County of Sacramento **Department of Health Services** **Division of Behavioral Health Services** **Policy and Procedure**	Policy Issuer (Unit/Program)	**QM**
	Policy Number	**QM-03-07**
	Effective Date	**06-07-2005**
	Revision Date	**07/01/2025**
Title: **Staff Registration/Credentialing**	Functional Area: **Beneficiary Protection**	
Approved By: (Signature on File) **Signed version available upon request** **Alexandra Rechs, LMFT** Program Manager, Continuous Quality Improvement, Quality Assurance		

BACKGROUND/CONTEXT:

Sacramento County Behavioral Health Services (BHS) is responsible for assuring that the mental health and substance use prevention and treatment services provided to members are commensurate with the scope of practice, training and experience of the staff utilized. Behavioral Health Services, Quality Assurance (QA) must certify all staff providing mental health and substance use prevention and treatment services are in accordance with Title 9, Welfare and Institution Code, and Business and Professions Code regulations. BHS is responsible for issuing a Staff Identification when the credentialing requirements are met. Providers are encouraged to register staff immediately upon hire to avoid credentialing delays or challenges with billing activities. In addition, licensed staff must register with QA as QA maintains confirmation of licensure for staff performing in a licensed position whether or not they provide direct mental health or substance use prevention and treatment services, or bill for any services provided.

DEFINITIONS:

Licensed Practitioner of the Healing Arts (LPHA)

An LPHA is an individual who may provide or direct others in providing specialty mental health or substance use prevention and treatment services. Direction may include, but is not limited to, acting as a clinical team leader, providing direct or functional supervision of service delivery, and approval of client plans. The LPHA directing services is ultimately responsible for the specialty mental health or substance use prevention and treatment services provided. An LPHA must sign staff registration applications, as required, and must possess and maintain a valid California Professional License at all times in one of the following professional classifications (California Code of Regulations, Title 9, Division 1, Article 8.):

1. **Psychiatrist**, **Medical Doctor (MD)**, **Psychiatric Resident***
2. **Doctor of Osteopathy (DO)**
3. **Licensed Clinical Psychologist (PSY, Ph.D., PsyD)**
4. **Registered or Advance Practice Pharmacist**
5. **Licensed Clinical Social Worker (LCSW)**
6. **Licensed Marriage and Family Therapist (LMFT)**
7. **Licensed Professional Clinical Counselor (LPCC)**
8. **Registered Nurse**
9. **Nurse Practitioner, Nurse Practitioner Psychiatric Specialist (NP, NPPS) ***
10. **Physician Assistant (PA)***

* A psychiatric resident is either an individual with a Postgraduate Training License (PTL) or an individual who has completed the requirements for the PTL and has an active Physician and Surgeon or Doctor of Osteopathy license in good standing and is enrolled in an Accreditation

Council for Graduate Medical Education (ACGME) Board-approved California residency or fellowship program to obtain a specialty in psychiatry.

*** Nurse Practitioner, Nurse Practitioner Psychiatric Specialist (NP, NPPS)**

- See Policy and Procedures # QM-03-04-Nurse Practitioner for additional details.

***Physician Assistant (PA)**

- See Policy and Procedures # QM-03-09-Physician Assistant for additional details

Certified Nurse Specialist (CNS)

A CNS possesses a valid California CNS license from the Board of Registered Nursing (BRN). In California a CNS does not have prescriber authority, meaning that they are not allowed to prescribe medication but are able to administer medications.

License Waivered, or Registered

A licensed waivered or registered individual is permitted to provide the same specialty mental health or substance use prevention and treatment services as a Licensed Practitioner of the Healing Arts (LPHA). However, they can only direct these services under the supervision of an LPHA. Additionally, a licensed waivered or registered staff member is not authorized to sign staff registration applications that require a licensed staff signature, nor can they co-sign clinical documentation requiring a licensed staff signature. A registered professional staff member or licensed waivered staff refers to an individual who is an Associate Marriage and Family Therapist (AMFT), an Associate Clinical Social Worker (ASW), an Associate Professional Clinical Counselor (APCC) or a licensed waivered staff member has been granted a Professional Licensure Waiver (PLW) by the Department of Health Care Services (DHCS) to provide mental health services as per Welfare and Institutions Code (W&I Code) section 5751.2, subdivision (f)(1), and/or is in good standing with their respective Board. The staff member must fit into one of the following categories:

1. A person with a **Master's Degree** registered with the appropriate licensing body and earning hours or testing for licensure, enabling them to offer LPHA-equivalent services.
2. An unlicensed individual with a **PhD/PsyD employed or under contract with the MHP with a degree in psychology and** is granted a Professional Licensure Waiver (PLW) by the State Department of Health Care Services (DHCS)***** *(See Business and Professions Code Section 2914, subdivision (d)(1) and CCR, Title 16, Section 1387)*
3. A PLW may be requested from DHCS for psychologists, clinical social workers, marriage and family therapists, or professional clinical counselors who have been recruited for employment from outside of California and is employed or under contract with the MHP or Sacramento County contracted provider to provide specialty mental health services. The individual must have the minimum amount of professional experience to gain admission to the applicable California licensing examination for their profession.

***See P & P #03-06 Licensure Waiver and Monitoring of Accrued Supervised Hours for details.**

Licensed Vocational Nurse (LVN)

An LVN possesses a valid California LVN license. Must meet specific criteria to direct specialty mental health or substance use prevention and treatment services. **(See P&P # 04-01 Site Certification for details).**

Psychiatric Technician (PT)

A PT possesses a valid California PT license. Must meet specific criteria to direct specialty mental health or substance use prevention and treatment services. **(See P&P # 04-01 Site Certification for details)**

Registered Pharmacist or Advanced Practice Pharmacist

A Pharmacist possesses a valid California State Board of Pharmacy license in good standing.

Occupational Therapist

Occupational Therapists possess a valid California OT license and are individuals who are at least 18 years of age, meet all applicable education, training, and licensure requirements, and provide services that support the ability of members to participate in meaningful activities within a variety of environments.

Medical Assistant

Medical Assistants are individuals who are at least 18 years of age, meet all applicable education, training and/or certification requirements, and provides administrative, clerical, and technical supportive services, according to their scope of practice, and provides services under the supervision of a licensed physician and surgeon as established by the corresponding state authority, or to the extent authorized under state law, a nurse practitioner or physician assistant that has been delegated supervisory authority by a physician and surgeon. The licensed physician and surgeon, nurse practitioner or physician assistant must be physically present in the treatment facility (medical office or clinic setting) during the provision of services by a medical assistant.

Mental Health Rehabilitation Specialist (MHRS)

A MHRS provides specialty mental health services under the direction of a licensed or license waived staff. A MHRS requires co-signatures on clinical documentation in accordance with applicable QA policies and procedures and the most current Procedure Code Manuel. A MHRS is an individual who meets one of the following requirements:

1. **Master's Degree** or **PhD** and two (2) years of full-time/equivalent (FTE) direct care experience in a mental health setting.
2. **Bachelor's Degree** and four (4) years FTE direct care experience in a mental health setting.
3. **Associate Arts Degree** and six (6) years of FTE direct care experience in a mental health setting. At least two of the six years must be post AA degree experience in a mental health setting.

FTE Experience may be direct services provided in a mental health setting in the field of:

1. **Physical Restoration**
2. **Psychology**
3. **Social Adjustment**
4. **Vocation Adjustment**

Other Qualified Provider (OQP)

An Other Qualified Provider practices specialty mental health services or substance use prevention and treatment services under the direction of a licensed or license waived staff. California's Medicaid State Plan (Medi-Cal) defines Other Qualified Provider as an individual at least 18 years of age with at minimum a high school diploma or equivalent degree determined to be qualified to provide the service by the county behavioral health department. As of July 1, 2023, the following classifications were registered/re-registered into the OQP classification:
Mental Health Assistants (I, II, III) and Non-certified Peers.

Clinical Trainee (Student)

A Clinical Trainee (Student) is an unlicensed individual who is enrolled in a post-secondary educational degree program in the State of California that is required for the individual to obtain licensure as a Licensed Mental Health Professional; is participating in a practicum, clerkship, or internship approved by the individual's program; and meets all relevant requirements of the program and/or applicable licensing board to participate in the practicum, clerkship, or internship and provides rehabilitative services, including, but not limited to, all coursework and supervised practice requirements. Evidence of active participation in a practicum, clerkship, or internship is required for this classification. Evidence can be in the form of a current school transcript showing the active period, or a signed attestation letter from the educational institution on their letterhead verifying the active period, or a copy of the signed MOU/Agreement between the educational institution and

the BHS provider detailing the active period.

