

**INSTRUCTIONS FOR COMPLETION OF THE STAFF INFORMATION****DHCS 5026 (Revised 05/2025)**

Submit completed form electronically to [DHCSNTP@dhcs.ca.gov](mailto: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****Facility Type**

**This section must be completed by all applicants.**

Check the appropriate box for the type of facility.

**Narcotic Treatment Program (NTP)** – A licensed opioid use disorder treatment program, whether inpatient or outpatient, which offers all of the following: evaluation, maintenance treatment and/or detoxification treatment, and other services in conjunction with medication for opioid use disorder.

**Medication Unit (MU)** – A DEA registered facility established as part of, but geographically separate from, a narcotic treatment program, from which appropriately licensed program staff, contractors working on behalf of the program, or community pharmacists dispense or administer controlled medication for opioid use disorder, and which may provide other treatment services. Medication units are a brick-and-mortar location and do not include mobile narcotic treatment programs.

**Office-Based Narcotic Treatment Network (OBNTN)** – A network of providers, that are affiliated and associated with a primary NTP, offering one or more of the following: evaluation of medical, employment, alcohol, criminal, and psychological problems; screening for diseases that are disproportionately represented in the substance use disorder population; counseling by substance use disorder counselors that are evaluated through ongoing supervision; and professional medical, treatment, and behavioral health services, on-site or by referral.

**SECTION B****Staff Hours**

**PLEASE NOTE:** If a staff member performs more than one role, specify the number of hours spent in each role. For Example: A staff member serves as both a dispensing nurse and counselor. Under

medical services, list the staff member and the number of hours spent dispensing medication. Under counseling services, list the staff member and the number of hours spent providing counseling services.

**Example:**

Medical					Scheduled Hours						
Name	Function	License Number	Total Hours Per Week		Mon	Tue	Wed	Thu	Fri	Sat	Sun
Jane Doe	Nurse	VN12345	20		5am-9am	5am-9am	5am-9am	5am-9am	5am-9am		
Counseling					Scheduled Hours						
Name	Certifying Organization /Licensing Body	Certification /License Number	Case load	Total Hours Per Week	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Jane Doe	CCAPP	CN12345	10	20	10am-2pm	10am-2pm	10am-2pm	10am-2pm	10am-2pm		

**Administration**

**Name** – Enter the name of the staff member.

**Function** – Enter the function of the staff member.

**License Number** – If applicable, enter the professional license number of the staff member.

**Total hours per week** – Enter the number of hours, per week, that the staff member works for the program location, including services provided via telehealth.

**Scheduled Hours** – Enter the schedule of hours, per day, that the staff member works for the program location, including services provided via telehealth.

**Medical**

**PLEASE NOTE:** Pursuant to CCR, Title 9, §10260 (a)-(b), the program physician or physician extender shall be responsible for administering or dispensing to patients all medications used in replacement narcotic therapy. Under the program physician's direction, appropriately licensed program personnel may administer or dispense these medications to patients as authorized by §11215 of the Health and Safety Code.

**Name** – Enter the name of the staff member.

**Function** – Enter the function of the staff member.

**License Number** – Enter the professional license number of the staff member.

**Total hours per week** – Enter the number of hours, per week, that the staff member works for the program location, including services provided via telehealth.

**Scheduled Hours** – Enter the schedule of hours, per day, that the staff member works for the program location, including services provided via telehealth.

**Counseling**

**PLEASE NOTE:** Pursuant to CCR, Title 9, §10125, program staff who provide counseling services (as defined in §13005) shall be exempt, licensed, certified, or registered to obtain certification or licensure pursuant to Chapter 8 (commencing with §13000).

**Name** – Enter the name of the staff member.

**Certifying Organization/Licensing Body** – Enter the name of the counselor certifying organization or licensing body.

**Certification/License Number** – If applicable, enter the counselor license number of the staff member.

**Registration Number** – If applicable, enter the counselor registration number of the staff member.

**Caseload** – Enter the number of patients assigned to the counselor.

**Total hours per week** – Enter the number of hours, per week, that the counselor works for the program location, including services provided via telehealth.

**Scheduled Hours** – Enter the schedule of hours, per day, that the counselor works for the program location, including services provided via telehealth.

<b>Section A</b>	<b>Facility Type</b>
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Check one box:

Narcotic Treatment Program CCR, Title 9, §10030

Medication Unit CCR, Title 9, §10020

Office-Based Narcotic Treatment Network CCR, Title 9, §10021

<b>Section B</b>	<b>Staff Hours</b>
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<b>Administration</b>	<b>Scheduled Hours</b>
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Name	Function	License Number	Total Hours Per Week	Mon	Tue	Wed	Thu	Fri	Sat	Sun

<b>Medical</b>	<b>Scheduled Hours</b>
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Name	Function	License Number	Total Hours Per Week	Mon	Tue	Wed	Thu	Fri	Sat	Sun

Counseling						Scheduled Hours						
Name	Certifying Organization/ Licensing Body	Certification/License Number	Registration Number	Caseload	Total Hours Per Week	Mon	Tue	Wed	Thu	Fri	Sat	Sun

**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.