SONOMA COUNTY DEPARTMENT OF HEALTH SERVICES: BEHAVIORAL HEALTH DIVISION
STAFF NUMBER & SmartCare REQUEST FORM

For all staff request forms, credentialing request/questions, and form submission please contact Department of Health Services/Revenue Management (DHS-RMU-Credentialing@sonoma-county.org) **All fields are required** to issue as staff number. Put “N/A” if not applicable to staff position.

Does employee need access to SmartCare Y/N? ☐ **Form Submission Date**: ☐

Request reason (mark one box):

☐ **New Employee** ☐ **Termination of Employee** ☐ **Update Employee Information** (Provide reason): ☐

Date of Hire: ☐ **Effective Date:** (no more than 30 days prior to submission date) ☐

Last Name: ☐ **First Name:** ☐ **Date of Birth:** ☐

Gender: ☐ M ☐ F ☐ UNK ☐ OTH **Full-Time Equivalent:** (1.0 FTE = 40 hrs/wk) ☐

Language(s):

☐ American Sign Language	☐ French	☐ Mandarin	☐Russian
☐ Arabic	☐ Hmong	☐ Mien	☐ Samoan
☐ Armenian	☐ Ilocano	☐ Other Chinese Languages	☐ Spanish
☐ Cambodian	☐ Italian	☐ Other Non-English	☐ Tagalog
☐ Cantonese	☐ Japanese	☐ Polish	☐ Thai
☐ English	☐ Korean	☐ Portuguese	☐ Turkish
☐ Farsi	☐ Lao	☐ Other Sign Language	☐ Unknown/Not Reported
			☐ Vietnamese

License / Registration / Certification / Job Class:		
	☐ Associate Clinical Social Worker (ASW)	☐ Mental Health Rehabilitation Specialist (MHRS)
	☐ Associate Marriage and Family Therapist (AMFT)	☐ Physician (MD)
	☐ Associate Professional Clinical Counselor (APCC)	☐ Physician Assistant (PA) / Nurse Practitioner (NP)
	☐ Certified Medical Assistant	☐ Psychiatric Technician / Licensed Vocational Nurse
	☐ Certified Peer Support Specialist	☐ Registered Nurse (RN)
	☐ Licensed Clinical Social Worker (LCSW)	☐ Senior Office Assistant / Clerical Staff
	☐ Licensed Marriage and Family Therapist (LMFT)	☐ Substance Use Disorder Counselor / AODS Counselor
	☐ Licensed Professional Clinical Counselor (LPCC)	☐ Graduate Student Trainee: ☐
	☐ Licensed or Waivered PhD or PsyD (*, **)	☐ Other Qualified Provider

Additional Access Requirements:		
	☐ Billing	☐ Medical Records
	☐ Clinical Supervision	☐ Quality Assurance / Quality Improvement / PPEA
	☐ Medical Director	

*Out-of-State Psychologists, LCSW’s, LPCC’s and MFT’s must be waived by Department of Health Care Services (DHCS) prior to claiming to Medi-Cal insurance for services that require the practitioner to hold a license. Call 707-565-4868 to initiate the DHCS waiver process.

** Psychologist Candidates are to be waived by DHCS prior to claiming to Medi-Cal Insurance for services that require the practitioner to hold a license. Psychologist Candidates include Registered Psychologists and Psychological Assistants who have completed 48 semester/trimester or 72 quarter units of graduate coursework, not including thesis, internship or dissertation and are gaining the experience required for licensure. Clinical psychology students do not require a waiver and provide services in accordance with the requirements for Graduate Students, unless they are employed or under contract to provide Medi-Cal SMS. Call 707-565-4868 to initiate the DHCS waiver process. For additional information, refer to the “Documentation and Scope of Practice Guidelines” at https://sonomacounty.ca.gov/a/113732.

Mental Health Provider Practice Focus: ***Select practice focus areas for the provider, no more than 5***

☐ Adjustment D/O
☐ Anxiety D/O
☐ Bi-polar D/O
☐ D/O Usually First Diagnosed in Infancy / Childhood / Adolescence
☐ Delirium, Dementia, Amnesia & other Cognitive D/O
☐ Depressive D/O
☐ Dissociative D/O
☐ Eating D/O
☐ Factitious D/O
☐ Impulse-Control D/O
☐ Mood D/O
☐ Personality D/O
☐ Schizophrenia & Other Psychotic D/O
☐ Somatoform D/O
☐ SUD D/O

Mental Health Provider Types:

☐ Mental Health Services
☐ Crisis Intervention
☐ Targeted Case Management
☐ ICC
☐ IHBS
☐ Medication Support

SUD Provider Types:

☐ Outpatient
☐ Intensive Outpatient
☐ Narcotic Treatment
☐ Withdrawal Management
☐ Residential

MH/SUD Age Group Served: ***Identify the age group of clients that provider can serve.***

☐Adult – 21+ ☐ Youth – under 21

MH/SUD Staff Service Locations: ***Check all service locations that provider will be utilizing for clients.***

☐Telehealth ☐Face to Face ☐Field Based Services

MH/SUD For Field Based Services please list maximum distance that provider will be permitted to travel: ☐

Provide the information requested below in the columns on the right:	**Youth – Under 21**	**Adults – 21+**
Max # Medi-Cal Members: estimate the maximum caseload the provider could have at any given point in time for adults and youth *(e.g., 25 clients)*		
On average, how many **total full time equivalents (FTE)** will the provider be working with youth and with adults? *(e.g., Youth 0.10 FTE, Adults 0.90 FTE)* If the staff member will work at multiple sites, provide the FTE that they will provide at each site. Total FTE should not add up to more than total on page 1. **Program / Site 1:**		
Program / Site 2:		
Program / Site 3:		

Agency:	**Program #2** (If staff works for a second site):
Program / Site Name 1:	Program / Site Name 2:
Program / Site Supervisor:	Program / Site Supervisor:
Name of previous staff in this position (for organizational chart / hierarchy):	Name of previous staff in this position (for organizational chart / hierarchy):
Address where services to be rendered:	Address where services to be rendered:
Phone #:	Phone #:
Staff Email Address:	Staff Email Address:

Complete all applicable fields:

License Type:	Registration Type:	Certification Type:
License #:	Registration #:	Certification #:
Expiration Date:	Expiration Date:	Expiration Date:

NPI #: (Required of all staff that are HIPAA-covered)

Taxonomy #:

DEA #: (if applicable)

Submitted By/Title:

Phone #:

Email: