COUNTY OF YOLO
Health and Human Services Agency
137 N. Cottonwood Street • Woodland, CA 95695 (530) 666-8630 • www.yolocounty.org

Practitioner Application

Please select the type of request for this application	Check Only One
New Enrollment (never enrolled before): Complete the entire form.	☐
Renewal, Update Credentialing or Make Changes: Complete the entire Form	☐
Termination: Only complete Sections 2 and 4 When a Practitioner no longer requires a Practitioner ID Enrollment Number, submit a Termination Request within 10 business days.	☐
Supporting Roles (Admin, Fiscal, Analyst): Do not complete this form. Instead complete the Avatar Request and Access Agreement online: https://forms.office.com/g/XpEeL9VH9K	

Before submitting this application, please ensure the following to avoid delays in processing:

- Accurate information *or* N/A is entered into required fields:
- The form has appropriate signatures and dates; and
- All required documentation is included.

Completed applications will be processed within 14 days of receipt.
Incomplete applications will be returned for completion.

Approved methods to submit the form and required documents	
FAX	(530) 666-8294
Encrypted Email	HHSAQualityManagement@yolocounty.org

Please address any questions or concerns to HHSAQualityManagement@yolocounty.org

Section 1:
Practitioner Classifications & Required Documentation

Select One	Classification	Select One	Required Documents	Attached to Application
☐	**Mental Health Rehabilitation Specialist (MHRS)**	MHRS ☐ MHRS Special Consideration ☐	MHRS/MHW Application	☐
			Transcript(s)	☐
			Highest degree earned	☐
			Resume (Indicate F/T or P/T Status, MM/YYYY)	☐
☐	**Mental Health Worker (MHW)**	MHW ☐ MHW Special Consideration ☐	MHRS/MHW Application	☐
			Transcript(s)	☐
			Highest degree earned	☐
			Resume (Indicate F/T or P/T Status, MM/YYYY)	☐
☐	**Clinical Trainee (Graduate Student Intern)**	Medical Student in Clerkship ☐ LCSW, LMFT or LPCC ☐ Psychologist ☐ Registered Nurse ☐ Vocational Nurse ☐ Psychiatric Technician ☐ Pharmacist ☐ Nurse Practitioner/ Clinical Nurse Specialist ☐ Occupational Therapist ☐ Physician Assistant ☐	Student Intern Application	☐
			Transcript(s)	☐
			Proof of approved internship/practicum	☐
			Proof of supervisor's qualifications	☐
☐	**Peer Support Worker**	Certified Peer Support Worker ☐	Peer Support Certification	☐
☐	**Substance Use Disorder (SUD) Counselor**	CAC ☐ CADC I ☐ CADCII/III ☐ CATC II ☐ RADT I/II RAS II ☐ SUD RC ☐ SUDCC I/II/III/IV ☐ Other:	CAADE/CADTP/CC Registration <u>OR</u> Certificate	☐
			Transcript(s) <u>OR</u> Highest degree earned	☐
☐	**Licensed or Registered with the Board of Behavioral Sciences**	LCSW ☐ LMFT ☐ LPCC ☐ ACSW ☐ AMFT ☐ APCC ☐	License or Registration	☐
			NPDB- Official Copy (Licensed Clinicians only)	☐
			PAVE Enrollment (Licensed Clinicians only)	☐
☐	**Licensed or Registered Nurse or Psych Tech**	LVN ☐ NP ☐ RN ☐ LPT ☐	License or Registration	☐
			Controlled Substance Registration Certificate (NP only)	☐

See the next page for additional classifications

☐	**Licensed with the Medical Board of California Physician and Surgeon**	MD ☐ PA ☐	Pocket Certificate	☐
			Controlled Substance Registration Certificate	☐
			NPDB- Official Copy	☐
			PAVE Enrollment	☐
☐	**Licensed with the Board of Psychology**	PsyD ☐ PhD ☐	Pocket Certificate	☐
			NPDB- Official Copy	☐
			PAVE Enrollment	☐
☐	**Waivered Staff***	PsyD ☐ PhD ☐ Out of State PsyD, LCSW, LMFT, LPCC ☐ *Until the waiver is approved, staff may only be credentialed and provide services within a non-licensed scope of practice as granted.	Completed DHCS 1739 Form	☐
			Proof of 3000 hrs. supervised professional experience	☐
☐	**Medical Assistant**	Certified Medical Assistant ☐	If you believe you qualify for this classification, please reach out to BH-QM	
☐	**Licensed Occupational Therapist**	Occupational Therapist ☐	License	☐
			Degree from accredited OT education program	☐
			Proof of eligibility or completion of the entry-level certification exam	☐

