submit these changes to the Department on this Application for Protocol Amendment form DHCS 1832.

Relocation – A change in the mobile NTP's approved overnight parking location.

Permanent Change to Approved Standard Daily Route – Any permanent change to the approved standard daily route for mobile NTP to and from the service/dispensing location(s).

Addition, Reduction or Termination of Services – Any addition, reduction or termination of services provided at the mobile NTP.

Modification of Vehicle – Any change to the physical structure or floor plan of the mobile NTP, including expansions or modifications to dispensing stations.

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Replacement of MNTP Vehicle – Any replacement of the mobile NTP vehicle.

Other – All other changes in the protocol and supplemental written protocol.

SECTION B	Existing Licensee 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/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: 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.

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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.

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 C Vehicle Information

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.

SECTION D Relocation of Overnight Parking Location

This section must be completed by applicants applying for relocation of an overnight parking location.

For relocation of a Department approved mobile NTP location, additional documentation is required.

Written Statement Explaining Relocation – Check box to indicate that a written statement is attached to this form.

Statement must include:

- The proposed effective date of the relocation of the mobile NTP overnight parking location.
- The estimated impact that the relocation of the overnight parking location will have on the population and area served, as well as funding, budget, and staff.
- Any changes to plan of operation.
- Any other portion of the previously Department approved protocol affected by the relocation.

Drug Enforcement Administration (DEA) Approval – Attach approval from the DEA for the proposed overnight parking location.

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Proposed Mobile NTP Parking Location - 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 parking location.

County – Enter the county of the parking location.

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

SECTION E Permanent Change to Approved Standard Daily Route

This section must be completed by applicants applying to change the permanent standard daily route for mobile NTP services/dispensing.

For change in the approved standard daily route of a mobile NTP route, additional documentation is required.

Written Statement Explaining Change in Standard Daily Route – Check box to indicate that a written statement is attached to this form.

Statement must include:

- The proposed effective date of the change to the permanent route for the mobile NTP.
- The proposed parking location, including the street address, city, county and zip code.
- Any changes to plan of operation.
- Any other portion of the previously Department approved protocol affected by the relocation.

Updated Map – Attach an updated map showing the proposed 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.

Section F Addition, Reduction or Termination of Services

This section must be completed by applicants applying for an addition, reduction or termination of services.

Please Note: In addition to dispensing medications for opioid use disorder treatment, a mobile NTP may provide any of the additional services, if approved by the Department: collecting samples for drug testing or analysis; dispensing take-home medications; admission; medical evaluation; and/or

counseling. A mobile NTP seeking approval from the Department to provide any additional services shall, at a minimum, have a separate, soundproof area for patient confidentiality with adequate space to provide the requested services.

Addition, Reduction or Termination of Services – Check box to indicate the type of service that is being added, and/or reduced. In addition, check box to indicate that a written statement is attached to this form.

Written Statement Explaining Addition, Reduction or Termination of Services:

Statement must include:

- The proposed effective date of the addition, reduction or termination of services.
- The estimated impact that the addition, reduction or termination of services will have on the population and area served, as well as funding, budget, and staff.
- Any changes to plan of operation.
- Any change in floor plan due to the addition, reduction or termination of services.
- Any other portion of the previously Department approved protocol affected by the addition, reduction or termination of services.

List the New Days and Hours of Operation and/or Medication Dispensing - This section must be completed for any change in hours of operation and/or dispensing.

Section G	**Modification to Vehicle**

This section must be completed by applicants applying for change in the physical structure or modification to vehicle.

For a change or modification to vehicle in physical structure, additional documentation is required.

Written Statement Explaining the Replacement or Modification to Vehicle – Check box to indicate that a written statement is attached to this form.

Statement must include:

- The proposed effective date of the change or modification to vehicle.
- A narrative describing the changes or modifications to vehicle.
- The estimated impact that the change or modification to vehicle will have on the population and area served, as well as funding, budget, and staff.
- Any changes to plan of operation.
- Any other portion of the previously Department approved protocol affected by the

modification to the mobile NTP vehicle.

Updated Vehicle Floor Plan – Attached an updated vehicle floor plan, along with pictures that include the proposed change or modification to the vehicle for which you are applying.

Section H Replacement of Vehicle

This section must be completed by applicants applying for a replacement of the mobile NTP vehicle.

For a replacement of a mobile NTP vehicle, additional documentation is required.

Written Statement Explaining the Vehicle Replacement – Check box to indicate that a written statement is attached to this form.

Statement must include:

- The proposed effective date of the replacement mobile NTP vehicle.
- A narrative describing the replacement mobile NTP vehicle.
- The estimated impact that the replacement mobile NTP vehicle will have on the population and area served, as well as funding, budget, and staff.
- Any changes to plan of operation.
- Any other portion of the previously Department approved protocol affected by the replacement mobile NTP vehicle.

Vehicle Floor Plan and Photograph of Replacement Mobile NTP Vehicle – Attached a vehicle floor plan, along with photographs that show the replacement mobile vehicle for which you are applying.

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

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.

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Section A	**Type of Amendment**

Check all that apply:

- ☐ Relocation of where the mobile NTP is parked overnight
- ☐ Permanent change in the standard daily route to and from the service/dispensing location(s)
- ☐ Addition, reduction, or termination of service(s)
- ☐ Modification of mobile NTP vehicle, including expansions or modifications of dispensing stations
- ☐ Replacement of the mobile NTP vehicle
- ☐ Other

Section B	**Existing Licensee Information**
License Number:	National Provider Identifier (NPI):
Name of Legal Entity:	
Name of Mobile NTP (if different than name of legal entity):	

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Section B (Continued)	**Existing Licensee Information**	
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:		
Section C	**Vehicle Information**	
Vehicle Identification Number:		
Vehicle License Plate Number:	Vehicle Year:	
Vehicle Make:	Vehicle Model:	
Insurance Company:	Policy Number:	

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Section D	**Relocation of Overnight Parking Location**	
Attach the following: ☐ Written Statement Explaining Relocation ☐ Drug Enforcement Administration (DEA) Approval		
Proposed Mobile NTP Parking Location/Street Address:		
City:	County:	Zip Code:
Section E	**Permanent Change to Approved Standard Daily Route**	
Attach the following: ☐ Written Statement Explaining the Permanent Change to Approved Standard Daily Route ☐ Updated Map of Proposed Standard Daily Route		
Section F	**Addition, Reduction or Termination of Services**	
Check all that apply: ☐ Collecting Samples for Drug Testing or Analysis ☐ Admission ☐ Medical Evaluation ☐ Counseling ☐ Change in Program Operating and/or Dispensing Hours		
Attach the following: ☐ Written Statement Explaining Addition, Reduction or Termination of Services		

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List the new Days and Hours of Operation and/or Medication Dispensing (if applicable):

Scheduled Mobile NTP Hours						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Section G Modification to Vehicle

Attach the following:

☐ Written Statement Explaining Modification to the Vehicle

☐ Updated Vehicle Floor Plan and Pictures

Section H Replacement of Vehicle

Attach the following:

☐ Written Statement Explaining the Vehicle Replacement

☐ Vehicle Floor Plan and Photographs

☐ Vehicle Registration

Vehicle Identification Number:	
Vehicle License Plate Number:	Vehicle Year:
Vehicle Make:	Vehicle Model:
Insurance Company:	Policy Number:

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Section I	**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).