SONOMA COUNTY DEPARTMENT OF HEALTH SERVICES: BEHAVIORAL HEALTH DIVISION
SUBSTANCE USE DISORDER SECTION
SMARTCARE ACCESS REQUEST FORM

Please email DHS Revenue Management Unit dhs-finance-rmu@sonoma-county.org for questions regarding SmartCare Access

Check one box below

☐ New Employee

☐ Updated Employee Information
Updated Reason: _____

☐ Termination of Employee

Effective Date (no more than 30 days prior to submission date): ___/___/___

Last Name: _____ First Name: _____ Gender: M ◯ F ◯

Date of Birth: ___/___/___ Date of Hire: ___/___/___

Date SWITS Access needed: ___/___/___ Full-Time Equivalent (FTE) _____ (1.0=40 hrs, i.e. 1.0, 0.8, 0.5)

Ethnicity:

☐ Cuban
☐ Mexican/Mexican American
☐ Not Hispanic
☐ Other Hispanic/Latino
☐ Puerto Rican
☐ Unknown

Languages:

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

License/ Registration/ Certification/ Job Class:

☐ Associate Clinical Social Worker (ASW)
☐ Associate Marriage and Family Therapist (AMFT)
☐ Licensed Professional Clinical Counselor (LPCC)
☐ (RN) Professional Clinical Counselor Intern (PPCi)
☐ Graduate Student Intern or Trainee
☐ Licensed Clinical Social Worker (LCSW)
☐ Licensed Marriage and Family Therapist (LMFT)
☐ Physician Assistant (PA)
☐ Registered Nurse (RN)
☐ Physician (MD)
☐ Senior Office Assistant/Clerical
☐ Substance Use Disorder Counselor/AODS Counselor I/II ☐
☐ Other Medical Professionals (i.e., PA's or PNP's)

Age Group Served: ***Identify the age group of clients that provider will be serving.***

☐ Adult – 21+
☐ Youth – under 21

SUD Provider Service Types: ***Check all service types that provider will be providing to clients.***

☐ Outpatient
☐ Intensive Outpatient
☐ Narcotic Treatment
☐ Withdraw Management
☐ Residential

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

☐ Telehealth
☐ Face-to-Face
☐ Field Based Service

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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+**
On average, what percentage of the total time will be working with youth and with adults *(e.g., 50%)*		
Max # Medi-Cal Members allowed: estimate the maximum caseload the provider could have at any given point in time for adults and youth *(e.g., 25 clients)*		

Agency attests training will be completed by:

SWITS Training Completed Date:_____
CalOMS Training Completed Date: _____
ASAM Training Completed Date:_____

Complete all applicable field(s):

License Type: _____ License #: _____ Expiration Date:	Registration Type: _____ Registration #: _____ Expiration Date:	Certification Type: _____ Certification #: _____ Expiration Date:
NPI # - Required of all health care staff that Are HIPAA-covered _____ **DEA** # (if applicable) _____	**Taxonomy #:** _____	

	Agency #1:	**Agency #2:** (If staff works for a second agency)
Agency Name: Address where services to be rendered: Phone #: Email Address:	_____ _____ _____	_____ _____ _____

For County Use Only

SWITS User Logon Assigned: _____ Date Staff Directly Notified: ____/__/__

Date Request Received: / / By: