INSTRUCTIONS FOR COMPLETION OF THE APPLICATION FOR LICENSE RENEWAL FORM DHCS 4029

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.

A Medication Unit (MU) or Office-Based Narcotic Treatment Network (OBNTN) must fill out sections A and B. If you have more than one MU or OBNTN attach additional Section B information.

Section A Applicant 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 License Date – Enter the initial effective date of the Narcotic Treatment Program (NTP) license.

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

Drug Medi-Cal (DMC) Certification Number – Enter the Certification Number associated with the facility. If you need additional information or do not know the DMC Certification Number, please contact the Provider Enrollment Division at: https://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx

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.

Tax Status – Check the box which applies to your business structure for tax purposes.

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 at: 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 facility.

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 and behavioral health services provided by the NTP.

Licensed Patient Capacity – Enter the Department approved licensed patient capacity for maintenance and detoxification treatment.

Operating Hours (M-F) – Enter the facility hours of operation from Monday through Friday.

Telehealth- Enter the services available via telehealth and hours the facility provides services via telehealth Monday through Friday, if applicable. Please enter NA if not applicable.

Dispensing Hours (M-F) – Enter the facility hours of dispensing medication from Monday through Friday.

Weekend Operating Hours – Enter the facility hours of operation for Saturday and Sunday.

Telehealth – Enter the services available via telehealth and hours the facility provides services via telehealth Saturday and Sunday, if applicable. Please enter NA if not applicable.

Weekend Dispensing Hours – Enter the facility hours of dispensing medication for Saturday and Sunday.

Section B	**MU/OBNTN**

This section must be completed for each MU or OBNTN that is operating under the license of the Primary NTP that is applying for license renewal.

DMC Certification Number – Enter the DMC Certification Number associated with the facility. If you need additional information or do not know the DMC Certification Number, please contact the Provider Enrollment Division at: https://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx

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 SOS and as it appears on the entity's Articles of Incorporation. If you need additional information, please contact the SOS at: http://kepler.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: http://kepler.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: http://kepler.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 MU or OBNTN – 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 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 facility.

Name of Program Director – Enter the name of the person who has primary administrative responsibility for operation of the NTP.

Section C	**Annual Maintenance Report**

This section must be completed by all applicants.

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

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

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

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

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

Naltrexone Maintenance Treatment – Enter the total number of patients in naltrexone detoxification treatment on January 31st of the current year.

Methadone Maintenance Dosage Level – Complete all fields based on program census data on January 31st of the current year for patients in methadone maintenance treatment.

Buprenorphine Maintenance Dosage Level – Complete all fields based on program census data on January 31st of the current year for patients in buprenorphine maintenance treatment.

Naltrexone Maintenance Dosage Level – Complete all fields based on program census data on January 31st of the current year for patients in naltrexone maintenance treatment.

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

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

Naltrexone Detoxification Dosage Level – Complete all fields based on program census data on January 31st of the current year for patients in naltrexone detoxification treatment.

Section D 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

Section A	**Applicant Information**	
Application for Fiscal Year:		Original License Date:
DMC Certification Number:		NPI:
Name of Legal Entity:		License Number:
Name of Narcotic Treatment Program (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 (if applicable Room/Suite/Unit):		
City:	County:	Zip Code:
Mailing Address (if applicable Room/Suite/Unit)/(if different than facility street address):		
City:	County:	Zip Code:
Telephone Number:	Fax Number:	
Name of Program Sponsor:		
Name of Program Director:		
Name of Medical Director:		
Licensed Patient Capacity:		
Operating Hours (M-F):	Telehealth Hours (M-F):	Dispensing Hours (M-F):
Weekend Operating Hours:	Weekend Telehealth Hours:	Weekend Dispensing Hours:

Section B	**MU/OBNTN**	
DMC Certification Number:		
NPI:		
Name of Legal Entity:		
Name of MU or OBNTN (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 (if applicable Room/Suite/Unit):		
City:	County:	Zip Code:
Mailing Address (if applicable Room/Suite/Unit)/(if different than facility street address):		
City:	County:	Zip Code:
Telephone Number:	Fax Number:	
Name of Program Director:		
Section C	**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:		
Total Number of Patients in Naltrexone 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:		