A Clinical Trainee is one of the following:

1. "Medical Student in Clerkship (Physician Clinical Trainee)" participating in a field trainee placement while enrolled in an accredited Medical School for a degree in medicine (Doctor of Medicine (MD) or Doctor of Osteopathy (DO). Psychiatrist co-signature required.
2. "Psychologist Clinical Trainee participating in a field trainee placement while enrolled in an accredited PhD/PsyD Psychology program. LPHA- co signature required.
3. "Master's Level LPHA Clinical Trainee" participating in a field trainee placement while enrolled in an accredited Masters in Social Work (MSW) or Masters of Art (MA)/Masters of Science (MS) Counseling program. LPHA co- signature required.

As of May 2024, DHCS has approved the following clinical trainee classifications for those who are participating in field trainee placements in behavioral health settings:

4. Nurse Practitioner/Clinical Nurse Specialist
5. Occupational Therapist
6. Clinical Pharmacist
7. Physician Assistant Registered Associate
8. Psychiatric Technician
9. Registered Nurse
10. Licensed Vocational Nurse

Trainee extensions – Students who have graduated and wish for trainee hours to count towards BBS required hours must submit to a LIVE Scan fingerprinting prior to graduation and provided evidence to Sacramento County. Otherwise, a signed letter (attestation) from the trainee is required acknowledging these hours will not count toward BBS licensure.

Alcohol and Other Drug (AOD) Certified/Registered Counselor

Certified/Registered AOD Counselor is an individual who has completed program requirements and is certified by a DHCS Designated Certifying Organization. The individual must remain in good standing with their certifying organization to provide substance use prevention and treatment services for DBHS.

Certified Peer Specialist

Certified Peer Specialists are individuals with lived experience as behavioral health clients, family members, or caregivers. Their role is to provide support and to help others navigate complex social systems within the behavioral health system. To use the recently added Certified Peer Specialist Medi-Cal Service Codes, the peer must be at least 18 years of age, possess at minimum a High School Diploma or High School Equivalency Diploma (GED), have participated in a DHCS approved peer training program, and have passed the certification exam. Certified Peer Specialists must maintain an active certification to perform in this role.

PURPOSE:

The purpose of this policy and procedure is to delineate the staff classifications and the corresponding qualifications, education, and documentation requirements, for all staff providing mental health and substance use and prevention services. It is the policy of Behavioral Health Services to certify each qualifying staff providing mental health and/or substance use and prevention services, directly or indirectly. A Staff Identification (ID) is issued based on meeting requirements for each classification. It is recommended that providers register staff upon hire into the appropriate classification. Staff may not provide billing activities prior to registering with QM. Failure to register a staff prior to the staff providing services to clients at a MHP or SUPT provider site where the staff is employed may result in disallowance of all claims submitted by this staff until the staff is appropriately registered. The

registration date is the date QM receives the completed registration packet. Knowingly registering a staff member into a classification for which the staff does not qualify, or for a duration beyond the timeframe of qualification, may result in disallowance of all billing claims submitted by this staff when the staff was working out of scope. Please update QM immediately with classification updates.

Completing staff registration in SmartCare requires shared data entry responsibilities between QM and Sacramento County Electronic Health Record (EHR) teams. Due to this new process both the Staff Registration/Credentialing Application, supporting forms and documents, AND the EHR Training Registration Form will all be sent directly to the QM Staff Registration email box at **DHSQMStaffReg@saccounty.gov. Providers who do not use the County EHR are still required to register all licensed staff and other staff providing direct care services to BHS members. It is not necessary, however, to take the EHR training.**

Provider Application and Validation for Enrollment System (PAVE) is a secure, interactive, web-based system for providers to enroll in the Medi-Cal Fee-for-Service program. All designated staff providing direct-care services to BHS members must provide evidence of enrollment in PAVE during the Staff Registration process.

Medi-Cal Rx is the Medi-Cal pharmacy benefit in the fee-for-service delivery system statewide, standardized under one delivery system. Prescribers are required enroll in the Medi-Cal Rx Provider Portal at https://uac.primetherapeutics.com and provide evidence of enrollment during the Staff Registration process. Non-prescribers, MAT/NTP/OTP medical staff who dispense and administer medications, but do not prescribe medications, and medical staff who **solely** work in an inpatient hospital setting with an in-house pharmacy are exempt from this requirement.

DETAILS:

I. Staff Registration/Credentialing Application

The completed Quality Management Staff Registration/Credentialing Application Form (Attachment A or A1), the SSN Consent Form (Attachment C), and a copy of the NPI printout is submitted to Quality Management with all the required supporting documentation for the requested professional classification at the start of employment. Please ensure the NPI taxonomy is correct for the classification being requested on the NPPES NPI Registry system prior to registration (see Staff Registration/Credentialing Checklist for guidance)

A. Specify the reason for the application:

1. **New** – This staff is unknown to the MHP or SUPT and does not possess a Staff Identification (ID). An EHR Account/Training Registration form must be completed for both CalMHSA LMS and Sacramento County BHS-EHR live trainings and submitted with the Staff Registration packet. This is required for new user account creation and must be signed by the agency's Authorized Approver. This form can be found on the BHS website at BHS EHR Training Registration Form

2. **Update**- This staff possesses a Staff ID, and the agency wishes to change information previously submitted. Example: Name change, professional classification, employment status. **Please note** when staff changes are made, an updated registration form must be completed and submitted along with any applicable supporting documentation. Failure to register the staff or update credentialing information with QM in a timely manner causes this staff to be out of compliance with this P&P. All billings incurred prior to registration to the new program may be disallowed.

3. **Termination** – This staff is terminated from current employer program(s) within the MHP or SUPT Plans.

4. **Date** – Date application is being completed.

B. Agency

1. Agency name
2. Agency phone number of the staff registration contact person within the agency
3. Agency contact person's name for staff registration issues
4. Agency contact person's email address

C. Applicant

1. Applicant Name. ***It must match the name on NPI Registry and Professional Board or Certifying Organization, or Peer Certification, if applicable.***
2. Date of Birth (**required to query State and Federal databases mandated as part of the credentialing process),**
3. Previous Name/AKA – indicate any previous name(s) submitted.
4. Staff email – Work email associated with the MHP/SUPT employer.
5. National Provider Number (NPI) – Write NPI number on the form and attach the NPPES printout.
6. Taxonomy (see Staff Registration/Credentialing Checklist for guidance on choosing the correct taxonomy code.)
7. Gender **(Required for Staff Registration)**
8. Date of Employment with current agency program.
9. Termination Date - Provider is required to update Quality Management of the termination date when a staff is no longer employed at a provider agency or program. Submission of the BHS EHR Training Registration Form is required to deactivate this staff in SmartCare. **<u>This step is imperative to prevent unintended violations with compliance regulations.</u>**
10. Employment Status – indicate appropriate status.
11. Area of Expertise – Please indicate the population being served by the MHP/SUPT program.

D. SmartCare Classification

1. Indicate the specific classification for which this staff qualifies and is being hired.
2. For Registered or Licensed Clinicians – indicate Registration/License Number and Expiration Date – submit copy of professional registration or license.
3. For Registered or Certified AOD Counselors – submit a copy of the certifying Board's registration or certification.
4. DEA Number, Start Date, and Expiration Date – prescribers must provide a copy of their DEA license.
5. Peer Certification Number – submit a copy of the Peer Certification
6. Board/Certification Organization Name (For Licensed, licensed waivered, AOD counselors and Certified Peer Specialists)

II. Professional Classification Supporting Documentation and Permissions

A. LPHA Licensed Physician Class: Medical Doctor (MD), Psychiatrist, Doctor of Osteopathy (DO), Nurse Practitioner (NP), Physician Assistant (PA)

1. See Staff Registration/Credentialing Checklist – Sections I and II or V for Residents or Fellows
2. MDs and DOs are able to provide supervision for Nurse Practitioners and Physician Assistants with signed written agreement.
3. Psychiatric Resident or Fellow must also complete the Resident Application (Attachment E) attesting to the type of resident/fellow they are.

