SKILLED PROFESSIONAL MEDICAL PERSONNEL (SPMP)
Questionnaire

Name of Employee: _____

Name of Employee's Supervisor: _____

Name of Local Governmental Agency Coordinator:_____

To determine whether you qualify for federally funded reimbursement claims as an SPMP, please complete the following questionnaire and return it to the Local Governmental Agency (LGA) Coordinator no later than (**Due Date:**_____).

Agency/Claiming Unit: _____

Position Classification: _____

Describe duties and list specific examples of how you use your medical knowledge or skills to perform County-Based Medi-Cal Administrative Activities (CMAA) for the claiming unit:

*Please add a separate page if additional space is needed.

1) Are you a physician licensed to practice medicine in the State of California?

   a) **YES**.

      i) Provide the license number: _____

      ii) Attach a copy of your license, if available.

      iii) Sign this form and return it.

   b) **NO**. Proceed to Question 2.

2) Have you completed an educational program in a health-related field?

   a) **YES**.

      i) Which health-related field:

      _____

      ii) Highest academic degree received in that field:

      _____

      iii) Subject of your academic degree (Major):

      _____

      iv) Name of the college/university where degree was obtained:

      _____

      v) Attach a copy of your degree, if available.

   b) **NO**. Proceed to Question 3.

3) Did your educational program last at least two years? ☐Yes ☐No

4) Did your educational program lead to a license in a medically related profession?

   a) **YES**.

      i) Provide the license type, number, and issuing state.

      _____

      ii) Sign this form and return it.

      iii) Attach a copy of your license, if available.

   b) **NO**. Proceed to Question 5.

5) Did your educational program lead to a certification or registration by a recognized National or California State health or health-related certifying organization?

   a) **YES**.

      i) Provide the Certification/Registration Type:

      _____

      ii) Provide the Certification/Registration Number (if appropriate):

      _____

      iii) Provide the name of the Certifying/Registration Organization:

      _____

      iv) Sign this form and return it.

      v) Attach a copy of your Certificate/Registration, if available.

   b) **NO**. Proceed to Question 6.

6) Did part of your educational program involve medical or health-related training including fieldwork (e.g., in health, mental health, or substance abuse)?

   a) **YES**.

      i) Describe the training/fieldwork:

      _____
      _____
      _____
      _____
      _____

      ii) Sign the form and return it.

      iii) Attach a copy of your certificates or documentation describing training, if available.

   b) **NO**. Proceed to Question 7.

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

   a) **YES**.

      i) List the courses below:

      _____
      _____
      _____
      _____

      ii) Sign the form and return it.

      iii) Attach a copy of your certificates or documentation describing training, if available.

   b) **NO**. Proceed to Question 8.

8) How many years of experience do you have performing duties in a medically related profession?

   ☐ 3 or more years ☐ 2 years ☐ 1 year ☐ Less than 1 year

   a) Attach documentation of your experience, if applicable.

_____ _____
Signature of Claimant/Employee Date

Supervisor and LGA Coordinator's Section

Supervisor's statement of additional qualifying requirements for SPMP status:

_____
_____
_____
_____

LGA Coordinator's recommendations:

_____
_____
_____
_____
_____

_____ _____
Signature of LGA Coordinator's Date

CMAA Program Staff Section

I have reviewed the SPMP Questionnaire and the attached documentation and have determined:

☐ The Claimant/Employee meets the essential requirements of an SPMP.

☐ The Claimant/Employee does not meet the essential requirements of an SPMP.

_____ _____
Signature of CMAA Program Staff Date