

For DSHS Use Only
Budget Code #: ZZ105-173

Receipt #: _____
\$ Amt.: _____

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
Narcotic Treatment Program Application & Status Report
Regulatory Licensing Unit/Facility Licensing Group
Mail Code 2003
P.O. Box 149347
Austin, Texas 78714-9347
512/834-6600/www.dshs.state.tx.us/hfp/



- | | |
|---|---|
| <input type="checkbox"/> New/Initial Applicant
Remit \$1000 with application | <input type="checkbox"/> New/Initial Patient Fees
Total patients applying for: _____
Remit \$60 for each requested patient |
| <input type="checkbox"/> Medication Unit
Total Medication Units: _____
Remit \$150 for each medication unit | <input type="checkbox"/> Hospital Narcotic Drug Detoxification
Remit \$200 initial application fee |
| <input type="checkbox"/> Renewal Applicant
Remit \$60 for each licensed patient
<i>If late, remit a delinquency fee of \$350 for filing late status report</i>
<i>If late, remit a delinquency fee of \$5 per each patient approved to treat</i> | Permit #: _____
EXP. DATE: _____ |
| <input type="checkbox"/> Hospital Detoxification Unit Renewal Applicant
Remit \$400 renewal fee
<i>If late, remit \$100 delinquency fee for late renewal fee payment</i>
<i>If late, remit \$250 delinquency fee for filing late status report</i> | |
| <input type="checkbox"/> Change in Status/Increase Approved to Treat (ATT)
Remit \$60 for each additional client
Currently Licensed Patients: _____ Increase to: _____
<i>Signature below confirms program will provide adequate facility and staff capacity to accommodate increase.</i> | Permit #: _____ |

Tax ID Number: _____

Legal Name of Narcotic Treatment Program/Hospital (corporate name; individual's name, if a sole proprietorship; name of partnership and each partner – Attach additional sheet, if needed; name of corporation, limited partnership, limited liability partnership, limited liability company, etc...) **For entities required to file with the Texas Secretary of State's office, attach a current certificate of status from the Texas Secretary of State's Office.**

Assumed Name, if applicable (attach certificate of assumed name)

This section must be completed in full:

Permit Address

City State Zip Code

Telephone Number County Region

Mailing Address (if different from above)

City State Zip Code

Telephone Number

FDA Approved Drugs to be utilized:

- Methadone
 Buprenorphine
 Other, specify: _____

Name of Sponsor/Title

Program Sponsor E-mail Address

Name of Medical Director/Title

Name of Program Physician/Title (if different from Medical Director)

Name of Program Director/Administrator/Title

Name of Pharmacist (if applicable)/Title

Central Registry Email Address

Clinic Fax Number

To the best of my knowledge, the information on this Application and Status Report are true and correct. I agree to comply with Chapter 229 and applicable rules and statutes.

Signature of Program Sponsor/Title

Date

**TEXAS DEPARTMENT OF STATE HEALTH SERVICES
NARCOTIC TREATMENT PROGRAM – STATUS REPORT**

Ensure all items indicated below are included with your initial/renewal application packet; incomplete packets are subject to delinquent fees for renewal applicants and will delay processing. It is suggested that you submit the required documents in a timely manner to ensure sufficient time for review and response as necessary.

NEW/INITIAL APPLICANTS:

- New/Initial Facility Licensure Application completed in full & signed;
- Statement that the applicant has read, understands, and agrees to follow all federal and state regulations concerning operation of a narcotic treatment program.
- Copy of DEA Application (Program & Physicians);
- Copy of SAMHSA Application;
- Copy of DPS Controlled Substance Registration (Physicians);
- Copy of Medical Permits for Physicians; including Curriculum Vitae
- Copy of CARF, JCAHO, or COA Accreditation assertion/application;
- Copy of SAMHSA OTP Extranet Physician Account Application for Patient Exception Requests
- Copy of current TDL, personal mailing address and telephone number, license/credentials, and resume; indicating approximate work hours for program sponsor, program director, registered nurse(s), licensed vocational nurse(s), registered pharmacist(s), counselor(s), and other personnel who will be involved in the treatment of opiate addiction;
- Submit the following to demonstrate service ability of the program at the proposed location:
 - Disclosure of the source and adequacy of financial assets necessary to operate the program;
 - If applicable, the compliance history of the applicant, which includes any issues reported to the department by SAMHSA, DEA or other regulatory agency;
 - Map showing proximity of the proposed NTP to existing programs with a three mile radius;
 - A description of how the new program will ensure it will provide treatment services for an underserved population and not duplicate treatment services for existing patient in treatment at an established program in the same area;
 - Copies of planned promotional materials, advertisements, and other techniques to publicize the proposed program;
 - Procedures that will be used to identify whether a patient is enrolled in another clinic. Demonstrate how the central registry is to be incorporated into the procedure;
 - A description of how individual doses will be administered/dispensed and by whom. Procedures for patient identification, drug dilution, drug preparation, take-out preparation, dispensing log, and perpetual inventory;
 - Procedures for the screening of licit and illicit drugs. Include protocols for storage, labeling, and handling of samples by staff. Include steps taken to minimize the falsification and tampering of samples by the patients; and

Additional Documentation for Medication Units:

- Completed Medication Unit Site Information;
- Documentation that ensures drug test analysis will be performed in a laboratory approved under the Clinical Laboratory Improvement Amendments (CLIA) and all applicable Texas state standards.

Additional Documentation for Hospital Narcotic Drug Detoxification Treatment

- Copy of Federal form SMA-162 filed with SAMHSA;
- Copy of Federal form DEA 363 filed with DEA;
- Name and license number of Pharmacist;
- Copy of Application for registration by DEA as NTP for detoxification

RENEWALS:

- Renewal Facility Licensure Application completed in full & signed;
- Copy of current DEA Approval (Program & Physicians);
- Copy of current SAMHSA Approval;
- Copy of current DPS Controlled Substance Registration for Physicians;
- Copy of current Medical Permits for Physicians;
- Copy of current CARF, JCAHO, or COA Accreditation
- A signed/dated statement from the Program Sponsor that the number of patients treated by the program is in direct proportion to the number of counselors employed by the program. This proportion is a maximum of 50 patients for each counselor.

Additional Documentation for Medication Units:

- Completed Medication Unit Site Information;
- Documentation that ensures drug test analysis will be performed in a laboratory approved under the Clinical Laboratory Improvement Amendments (CLIA) and all applicable Texas state standards.

Additional Documentation for Hospital Narcotic Drug Detoxification Treatment

- Copy of approval on Federal form SMA-162 issued by SAMHSA;
- Copy of approval on Federal form DEA 363 issued by DEA;
- Name and license number of Pharmacist;
- Copy of registration by DEA as NTP for detoxification

Direct all correspondence/inquires to:

**Department of State Health Services
Regulatory Licensing Unit
Facility Licensing Group/Mail Code 2835 OR MC 2003 (if you remit fees with the packet)
P.O. Box 149347,
Austin, TX 78714-9347**

**TEXAS DEPARTMENT OF STATE HEALTH SERVICES
NARCOTIC TREATMENT PROGRAM - MEDICATION UNIT SITE INFORMATION**

TO BE COMPLETED BY MEDICATION UNITS ONLY:

Complete this page for each program site where the medication unit services are to be provided. Permit # _____
(If necessary, make additional copies)

Medication Unit Physical address		
City	State	Zip Code
Telephone Number	County	Region
Responsible Physician(s):		
Name	Title	
Name	Title	