B. Registered Nurse (RN), Licensed Vocational Nurse (LVN), Certified Nurse Specialist (CNS), Pharmacist, Psychiatric Technician (PT), Occupational Therapist (OT)

1. See Staff Registration/Credentialing Checklist – Sections I and III

C. LPHA Licensed Non-Physician Class: Licensed Marriage and Family Therapist, Licensed

Clinical Social Worker, Licensed Professional Clinical Counselor

1. See Staff Registration/Credentialing Checklist – Sections I and IV
2. May co-sign for any staff's work.
3. May provide services and supervision in accordance with the professional class scope of practice.
4. All LPHAs providing clinical supervision must be registered with QM whether or not they are providing direct care services or work on-site at a provider agency.

D. License Registered/Waived Professional Class: Associate Clinical Social Worker (ASW), Associate Marriage and Family Therapist (AMFT), Associate Professional Clinical Counselor (APCC), and Waivered Psychologist.

1. See Staff Registration/Credentialing Checklist – Sections I and VI
2. Registration with the BBS must be maintained until licensure is confirmed. Staff will not be considered registered/waived for any period during which the BBS registration is allowed to expire due to delinquency, renewal pending, cancellation, revocation, suspension, etc.
3. The BBS Supervision Agreement (ASW, AMFT, APCC) must be maintained until the candidate is licensed. The supervisor of record on the BBS Supervision Agreement must match the supervisor's name on the Registered Professional LPHA Application and the supervisor must be registered with QM.
4. If there is a change in clinical supervisor, a new BBS Supervision Agreement is due to QM.
5. If there is more than one staff providing clinical supervision, submit a BBS Supervision Agreement and Registered Professional LPHA Application for each supervisor.
6. Once clinical hours have been approved by the BBS, the Supervision Agreement located at the bottom portion of the Registered Professional LPHA Application (Attachment F) may be utilized in lieu of the BBS Statement of Responsibility. A copy of the State of California Notice of Eligibility letter indicating eligibility to test for the clinical exam is required as proof of clinical hours completion or "being in the testing phase."
7. For Waivered Psychologists – QM will forward this application to DHCS with all the required documents for consideration. If approved, DHCS will determine the start and end date of the waiver period.

E. MHRS Professional Class

1. See Staff Registration/Credentialing Checklist – Sections I and VII

F. Trainees: Medical Student in Clinical Clerkship (Physician Clinical Trainee), Psychologist Clinical Trainee, Master Level LPHA Clinical Trainee, Nurse Practitioner/Clinical Nurse Specialist, Occupational Therapist, Clinical Pharmacist, Physician Assistant Registered Associate, Psychiatric Technician, Registered Nurse, or Licensed Vocational Nurse.

1. See Staff Registration/Credentialing Checklist – Sections I and VIII
2. Trainees will have access to the CalAIM Assessment and the diagnosis form in SmartCare while in their trainee placement. They will have access to the same procedure codes for services provided as their licensed supervisor.
3. The Trainee classification is approved for up to one year at a time.
4. The Trainee status terminates when the placement term expires or the trainee graduates. If the trainee remains with BHS post-placement, the trainee must submit an application for the appropriate classification for which s/he qualifies.
5. Co-signature is required by a licensed individual of the same discipline or higher.
6. **May not co-sign for other staff.**

F1. Trainee Extension - An individual can request a trainee extension when any of the following occurs:

1. The individual remains a trainee, and the internship/practicum lasts longer than the requested timeframe with the same provider.
2. The trainee has completed required coursework but must remain in the current placement to complete their degree requirements.

3. The trainee has graduated from school and the provider at the time of graduation intends to hire the trainee, with no break in service, for continuity of care with clients receiving therapy services by the trainee while the trainee applies to the Board of Behavioral Sciences to become an AMFT, ASW, APCC.
    a. Post-graduate extensions are for up to 90 days. Additional extensions may be available on a limited basis for the purpose of BBS registration. Supporting documentation of extenuating circumstances is required.
    b. If the trainee intends to count supervised experience gained during the window of time between the degree award date and the issue date of the Associate number, Per the BBS 90-day Rule, Live Scan fingerprinting is required prior to gaining post-degree experience hours.
    c. If the Trainee does not plan to count post-degree experience towards BBS clinical hours, Live Scan fingerprinting is not required, however, the extension request must include a written attestation signed by the trainee attesting to their understanding of the BBS 90-day Rule requirement and their decision to abandon the potential clinical hours.

*QM may require verification from the school of the trainee's educational status.

G. Medical Assistant:
1. See Staff Registration/Credentialing Checklist – Sections I and IX

H. Other Qualified Provider
1. See Staff Registration/Credentialing Checklist – Sections I and X

I. Certified Peer Specialist Classification:
1. See Staff Registration/Credentialing Checklist – Sections I and XI

J. Registered or Certified Alcohol and Other Drug (AOD) Counselor
1. See Staff Registration/Credentialing Checklist – Sections I and XII

K. Community Health Worker (CHW)
1. See Staff Registration/Credentialing Checklist – Sections I and XIII

III. Quality Management Staff Certification document

A. QM will return the signed application to the agency following inspection of all the required supporting documents.
1. The Staff ID will be issued/activated when BHS certifies the staff.
2. The documents must be maintained in the agency staff file.

IV. Registry Staff

A. Registry staff may be utilized by the MHP or SUPT provider agencies when the staff meets the requirements for the professional class being requested and submits the required supporting documentation.

B. The agency must document that an appropriate orientation was provided to this staff. Orientation must include, but is not limited to, documentation and program level HIPAA training.

C. The Registry must provide the agency with verification that the staff completed the general HIPAA training.

REFERENCE(S)/ATTACHMENTS:

- Title 9. Division I, Chapter 3, Article 8; Welfare & Institutions Code Section 5600, 5750, 5751
- Title 9 Division 4, Chapter 3, Subchapter 3, Article 1
- Title 9 Division 4, Chapter 4, Subchapter 3, Article 1
- Title 9 Division 4, Chapter 5, Subchapter 3, Article 2
- Title 9 Division 4, Chapter 8, Subchapter 1,2 ,3

- Business and Professions Code Section 2900-2918, 4980.02, 4980.43, 4996.23, 4996.9,4999.20, 4999.46, 4989.14
- DHCS MHSUDS Information Notice 14-005
- DHCS MHSUDS Information Notice 17-008
- DHCS MHSUDS Information Notice No. 17-040
- DHCS MHSUDS Information Notice No.: 18-019
- DHCS MHSUDS Information Notice No.: 18-056
- DHCS BHIN No.: 20-069
- DHCS BHIN No.: 20-063
- Attachment A – MHP Staff Registration/Certification Application
- Attachment A1 - SUPT Staff Registration/Certification Application
- Attachment B – Staff Registration/Certification Checklist
- Attachment C – Social Security Number (SSN) Consent Form
- Attachment D – Licensed Staff Application
- Attachment E – Resident Application
- Attachment F – Registered Professional LPHA Application
- Attachment G – LPHA Licensure Waiver Application for Psychologist
- Attachment H – Clinical Trainee (Student) Application
- Attachment I – Mental Health Rehabilitation Specialist Application (MHRS)
- Attachment J – AOD Counselor Application
- Attachment K – Community Health Worker Attestation
- Attachment L – Taxonomy codes
- EHR Training Request Form

RELATED POLICIES:

- No. 03-06 Licensure Waiver and Monitoring of Accrued Supervised Hours
- No. 03-04 Nurse Practitioner
- No. 03-09 Physician Assistant
- No. 03-15 Community Health Worker (CHW) and Enhanced CHW Services
- No. 10-26 Core Assessment
- No. 10-27 Problem List and Care Planning – MHP and DMC-ODS

DISTRIBUTION:

Enter X	DL Name	Enter X	DL Name
X	Mental Health Staff	**X**	Children's Contract Providers
X	Mental Health Treatment Center	**X**	Substance Use Prevention and Treatment Services
X	Adult Contract Providers		

CONTACT INFORMATION:

- Quality Management Information QMInformation@SacCounty.gov
- Quality Management Staff Registration DHSQMStaffReg@saccounty.gov

Sacramento County Department of Health Services
Division of Behavioral Health
QUALITY MANAGEMENT
STAFF REGISTRATION/CREDENTIALING APPLICATION
Specialty Mental Health Services (SMHS)

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

Mental Health 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)

