TEXAS Department of State Health Services

For Office Use Only	
Budget:	ZZ105
Fund:	173
CFN:	

DRUGS AND MEDICAL DEVICES DIVISION
NARCOTIC TREATMENT PROGRAM
HOSPITAL NARCOTIC DRUG DETOXIFICATION TREATMENT MEDICATION UNIT
APPLICATION FOR PERMIT
(Texas Health and Safety Code, Chapter 466)

Return this completed form and **nonrefundable fee** to **THE TEXAS DEPARTMENT OF HEALTH, DRUGS AND MEDICAL DEVICES DIVISION, 7B707-173, 1100 WEST 49TH STREET, AUSTIN, TEXAS 78756.** Make check or money order payable to: TEXAS DEPARTMENT OF HEALTH. For additional licensure assistance please contact us by phone at (512) 834-6600, fax (512) 834-6638, or email at ntp@dshs.state.tx.us. Additional information may be found on our website at www.dshs.state.tx.us/license.shtm

FAILURE TO PROVIDE ALL FORMS AND INFORMATION REQUIRED BY LAW WILL DELAY ISSUANCE OF CERTIFICATE

1. Purpose of the Statement:

- ❑ APPLICATION FOR A NEW PERMIT
  - ❑ Narcotic Treatment Program (NTP) – (including change of ownership, change of location)
  - ❑ Hospital Narcotic Drug Detoxification Treatment Program (HNDDTP)
  - ❑ Medication Unit
- ❑ APPLICATION FOR AMENDED LICENSE
  - ❑ Change of Facility Name Effective Date: _____
  - Other _____

2. Complete in full:

Name of Program / Hospital / Medication Unit _____

Address to be Permitted: _____
Address City County State Zip Code

Mailing Address _____
Address City County State Zip Code

Telephone Number at Program Address (____) _____ Fax Number at Program Address (____) _____

Other Telephone Number(s) (____) _____ (____) _____

Ownership description (Board of Directors/Partnership/Corp-please identify type and names of parties - attach a supplemental sheet if needed):

_____

Program Sponsor: _____

Program Director / Administrator: _____

Medical Director for the NTP, Medication Unit Pharmacy Director, or Responsible Physician appointed by the Hospital to oversee the HNDDTP:

_____

Pharmacist: _____

3. Schedule of Fees: Please mark the appropriate box and submit fee accordingly.

PROGRAM FEES: ☐ $1000.00 - Initial Fee for a NTP ☐ $150.00 -Initial Fee for each Medication Unit
HOSPITAL FEES: ☐ $250.00 - Initial Fee for Hospital Narcotic Drug Detoxification Treatment

4. Approximate Number of Patients To Be Treated At Any Given Time At The Narcotic Treatment Program:

_____ Methadone _____ Buprenorphine _____Other (please specify)

5. Number of Beds in Hospital _____ Number of Beds Committed to Narcotic Treatment _____

6. Program Funding Sources (Check each appropriate agency and attach the address of each)

☐ NIDA	☐ State Government	☐ Public Health Service
☐ US Courts	☐ City / County Government	☐ Indian Health Services
☐ Private Charities	☐ Private Insurance	☐ Veterans Administration
☐ Client Fees	☐ Bureau of Prisons	☐ Other _____

The following documents MUST be submitted to the Texas Department of Health as part of your Application:

a) A completed Narcotic Treatment Program / Hospital Narcotic Drug Detoxification Treatment Medication Unit Application Questionnaire (to be submitted on Program Letterhead).
b) A completed copy of Form SMA-162, Application for Certification to Use Opioid Drugs in a Treatment Program under 42 CFR Sec. 8.11 (without attachments). The original must be submitted to the Substance Abuse and Mental Health Services Administration (SAMHSA).

As the person responsible for the program, I submit this application for approval to use approved narcotic drugs in a program for detoxification and/or maintenance treatment for narcotic addicts in accordance with 42 Code of Federal Regulations (CFR) Part 8,Opioid Drugs in Maintenance and Detoxification Treatment of Opiate Addiction, and 25 Texas Administrative Code (TAC) Section 229, Minimum Standards for Narcotic Treatment Programs. I understand the SAMHSA and State approvals are necessary to obtain a registration from the Drug Enforcement Administration (DEA).

I. I have a copy of, or access to 42 Code of Federal Regulations (CFR) Part 8,Opioid Drugs in Maintenance and Detoxification Treatment of Opiate Addiction. I have read, understand and will comply with the standards established under that regulation which governs the treatment of narcotic addiction with approved narcotic drugs.

II. I have a copy of, or access to 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records. I have read and understand the requirements to maintain the confidentiality of alcohol and drug abuse treatment patient records. I agree to protect the identity of all patients in accordance with the regulations.

III. I have a copy of, or access to 25 Texas Administrative Code (TAC) Section 229, Minimum Standards for Narcotic Treatment Programs. I have read, understand and will comply with the standards established under that regulation which governs the state standards of treatment of narcotic addiction with approved narcotic drugs.

IV. I shall comply with the security standards for the distribution of controlled substances, as required by 21 CFR 1301, Registration of Manufacturers, Distributors, and Dispensers of Controlled Substances.

V. I agree to adhere to all rules, directives, and procedures, set forth in 42 CFR Part 8, 25 TAC Section 229, and any regulation regarding the use of a narcotic drug for the treatment of narcotic addiction which may be promulgated in the future. I shall inform other individuals who work in this treatment program of the provisions of these regulations, and monitor their activities to assure compliance with the provisions.

VI. I understand that failure to abide by the rules, directives, and procedures described above may cause a suspension or revocation of approval of my registration by SAMHSA, DEA, or the Texas Department of Health (TDH).

CURRENT VERIFICATION: *I affirm that the above statements are true and correct and that no reasons exist for which the Commissioner of Health may refuse this form, or at a later date revoke or suspend our permit. I further affirm, by signature hereon, that I am not currently delinquent in the payment of any corporation franchise taxes owed the State of Texas under Chapter 171, Tax Code. I have not been convicted of a felony or misdemeanor.*

DRUG APP VERIFICATION: I SWEAR OR AFFIRM THAT THE ABOVE STATEMENTS ARE TRUE AND CORRECT. I FURTHER CERTIFY BY SIGNATURE HEREON, THAT I HAVE READ, UNDERSTOOD, AND AGREE TO ABIDE BY THE PROVISIONS OF 25 TEXAS ADMINISTRATIVE CODE, SECTIONS 229.252(A)(1), AND THE TEXAS FOOD, DRUG, AND COSMETIC ACT, HEALTH AND SAFETY CODE, CHAPTER 431. I ALSO CERTIFY THAT I AM NOT CURRENTLY DELINQUENT IN THE PAYMENT OF ANY CORPORATION FRANCHISE TAXES OWED THE STATE OF TEXAS UNDER CHAPTER 171, TAX CODE; NOR AM I DELINQUENT IN THE PAYMENT OF ANY CHILD SUPPORT OWED UNDER CHAPTER 232, FAMILY CODE. I CERTIFY THAT I HAVE NOT BEEN CONVICTED OF A FELONY OR MISDEMEANOR THAT INVOLVES MORAL TURPITUDE.

_____ *Signature*

_____ *Date*

- ❑ Owner
- ❑ Partner
- ❑ President
- ❑ Corporate Designee – Copy of Resolution must accompany application
- ❑ Hospital Administrator

_____ *Printed Name of Applicant*

Tax Payer ID Number _____

Name of Application Preparer _____ *Phone Number* _____