

SPMP Questionnaire

DATE:

TO:

FROM:

RE: SKILLED PROFESSIONAL MEDICAL PERSONNEL
QUESTIONNAIRE FOR CLAIMING STATUS

To determine whether you qualify as Skilled Professional Medical Personnel for claims being made for Medi-Cal administration, please complete the following form and return it to the person indicated above no later than _____ as this is very important for our funding. Thank you.

Name _____

Department _____

Position Classification _____

1.A Does this position require that it be filled with one of the classifications listed in the FFP Guidelines, Fiscal Section of these Policies and Procedures

1.B Are you a physician licensed to practice medicine in the State of California? _____

If YES, provide license number (_____), sign this form and turn it in.
If NO, proceed to Question 2.

2. Have you completed an educational program in a health or health-related field? _____

If YES, list the highest academic degree you received in a health or health-related field, the subject in which it was received, and the name of the college/university where it was earned, and proceed to Question 3.

_____ Academic Degree Field

_____ College/University

If NO, stop, sign this form and turn it in.

3. Did your educational program last at least two years? _____

If YES, proceed to Question 4.
If NO, stop, sign this form and turn it in.

4. Did your educational program lead to a California licensure in a medically-related profession?

If YES, provide license type and number, and sign this form and turn it in.

License Type

License Number

If NO, proceed to Question 5.

5. Did your educational program lead to certification or registration by a health or health-related national or California certifying organization?_____

If YES, please provide certification/registration type and number (if appropriate), the name of the certifying organization, and sign this form and turn it in.

Certificate/Registration Type

Cert./Reg. Number

Certifying/Registry Organization

If NO, proceed to Question 6.

6. Did part of your educational program involve medical or health-related training including fieldwork (for example, in the area of health, mental health, or substance abuse)?_____

If YES, describe the training/fieldwork and sign the form and turn it in.

If NO, proceed to Question 7.

7. As a part of your educational program, did you take any courses, which had a medical or health-related focus (for example, about health, mental health or substance abuse)?_____

If YES, list these courses below and sign this form and turn it in.

If NO, sign this form and turn it in.

Signature

Date

SPMP QUESTIONNAIRE INSTRUCTIONS

The following instructions are to be used when completing the SPMP Questionnaire:

Item	Information to Enter
Date	Enter the date that this SPMP Questionnaire is being completed.
TO	Address the Questionnaire to the Agency MCH Director.
FROM	Enter the name of the person forwarding the Questionnaire to the MCH Director.
Name	Enter the name of the staff for which the Questionnaire is being completed.
Department	Enter the name of the Department staff for which the Questionnaire is being completed.
Position Classification	Provide the position classification name for the staff for which the Questionnaire is being completed.
1.A	Ensure that the Agency Job Specification for the position this staff occupies, requires it be filled with one of the classifications listed in the FFP Guidelines, Fiscal Section.
1.B	Answer YES or NO. If the answer is YES, sign and date the Questionnaire and forward it to the Agency MCH Director. If the answer is NO, proceed to Question 2.
2.	Answer YES or NO. If the answer is YES, list the highest academic degree received in a health or health related field, subject in which it was received and name of college or university where it was earned. Proceed to Question 3. If the answer is NO, sign and date the Questionnaire and forward it to the Agency MCH Director.
3.	Answer YES or NO. If the answer is YES, proceed to Question 4. If the answer is NO, sign and date the Questionnaire and forward it to the Agency MCH Director.
4.	Answer YES or NO. If the answer is YES, list the license type and number. Sign and date the Questionnaire and forward it to the Agency MCH Director. If the answer is NO, proceed to question 5.
5.	Answer YES or NO. If the answer is YES, list certification/registration type and number (if appropriate), name of the certifying organization. Sign and date the Questionnaire and forward it to the Agency MCH Director. If the answer is NO, proceed to Question 6.
6.	Answer YES or NO. If the answer the YES, briefly describe the training/fieldwork, sign and date the Questionnaire and forward to the Agency MCH Director. If the answer is NO, proceed to Question 7.
7.	Answer YES or NO. If the answer is Yes, list appropriate courses. Sign the Questionnaire and forward it the Agency MCH Director. If the answer is NO, sign and date the Questionnaire and forward it to the Agency MCH Director.

You meet the SPMP eligibility requirements if your position requires that it be filled from one of the listed classifications in the FFP Guidelines, Fiscal Section and if you answered:

- **YES** to Question 1A and
- **YES** to Question 1B, or
- **YES** to Questions 2, 3, and 4, or
- **YES** to Questions 2, 3, and 5.

You do not meet the SPMP eligibility requirements if you answered:

- **NO** to either Questions 2, 3, **OR** 7.

Respondents who complete either Question 6 or 7 must be evaluated on a case-by-case basis depending on the nature and extent of the health-related training received in their education program. Contact your Program Consultant or your Contract Manager for assistance.