State Of New Mexico
Regulation and Licensing Department
NEW MEXICO COUNSELING & THERAPY PRACTICE BOARD
Mailing Address: P.O. Box 25101, Santa Fe, New Mexico 87505
Physical Address: 2550 Cerrillos Drive, Santa Fe, NM
Phone: 505-476-4622 Fax: 505-476-4645

2014 LPC-RIMHC-LDAC-LAAC-LADAC RENEWAL FORM

Full Name _____

Address: _____**City** _____

State_____ **Zip** _____

License Type: _____**License number:**_____

Is the above a new address change? _____ **Yes** _____ **No**

To renew your license for **October 1, 2014** through **September 30, 2016,** complete this renewal application and return with renewal fee of **$150.00** 40 hours of CEU's, part of the 40 are 6 hours of ethics.

Pursuant 61-9A-23 LAPSED/EXPIRED LICENSE: If a license is not renewed by September 30, 2014 the license is considered expired and the licensee must immediately **refrain** from practice.

Pursuant 61-9A-23 LATE RENEWAL PENALTY: After September 30, 2014, the licensee may renew within a thirty (30) day grace period (Grace Period October 1, 2014 through October 31, 2014) by submitting payment of $75.00 renewal fee, plus $100.00 late fee and compliance with all renewal requirements. CEUs must have been acquired from October 1, 2012 through September 30, 2014. CEUs acquired prior to October 1, 2012 or after September 30, 2014 are NOT ACCEPTABLE.

Pursuant 61-9-A-23 MISSED RENEWAL DEADLINE: A license that is not renewed within 30 days of expiration (October 31, 2014) must reapply, meet all current requirements, submit all documentation and required application fees.

Pursuant to 16.27.16.9 CONTINUING EDUCATION: Forty (40) hours of continuing education are required for this renewal cycle, part of the 40 are six hours of ethics. If you have been licensed for less than two years you are required to submit 20 hours of CEU's and part of the 20 are six hours of ethics. **G.** Internet correspondence shall not exceed 12 hours for a license renewal period. **H.** Home studies continuing education shall not exceed 12 hour for a license period.

FAXED COPIES ARE NOT ACCEPTABLE

NOTICE

CASH IS NO LONGER ACCEPTED as a form of payment for all business transactions including but not limited to licenses, permits, fees, and penalties. Payment must be made in one of the following methods: Check, Cashier's Check, Money Order, or Credit Card (where authorized).

When you provide a check as payment, you authorize The State of New Mexico to either use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction.

1. Payment method: credit card ____ MC _____ VISA

Number: _____Expiration date: _____ Amount $_____

_____

Signature Date

You may also submit payment in the form of a check, cashier check or money order.

The board office will return your renewal application if questions are not answered.

2. GIVE DETAILS OF ANY "YES" ANSWERS TO QUESTIONS 1-5 ON A SEPARATE SHEET OF PAPER. If you have previously submitted information it is on file and duplicate information is not required.

1. Are you in arrears in court-ordered child support in New Mexico? ___Yes ___No
2. Have you been convicted of a felony? ___Yes ___No
3. Have you had any disciplinary action taken against you in any state? ___Yes ___No
4. Have you been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid in your behalf, or paid such a claim yourself? ___Yes ___No
5. Are you currently providing supervision? ___Yes __No

3. **RETIREMENT STATUS:** To place your license on retirement status please read the information below, sign, date and send this form back to the NM Counseling and Therapy Practice Board, postmarked no later than September 30, 2014

As stated in Part 3, section 11.2 a retired license status may be restored within five years of being placed on retirement status by notifying the board in writing, providing the board with proof of having completed a total of 40 hours of continuing education during the retirement period, and paying reinstatement fee of $100.00 plus licensure fee. A license that has been retired for less than two years must submit 20 hours of CEUs.

I am requesting to place my license on retirement status.

_____ _____

Signature **Date**

4. Please staple copies of your acquired certificates. Your certificates must contain the following information:

1. Dates 2. Course title 3. CEU Hours 4. Approved By

5. I understand that if I falsify any part of my renewal form I will be subject to disciplinary action up

to and including revocation of my license.

I certify that all of the information in this renewal form is correct to the best of my knowledge.

