



Credentialed Mental Health Screener Application

I. Credentialed Mental Health Screener Application

a. Personal Information

i. For this section, please provide your personal contact information, not your professional or work information.

1. Last Name: _____
2. First Name: _____
3. Middle Initial: _____
4. Address: _____
5. City: _____
6. State: _____
7. Zip: _____
8. E-Mail: _____
9. Phone: _____

b. Application Type

i. I am a:

(Select one option best describing you)

- ☐ Psychiatrist
- ☐ Physician
- ☐ Bachelor of Science in Nursing
- ☐ Psychiatry Resident
- ☐ APRN, LCSW, LMFT, LPCMH, PSYCHOLOGIST, or PA-C
- ☐ LMSW, LACMH
- ☐ Bachelor's Level Behavioral Health Clinician
- ☐ Other

c. Psychiatrist Registration

i. Please select one option for each question

1. I have a valid Delaware medical license.

☐ True

☐ False

Please attach a copy of your Delaware medical license.

2. I have completed an accredited residency training program in psychiatry.

☐ True

☐ False

Please attach documentation showing your completion of an accredited residency training program in psychiatry.



3. I have read, understand, and agree to comply with the requirements of 16 Del.C. ch. 50, 16 Del. Admin. C. § 6002 (as modified by 27 Del. Reg. 185 (Sep. 2023)), and the Division's policies.

☐ True

☐ False

- d. *I certify, under penalty of perjury, that my answers and the information on this form are true and correct to the best of my knowledge, information, and belief.*

Signature: _____

Date: _____

e. Additional Information

- i. Please submit this application and supporting documentation to:
dhss_dsamh_mhscreeener@delaware.gov
- ii. Incomplete applications will be denied.
- iii. After receiving your application for registration, the Division will review the application and notify you of your registration or denial by email to the email address you listed on this form.
- iv. If you are successfully registered, your registration is valid for 10 years from the date the Division notifies you.
- v. Under 16 Del. Admin. C. § 6002-5.0 (as modified by 27 Del. Reg. 185 (Sep. 2023)), you may not conduct a screening until you are registered by the Division.
- vi. You may direct questions to:
dhss_dsamh_mhscreeener@delaware.gov

f. Checklist

- ☐ Completed and signed application
- ☐ Delaware medical license



II. Physician Credentialing

a. Please select one option for each question

- i. I have a valid Delaware medical license.

☐ True

☐ False

Please attach a copy of your Delaware medical license

- ii. I have read, understand, and agree to comply with the requirements of 16 Del.C. ch. 50, 16 Del. Admin. C. § 6002 (as modified by 27 Del. Reg. 185 (Sep. 2023)), and the Division's policies.

☐ True

☐ False

- b. I certify, under penalty of perjury, that my answers and the information on this form are true and correct to the best of my knowledge, information, and belief.

Signature: _____

Date: _____

c. Additional Information

- i. Please submit this application and supporting documentation to:
dhss_dsamh_mhscreeener@delaware.gov
- ii. Incomplete applications will be denied.
- iii. After receiving your application, the Division will review your application and register you.
- iv. The Division will notify you of your credentialing or denial by email to the email address you listed on this form.
- v. Under 16 Del. Admin. C. § 6002-5.0 (as modified by 27 Del. Reg. 185 (Sep. 2023)), you may not conduct a screening until you are credentialed by the Division.
- vi. You may direct questions to:
dhss_dsamh_mhscreeener@delaware.gov

d. Checklist

☐ Completed and signed application

☐ Delaware medical license



III. Psychiatric Resident Registration

a. Please select one option for each question

- i. I have a valid Delaware medical training license.

☐ True

☐ False

Please attach a copy of your Delaware medical training license.

- ii. I am enrolled in an accredited residency training program in psychiatry.

☐ True

☐ False

Please attach documentation showing your enrollment in an accredited residency training program in psychiatry.

- iii. I have read, understand, and agree to comply with the requirements of 16 Del.C. ch. 50, 16 Del. Admin. C. § 6002 (as modified by 27 Del. Reg. 185 (Sep. 2023)), and the Division's policies.

☐ True

☐ False

- b. I certify, under penalty of perjury, that my answers and the information on this form are true and correct to the best of my knowledge, information, and belief.**

Signature: _____

Date: _____

c. Additional Information

- i. Please submit this application and supporting documentation to:
dhss_dsamh_mhscreeener@delaware.gov
- ii. Incomplete applications will be denied.
- iii. You must complete the Division's required training.
- iv. After receiving your application and after you successfully complete the required training, the Division will review your application.
- v. The Division will notify you of your credentialing or denial by email to the email address you listed on this form.
- vi. If you are credentialed, your credential is valid for 2 years from the date the Division notifies you.
- vii. Under 16 Del. Admin. C. § 6002-5.0 (as modified by 27 Del. Reg. 185 (Sep. 2023)), you may not conduct a screening until you are credentialed by the Division.
- viii. You may direct questions to:
dhss_dsamh_mhscreeener@delaware.gov

d. Checklist

- ☐ Completed and signed application



- ☐ Delaware medical training license
- ☐ Documentation of enrollment in a residency program



IV. Licensed Mental Health Practitioner Credentialing

a. I am a:

Please select one option best describing you.

- ☐ APRN
- ☐ LPCMH
- ☐ LCSW
- ☐ PSYCHOLOGIST
- ☐ LMFT
- ☐ PA-C

b. I have a valid Delaware License.