- ◯ MD Medical Doctor (Psychiatrist, Psychiatric Resident, or Fellow)
- ◯ DO Doctor of Osteopathy
- ◯ Ph.D. Doctor of Philosophy (Clinical Psychologist)
- ◯ PsyD Doctor of Psychology (Clinical Psychologist)
- ◯ NP Nurse Practitioner
- ◯ PA Physician Assistant
- ◯ CNS Clinical Nurse Specialist
- ◯ LVN Licensed Vocational Nurse
- ◯ RN Registered Nurse
- ◯ PT Psychiatric Technician
- ◯ OT Occupational Therapist
- ◯ LCSW Licensed Clinical Social Worker
- ◯ LMFT Marriage and Family Therapist
- ◯ LPCC Licensed Professional Clinical Counselor
- ◯ Waivered Psychologist
- ◯ ASW Associate Social Worker
- ◯ AMFT Associate Marriage Family Therapist
- ◯ APCC Associate Professional Clinical Counselor
- ◯ MHRS Mental Health Rehabilitation Specialist
- ◯ Certified Peer Specialist

Trainee:

- ◯ Master's Degree LPHA ◯ NP ◯ PA
- ◯ Physician Clinical ◯ CNS ◯ LVN
- ◯ Psychological Clinical ◯ PT ◯ RN
- ◯ OT

- ◯ Other Qualified Provider
- ◯ Medical Assistant
- ◯ AOD Counselor
- ◯ 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 *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.*	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? *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.*	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:

- ◯ Lic. Psychiatrist
- ◯ Lic. Physicians
- ◯ Lic. Psychologist
- ◯ LCSW
- ◯ LMFT
- ◯ LPCC
- ◯ Registered Nurse
- ◯ Cert. Nurse Specialist
- ◯ Nurse Practitioner
- ◯ Lic. Vocational Nurse
- ◯ Psych. Technician
- ◯ MHRS
- ◯ Physician Assistant
- ◯ Pharmacist
- ◯ Occupational Therapist
- ◯ ASW
- ◯ AMFT
- ◯ APCC
- ◯ Waivered Psychologist
- ◯ Other Qualified Provider (Includes All Trainees)
- ◯ Certified Peer

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: _____

Service Types (choose all that apply):

- ☐ Mental Health Services
- ☐ Case Management
- ☐ Crisis Intervention
- ☐ Medication Support
- ☐ Intensive Care Coordination
- ☐ Intensive Home-Based Services

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:

DSM Practice Focus (you may select up to 5 (five):

- [ ] 1D – Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence
- [ ] CD- Delirium, Dementia, and Amnestic and Other Cognitive Disorders
- [ ] GM – Mental Disorders Due to a General Medical Condition Not Elsewhere Categorized
- [ ] SR – Substance-Related Disorders
- [ ] PS – Schizophrenia and Other Psychotic Disorders
- [ ] DS – Depressive Disorders
- [ ] BP – Bi-Polar Disorders
- [ ] MD – Mood Disorders
- [ ] AD – Anxiety Disorders
- [ ] SD – Somatoform Disorders
- [ ] FD – Factitious Disorders
- [ ] DD – Dissociative Disorders
- [ ] SG – Sexual and Gender Identity Disorders
- [ ] ED – Eating Disorders
- [ ] SL – Sleep Disorders
- [ ] IC – Impulse-Control Disorders Not Otherwise Elsewhere Categorized
- [ ] PD – Personality Disorders

Site Information

Information must be complete for each program and site address staff works. **Additional site entries can be found on the next page.**

Site #1 Program Name _____

Street Address_____ Suite # _____ City_____ Zip_____

*FTE Adult: _____ *FTE Youth: _____ **Max Caseload Adult:_____ **Max Caseload Youth:_____

Hire Date: _____ Term Date:_____

Age Group Served:

◯ 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 #2 Program Name _____

Street Address_____ Suite # _____ City_____ Zip_____

*FTE Adult: _____ *FTE Youth: _____ **Max Caseload Adult:_____ **Max Caseload Youth:_____

Hire Date: _____ Term Date:_____

Age Group Served:

◯ 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 #3 Program Name _____

Street Address_____ Suite # _____ City_____ Zip_____

*FTE Adult: _____ *FTE Youth: _____ **Max Caseload Adult:_____ **Max Caseload Youth:_____

Hire Date: _____ Term Date:_____

Age Group Served:

◯ 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+

* FTE Adult and FTE Children – For each site and age group served by the staff, enter the percentage of a full-time equivalent (FTE) position each staff is available to serve beneficiaries. Enter the percentage as a numeric three-digit value that is greater than or equal to "000" and less than or equal to "100". For example, 20 hours per week or 0.5 FTE would equate to "050." If a staff serves adults and children/youth, the staff's FTE percentage should be reported for each age group. For example, if one FTE staff serves children/youth 30% of the time and adults 70% of the time, enter the respective FTE value for that age group (i.e., 030 for 0-20; 070 for 21+).

** Caseload Adult and Max Caseload Children – This identifies the maximum caseload assigned to a staff per site and per age group served by the staff. If the staff does not have a set caseload, then enter the maximum number of beneficiaries the staff is able to serve in a typical work week.

Send completed form to:

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

Site #4 Program Name _____

Street Address_____ Suite # _____ City_____ Zip_____

*FTE Adult: _____ *FTE Youth: _____ **Max Caseload Adult:_____ **Max Caseload Youth:_____

Hire Date: _____ Term Date:_____

Age Group Served:

◯ 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 #5 Program Name _____

Street Address_____ Suite # _____ City_____ Zip_____

*FTE Adult: _____ *FTE Youth: _____ **Max Caseload Adult:_____ **Max Caseload Youth:_____

Hire Date: _____ Term Date:_____

Age Group Served:

◯ 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 #6 Program Name _____

Street Address_____ Suite # _____ City_____ Zip_____

*FTE Adult: _____ *FTE Youth: _____ **Max Caseload Adult:_____ **Max Caseload Youth:_____

Hire Date: _____ Term Date:_____

Age Group Served:

◯ 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 #7 Program Name _____

Street Address_____ Suite # _____ City_____ Zip_____

*FTE Adult: _____ *FTE Youth: _____ **Max Caseload Adult:_____ **Max Caseload Youth:_____

Hire Date: _____ Term Date:_____

Age Group Served:

◯ 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+

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
- ◯ MD Medical Doctor
- ◯ Licensed Psychiatrist
- ◯ Medical Resident/ACGME Fellow
- ◯ Medical Intern
- ◯ NP Nurse Practitioner
- ◯ PA Physician Assistant
- ◯ RN Registered Nurse
- ◯ CNS Clinical Nurse Specialist
- ◯ LVN Licensed Vocational Nurse
- ◯ PT Psychiatric Technician
- ◯ Medical Assistant
- ◯ OT Occupational Therapist
- ◯ Registered or Advanced Practice Pharmacist
- ◯ Ph.D. Doctor of Philosophy (Clinical Psychologist)
- ◯ PsyD Doctor of Psychology (Clinical Psychologist)
- ◯ LCSW Licensed Clinical Social Worker
- ◯ LPCC Licensed Professional Clinical Counselor
- ◯ MFT Marriage and Family Therapist
- ◯ Waivered Psychologist
- ◯ ASW Associate Social Worker
- ◯ AMFT Associate Marriage Family Therapist
- ◯ APCC Associate Professional Clinical Counselor
- ◯ Certified Peer Specialist
- ◯ Certified AOD Counselor
- ◯ Registered AOD Counselor

Clinical Trainees:

- ◯ Master's Clinical
- ◯ Medical Clinical Clerkship
- ◯ Psychologist
- ◯ Pharmacist
- ◯ Licensed Vocational Nurse
- ◯ NP/Nurse Specialist
- ◯ Physician Assistant Registered
- ◯ Assoc Occupational Therapist
- ◯ Psychiatric Technician
- ◯ Registered Nurse

- ◯ 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 *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.*	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? *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.*	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
- ◯ Nurse Practitioner
- ◯ Physician Assistant
- ◯ Registered Nurse
- ◯ Pharmacist
- ◯ Lic. Psychologist
- ◯ LCSW
- ◯ LMFT
- ◯ LPCC
- ◯ Certified Peer
- ◯ Lic. Vocational Nurse
- ◯ Registered SUD Counselors
- ◯ Certified SUD Counselors
- ◯ Licensed Eligible Practitioners Working Under Supervision of a Licensed Clinician
- ◯ Other Qualified Provider

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

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+

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+

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+

Send completed form to:

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

Sacramento County Department of Health Services
Division of Behavioral Health
QUALITY MANAGEMENT
STAFF REGISTRATION/CREDENTIALING CHECKLIST

I. All Provider Staff: Please include the following with the completed registration packet

- ☐ Registration/Credentialing Form – Provide your full legal name. Do not use nicknames, initials, or abbreviations. All applicable sections of the form must be complete. Also, if you answer "yes" to any of the attestation questions A-M, provide full details on a separate sheet of paper.
- ☐ SSN Consent Form – Provide your full legal name. Do not use nicknames, initials, or abbreviations. Attachment C
- ☐ Copy of NPI registration with valid taxonomy. (Note: Taxonomy code must be designated as primary.) (Click the attached link to create/update NPI - NPPES (hhs.gov))
- ☐ 274 Provider Information – Both MHP and SUPT
- ☐ EHR Account/Training Registration Form – For New Staff or New Permission requests

See Attachment L for valid Taxonomy Codes

II. If you are a MD, Psychiatrist, LP, DO, NP, or PA please submit the following:

- ☐ All the documents listed in Section I Registration
- ☐ Copy of current Unrestricted DEA
- ☐ Copy of current Professional License
- ☐ Licensed Staff Application (Attachment D)
- ☐ Proof of ORP enrollment (approval letter or screenshot from your PAVE account showing the "approved" status of your application. If you are still waiting for approval, please submit a screenshot from your account showing that you have submitted your application.