_____

SIGNATURE **DATE**

Submit Renewal Notice, Payment and copies of your continuing education certificates to:

New Mexico Counseling and Therapy Practice Board
P.O. Box 25101
Santa Fe, NM 87505

The Board does not accept the following for continuing education:

Acupuncture, Yoga, Occupational Therapy, CPR, Dance Therapy; Nursing continuing education or hypnotherapy.

3. 16.27.16.9 ACCEPTABLE CONTINUING EDUCATION COURSES:

A. approved by certifying groups such as the national board for certified counselors, American marriage and family therapy regulatory board, American art therapy, association international certification reciprocity consortium, national association of alcohol and drug abuse council;
B. approved by other regulatory boards of related mental health or substance abuse fields, including psychiatry, psychology and social work;
C. sponsored by international, national, regional or state mental health professional associations including psychiatry, psychology and social work, or state and federal divisions of substance abuse; or
D. publication of professional writings and presenting board approved educational courses shall be awarded in a manner consistent with Part 16, section 16.27.16.8 and shall not exceed 20 hours for a license renewal period.
E. approved by the New Mexico counseling and therapy practice board;
F. internet continuing education correspondence shall not exceed 12 hours for a license renewal
period.
G. home studies continuing education shall not exceed 12 hours for a license renewal period.

The board office does not provide receipts, please submit payment by money order or cashier check and keep copies of receipt.

HOUSE BILL 19
MANDATORY SURVEY

Please provide the following information about your practice in New Mexico.

An asterisk (*) indicates that an answer is REQUIRED.

New Mexico License Number: _____

CURRENT WORK STATUS (Select all that apply)*

- ☐ Practice in New Mexico
- ☐ Practice Medicine in another state: ☐ TX ☐ CO ☐ AZ ☐ Other
- ☐ Permanently or Temporarily Inactive in New Mexico
- ☐ Retired, but maintain an active license
- ☐ Retired and do not maintain an active license
- ☐ Current Resident of Fellowship Training

CURRENT ACTIVITIES

How many weeks per year do you practice in NM? *_____

How many hours per week do you practice in NM? *_____

For you practice in New Mexico, approximately what percent of your time was spent on the following activities (percentage of all selected activities should total 100%)

	Direct Patient Care*
	Teaching/Precepting
	Research
	Healthcare Administration
	Other, Please Specify_____

For Direct Patient Care, approximately what percent of your time was spent in the following types of facilities (percentage should total 100%)

	Hospital/Inpatient*
	Outpatient/Clinic*
	Mobile Services
	Other, Please Specify:_____

LOCATION OF EDUCATION AND TRAINING

	New Mexico	Other U.S. state Or Canada	Foreign country	Not Applicable
Location of the high school from which you graduated: *	☐	☐	☐	☐
Location of the undergraduate college or university from which you graduated: *	☐	☐	☐	☐
Location of the licensure training from which you graduated:*	☐	☐	☐	☐
Location of primary specialty training:	☐	☐	☐	☐
Location of secondary specialty training:	☐	☐	☐	☐

PRACTICE SPECIALTY(IES) IN WHICH YOU SPEND MOST OF YOUR PROFESSIONAL TIME*

Primary Specialty:*_____

% Patient care time for primary specialty:_____

Secondary Specialty:_____

% Patient care time for secondary specialty:_____

TRAINING AND CERTIFICATION

	Yes	No
Completed accredited residency programs for primary specialty? *	☐	☐
Board certified/Certificate of Added/Special Qualifications for primary specialty?	☐	☐
Completed accredited residency programs for secondary specialty?	☐	☐
Board certified/Certificate of Added/Special Qualifications for secondary specialty?	☐	☐

HOSPITAL ADMITTING PRIVILEGES

Number of hospitals in New Mexico at which you have admitting privileges *

☐None ☐One ☐Two ☐Three or more

REIMBURSEMENT: PAYMENT SOURCES*

Primary source of payment for patient care **(select top 3)**:

- ☐ Medicare
- ☐ Medicaid
- ☐ Tricare/VA/HIS
- ☐ Private Insurance
- ☐ Self-pay
- ☐ Bad Debt/Charity
- ☐ Other
- ☐ Do Not Know or Not Applicable
- ☐ Other: _____

% of patients with Medicare as their primary payer: * _____

% of patients with Medicaid as their primary payer: * _____

%of patients with Tricare/VA/HIS as their primary payer:* _____

% of patients with Private Insurance as their primary payer: * _____

% of patients with Self-pay as their primary payer: * _____

% of patients with Bad Debt/Charity as their primary payer: * _____

% of patients with Other as their primary payer: _____

Provide an approximate monetary value for the uncompensated patient care you provided during the last year for emergency services: ☐

