MEDI-CAL CERTIFICATION/RE-CERTIFICATION
GUIDE FOR PERTINENT INFORMATION

CURRENT DATE:	
Provider Number:	
Provider Name:	
Primary Practice Location Address:	
Provider Phone Number:	
Provider Fax Number:	
ADA Accessible?	Yes/No?

Head of Service (HOS):	
HOS Contact Number:	
HOS Email Address:	
Fire Clearance Granted On:	
Service Areas Served:	
Source of Referrals:	

Days & Hours of Operations: _____

After Hour Procedures: _____

Race/Ethnicity of Population Served	
White	%
Black or African American	%
American Indian or Alaska Native	%
Asian	%
Hispanic, Latino, or Spanish Origin	%
Native Hawaiian or Pacific Islander	%
Other	%

Please provide the following information *(current estimate)*:	
Number of Open Cases:	
Age Range of Clients:	
Percentage of Medi-Cal Clients:	%
Length of Treatment of Medi-Cal SMHS:	
Monthly Census of Clients Served Face-to-Face/Telehealth:	
Languages Spoken by Bilingual Staff:	

PROVIDER'S STAFF DISCIPLINES	TOTAL # FOR EACH DISCIPLINE	TOTAL FTEs FOR EACH DISCIPLINE	% of FIELD TIME FOR EACH DISCIPLINE
Psychiatrist			%
Licensed Psychologist			%
Waivered Psychologist			%
Physician			%
RN			%
NP			%
LPT			%
LVN			%
LCSW			%
ACSW			%
LMFT			%
AMFT			%
LPCC			%
APCC			%
Certified Professionals*			%
MH Rehabilitation Specialist			%
Case Managers			%
Others			%
School-Linked Services: *Please include a copy of the MOU(s)* and ensure the school's name(s), address(es), phone number(s) and hours of operation are listed			

* Occupational Therapist; Recreation Therapist; Music Therapist; Art Therapist; Dance Therapist; Movement Therapist.