All prescribing MDs, DOs, NPs, and PAs are required to provide proof of enrollment in the Medi-Cal Rx Provider Portal at https://uac.primetherapeutics.com/ . Non-prescribers, MAT/NTP/OTP medical staff, and those who solely working in an inpatient hospital setting with an in-house pharmacy are exempt from this requirement.

III. If you are a RN, LVN, CNS, Pharmacist, PT, and OT please submit the following:

- ☐ All the documents listed in Section I
- ☐ Licensed Staff Application (Attachment D)
- ☐ Copy of current Professional License/Certification

IV. If you are a LMFT, LCSW, LPCC, or Licensed Psychologist, please submit the following:

- ☐ All the documents listed in Section I
- ☐ Licensed Staff Application (Attachment D)
- ☐ Copy of current Professional License and BBS Printout
- ☐ Proof of ORP enrollment (approval letter or screenshot from your PAVE account showing the "approved" status of your application. This applies to licensed clinicians who bill Medi-Cal for services rendered.

V. If you are a Psychiatric Resident or Fellow:

- ☐ All the documents listed in Section I
- ☐ Copy of DEA license, if applicable
- ☐ Copy of Postgraduate Training License (PTL), Physician and Surgeon License, or Doctor of Osteopathy License
- ☐ Resident or Fellow Application (Attachment E) or Attachment D if PTL exempt

VI. If you are an AMFT, ASW, APCC, Waivered Psychologist, or Out-of-State licensed applicant please submit the following:

- ☐ All the documents listed in Section I
- ☐ Copy of current Registration and BBS Printout

Registered Professional LPHA Request (Attachment F) & **Supervisor Responsibility Agreement**
ASW – BBS Supervisor Agreement (ASW)
AMFT – BBS Supervisor Agreement (AMFT)
APCC – BBS Supervisor Agreement (APCC)

- ☐ *DHCS Mental Health Professional Licensing Waiver Request (Attachment G)
- ☐ *Copy of Doctoral Degree or certified copy of the individual's most current doctoral program transcript. The transcript must include the individual's full name, name of the institution, and demonstrate that the individual has completed the doctoral program, or the minimum number of units. (See QM-PP-03-07)

OR

- ☐ *Evidence of the out-of-state license and evidence from the California licensing board that the individual has been accepted to sit for the applicable licensing exam.
- ☐ *Resume
- ☐ *Copy of current, valid registration issued by the Board of Psychology, if applicable.

*(For Waivered Psychologist or Out-of-State Applicants Only)

VII. If you are a MHRS, please submit the following:

All the documents listed in Section I

☐ Resume

☐ Copy of degree or official transcript demonstrating that you have completed your coursework.

☐ Mental Health Rehabilitation Specialist Application (Attachment I)

VIII. If you are a Medical Student Clinical Clerkship (Physician Clinical Trainee), Psychological Clinical Trainee, Master Level Clinical Trainee, Nurse Practitioner/Clinical Nurse Specialty Trainee, Occupational Therapist Trainee, Clinical Pharmacist Trainee, Physician Assistant Registered Associate Trainee, Psychiatric Technician Trainee, Registered Nurse Trainee, or Licensed Vocational Trainee please submit the following:

☐ All the documents listed in Section I

☐ Trainee Application (Attachment H)

☐ Evidence of active internship/practicum status from school or program

☐ Trainee Extension (Attachment H1) and LIVE Scan or attestation (for graduates)

IX. If you are a Medical Assistant, please submit the following:

☐ All the documents listed in Section I

☐ Proof of training required in CCR Title 16 Sections 1366, 1366.1, or 1366.2 (Provide ONE of the following):

- Certification in writing from the supervising physician of the place and date the training was administered, the content and duration of the training, and that the medical assistant was observed by the certifying physician to demonstrate competence in the performance of each task or service. This certification must be signed by the supervising physician.

OR

- Degree or certificate from a secondary or adult education program in a community college, or an accredited postsecondary institution.

X. If you are an Other Qualified Provider, please submit the following:

☐ All the documents listed in Section I

☐ Proof of highest level of education (Provide ONE of the following):

- High School Diploma, GED, degree, or official transcript

OR

- School verification letter that course work was completed

XI. If you are a Certified Peer Specialist, please submit the following:

☐ All the documents listed in Section I

☐ Proof of highest level of education (Provide ONE of the following):

- High School Diploma, GED, degree, or official transcript OR
- School verification letter that course work was completed

☐ Peer Specialist Certification

XII. If you are an Alcohol and Other Drug Counselor, please submit the following:

☐ All the documents listed in Section I

☐ Copy of Certification or Registration from DHCS Designated Organization (i.e., CAADE, CADTP, CCAPP)

☐ AOD Counselor Application (Attachment J)

XIII. If you are a Community Health Worker, please submit the following:

☐ All the documents listed in Section I

☐ Supervisor Agreement

☐ CHW Application (Attachment K) Attestation that applicant meets the required minimum qualifications:

- Training Pathway – Completion of California Department of Health Care Access and Information (HCAI) approved CHW training program based on the statewide requirements. *This option will be available once HCAI has developed the process for training and certification.*

  OR

- Experience Pathway – To qualify for this pathway, experienced CHWs applying for the state CHW certificate will be required to meet either option A or B.
  - Option A: Submit 500 verified hours and attest to at least 2000 hours worked as a CHW (approximately 1 year of full-time work as an employee or a volunteer)
  - Option B: Submit proof completion of a training program that is currently approved for the Training Pathway and provide proof of completing 10 hours of field experience.

Sacramento County Department of Health Services
Division of Behavioral Health
QUALITY MANAGEMENT
SOCIAL SECURITY NUMBER CONSENT FORM

Sacramento County Behavioral Health Plan (BHS) is required to conduct federal exclusion database checks at the time of credentialing and recredentialing providers. This includes querying the Social Security Administration's Death Master File and National Practitioner Data Bank. These two database checks require the provider's Social Security number. Below is a form to authorize the Provider Services Staff of the Sacramento County Behavioral Health Division to use your Social Security number for these two required federal exclusion database checks.

Section I: Identifying Information

Provider's Legal Name:

Last: _____ First: _____ Middle: _____

Date Of Birth (MM/DD/YYYY): _____ NPI Number: _____

Social Security Number: _____

Section II: Signature

I authorize Sacramento County Behavioral Health Quality Management (QM) Unit to use my Social Security Number for purposes of identification when corresponding with the National Practitioner Data Bank and checking the Social Security Administration's Death Master File.

Print Name: _____

Signature: _____ Date:_____
(Stamped or Electronic Signature is Not Acceptable)

This form will only be viewed by QM Credentialing staff and will be destroyed once the initial check is complete.

Attachment D

Sacramento County
Department of Health Services
Division of Behavioral Health Services
LICENSED STAFF APPLICATION

Agency_____Date_____

Contact Person_____Phone_____

Contact Person's Email_____

I attest that I, _____, am licensed to provide behavioral health care services in the State of California.

I possess the following active license in good standing (choose one option below):

- ◯ Certified Nurse Specialist (CNS)*
- ◯ Licensed Vocational Nurse (LVN)*
- ◯ Licensed Psychologist (PsyD or PhD)
- ◯ Licensed Clinical Social Worker (LCSW)
- ◯ Licensed Marriage and Family Therapist (LMFT)
- ◯ Licensed Professional Clinical Counselor (LPCC)
- ◯ Doctor of Osteopathy (DO)
- ◯ Medical Doctor (MD)
- ◯ Physician Assistant (PA)
- ◯ Nurse Practitioner (NP)
- ◯ Registered Nurse (RN)*
- ◯ Pharmacist*
- ◯ Psychiatric Technician (PT)*
- ◯ Occupational Therapist (OT)*

- Classifications with an asterisk* are exempt from PAVE and/or Medi-Cal Rx Enrollment

I certify that the following statement(s) are true (Choose the correct option)

PAVE

☐ In my role, I will bill Medi-Cal for services rendered to clients. I understand that I must enroll in PAVE and submit evidence of enrollment to BHS.

☐ In my role, and I will **not** bill Medi-Cal for services rendered to clients. PAVE enrollment is **not** required.

Medi-Cal Rx

☐ As a prescriber of medications, I understand I must enroll, and provide BHS with evidence of enrollment, in Medi-Cal Rx to administer Medi-Cal Pharmacy benefits.

☐ In my role as a medical staff, I will not prescribe medications to clients. Therefore, enrollment in Medi-Cal Rx is not required.

Printed Name:_____

Signature:_____ Date_____

Sacramento County

Department of Health Services

Division of Behavioral Health Services

RESIDENT/FELLOW APPLICATION

Agency_____ Date_____

Contact Person_____ Phone_____

Contact Person Email_____

I attest that I, _____, am a medical resident in a California Accreditation Counsil for Graduate Medical Education (ACGME) accredited postgraduate training program.

Name of University_____

Select classification:

☐ Postgraduate Training Licensee (PTL). I attest that I possess an active PTL license and may only engage in the practice of medicine in connection with my duties with this residency program under the supervision of a licensed physician.

☐ Psychiatry Resident/Fellow. I attest that I possess an active Physician and Surgeon license or Doctor of Osteopathy license and am participating in a residency/fellowship program specializing in the field of psychiatry under the supervision of a licensed psychiatrist

Select correct statement(s):

☐ I have a Postgraduate Training License (PTL). I am under clinical supervision by a licensed physician and am exempt from the requirement to enroll in PAVE and Medi-Cal Rx.

☐ My license is unrestricted and I will provide direct care services to clients. (PAVE enrollment required)

☐ My License is unrestricted and I will prescribe mediations to clients. (Medi-Cal Rx enrollment required)

My residency begins on _____ and ends on _____
The end date cannot go beyond the expiration period on the PTL/MD/DO license. May update upon license renewal.

Resident/Fellow Signature_____ Date_____

Clinical Supervisor's Name_____ Discipline/License#_____

Clinical Supervisor's Signature_____ Date_____

QM Approval: Rolanda Adams, LCSW_____ Date_____

Sacramento County

Department of Health Services

Division of Behavioral Health Services

REGISTERED PROFESSIONAL LPHA APPLICATION

Agency: _____ **Date:** _____.

Contact Person: _____ **Phone:** _____.

This letter is to request an approval to provide services as an LPHA for the following employee under Title 9, Section 1810.254, Caliornia Code of Regulations (CCR).

I, _____, am requesting approval to provide services as a Registered Professional .
Print Name

I earned a _____ degree on _____
MSW, MS, MA, PhD, or EdD Date

I initially registered with the Board of Behavioral Sciences (BBS) on _____
Date

Attached are copies of my current BBS Associate Registration, BBS licensure status printout, and BBS Supervisor's Responsibility Statement. I understand that my approval will expire **six (6) years** from the initial date of BBS registration. I understand that I must remain registered with the BBS and under supervision until I become licensed. QM must receive renewal of the BBS registration prior to the expiration date. I will not be considered approved for any period during which I allowed my registration to expire. If there is a change in supervisor, I must submit a new BBS Supervisor's Responsibility Statement to Quality Management (QM).

Applicant: _____ Date: _____
Signature and Date

SUPERVISOR'S STATEMENT - This Statement meets the requirements for supervision **in lieu of** the BBS Supervisor's Responsibility Statement if the candidate is in the testing process for licensure.

As the agency supervisor, I attest that I have and will maintain a current license in good standing in California. I have had sufficient experience, training, and education in the area of clinical supervision to competently supervise trainees and associates.

Clinical Supervisor's Name _____ Type of licensure: _____
Print Name

Clinical Supervisor: _____
Signature Date

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Mental Health Professional Licensure Waiver (PLW) Application

PLW Application Instructions

Instructions: Read all the instructions included on this form carefully and complete each item requested. For additional information, please review California Welfare and Institutions Code section 5751.2, and the California Code of Regulations, Title 9, Division 1, Chapter 11.5 commencing with Section 1870, which outlines the requirements for Professional Licensure Waiver (PLW).

While the PLW application is under review, the new Mental Health Plan (MHP) or local mental health department (LMHD) shall not allow an individual to provide mental health services, where a professional licensure waiver is required.

Do not leave any questions, boxes, lines, or fields blank. Enter N/A if not applicable.

Applicants should not provide personal information that is not requested.

Eligibility requirements for a PLW:

Individuals acquiring a professional license to provide mental health services:

An individual shall meet the criteria specified below to be eligible for a PLW (California Code of Regulations, Title 9, Division 1, Chapter 11.5, § 1876(a)(1)(A-B)):

(1) Be employed or under contract with the MHP or LMHD or provider subcontracting with the MHP or local mental health department to provide mental health services for the purposes of acquiring supervised professional experience required for licensure as a psychologist, as set forth under Business and Professions Code Section 2914 and Title 16 California Code of Regulations Section 1387; and either:

(A) Have earned a doctorate degree from an accredited or approved college or institution of higher education as set forth under Business and Professions Code Section 2914; or

(B) Be currently enrolled in a doctoral program and have completed a minimum of 48 semester/trimester or 72 quarter unit of graduate coursework in psychology not including thesis, internship, or dissertation, at an accredited or approved college or institution of higher education as set forth under Business and Professions Code Section 2914.

When submitting a PLW application for an unlicensed psychologist, the MHP or LMHD shall submit a current, certified doctoral program transcript (California Code of Regulations, Title 9, Division 1, Chapter 11.5, § 1878(a)(1-2)).

Individuals who are an out-of-state licensed professional:

An individual shall meet the criteria specified below to be eligible for a PLW (California Code of Regulations, Title 9, Division 1, Chapter 11.5, § 1876(a)(2)(A-C))**:**

(A) Be one of the following out-of-state licensed professionals:

1. Psychologist;

2. Clinical social worker;

3. Marriage and family therapist; or

4. Professional clinical counselor;

(B) Be recruited for employment from outside of California and employed or under contract with the MHP or LMHD or provider subcontracting with the MHP or LMHD to provide mental health services; and

(C) Have the minimum amount of professional experience, to gain admission to the applicable California licensing examination for their profession.

When submitting a PLW application for an out-of-state licensed professional, the MHP or LMHD shall submit a copy of the issued license that includes the individual's full name, license number, and name of the state they are licensed in and evidence from the appropriate California licensing board that the individual seeking the PLW has been granted admission to the applicable California licensing examination for their profession (California Code of Regulations, Title 9, Division 1, Chapter 11.5, § 1876(a)(3)(A-B)).

SUBMISSION: The completed PLW application and all required documentation are to be submitted to the Department of Health Care Services (DHCS) via email to MHLicensingWaivers@dhcs.ca.gov.

Section A Mental Health Plan (MHP) OR Local Mental Health Department (LMHD) Information Section

1. **Name of the MHP or LMHD:** Enter the name of the MHP or LMHD submitting the PLW application.

2. **Mailing address:** Enter the street address of the MHP or LMHD's mailing address. If applicable, enter the room or suite number of the MHP or LMHD's mailing address.
   2a. **City:** Enter the city of the MHP or LMHD's mailing address.
   2b. **State:** Enter the state of the MHP or LMHD's mailing address.
   2c. **Zip code:** Enter the zip code of the MHP or LMHD's mailing address.

3. **Email address:** Enter the MHP or LMHD's email address for communication regarding the PLW.

4. **Telephone number:** Enter the MHP or LMHD's telephone number, including area code and extension, if any, for communication regarding the PLW.

Section B Individual Seeking PLW Information Section

1. **Full legal name:** Enter the full legal name of the individual seeking PLW. Include first name, middle name (if applicable), and last name, as well as any aliases or maiden names.

2. **Email address:** Enter the email address of the individual seeking PLW.

3. **The start date for the individual seeking PLW to provide mental health services:** Enter the date the individual seeking PLW is expected to begin providing mental health services in the position requiring a PLW. PLW approvals will not be backdated.

Mental Health Professional Licensure Waiver (PLW) Application

Section C Type of PLW Application

Check the appropriate box that corresponds to the type of PLW application being made by the applicant on behalf of an individual seeking a PLW. Select one.