Provide an approximate monetary value for the uncompensated patient care you provided during the last year for non-emergency services: ☐

PATIENT CARE PRACTICE LOCATIONS*

For PRIMARY location of patient care:

PRIMARY patient care street address:	
PRIMARY patient care city/town:	
PRIMARY patient care state:	
PRIMARY patient care 5-digit zip code:	
Weekly PRIMARY patient care hours:	
Weekly PRIMARY number of patients:	

For SECONDARY location of patient care:

SECONDARY patient care street address:	
SECONDARY patient care city/town:	
SECONDARY patient care state:	
SECONDARY patient care 5-digit zip code:	
Weekly SECONDARY patient care hours	
Weekly SECONDARY number of patients:	

PRACTICE SETTINGS

What best describes your PRIMARY location practice? *

- ☐ Independent Practice
- ☐ Group Practice-Employee/Staff
- ☐ Organizationally affiliated (i.e. University, or Health Plan staff)
- ☐ Hospital-Inpatient
- ☐ Hospital-Outpatient dept. /satellite clinic
- ☐ Hospital-Emergency Room
- ☐ Federal Qualified Health Clinic (FQHC)
- ☐ Nursing home/Home Health agency
- ☐ Private health center/clinic
- ☐ Public/Non-profit community health center (non-FQHC)
- ☐ Other licensed community clinic
- ☐ Military/VA health facility
- ☐ Indian Health Service clinic
- ☐ Locum Tenens
- ☐ Multi-Specialty Practice-Employee/staff
- ☐ Nurse Managed Clinic
- ☐ Other (please specify):_____

What best describes your PRIMARY location practice size? *

- ☐ Solo Independent Practitioner
- ☐ Solo Independent Practitioner + Intermediate
- ☐ Two Independent Practitioners
- ☐ Three or Four Independent Practitioners
- ☐ Five to Nine Independent Practitioners
- ☐ Ten or More Independent Practitioners

What best describes your SECONDARY location practice?

- ☐ Independent Practice
- ☐ Group practice-Employee/Staff
- ☐ Organizationally affiliated (i.e. University, or Health Plan staff)
- ☐ Hospital-inpatient
- ☐ Hospital-Outpatient dept. /satellite clinic
- ☐ Hospital-Emergency Room
- ☐ Federal Qualified Health Clinic (FQHC)
- ☐ Nursing home/Home Health Agency
- ☐ Private health center/clinic
- ☐ Public/Non-profit community health center (non-FQHC)
- ☐ Other licensed community clinic

- ☐ Military/VA health facility
- ☐ Indian Health Service Clinic
- ☐ Locum tenens
- ☐ Multi-Specialty Practice-Employee/staff
- ☐ Nurse Managed Clinic
- ☐ Other (please specify):_____

What best describes your SECONDARY location practice size?

- ☐ Solo Independent Practitioner
- ☐ Solo Independent Practitioner + Intermediate
- ☐ Two Independent Practitioners
- ☐ Three or Four Independent Practitioners
- ☐ Five to Nine Independent Practitioners
- ☐ Ten or More Independent Practitioners

CURRENT PRACTICE CAPACITY

What describes your current patient care practice capacity?*

- ☐ My practice is full: I cannot accept any new/additional patients
- ☐ My practice is nearly full: I can accept a few new/additional patients
- ☐ My practice is far from full: I can accept new/additional patients
- ☐ Not Applicable

MEANINGFUL USE OF HEALTH INFORMATION TECHNOLOGY (HIT) AND ELECTRONIC HEALTH RECORD (EHR) IN YOUR PRACTICE

Does your practice CURRENTLY have the following HIT/EMR capacity? (select all that apply)*	
☐	Computerized Provider Order Entry (CPOE)
☐	E-Labs (Order, Retrieve and Store results)
☐	Create Registries (e.g. registry of patient with diabetes)
☐	Quality Reporting
☐	Record Demographics (e.g. patient race/ethnicity, insurance status)
☐	Patient access to electronic copy of health records
☐	E-Prescribing
☐	Patient timely access to labs, x-ray and other results
☐	Record Vital Signs (e.g. height, weight, blood pressure)
Does your practice PLAN TO HAVE IN THE NEXT YEAR? (select all that apply)*	
☐	Computerized Provider Order Entry (CPOE)
☐	E-Labs (Order, Retrieve and Store results)
☐	Create Registries (e.g. registry of patient with diabetes)
☐	Quality Reporting
☐	Record Demographics (e.g. patient race/ethnicity, insurance status)
☐	Patient access to electronic copy of health records
☐	E-Prescribing
☐	Patient timely access to labs, x-ray and other results
☐	Record Vital Signs (e.g. height, weight, blood pressure)

