N.C. Department of Health and Human Services
Division of Health Service Regulation
Mental Health Licensure and Certification Section
2718 Mail Service Center ■ Raleigh, North Carolina 27699-2718

Medication/Mobile Unit Licensure Application Packet

N.C. Department of Health and Human Services
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Mental Health Licensure and Certification Section
2718 Mail Service Center ■ Raleigh, North Carolina 27699-2718

Instructions for Completing an Opioid Treatment Program (OTP) Application

Overview

1. This set of instructions is designed to assist the agency in completing an application for a mobile and/or medication unit.
2. Each mobile and/or medication unit is considered independent; therefore, an individual application is required for each unit.
3. If all requested information is not provided, it will delay the processing of the application.
4. If any requested information does not apply to the agency's facility, please indicate this by writing "N/A."
5. The OTP Medication Units and Mobile Units are permitted to operate within a radius of 75 miles from the Licensed Opioid Treatment Program facility.

Licensure application Type

1. Check the appropriate box for the action requested by the agency.

Section I Main Site License information

1. Current Facility Name: Enter the name printed on the current license.
2. License Number: Enter the current license number found on the license.
3. FID: Provide the FID number printed on the license.
4. Current Facility Site Address: Enter the physical site location listed on the most current license.
5. Phone Number: Provide the facility's phone number
6. Local Management Entity/Managed Care Organization (LME/MCO): List the names of any LME/MCOs with which the facility has a contract.

Section II Mobile Unit Vehicle information

7. Vehicle Name: Enter the vehicle's name. For example, Vehicle 1 will be referred to as Vehicle 1, Vehicle 2 will be Vehicle 2, and so on.
8. Make/Model: Specify the make and model of the vehicle.
9. Year: Indicate the year the vehicle was manufactured.
10. Vehicle Identification Number (VIN): Provide Vehicle Identification Number (VIN).
11. License Plate Number: Enter the vehicle's license plate number
12. Insurance Agency: Name the agency that currently holds the policy.
13. Insurance Policy Number: Provide the insurance policy number.

Section III Medication Unit information

14. Medication Unit (MU) Name: Enter the name of the MU. For example, MU 1 will be labeled as MU1. MU2 will be labeled as MU2, and so on.
15. Address of the proposed site: List the address. This should be the site's physical address as stated on the most current license.
16. Phone Number: Provided the phone number of the facility and unit.

Section IV Agency Staff and DEA Information

17. Drug Enforcement Administration (DEA) date of approval and Letter.
18. Name of Facility Director: Include name, title, phone number and email address.
19. OTP Medical Director: Include name, title, phone number and email address.
20. Contact Person for Applications: Include Name, title, phone number and email address.
21. State Opioid Treatment Authority (SOTA)- Include the current SOTA approval letter.

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Section V Substance /Outpatient Services

Check each specific program service that is provided at the Medication or Mobile unit.

Fees: $265.00 per unit

Make check payable to
N.C. Division of Health Service Regulation

Send application with the required information to:
Division of Health Service Regulation
MH Licensure & Certification Section
1800 Umstead Drive
2718 Mail Service Center
Raleigh, NC 27699-2718

Checklist

Incomplete applications will be returned to the sender without processing, accompanied by a letter explaining the incorrect or missing information.

Medication Unit Checklist

	Item	Completed
1	Floor Plan Identifying all spaces in the Medication Unit *(all levels/floors, dimensions, doors, windows, smoke detectors, bathrooms, closets)*	
2	Photos (Interior & Exterior)	
3	Zoning Approval (original) Required for application to move forward	
4	LME/MCO Support Letter	
5	Fire Inspection (clear copy or original)	
6	Sanitation Inspection (clear copy or original) if serving food	
7	Building Inspection (original) if applicable for new construction or renovation of building	
8	Preliminary Program approval from SOTA	
9	Drug Enforcement Administration (DEA) Approval	
10	Provide current Secretary of State Report documenting Active Status.	

Mobile Unit Checklist

	Item	Completed
1	Insurance policy card (current – Insurance Agency & Insurance Policy #)	
2	Floor Plan Identifying all spaces in the mobile unit	
3	Current vehicle registration card (Vehicle Identification Number – VIN)	
4	Photos of the outside of the unit and inside the unit	
5	Preliminary Program approval from SOTA	
6	Drug Enforcement Administration (DEA) Approval	
7	LME/MCO Support Letter	
8	Provide current Secretary of State Report documenting Active Status	

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Medication/Mobile Unit LICENSE APPLICATION FOR MH/DD/SAS FACILITIES

TYPE OF APPLICATION

Mobile Unit ☐
Medication Unit ☐

Section I: Main Site Licensed Information		
Facility Name:	License Number:	FID:
Address:		
City	County	Phone Number
Local Management Entity/Managed Care Organization (LME/MCO):		
Section II: Mobile Unit Vehicle Information *If Applicable*		
Name:		
Make/Model:	Year:	
Vehicle Identification Number (VIN):		
License Plate Number:	Insurance Agency:	Ins Policy #:
Section III: Medication Unit Information *If Applicable*		
Name:		
Address		
City	County	Phone number
Section IV: Agency Staff and Drug Enforcement Administration (DEA) Information		
DEA Date of Approval: _____ (***approval letter must be submitted with this application)***		
SOTA Approval Date: _____ (***approval letter must be submitted with this application)***		
Director/Licensee Name:	Title:	
Phone:	Email:	
OTP Medical Director Name:	Title:	
Phone:	Email:	
Contact person for application	Title	
Primary Number:	Cell phone:	

V: Substance Use Disorder /Outpatient Services			
Check the box beside each specific program service(s) for which the agency's mobile/medication unit is providing.			
	Individual Counseling		Group Counseling
	Family Counseling		Medication Dosing
	Drug Screens		
	Other: Please List:		

Applicant Declarations	
I declare the following: • The agency will notify the department if changes occur in any information provided in sections I, II or III of this application after licensure is granted. • No person named in this application has had a license or certification for a treatment service or health care agency denied, revoked, or suspended. • No person named in this application is currently on the Penalty Tracking Data Base. • The information contained in this application and on all documents submitted with this application is true, accurate, and complete to the best of my knowledge.	
Signature of Administrator or Legal Representative	Date Signed
The printed name of the person signing the form	Title
Phone Number	Email