- **New PLW application:** for an individual acquiring a professional license to provide mental health services; or
- **New PLW application:** for an individual with an out-of-state license; or
- **Individual with a change in employment**: for an individual with an existing approved PLW.

Section D New PLW Application

Individual acquiring a professional license to provide mental health services

If the type of PLW application selected is for an “individual acquiring professional license to provide mental health services," provide the following information:

1. **Name of the doctorate degree:** Enter the name of the doctorate degree obtained or being pursued by the individual seeking PLW.
2. **Date doctorate degree conferred:** If the individual has earned their doctorate degree, enter the date the degree was conferred in the format of Month/Day/Year. If the individual is still pursuing their doctorate degree, enter N/A.
3. **Name of the college or institution of higher education:** Enter the name of the college or institution that conferred the doctorate degree, or college or institution the individual seeking PLW is pursuing a doctorate degree at.
4. **If currently enrolled in a doctoral program, number of units completed:** If the individual seeking PLW is currently enrolled in a doctoral program, enter the number of units of graduate coursework in psychology (excluding units earned for thesis, internship, or dissertation) completed thus far. Specify whether units are measured by semesters/trimesters or quarters.

Section E New PLW Application

Individual with an out-of-state license

If the type of PLW application selected is for an “individual with an out-of-state license,” provide the following information:

1. **Type of License:** Check the appropriate box that corresponds to the out-of-state license held by the individual seeking PLW.
2. **License number:** Enter the license number associated with the out-of-state license held by the individual seeking PLW.
3. **State issued:** Enter the name of the state where the out-of-state license was issued.
4. **License issued date:** Enter the issue date of the out-of-state license in the format of Month/Day/Year.
5. **License expiry date:** Enter the expiration date of the out-of-state license in the format of Month/Day/Year.

Mental Health Professional Licensure Waiver (PLW) Application

Section F Individual with a change in employment (For individuals with an existing approved PLW)

This section is to be used for circumstances in which an individual with an existing approved PLW will be employed by a new MHP or LMHD, or by a provider subcontracting with a new MHP or LMHD.

If the type of PLW application selected is for an "individual with a change in employment (for individuals with an existing approved PLW)" provide the following information:

1. **Name of the MHP or LMHD the PLW was initially issued in:** Enter the name of the MHP or LMHD where the waivered individual was or is employed or under contract.
2. **PLW end date:** Enter the end date of the existing PLW.

Section G Declaration This section is to be completed by QM

All PLW applications must be submitted, signed, and dated by the Director or Designee of the MHP or LMHD on file with DHCS.

1. **Name of Director/Designee of MHP or LMHD:** Enter the name of Director or Designee of MHP or LMHD.
2. **Signature of Director/Designee of MHP or LMHD:** Include the signature of the Director or Designee of MHP or LMHD.
3. **Date:** Enter the date the PLW application was signed.

Mental Health Professional Licensure Waiver (PLW) Application

Section A	**Mental Health Plan or Local Mental Health Department Information**	
1. Name of the Mental Health Plan (MHP) or Local Mental Health Department (LMHD):		
2. Mailing address:		
2a. City:	2b. State:	2c. Zip code:
3. Email address:	4. Telephone number:	

Section B	**Individual Seeking PLW Information**
1. Full legal name: (Include first name, middle name (if applicable), and last name, as well as any aliases or maiden names)	
2. Email address:	
3. Date individual seeking PLW is expected to begin providing mental health services in the position requiring waiver:	

Section C	**Type of PLW Application** (Select one)

☐ New PLW application: Individual acquiring a professional license to provide mental health services. *(Complete sections A, B, C, D and G)*

☐ New PLW application: Individual with an out-of-state license. *(Complete sections A, B, C, E and G)*

☐ Individual with a change in employment (for an individual with an existing approved PLW). *(Complete sections A, B, C, F and G)*

Section D	**New PLW Application** **Individual acquiring a professional license to provide mental health services information**
1. Name of the doctorate degree/program:	2. Date doctorate degree conferred: *(Transcript submission required)*

Mental Health Professional Licensure Waiver (PLW) Application

3. Name of the college or institution of higher education:
4. If currently enrolled in a doctoral program, number of graduate units completed: *(Transcript submission required)* Semester/Trimester units _____ Quarter units _____
Section E New PLW Application **Individual with an out-of-state license information**
1. Type of License: (Select one) ☐ Psychologist ☐ Clinical Social Worker ☐ Professional Clinical Counselor ☐ Marriage and Family Therapist

2. License number:	3. Name of the state:
4. License issue date:	5. License expiry date:

Section F Individual with a change in employment **(For individuals with an existing approved PLW)**
1. Name of the MHP or LMHD the PLW was issued in:
2. PLW end date:

Mental Health Professional Licensure Waiver (PLW) Application

Section G	Declaration

I declare under penalty of perjury under the laws of the State of California that the foregoing information and any attachment is true, accurate, and complete to the best of my knowledge and belief.

Print name of Director/Designee of MHP or LMHD:

Signature of Director/Designee of MHP or LMHD:

Date:

Privacy Statement

This form is used to request a professional licensure waiver. The information requested in this form is required by the Department of Health Care Services (Department). Any personal and health information collected in this form by the Department is subject to limitations in the Information Practices Act (IPA), the Health Insurance Portability and Accountability Act (HIPAA), and other state policy. The Department will not use or share your information unless authorized by you, or by the individual to whom it pertains, in writing or as authorized by law. All information requested in this form is mandatory. If you do not provide all information requested in this form, your application will be deemed incomplete. If missing information is not provided as required, review of this application will be terminated, and denial of a professional licensure waiver provided. The Department may share or provide any of the information provided in or with this form to the California Health and Human Services Agency, the California State Controller's Office, the California Department of Consumer Affairs, the United States Department of Health and Human Services, and the United States Substance Abuse and Mental Health Services Administration, or other federal, state, or local agencies as appropriate. In most cases, you have a right to see personal information about you that is kept in federal and state records.
For more information or to obtain access to records containing your personal information maintained by the Department, contact:

Staff Services Manager I
County/Provider Oversight and Operations Support Section, Unit 4
Behavioral Health, MS 2621, P.O. Box 997413, Sacramento, CA 95899-7413
Phone: (916) 713-8633
Email: MHLicensingWaivers@dhcs.ca.gov

The Department is authorized to collect this information pursuant to California Welfare and Institutions Code section 5751.2 and California Code of Regulations, Title 9, Division 1, Chapter 11.5. The Department is also authorized to collect personal and health information for the administration of the Medi-Cal program. For more information on the Department's Privacy Practices, please visit https://www.dhcs.ca.gov/formsandpubs/laws/priv/Documents/Notice-of-Privacy-Practices-English.pdf and https://www.dhcs.ca.gov/Pages/Privacy.aspx.

Mental Health Professional Licensure Waiver (PLW) Application

If you wish to obtain a paper copy of the Department's privacy policy and practices, or wish to file a complaint, you may contact the Department's privacy officer by mail, email, or telephone at:

Privacy Office
c/o: Data Privacy Unit
Department of Health Care Services
P.O. Box 997413, MS 4722
Sacramento, CA 95899-7413

Email: incidents@dhcs.ca.gov

Telephone: (916) 445-4646

The privacy notice provided here is required by California Civil Code section 1798.17.

For Completion by the Department of Health Care Services

Date complete PLW application and supporting documentation received:	
Date PLW begins:	Date PLW ends:
Comments:	

This waiver is granted pursuant to California Code of Regulations Title 9, Division 1, Chapter 11.5.

Approved by:

Title:

Signature:

Date:

Sacramento County
Department of Health Services
Division of Behavioral Health Services
CLINICAL TRAINEE APPLICATION

Agency: _____ Date: _____

Contact Person: _____ Phone:_____

I attest that I,_____ am a student enrolled at an accredited college or university participating in a field placement. I understand that I may provide services similar to an LPHA, except for the privilege of co- signing for other staff throughout this placement.

Name of College/University: _____

☐ Medical Student Clinical Clerkship (Physician Clinician Trainee). Attending a medical school and participating in a clerkship or rotation to become a Medical Doctor (MD) or Doctor of Osteopathy (DO).

☐ Psychological Clinical Trainee

☐ Master's Degree Clinical Trainee

☐ Nurse Practitioner/Clinical Nurse Specialist

☐ Occupational Therapist

☐ Clinical Pharmacist

☐ Physician Assistant Registered Associate

☐ Psychiatric Technician

☐ Registered Nurse

☐ Licensed Vocational Nurse

☐ I understand that all of my documentation must be signed by a licensed individual of the same discipline or higher.