Application Continues Next Page

Section 2: Practitioner Request

Type of Request	New ☐	Renew ☐	Update/Change ☐	Termination ☐
Delivery System*	SUD ☐	MH ☐	*If providing services in both SUD and MH delivery systems, separate forms are required for each system.	
Date Request Submitted		**First Billable Date (Enrollment) or Last Billable Date (Termination)**		

Agency/Organization Name		
Street Address		
City	**State**	**Zip**

Practitioner Name as it appears on National Provider Identifier (NPI) and/or License.

NPI number is required for all applicants.

FIRST	**MI**	**LAST**	**Other (e.g., maiden name)**

Telephone Number		**Email Address**	
Date of Birth		**Social Security Number**	

Name of Authorized Representative, Manager or Supervisor

FIRST	**MI**	**LAST**

Telephone Number	
Email Address	

Practitioner Gender	Male ☐ Female ☐ Other ☐ Decline to Answer ☐		
Practitioner NPI #		**Primary Taxonomy Code that matches the NPI Registry**	
Clinical Trainee Supervisor Name (if applicable) – must have an active Pract. ID			

Practitioner California Professional License/Registration No.		**Expiration Date**	
DEA Registration No.		**Expiration Date**	

Practitioner's Full-Time Equivalent (FTE) allocation to each age category below (based on 40-hr/week)

Ages 0-20 :	Ages 21+:	All Ages:
1 FTE☐ 0.5 FTE ☐	1 FTE☐ 0.5 FTE ☐	1 FTE☐ 0.5 FTE ☐
Specify Other FTE: -	Specify Other FTE:	Specify Other: FTE: ____________

Non-English languages in which the practitioner is Certified or Fluent

Spanish ☐ Russian Specify Other Languages:

Section 3: Practitioner Attestation

ALL PRACTITIONERS MUST ANSWER ALL QUESTIONS

1. Are your practitioners' privileges in good standing?
   Yes ☐ No ☐
2. Do you have any history of suspensions or curtailments of privileges?
   Yes ☐ No ☐
3. Do you have any limitations that affect your ability to perform any of the position's functions, with or without accommodation?
   Yes ☐ No ☐
4. Do you have you a history of loss of license?
   Yes ☐ No ☐
5. Do you have you a history of felony convictions?
   Yes ☐ No ☐
6. Do you have history of loss or limitation of privileges or disciplinary activity?
   Yes ☐ No ☐
7. Do you have malpractice insurance in an adequate amount, as required for your provider type? (Practitioners are required to have Malpractice Insurance. This can be provided by your employer)
   Yes ☐ No ☐
8. Do you have any history of liability claims against you?
   Yes ☐ No ☐
9. Do you have a history of sanctions from participating in Medicare and/or Medicaid/Medi-Cal?
   Yes ☐ No ☐
10. Do you have any terminations from either Medicare or Medi-Cal?
    Yes ☐ No ☐
11. Are you on the Suspended and Ineligible Provider List?
    Yes ☐ No ☐
12. Are you using illegal drugs?
    Yes ☐ No ☐
13. Are you current on your mandatory medical and continuing education courses, as required by your state agency and/or licensing board?
    Yes ☐ No ☐ N/A ☐
14. Do you have any reports on file with the National Practitioner Data Bank (NPDB? The NPDB is a data base operated by the U.S. Department of Health and Human services that contains medical malpractice payment and adverse action reports on Behavioral Health professionals.
    Yes ☐ No ☐ N/A ☐
15. Have you completed all required medical residency and/or specialty training for your provider type?
    Yes ☐ No ☐
16. Have you had any sanctions or limitations against your license that were issued by any state's agencies or licensing boards?
    Yes ☐ No ☐ N/A ☐

Section 4: Signatures

I attest that all information provided in this form is true.

Print **Practitioner Name**	
Practitioner **Wet or Electronic (Esignature)** **Signature**	**Date**
Print **Authorized Representative,** **Manager or Supervisor Name**	
Authorized Representative, **Manager or Supervisor** **Wet or Electronic (Esignature)** **Signature**	**Date**

End of Application