Section C (Continued)		**Annual Maintenance Report**							
Patients in Maintenance Treatment by Dosage Level									
Methadone									
Dosage (mg.)	In-Person/No Take Home Supply Given		Receiving Take-Home Supply		Receiving Take-Home Supply		Receiving Take-Home Supply		Total	
			Time in Treatment 1-14 Days		Time in Treatment: 15-30 Days		Time in Treatment: 31 Days or More			
	M	F	M	F	M	F	M	F	M	F
0										
1-19										
20-39										
40-59										
60-79										
80-99										
100-119										
120-139										
140-159										
160-179										
180-199										
200-219										
220-239										
240-259										
260-279										
280-300+										
TOTALS	0	0	0	0	0	0	0	0	0	0
								GRAND TOTAL:	0	

Section C (Continued)			**Annual Maintenance Report**							
Patients in Maintenance Treatment by Dosage Level										
Buprenorphine										
Dosage (mg.)	In-Person/No Take Home Supply Given		Receiving Take-Home Supply		Receiving Take-Home Supply		Receiving Take-Home Supply		Total	
			Time in Treatment 1-14 Days		Time in Treatment: 15-30 Days		Time in Treatment: 31 Days or More			
	M	F	M	F	M	F	M	F	M	F
0										
2-4										
6-8										
10-12										
14-16										
18-20										
22-24										
26-28										
30-32										
34-36										
38-40										
42+										
TOTALS	0	0	0	0	0	0	0	0	0	0
								GRAND TOTAL:	0	

Section C (Continued)	Annual Maintenance Report									
Patients in Maintenance Treatment by Dosage Level										
Naltrexone										
Dosage (mg.)	In-Person/No Take Home Supply Given		Receiving Take-Home Supply		Receiving Take-Home Supply		Receiving Take-Home Supply		Total	
			Time in Treatment 1-14 Days		Time in Treatment: 15-30 Days		Time in Treatment: 31 Days or More			
	M	F	M	F	M	F	M	F	M	F
0										
0.001-1										
2-5										
6-10										
11-20										
21-30										
31-40										
41-50										
51-100										
101-150										
151-200										
201-250										
251-300										
301-350										
351-400										
401+										
TOTALS	0	0	0	0	0	0	0	0	0	0
								GRAND TOTAL: 0		

Section C (Continued)		**Annual Maintenance Report**							
Patients in Detoxification Treatment by Dosage Level									
Methadone									
Dosage (mg.)	In-Person/No Take Home Supply Given		Receiving Take-Home Supply		Receiving Take-Home Supply		Receiving Take-Home Supply		Total	
			Time in Treatment 1-14 Days		Time in Treatment: 15-30 Days		Time in Treatment: 31 Days or More			
	M	F	M	F	M	F	M	F	M	F
0										
1-19										
20-39										
40-59										
60-79										
80-99										
100-119										
120-139										
140-159										
160-179										
180-199										
200-219										
220-239										
240-259										
260-279										
280-300+										
TOTALS	0	0	0		0	0	0	0	0	0
								GRAND TOTAL:	0	

Section C (Continued)			**Annual Maintenance Report**							
Patients in Detoxification Treatment by Dosage Level										
Buprenorphine										
Dosage (mg.)	In-Person/No Take Home Supply Given		Receiving Take-Home Supply		Receiving Take-Home Supply		Receiving Take-Home Supply		Total	
			Time in Treatment 1-14 Days		Time in Treatment: 15-30 Days		Time in Treatment: 31 Days or More			
	M	F	M	F	M	F	M	F	M	F
0										
2-4										
6-8										
10-12										
14-16										
18-20										
22-24										
26-28										
30-32										
34-36										
38-40										
42+										
TOTALS	0	0	0	0	0	0	0	0	0	0
								GRAND TOTAL:	0	

Section C (Continued)		**Annual Maintenance Report**							
Patients in Detoxification Treatment by Dosage Level									
Naltrexone									
Dosage (mg.)	In-Person/No Take Home Supply Given		Receiving Take-Home Supply		Receiving Take-Home Supply		Receiving Take-Home Supply		Total	
			Time in Treatment 1-14 Days		Time in Treatment: 15-30 Days		Time in Treatment: 31 Days or More			
	M	F	M	F	M	F	M	F	M	F
0										
0.001-1										
2-5										
6-10										
11-20										
21-30										
31-40										
41-50										
51-100										
101-150										
151-200										
201-250										
251-300										
301-350										
351-400										
401+										
TOTALS	0	0	0	0	0	0	0	0	0	0
								GRAND TOTAL:	0	

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. 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 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.