- ☐ True
- ☐ False

Please attach a copy of your Delaware license.

c. I have at least 2 years of direct experience providing clinical services to individuals with mental health conditions.

- ☐ True
- ☐ False

Please attach a resume or CV that includes your direct experience providing clinical services.

d. (To be completed by APRN only):

I am certified as a psychiatric-mental health nurse practitioner by the American Nurses Credentialing Center.

- ☐ True
- ☐ False

Please attach a copy of your certification.

e. (To be completed by PA-C only)

I am certified in psychiatry by the National Commission on Certification of Physician Assistants.

- ☐ True
- ☐ False

Please attach a copy of your certification.

f. I have read, understand, and agree to comply with the requirements of 16 Del.C. ch. 50, 16 Del. Admin. C. § 6002 (as modified by 27 Del. Reg. 185 (Sep. 2023)), and the Division's policies.

- ☐ True
- ☐ False



- g. I certify, under penalty of perjury, that my answers and the information on this form are true and correct to the best of my knowledge, information, and belief.

Signature: _____

Date: _____



h. Additional Information

- i. Please submit this application and supporting documentation to:
dhss_dsamh_mhscreeener@delaware.gov
- ii. Incomplete applications will be denied.
- iii. You must complete the Division's required training and pass the Division's exam.
- iv. After receiving your application and after you successfully complete the required training and pass the exam, the Division will review your application.
- v. The Division will notify you of your credentialing or denial by email to the email address you listed on this form.
- vi. If you are credentialed, your credential is valid for 2 years from the date the Division notifies you.
- vii. Under 16 Del. Admin. C. § 6002-5.0 (as modified by 27 Del. Reg. 185 (Sep. 2023)), you may not conduct a screening until you are credentialed by the Division.
- viii. You may direct questions to:
dhss_dsamh_mhscreeener@delaware.gov

i. Checklist

- ☐ Completed and signed application
- ☐ Delaware license
- ☐ Certification (if necessary)
- ☐ Resume or CV



V. Unlicensed Mental Health Practitioner Credentialing

a. I have completed at least a:

☐ Bachelor's Degree

☐ Master's Degree

Please attach documentation showing your completion of a degree.

b. My degree is from an accredited institution.

☐ True

☐ False

c. My degree is in a mental health related field.

☐ True

☐ False

d. My degree is in: _____

e. *(To be completed by bachelor's degree only)*

I have at least 4 years of direct experience providing clinical services to individuals with mental health conditions.

☐ True

☐ False

Please attach a resume or CV that includes your direct experience providing clinical services.

f. *(To be completed by master's degree only)*

I have at least 2 years of direct experience providing clinical services to individuals with mental health conditions.

☐ True

☐ False

Please attach a resume or CV that includes your direct experience providing clinical services.

g. I practice under the supervision of a psychiatrist.

☐ True

☐ False

Please have your supervising psychiatrist complete section VIII of this application.

h. I have read, understand, and agree to comply with the requirements of 16 Del.C. ch. 50, 16 Del. Admin. C. § 6002 (as modified by 27 Del. Reg. 185 (Sep. 2023)), and the Division's policies.

☐ True

☐ False



- i. I certify, under penalty of perjury, that my answers and the information on this form are true and correct to the best of my knowledge, information, and belief.

Signature: _____

Date: _____



j. Additional Information

- i. Please submit this application and supporting documentation to:
dhss_dsamh_mhscreeener@delaware.gov
- ii. Incomplete applications will be denied.
- iii. You must complete the Division's required training and pass the Division's exam.
- iv. After receiving your application and after you successfully complete the required training and pass the exam, the Division will review your application.
- v. The Division will notify you of your credentialing or denial by email to the email address you listed on this form.
- vi. If you are credentialed, your credential is valid for 2 years from the date the Division notifies you.
- vii. Under 16 Del. Admin. C. § 6002-5.0 (as modified by 27 Del. Reg. 185 (Sep. 2023)), you may not conduct a screening until you are credentialed by the Division.
- viii. You may direct questions to:
dhss_dsamh_mhscreeener@delaware.gov

k. Checklist

- ☐ Completed and signed application
- ☐ Documentation of degree
- ☐ Resume or CV
- ☐ Supervising psychiatrist form



VI. Supervising Psychiatrist Form

a. *This section must be completed by the applicant's supervising psychiatrist.*

- i. **Last Name:** _____
- ii. **First Name:** _____
- iii. **Middle Initial:** _____
- iv. **Address:** _____
- v. **City:** _____
- vi. **State:** _____
- vii. **Zip:** _____
- viii. **E-Mail:** _____
- ix. **Phone:** _____

b. *Please select one option for each question*

i. I am registered to perform screenings.

☐ **True**

☐ **False**

ii. *(If unregistered)*

I have a valid Delaware medical license.

☐ **True**

☐ **False**

Please attach a copy of your Delaware medical license.

iii. *(If unregistered)*

I have completed an accredited residency training program in psychiatry.

☐ **True**

☐ **False**

Please attach documentation showing your completion of an accredited residency training program in psychiatry.

iv. The applicant, _____, practices under my direct supervision.

☐ **True**

☐ **False**

c. I have read and understand the requirements of 16 Del.C. ch. 50, 16 Del. Admin. C. § 6002 (as modified by 27 Del. Reg. 185 (Sep. 2023)), and the Division's policies related to psychiatrist supervision of a credentialed mental health screener.

☐ **True**

☐ **False**



- d.* I certify, under penalty of perjury, that my answers and the information on this form are true and correct to the best of my knowledge, information, and belief.

Signature: _____

Date: _____