TEXAS Health and Human Services

Narcotic/Opioid Treatment Program Application

Service Code: 529201044

☐ **New/Initial Applicant**
Remit $1000 with application

☐ **New/Initial Patient Fees**
Total patients applying for: _____
Remit $60 for each requested patient

☐ **Hospital Narcotic Drug Detoxification**
Remit $200 initial application fee

☐ **Medication Unit**
Total Medication Units: _____
Remit $150 for each medication unit

☐ **Renewal Applicant** **Permit #:** _____
Remit $60 for each licensed patient
If late, remit a delinquency fee of $350 for late status report
If late, remit a delinquency fee of $5 per each patient approved to treat
Exp. Date: _____

☐ **Hospital Detoxification Unit Renewal Applicant**
Remit $400 renewal fee
If late, remit $100 delinquency fee for late renewal fee payment
If late, remit $250 delinquency fee for filing late status report

☐ **Change in Status/Increase Approved to Treat (ATT)** **Permit #:** _____
Remit $60 for each additional client
Currently Licensed ATT: _____ **Increase ATT to:** _____
Signature below confirms program will provide adequate facility and staff capacity to accommodate increase.

_____ _____
Legal Name of Narcotic Treatment Program/Hospital **Tax ID Number**
(Attached a current certificate of status from the Texas Secretary of State's Office.)

_____
Assumed Name *(If applicable, attach a certificate of assumed name.)*

This section must be completed in full:

_____
Permit Address

_____
City **State** **Zip**

_____
Telephone Number **County**

_____
Mailing Address (if different from above)

_____
City **State** **Zip**

_____
Telephone Number

FDA Approved Drugs to be utilized:
- ☐ **Methadone**
- ☐ **Buprenorphine**
- ☐ **Other, specify:** _____

_____
Program Sponsor Name/Title

_____
Program Sponsor Email Address

_____
Medical Director Name/Title

_____
Program Physician Name/Title

_____
Program Director/Administrator Name/Title

_____
Pharmacist Name

_____
Central Registry Email Address

_____
Clinic Fax Number

To the best of my knowledge, the information on this application is true and correct. I agree to comply with Chapter 229 and applicable rules and statues.

_____ _____
Program Sponsor Signature **Date**

Revised 11/2018

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Ensure all items indicated below are included with your initial/renewal application packet; incomplete packets are subject to delinquent fees for renewal application and will delay processing.

New/Initial Applicant:

- ☐ New/Initial NTP Application completed and signed.
- ☐ Statement that the applicant has read, understands, and agrees to follow all federal state regulations concerning operation of a narcotic treatment program.
- ☐ Copy of DEA application (Program & Physician).
- ☐ Copy of SAMHSA application.
- ☐ Copy of Medical Permits for Physicians, including Curriculum Vitae.
- ☐ Copy of CARF, JCAHO, or COA Accreditation assertion/application.
- ☐ 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.

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 NTP Application completed and signed.
- ☐ Copy of current DEA approval (Program and Physicians)
- ☐ Copy of current SAMHSA approval.
- ☐ Copy of current Medical Permits for Physicians.
- ☐ Copy of current CARF, JCAHO, or COA Accreditation.
- ☐ A signed/dated statement form 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.

Contact Information:

Facility Licensing Group: 512-834-6648
Substance Abuse Compliance Group: 512-231-5642

Submit application with fee:

Texas Health and Human Services Commission
ARTS
P.O. Box 149055
Austin, Texas 78714-9055

Submit application without fee:

Texas Health and Human Services Commission
Facility Licensing Group – MC 2835
P.O. Box 149347
Austin, Texas 78714-9347

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TO BE COMPLETED BY MEDICATION UNITS ONLY:

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

Permit #: _____

_____

Medication Unit Physical Address

_____

City **State** **Zip**

_____

Telephone Number **County**

_____

Responsible Physician(s)

_____

Name **Title**

_____

Name **Title**