REFERRAL DIFFICULTIES

Identify the specialties that you or your patients have the greatest difficulty scheduling/obtaining/arranging a timely appointment **when making referrals** (MARK UP TO 3 SPECIALTIES)*

- ☐ Advanced practice certified chiropractor
- ☐ Social Worker
- ☐ Social Worker- Clinical Specialty
- ☐ Social Worker - Medical Specialty
- ☐ Social Worker- School Specialty
- ☐ Social Worker - Researcher
- ☐ Social Work- Community Organizer
- ☐ Social Work Administrator
- ☐ Dental Public Health
- ☐ Endodontic
- ☐ Oral and maxillofacial surgery
- ☐ Orthodontics and dento-facial orthopedics
- ☐ Oral pathology
- ☐ Pediatric dentistry
- ☐ Periodontology
- ☐ Acupuncturists
- ☐ Cardiology/Vascular Specialists
- ☐ Chiropractors
- ☐ Dermatology
- ☐ Diabetic Educators
- ☐ Gynecology (only)
- ☐ Endocrinology and Metabolism
- ☐ Primary Care- Internal Medicine, Family
- ☐ Practice, Pediatrics, Geriatrics
- ☐ Infectious Disease
- ☐ Mental Health Adult, Child and Adolescent
- ☐ Nephrology
- ☐ Neurology
- ☐ Nutritionists
- ☐ Occupational/Rehabilitation - Physiary
- ☐ Medicine
- ☐ Oncology/Hematology
- ☐ Orthotists/Prosthetics
- ☐ Pain Management
- ☐ Physical Therapy
- ☐ Rheumatology
- ☐ Other:_____

RECRUITMENT EXPERIENCES *

How would you describe your experience in recruiting:	Easy	Somewhat Difficult	Very Difficult	Not Known or Now Applicable
Physicians	☐	☐	☐	☐
Nurses	☐	☐	☐	☐
Nurse Practitioners	☐	☐	☐	☐

Physician Assistants	☐	☐	☐	☐
Other Health Professionals	☐	☐	☐	☐

DEMOGRAPHIC INFORMATION*

Gender: ☐Male ☐Female

Hispanic, Latino or Spanish Origin: ☐Yes ☐No

Race (Select all that apply):

☐White or Caucasian
☐Black or African American
☐Native American or Alaska Native
☐Asian or Pacific Islander
☐Other:_____

NEAR FUTURE PRACTICE PLANS *

In the next 12 months I plan to (select all that apply):

☐Retire from patient care
☐Significantly reduce patient care hours
☐Move my practice to another geographic location in New Mexico
☐Move my practice out of New Mexico
☐None of the above

If you are retiring, moving or reducing patient care hours in the next 12 months, what are the factors that led to that decision? (Select all that apply)

☐Age
☐Geographic preference
☐Health
☐Practice Environment
☐Lack of Job Satisfaction
☐Gross Receipts Tax
☐Increasing Administrative/Regulatory Burden
☐Reimbursement Issues
☐Other:_____
☐N/A

PROFESSIONAL LIABILITY INSURANCE INCREASE THRESHOLDS

At what percent increase in your annual liability insurance above your current level would you consider?

Retiring from patient care?	%
Significantly reduce patient care hours?	%
Moving practice out of state?	%

MEDICARE PAYMENT DECREASE THRESHOLDS

At what percent decrease to your Medicare payment level would you consider:

Retiring from patient care?	%
Closing practice to NEW Medicare patients	%
Closing practice to ALL Medicare patients	%
Significantly reduce patient care hours?	%
Moving practice out of state?	%

When billing for services: *

- ☐ Submit billing through own license
- ☐ Submit billing through someone else's license
- ☐ Submit billing through Group/Hospital ID
- ☐ Do not know
- ☐ Other (please specify): _____