SKILLED PROFESSIONAL MEDICAL PERSONNEL QUESTIONNAIRE

Name of County Agency/Program Employee: _____

Name of County Agency/Program Employee's Supervisor: _____

Name of Local or County Agency/Program: _____

To help determine whether you qualify for enhanced (75/25) federal Title XIX funding as a skilled professional medical personnel (SPMP), please complete the following questionnaire and include it as part of your local/county agency's submission with any invoices.

Agency/Claiming Unit: _____

Position Classification: _____

Describe duties and list specific examples of how you use your medical knowledge or skills to perform activities for your local/county agency and associated program(s).

*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:

      _____

      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.

If you have answered **"NO"** for questions 1-8, you do not qualify for enhanced (75/25) federal Title XIX funding as an SPMP.

Signature of County Agency/Program Claimant/Employee Date

SUPERVISOR AND LOCAL/COUNTY AGENCY'S SECTION

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

Local/County Agency's comments:

Signature of Local/County Agency Date