

**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](mailto: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):**

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

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

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|--|---|---|
| <b>Additional Access Requirements:</b> | <input type="checkbox"/> Billing              | <input type="checkbox"/> Medical Records                                |
|  | <input type="checkbox"/> Clinical Supervision | <input type="checkbox"/> Quality Assurance / Quality Improvement / PPEA |
|  | <input type="checkbox"/> Medical Director     |   |

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

\*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>.

- 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:**

<b>Provide the information requested below in the columns on the right:</b>	<b>Youth – Under 21</b>	<b>Adults – 21+</b>
<b>Max # Medi-Cal Members:</b> 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 <b>total full time equivalents (FTE)</b> 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.		
<b>Program / Site 1:</b>		
<b>Program / Site 2:</b>		
<b>Program / Site 3:</b>		

<p><b>Agency:</b></p> <p>Program / Site Name 1:  <input type="text"/></p> <p>Program / Site Supervisor:  <input type="text"/></p> <p>Name of previous staff in this position (for organizational chart / hierarchy):  <input type="text"/></p> <p>Address where services to be rendered:  <input type="text"/></p> <p>Phone #: <input type="text"/></p> <p>Staff Email Address: <input type="text"/></p>	<p><b>Program #2</b> (If staff works for a second site):</p> <p>Program / Site Name 2:  <input type="text"/></p> <p>Program / Site Supervisor:  <input type="text"/></p> <p>Name of previous staff in this position (for organizational chart / hierarchy):  <input type="text"/></p> <p>Address where services to be rendered:  <input type="text"/></p> <p>Phone #: <input type="text"/></p> <p>Staff Email Address: <input type="text"/></p>
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**Complete all applicable fields:**

License Type: <input type="text"/>	Registration Type: <input type="text"/>	Certification Type: <input type="text"/>
License #: <input type="text"/>	Registration #: <input type="text"/>	Certification #: <input type="text"/>
Expiration Date: <input type="text"/>	Expiration Date: <input type="text"/>	Expiration Date: <input type="text"/>

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

**Taxonomy #:**

**DEA #:** (if applicable)

<p><b>Submitted By/Title:</b> <input type="text"/></p> <p><b>Phone #:</b> <input type="text"/></p> <p><b>Email:</b> <input type="text"/></p>
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