County of Los Angeles – Department of Mental Health

PRACTITIONER ENROLLMENT AND MAINTENANCE FORM
For FFS2 Providers

Submit Date: ___/___/_____

Registration Date: ___/___/_____ Request Type: ☐ New ☐ Update ☐ Name Change

Practitioner Information

Last Name_____ First Name_____ M_____

Gender ☐ Male ☐ Female ☐ Unknown Ethnicity_____

Language(s)_____

Office Location Information

FFS Provider#__ __ __ __ __ __ __ __ __

Address _____ Suite/Floor _____

City_____ Zip Code __ __ __ __ __ - __ __ __ __

Telephone (_____)_____ Fax (_____)_____

Email Address _____@_____

Credential Information

Discipline_____ Practitioner Category_____

Categories for Coverage_____

Taxonomy Description_____ Taxonomy Code __ __ __ __ __ __ __ __ __ __

NPI __ __ __ __ __ __ __ __ __ __ NPI Effective Date __/__/____

Professional License# __ __ __ __ __ __ __ __ __ __ __ Expiration Date ___/___/_____

DEA License# __ __ __ __ __ __ __ __ __ __ __ Expiration Date __/__/____

Malpractice Insurance

Insurance Company _____ Policy#_____

Expiration Date ___/___/_____

Group Association (if applicable)

Add ☐ Effective Date __/__/____ Remove ☐ Effective Date ___/___/_____

Group Name_____ FFS Provider#__ __ __ __ __ __ __ __ __

Add ☐ Effective Date ___/___/_____ Remove ☐ Effective Date ___/___/_____

Group Name_____ FFS Provider#__ __ __ __ __ __ __ __ __

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Services Provided

- ☐ Brief Psychotherapy
- ☐ Family Psychotherapy
- ☐ Medication Services
- ☐ Neuropsychological Testing
- ☐ Psychological Testing
- ☐ Day Rehabilitation & Treatment Intensive
- ☐ Crisis Intervention & Stabilization
- ☐ Inpatient
- ☐ Case Management
- ☐ Consultation & Liaison
- ☐ Plan Development
- ☐ Group Psychotherapy
- ☐ Impact of Medication on Testing Result
- ☐ Psychological testing that considers the influence of medication on test results

Clinical Expertise/Specialties

- ☐ Abuse Survivors
- ☐ AIDS/HIV
- ☐ Disorders of Adolescence
- ☐ Dissociative Disorders
- ☐ Dual Diagnosis
- ☐ Gang Members
- ☐ Group Therapy
- ☐ Mood Disorders
- ☐ Psychotic Disorders
- ☐ The Use of APA Guidelines in Child Protection Matters
- ☐ Adjustment Disorders
- ☐ Anxiety Disorders
- ☐ Disorders of Childhood
- ☐ Domestic Violence Perpetrators
- ☐ Eating Disorders
- ☐ Gender Identity Disorders
- ☐ Hearing Impaired
- ☐ Norm-Referenced Psychological Testing
- ☐ Sex Offenders
- ☐ Visually Impaired
- ☐ Adoption
- ☐ Attention-Deficit/Hyperactivity D/O
- ☐ Disorders of Infancy
- ☐ Domestic Violence Victims
- ☐ Family Therapy
- ☐ Grief/Bereavement
- ☐ Mobility Impaired
- ☐ Personality Disorders
- ☐ Substance Abuse
- ☐ Others, specify: _____

Service Areas

- ☐ Antelope Valley
- ☐ San Gabriel Valley
- ☐ Santa Monica/West Los Angeles
- ☐ Southeast Los Angeles
- ☐ San Fernando/Santa Clarita
- ☐ Metropolitan/Hollywood
- ☐ South Los Angeles
- ☐ Harbor/Long Beach

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Age Groups

- ☐ Children 0 - 5
- ☐ Children 6 - 13
- ☐ Adolescents 14 – 17
- ☐ Transition Youth 18 - 20
- ☐ Adults 21 - 59
- ☐ Adults 60 and over

Hospital Privileges (use separate sheet if at more than 8 locations)

Mailing Location Information

Address _____ Suite/Floor _____

City_____ Zip Code __ __ __ __ __ - __ __ __ __

Telephone (_____)_____ Fax (_____)_____

Email Address _____@_____

Authorized Contact

Authorized Contact_____ Signature_____

Email Address _____@_____

Form Completed By_____ Date Processed ___/___/_____

Does this provider accept referrals? ☐ Yes ☐ No

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