Mental Health Professional Licensure Waiver (PLW) Application

Section A	**Mental Health Plan or Local Mental Health Department Information**	
1. Name of the Mental Health Plan (MHP) or Local Mental Health Department (LMHD):		
2. Mailing address:		
2a. City:	2b. State:	2c. Zip code:
3. Email address:	4. Telephone number:	

Section B	**Individual Seeking PLW Information**
1. Full legal name: (Include first name, middle name (if applicable), and last name, as well as any aliases or maiden names)	
2. Email address:	
3. Date individual seeking PLW is expected to begin providing mental health services in the position requiring waiver:	

Section C	**Type of PLW Application** (Select one)

☐ New PLW application: Individual acquiring a professional license to provide mental health services. *(Complete sections A, B, C, D and G)*

☐ New PLW application: Individual with an out-of-state license. *(Complete sections A, B, C, E and G)*

☐ Individual with a change in employment (for an individual with an existing approved PLW). *(Complete sections A, B, C, F and G)*

Section D	**New PLW Application** **Individual acquiring a professional license to provide mental health services information**
1. Name of the doctorate degree/program:	2. Date doctorate degree conferred: *(Transcript submission required)*

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3. Name of the college or institution of higher education:
4. If currently enrolled in a doctoral program, number of graduate units completed: *(Transcript submission required)* Semester/Trimester units _____ Quarter units _____
Section E New PLW Application **Individual with an out-of-state license information**
1. Type of License: (Select one) ☐ Psychologist ☐ Clinical Social Worker ☐ Professional Clinical Counselor ☐ Marriage and Family Therapist

2. License number:	3. Name of the state:
4. License issue date:	5. License expiry date:

Section F Individual with a change in employment **(For individuals with an existing approved PLW)**
1. Name of the MHP or LMHD the PLW was issued in:
2. PLW end date:

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Section G	Declaration

I declare under penalty of perjury under the laws of the State of California that the foregoing information and any attachment is true, accurate, and complete to the best of my knowledge and belief.

Print name of Director/Designee of MHP or LMHD:

Signature of Director/Designee of MHP or LMHD:

Date:

Privacy Statement

This form is used to request a professional licensure waiver. The information requested in this form is required by the Department of Health Care Services (Department). Any personal and health information collected in this form by the Department is subject to limitations in the Information Practices Act (IPA), the Health Insurance Portability and Accountability Act (HIPAA), and other state policy. The Department will not use or share your information unless authorized by you, or by the individual to whom it pertains, in writing or as authorized by law. All information requested in this form is mandatory. If you do not provide all information requested in this form, your application will be deemed incomplete. If missing information is not provided as required, review of this application will be terminated, and denial of a professional licensure waiver provided. The Department may share or provide any of the information provided in or with this form to the California Health and Human Services Agency, the California State Controller's Office, the California Department of Consumer Affairs, the United States Department of Health and Human Services, and the United States Substance Abuse and Mental Health Services Administration, or other federal, state, or local agencies as appropriate. In most cases, you have a right to see personal information about you that is kept in federal and state records.
For more information or to obtain access to records containing your personal information maintained by the Department, contact:

Staff Services Manager I
County/Provider Oversight and Operations Support Section, Unit 4
Behavioral Health, MS 2621, P.O. Box 997413, Sacramento, CA 95899-7413
Phone: (916) 713-8633
Email: MHLicensingWaivers@dhcs.ca.gov

The Department is authorized to collect this information pursuant to California Welfare and Institutions Code section 5751.2 and California Code of Regulations, Title 9, Division 1, Chapter 11.5. The Department is also authorized to collect personal and health information for the administration of the Medi-Cal program. For more information on the Department's Privacy Practices, please visit https://www.dhcs.ca.gov/formsandpubs/laws/priv/Documents/Notice-of-Privacy-Practices-English.pdf and https://www.dhcs.ca.gov/Pages/Privacy.aspx.

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If you wish to obtain a paper copy of the Department's privacy policy and practices, or wish to file a complaint, you may contact the Department's privacy officer by mail, email, or telephone at:

Privacy Office
c/o: Data Privacy Unit
Department of Health Care Services
P.O. Box 997413, MS 4722
Sacramento, CA 95899-7413

Email: incidents@dhcs.ca.gov

Telephone: (916) 445-4646

The privacy notice provided here is required by California Civil Code section 1798.17.

For Completion by the Department of Health Care Services

Date complete PLW application and supporting documentation received:	
Date PLW begins:	Date PLW ends:
Comments:	

This waiver is granted pursuant to California Code of Regulations Title 9, Division 1, Chapter 11.5.

Approved by:

Title:

Signature:

Date: