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

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 ☐<br>No ☐ |
| N. FOR ALL LICENSED PHYSICIANS (MDs, LPs, and DOs), NURSE PRACTITIONERS, PHYSICIANS ASSISTANTS, LICENSED PSYCHOLOGISTS, LMFTs, LCSWs, and LPCCs ONLY.<br><br>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)<br>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)<br>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<br><br>*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 ☐<br>No ☐ |
| O. FOR ALL PHYSICIANS (MDs, LPs, and DOs), NURSE PRACTITIONERS, AND PHYSICIAN ASSISTANTS ONLY<br><br>Have you enrolled in the Medi-Cal Rx portal or has someone done so on your behalf?<br><br>*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 ☐<br>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

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:_____

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_____

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_____

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 #4 Program Name _____

Street Address_____ Suite # _____ City_____ Zip_____

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+

**Send completed form to:**

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