Mental Health Professional Licensure Waiver (PLW) Application

PLW Application Instructions

Instructions: Read all the instructions included on this form carefully and complete each item requested. For additional information, please review California Welfare and Institutions Code section 5751.2, and the California Code of Regulations, Title 9, Division 1, Chapter 11.5 commencing with Section 1870, which outlines the requirements for Professional Licensure Waiver (PLW).

While the PLW application is under review, the new Mental Health Plan (MHP) or local mental health department (LMHD) shall not allow an individual to provide mental health services, where a professional licensure waiver is required.

Do not leave any questions, boxes, lines, or fields blank. Enter N/A if not applicable.

Applicants should not provide personal information that is not requested.

Eligibility requirements for a PLW:

Individuals acquiring a professional license to provide mental health services:

An individual shall meet the criteria specified below to be eligible for a PLW (California Code of Regulations, Title 9, Division 1, Chapter 11.5, § 1876(a)(1)(A-B)):

(1) Be employed or under contract with the MHP or LMHD or provider subcontracting with the MHP or local mental health department to provide mental health services for the purposes of acquiring supervised professional experience required for licensure as a psychologist, as set forth under Business and Professions Code Section 2914 and Title 16 California Code of Regulations Section 1387; and either:

(A) Have earned a doctorate degree from an accredited or approved college or institution of higher education as set forth under Business and Professions Code Section 2914; or

(B) Be currently enrolled in a doctoral program and have completed a minimum of 48 semester/trimester or 72 quarter unit of graduate coursework in psychology not including thesis, internship, or dissertation, at an accredited or approved college or institution of higher education as set forth under Business and Professions Code Section 2914.

When submitting a PLW application for an unlicensed psychologist, the MHP or LMHD shall submit a current, certified doctoral program transcript (California Code of Regulations, Title 9, Division 1, Chapter 11.5, § 1878(a)(1-2)).

Individuals who are an out-of-state licensed professional:

An individual shall meet the criteria specified below to be eligible for a PLW (California Code of Regulations, Title 9, Division 1, Chapter 11.5, § 1876(a)(2)(A-C))**:**

(A) Be one of the following out-of-state licensed professionals:

1. Psychologist;

2. Clinical social worker;

3. Marriage and family therapist; or

4. Professional clinical counselor;

(B) Be recruited for employment from outside of California and employed or under contract with the MHP or LMHD or provider subcontracting with the MHP or LMHD to provide mental health services; and

(C) Have the minimum amount of professional experience, to gain admission to the applicable California licensing examination for their profession.

When submitting a PLW application for an out-of-state licensed professional, the MHP or LMHD shall submit a copy of the issued license that includes the individual's full name, license number, and name of the state they are licensed in and evidence from the appropriate California licensing board that the individual seeking the PLW has been granted admission to the applicable California licensing examination for their profession (California Code of Regulations, Title 9, Division 1, Chapter 11.5, § 1876(a)(3)(A-B)).

SUBMISSION: The completed PLW application and all required documentation are to be submitted to the Department of Health Care Services (DHCS) via email to MHLicensingWaivers@dhcs.ca.gov.

Section A Mental Health Plan (MHP) OR Local Mental Health Department (LMHD) Information Section

1. **Name of the MHP or LMHD:** Enter the name of the MHP or LMHD submitting the PLW application.

2. **Mailing address:** Enter the street address of the MHP or LMHD's mailing address. If applicable, enter the room or suite number of the MHP or LMHD's mailing address.
   2a. **City:** Enter the city of the MHP or LMHD's mailing address.
   2b. **State:** Enter the state of the MHP or LMHD's mailing address.
   2c. **Zip code:** Enter the zip code of the MHP or LMHD's mailing address.

3. **Email address:** Enter the MHP or LMHD's email address for communication regarding the PLW.

4. **Telephone number:** Enter the MHP or LMHD's telephone number, including area code and extension, if any, for communication regarding the PLW.

Section B Individual Seeking PLW Information Section

1. **Full legal name:** Enter the full legal name of the individual seeking PLW. Include first name, middle name (if applicable), and last name, as well as any aliases or maiden names.

2. **Email address:** Enter the email address of the individual seeking PLW.

3. **The start date for the individual seeking PLW to provide mental health services:** Enter the date the individual seeking PLW is expected to begin providing mental health services in the position requiring a PLW. PLW approvals will not be backdated.

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Section C Type of PLW Application

Check the appropriate box that corresponds to the type of PLW application being made by the applicant on behalf of an individual seeking a PLW. Select one.

- **New PLW application:** for an individual acquiring a professional license to provide mental health services; or
- **New PLW application:** for an individual with an out-of-state license; or
- **Individual with a change in employment**: for an individual with an existing approved PLW.

Section D New PLW Application

Individual acquiring a professional license to provide mental health services

If the type of PLW application selected is for an “individual acquiring professional license to provide mental health services," provide the following information:

1. **Name of the doctorate degree:** Enter the name of the doctorate degree obtained or being pursued by the individual seeking PLW.
2. **Date doctorate degree conferred:** If the individual has earned their doctorate degree, enter the date the degree was conferred in the format of Month/Day/Year. If the individual is still pursuing their doctorate degree, enter N/A.
3. **Name of the college or institution of higher education:** Enter the name of the college or institution that conferred the doctorate degree, or college or institution the individual seeking PLW is pursuing a doctorate degree at.
4. **If currently enrolled in a doctoral program, number of units completed:** If the individual seeking PLW is currently enrolled in a doctoral program, enter the number of units of graduate coursework in psychology (excluding units earned for thesis, internship, or dissertation) completed thus far. Specify whether units are measured by semesters/trimesters or quarters.

Section E New PLW Application

Individual with an out-of-state license

If the type of PLW application selected is for an “individual with an out-of-state license,” provide the following information:

1. **Type of License:** Check the appropriate box that corresponds to the out-of-state license held by the individual seeking PLW.
2. **License number:** Enter the license number associated with the out-of-state license held by the individual seeking PLW.
3. **State issued:** Enter the name of the state where the out-of-state license was issued.
4. **License issued date:** Enter the issue date of the out-of-state license in the format of Month/Day/Year.
5. **License expiry date:** Enter the expiration date of the out-of-state license in the format of Month/Day/Year.

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Section F	Individual with a change in employment (For individuals with an existing approved PLW)

This section is to be used for circumstances in which an individual with an existing approved PLW will be employed by a new MHP or LMHD, or by a provider subcontracting with a new MHP or LMHD.

If the type of PLW application selected is for an "individual with a change in employment (for individuals with an existing approved PLW)" provide the following information:

1. **Name of the MHP or LMHD the PLW was initially issued in:** Enter the name of the MHP or LMHD where the waivered individual was or is employed or under contract.
2. **PLW end date:** Enter the end date of the existing PLW.

Section G	Declaration

All PLW applications must be submitted, signed, and dated by the Director or Designee of the MHP or LMHD on file with DHCS.

1. **Name of Director/Designee of MHP or LMHD:** Enter the name of Director or Designee of MHP or LMHD.
2. **Signature of Director/Designee of MHP or LMHD:** Include the signature of the Director or Designee of MHP or LMHD.
3. **Date:** Enter the date the PLW application was signed.

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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: