



Sacramento County Department of Health Services
Division of Behavioral Health
QUALITY MANAGEMENT
STAFF REGISTRATION/CREDENTIALING
APPLICATION **Substance Use, Prevention, and
Treatment (SUPT)**

Staff ID (if known): _____ New: _____ Update: _____ Termination: _____ Date: _____

Agency Information

Agency Name: _____ Agency Phone Number: _____

Agency Contact Person: _____ Agency Contact Email: _____

Applicant Information

Applicant Name: _____ DOB: _____

Previous Name/AKA: _____ Staff Email: _____

NPI Number: _____ Taxonomy: _____ Gender: _____

Date of Employment: _____ Termination Date: _____

Employment Status:

Full Time

Part Time

Contracted

Temporary/On-Call

Volunteer

Area Of Expertise (select all that apply):

C – Child/Adolescent

A – Adult

G – Geriatric

S – Substance Abuse

SmartCare Classification (choose one and attach corresponding certification information)

DO Doctor of Osteopathy	Waivered Psychologist
MD Medical Doctor	ASW Associate Social Worker
Licensed Psychiatrist	AMFT Associate Marriage Family Therapist
Medical Resident/ACGME Fellow	APCC Associate Professional Clinical Counselor
Medical Intern	Certified Peer Specialist
NP Nurse Practitioner	Certified AOD Counselor
PA Physician Assistant	Registered AOD Counselor
RN Registered Nurse	Clinical Trainees:
CNS Clinical Nurse Specialist	Master's Clinical
LVN Licensed Vocational Nurse	Medical Clinical Clerkship
PT Psychiatric Technician	Psychologist
Medical Assistant	Pharmacist
OT Occupational Therapist	Licensed Vocational Nurse
Registered or Advanced Practice Pharmacist Ph.D.	NP/Nurse Specialist
Doctor of Philosophy (Clinical Psychologist)	Physician Assistant Registered
PsyD Doctor of Psychology (Clinical Psychologist)	Assoc Occupational Therapist
LCSW Licensed Clinical Social Worker	Psychiatric Technician
LPCC Licensed Professional Clinical Counselor MFT	Registered Nurse
Marriage and Family Therapist	Other Qualified Provider
	Community Health Worker

Start Date in Classification: _____

Certification/Registration/License#: _____ Lic. Exp. Date: _____

DEA Number: _____ DEA Start Date: _____ DEA Exp. Date: _____

Board/Certification Organization Name: _____

Attestation Questions: Please answer the following questions “Yes” or “No”. If you answer is “Yes” to any of the questions A – M, provide full details on a separate sheet of paper.

A. Has your license to practice in any jurisdiction, your Drug Enforcement Administration (DEA) registration or any applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions, or have you been fined or received a letter of reprimand or is such an action pending?	Yes No
B. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending?	Yes No
C. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract or is any such action pending?	Yes No
D. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?	Yes No
E. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?	Yes No
F. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending?	Yes No
G. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank?	Yes No
H. Have you been denied certification/recertification by a specialty board, or has your admissibility, certification or recertification status changed (other than changing from admissible to certified)?	Yes No
I. Have you ever been convicted of any crime (other than a minor traffic violation)?	Yes No
J. In the past (5) years, have you had a history of chemical dependency or substance abuse that might adversely affect your ability to competently and safely perform essential functions of a practitioner in your area of practice.	Yes No
K. Do you have an ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without direct threat to the health and safety of others?	Yes No
L. Have any judgments/arbitration or claims been entered against you, or settlements been agreed to by you within the last (7) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitrations against you pending?	Yes No

M. Are you currently engaged in the illegal use of drugs? (“Illegal use of drugs” means the use of controlled substances, obtained illegally, as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed health care practitioner. “Currently” does not mean on the day of or even the weeks preceding the completion of this application, rather, it means recently enough so that the illegal use may have an impact on one’s ability to practice.)	Yes No
N. FOR ALL LICENSED PHYSICIANS (MDs, LPs, and DOs), NURSE PRACTITIONERS, PHYSICIANS ASSISTANTS, LICENSED PSYCHOLOGISTS, LMFTs, LCSWs, and LPCCs ONLY. 1. Are you currently enrolled in the Provider Application and Validation for Enrollment (PAVE) portal for Medi-Cal? (Required for all provider types listed above) 2. Have you also completed an Ordering/Referring/Prescribing (ORP) application or has someone done so on your behalf? (Required for all provider types listed above) To confirm your ORP enrollment status, you can go to this website and enter your NPI number https://www.medi-cal.ca.gov/ORPEnroll/ORPEnroll.aspx <i>All Physicians (MD, LPS, and DO), Nurse Practitioners, Physician Assistants, Licensed Psychologists, LMFTs, LCSWs, and LPCCs are required to be enrolled in the PAVE Portal and have ORP enrollment in order to work within the Medi-Cal system.</i>	Yes No
O. FOR ALL PHYSICIANS (MDs, LPs, and DOs), NURSE PRACTITIONERS, AND PHYSICIAN ASSISTANTS ONLY Have you enrolled in the Medi-Cal Rx portal or has someone done so on your behalf? <i>All MDs, LPs, DOs, PA, and NPs are required to be enrolled in MC Rx partnered with Magellan to administer Medi-Cal Pharmacy benefits. All prescribers must be enrolled in this portal to provide services.</i>	Yes No

