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

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)

MD Medical Doctor (Psychiatrist, Psychiatric Resident)

DO Doctor of Osteopathy

LP Licensed Physician

Ph.D. Doctor of Philosophy (Clinical Psychologist)

Psy Psychologist (Licensed or Waivered)

PsyD Doctor of Psychology (Clinical Psychologist)

NP Nurse Practitioner

Registered Pharmacist or Advanced Practice Pharmacist

PA Physician Assistant

CNS Clinical Nurse Specialist

LVN Licensed Vocational Nurse

RN Registered Nurse

LCSW Licensed Clinical Social Worker

LMFT Marriage and Family Therapist

LPCC Licensed Professional Clinical Counselor

Certified/Registered AOD Counselor

ASW Associate Social Worker

AMFT Associate Marriage Family Therapist

APCC Associate Professional Clinical Counselor

MHRS Mental Health Rehabilitation Specialist

Certified Peer Specialist

Student - (MA Level Student, Doctoral Level Student)

Other Qualified Provider (Non-certified Peer and previously MHA-III, MHA-II, MHA-I)

Start Date in Classification: ____________________________

Certification/Registration/License#: ________________________ 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	Yes

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.)	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 – MHP ONLY

NACT Provider Type:

Lic. Psychiatrist	Cert. Nurse Specialist	Occupational Therapist
Lic. Physicians	Nurse Practitioner	ASW
Lic. Psychologist	Lic. Vocational Nurse	AMFT
LCSW	Psych. Technician	APCC
LMFT	MHRS	Waivered Psychologist
LPCC	Physician Assistant	Other Qualified Provider
Registered Nurse	Pharmacist	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 Training: Yes: No:

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 – MHP ONLY

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

Site #1 Program Name ____

Street Address_________________________________ Suite # _________ City_______________ Zip__________

*FTE Adult: _________ *FTE Youth: _______ **Max Caseload Adult:___________ **Max Caseload Youth:__________

Hire Date: ________________ Term Date:______________

Site #2 Program Name ____

Street Address_________________________________ Suite # _________ City_______________ Zip__________

*FTE Adult: _________ *FTE Youth: _______ **Max Caseload Adult:___________ **Max Caseload Youth:__________

Hire Date: ________________ Term Date:______________

Site #3 Program Name ____

Street Address_________________________________ Suite # _________ City_______________ Zip__________

*FTE Adult: _________ *FTE Youth: _______ **Max Caseload Adult:___________ **Max Caseload Youth:__________

Hire Date: ________________ Term Date:______________

Site #4 Program Name ____

Street Address_________________________________ Suite # _________ City_______________ Zip__________

*FTE Adult: _________ *FTE Youth: _______ **Max Caseload Adult:___________ **Max Caseload Youth:__________

Hire Date: ________________ Term Date:______________

Site #5 Program Name ____

Street Address_________________________________ Suite # _________ City_______________ Zip__________

*FTE Adult: _________ *FTE Youth: _______ **Max Caseload Adult:___________ **Max Caseload Youth:__________

Hire Date: ________________ Term Date:______________

* 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