Initial internship with _____(agency) begins on_____ and ends on _____
Date Date

QM Approves Start Date_____ and End Date_____
Date Date

Expected graduation date_____
Date

Clinical Supervisor's Name_____ Discipline/License#_____

Student Signature_____ Date_____

Clinical Supervisor Signature_____ Date_____

_____ Date_____

Approval: Rolanda Adams, LCSW, Quality Management Services

Sacramento County

Department of Health Services

Division of Behavioral Health Services

CLINICAL TRAINEE EXTENSION REQUEST

Agency: _____ Date:_____

Contact Person: _____ Phone:_____

I attest that I, _____, continue to be a student/trainee at an accredited college or university participating in a field placement at this agency. I understand that I may provide services similar to an LPHA, except for the privilege of co-signing for other staff throughout this placement.

Expected graduation date_____
Date

I attest that I,_____, graduated from an accredited college or university participating in a field placement. I understand that I may provide services similar to an LPHA, except for the privilege of co-signing for other staff throughout this placement.

Graduation date_____

Name of College/University: _____

QM Approves Extension Start Date_____ and End Date_____
Date Date

Clinical Supervisor's Name_____ Discipline/License#_____

Clinical Supervisor Signature_____ Date_____

Student/Trainee Signature_____ Date_____

_____ Date_____

Approval: Rolanda Adams, LCSW, Quality Management

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Sacramento County

Department of Health Services

Division of Behavioral Health Services

MENTAL HEALTH REHABILITATION SPECIALIST

APPLICATION

Agency: _____ **Date:** _____.

Contact Person: _____ **Phone:** _____.

I attest that I, _____, have the following education and experience required to qualify for the designation of Mental Health Rehabilitation Specialist, according to Title 9, Chapter 3, Article 8, Section 630.. I meet at least one of the indicated options below:

☐ **Option 1:** Master's Degree or PhD **and** two (2) years of full-time/equivalent (FTE) direct care experience in a mental health setting.

☐ **Option 2:** Bachelor's Degree **and** four (4) years of full-time/equivalent (FTE) direct care experience in a mental health setting.

☐ **Option 3:** Associate Arts Degree **and** six (6) years full-time/equivalent (FTE) direct care experience in a mental health setting. At least two of the six years must be post AA degree experience in a mental health setting.

Attached is my resume and college degree, which qualifies me for this position.

FTE Experience may be in a mental health setting as a specialist in the fields of:

*** Physical Restoration** *** Psychology**
*** Social Adjustment** *** Vocational Adjustment**

_____. _____.
Signature of Applicant Date

I have retained a copy of proof of education and experience for our on-site credentialing file. This file is available for review by Sacramento Behavioral Health Services at any time.

_____. _____.
Agency Representative's Signature Date

_____. _____.
Approval: BHS Quality Management Date

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Sacramento County

Department of Health Services

Division of Behavioral Health Services

AOD COUNSELOR APPLICATION

Agency: _____ **Date:** _____.

Contact Person: _____ **Phone:** _____.

I attest that I, _____, have the following qualifications required to register for the counselor classification category indicated below.

☐ Registered AOD Counselor –An individual who is successfully registered in a DHCS Designated Certifying Organization. This candidate must remain in good standing and complete certification within five (5) years from the date of registration.
Must submit proof of registration with a DHCS Designated Certifying Organization

☐ Certified AOD Counselor. An individual who has completed program requirements and/or passed an exam issued by the DHCS Designated Certifying Organization and is a "certified AOD Counselor". Must submit proof as a Certified AOD Counselor from a DHCS Designated Certifying Organization.

Applicant: _____. _____.
Signature Date

Agency Representative: _____. _____.
Signature Date

Quality Management: _____. _____.
Signature Date

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Sacramento County

Department of Health Services

Division of Behavioral Health Services

COMMUNITY HEALTH WORKER (CHW) ATTESTATION

Supervising Provider must be Medi-Cal enrolled, or have initiated Medi-Cal enrollment, and credentialed by Sacramento County Behavioral Health

Agency: _____ **Date:** _____.

Contact Person: _____ **Phone:** _____.

CHW Name: _____

Supervising Provider Name: _____

Supervising Provider NPI: _____

I, _____ (name of supervising provider), attest that

_____ (first and last name of the CHW), meets one of

the following requirements:

☐ **CHW Certificate Pathway –** *This option will be available once HCAI has developed the process for training and certification*

A valid certificate of completion of a curriculum that attests to demonstrated skills and/or practical training in the following areas: communication, interpersonal and relationship building, service coordination and navigation, capacity building, advocacy, education and facilitation, individual and community assessment, professional skills and conduct, outreach, evaluation and research, and basic knowledge in public health principles and social determinants of health (SDOH), as determined by the supervising provider. Certificate programs must also include field experience as a requirement. This certificate allows CHW to provide all services including violence prevention services.

☐ *Attached and submitted certificate*

☐ **Work Experience Pathway**

An attestation that the CHW has at least 2,000 hours of work experience as CHW in paid or volunteer within the previous three years and has demonstrated skills and practical training in the areas of communication, interpersonal and relationship building, service coordination and navigation, capacity building, advocacy, education and facilitation, individual and community assessment, professional skills and conduct, outreach,

evaluation and research, and basic knowledge in public health principles and social drivers of health (SDOH) as determined and validated by the supervising provider. The attestation should also include that the CHW will earn a valid certificate of competition of required curriculum within 18 months of the first CHW visit provided to a member.

☐ *Attached and submitted certificate*

The Supervising Provider must also attest to the following:

- Maintain evidence of the minimum qualifications as stated above.
- Conduct monitoring to ensure that this CHW completes a minimum of six hours of additional relevant training on an annual basis and maintain evidence of this training.
- Must provide direct or indirect oversight to CHW

The CHW's Supervising Provider must complete all sections of this attestation and attach all required documentation. The Supervising Provider must be a licensed provider and must have completed Health Plan credentialing and initiated Medi-Cal provider enrollment with DHCS at the time of submission of this attestation to Health Plan. Failure to provide a complete attestation and/or failure to attach all required documentation may result in a delay or rejection of the CHW's participation in Sacramento County's provider network.

Supervisor's Name _____ Type of licensure: _____
Print Name

Supervisor: _____
Signature Date

TAXONOMY CODES

Classification Type	Classification Abbreviation (first four alpha numeric characters)	Taxonomy	Modifier (if required)
Medical Doctor/Doctor of Osteopathy/Psychiatrist	MD/DO/Psych	Any of the 208 series	
MD/DO in Clerkship	MD/DO-Clerks	1744	None
Physician Assistant	PA		
Nurse Practitioner	NP	363L	
Nurse Practitioner Clinical Trainee	NP-CT	3902	HP
Registered Nurse	RN	Any of the 163W Series	
Registered Nurse Clinical Trainee	RN-CT	3902	TD
Clinical Nurse Specialist	CNS	364S	
Clinical Nurse Specialist -Clinical Trainee	CNS-CT	3902	HP
Licensed Vocational Nurse	LVN	164X	
Vocational Nurse Clinical Trainee	VN-CT	3902	TE
Licensed Psychiatric Technician	LPT	167G	
Psychiatric Technician Clinical Trainee	PT-CT	3902	HM
Psychologists	PhD/PsyD	103T	
Psychologist Clinical Trainee	PhD/PsyD – CT	3902	AH
Licensed Clinical Social Worker	LCSW	1041	
Associate Social Worker	ASW	1041	
Social Worker Clinical Trainee	SW-CT	3902	AJ
Licensed Marriage and Family Therapist	LMFT	106H	
Associate Marriage and Family Therapist	AMFT	106H	
Marriage and Family Therapist Clinical Trainee	MFT-CT	3902	AJ
Licensed Professional Clinical Counselor	LPCC	101Y	
Associate Professional Clinical Counselor	APCC	101Y	
Professional Clinical Counselor Clinical Trainee	PCC-CT	3902	AJ
Licensed Occupational Therapist	LOT	225X	
Occupational Therapist Clinical Trainee	OT-CT	3902	CO
Medical Assistant	MA	363AM	
Mental Health Rehabilitation Specialist	MHRS	2254	
Certified Peer Support Specialist	Cert Peer	175T	
Other Qualified Provider	OQP	3726	
Pharmacist	Pharm	1835	
Community Health Worker	CHW	172V	