I hereby affirm that the information submitted in the Attestation Questions, and any addenda thereto is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that intentionally withholding or omitting material information or intentionally submitting materially false or misleading information may result in denial of my application or termination of my privileges or employment.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

Print Full Legal Name _____

Signature _____

Date _____

NETWORK ADEQUACY INFORMATION

NACT Provider Type:

Physician	LCSW	Registered SUD Counselors
Nurse Practitioner	LMFT	Certified SUD Counselors
Physician Assistant	LPCC	Licensed Eligible Practitioners Working Under Supervision of a Licensed Clinician
Registered Nurse	Certified Peer	
Pharmacist	Lic. Vocational Nurse	
Lic. Psychologist		

Telehealth Provider: O = Only Telehealth Provided B = Both In-person and Telehealth Provided
N = No Telehealth Provided

Field Based Services: Yes: No: Distance Provider May Travel: _____

Cultural Competence (CC) Training: Yes: No: Hours of CC Training: _____

Arabic	Fluency: _____	Korean	Fluency: _____
Armenian	Fluency: _____	Mandarin	Fluency: _____
Cambodian (Khmer)	Fluency: _____	Other Chinese	Fluency: _____
Cantonese (Yue Chinese)	Fluency: _____	Russian	Fluency: _____
Farsi (Persian)	Fluency: _____	Spanish	Fluency: _____
Hmong:	Fluency: _____	Tagalog	Fluency: _____
American Sign Language	Fluency: _____	Vietnamese	Fluency: _____

Modality Type Provider – (Choose up to 7)

Outpatient Treatment (ASAM Level 1.0)	Intensive Outpatient Treatment (ASAM Level 2.1)
Withdrawal Management (ASAM Level 2)	Residential (ASAM 3.1)
Residential Withdrawal Mgmt (ASAM 3.2)	Residential (ASAM 3.5)
Opioid Treatment Program	

Site Information

Information must be complete for each program and site address staff works.

Site #1 Program Name _____			
Street Address _____		Suite # _____	City _____ Zip _____
Hire Date: _____		Term Date: _____	Max Caseload Adult: _____ Children: _____
Age Group Served: _____		Current Caseload Adult: _____ Children: _____	
C= Site Serves Children ONLY		A = Site Serves Adults ONLY	B = Site Serves Children and Adults
Definitions: MHP = Children 0-20; Adult 21		SUPT = Children 0-18; Adult 18+	

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Site #2 Program Name _____			
Street Address _____		Suite # _____	City _____ Zip _____
Hire Date: _____		Term Date: _____	Max Caseload Adult: _____ Children: _____
Age Group Served: _____		Current Caseload Adult: _____ Children: _____	
C= Site Serves Children ONLY		A = Site Serves Adults ONLY	B = Site Serves Children and Adults
Definitions: MHP = Children 0-20; Adult 21		SUPT = Children 0-18; Adult 18+	

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Site #3 Program Name _____			
Street Address _____		Suite # _____	City _____ Zip _____
Hire Date: _____		Term Date: _____	Max Caseload Adult: _____ Children: _____
Age Group Served: _____		Current Caseload Adult: _____ Children: _____	
C= Site Serves Children ONLY		A = Site Serves Adults ONLY	B = Site Serves Children and Adults
Definitions: MHP = Children 0-20; Adult 21+		SUPT = Children 0-18; Adult 18+	

Site #4 Program Name _____			
Street Address _____		Suite # _____	City _____ Zip _____
Hire Date: _____		Term Date: _____	Max Caseload Adult: _____ Children: _____
Age Group Served: _____		Current Caseload Adult: _____ Children: _____	
C= Site Serves Children ONLY		A = Site Serves Adults ONLY	B = Site Serves Children and Adults
Definitions: MHP = Children 0-20; Adult 21		SUPT = Children 0-18; Adult 18+	

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Send completed form to:

Email: DHSQMStaffReg@saccounty.gov -or- Fax: (916) 875-0877