CONTRA COSTA HEALTH SERVICES

RESET FORM

Contra Costa Mental Health Plan

CREDENTIALING/PRIVILEGING FORM

SEND TO: Behavioral Health Administration 1340 Arnold Dr., #200, Martinez, CA 94553
FAX (Provider Services): (925) 957-5217 **EMAIL:** Provider.Services@cchealth.org

PLEASE COMPLETE ALL SECTIONS AS APPLICABLE TO PREVENT DELAYS IN PROCESSING

I. IDENTIFYING INFORMATION

FIRST NAME (LEGAL NAME)	MIDDLE NAME	LAST NAME
AGENCY		
CURRENT HOME ADDRESS		
CITY	STATE	ZIP
DRIVER'S LICENSE NUMBER STATE EXPIRATION DATE	MEDI-CAL # (IF APPLICABLE)	MEDICARE # (IF APPLICABLE)

II. For Licensed Psychiatrists and Physicians Only ☐ N/A

Are you board certified or board eligible? ☐ Yes ☐ No

III. For Interns Only: ☐ N/A

PLEASE CHECK THE APPROPRIATE BOX AND PROVIDE THE REQUIRED DOCUMENTATION

☐ AMFT, ASW or APCC (Attach a copy of your BBS registration)

☐ Waivered Psychologist (Must obtain a DHCS waiver through Provider Services. Attach a copy of your resume and official transcript or degree.)

IV. For Trainees Only: ☐ N/A

Are you currently enrolled in a Master's/Doctoral degree program in a mental health or a closely related field? If yes, attach a copy of the following:

1. **Executed agreement or contract between agency and school AND**
2. **Field placement agreement signed by student, supervisor and/or training coordinator, and school field placement liaison.**

PLEASE CHECK THE APPROPRIATE BOX	
☐ Master's Degree Program ☐ Doctoral Degree Program	
SCHOOL	
MAJOR	DATE OF ENROLLMENT

V. EDUCATION HISTORY: Attach copies of diploma and/or degree completed in mental health or a closely related field or school verification letter that degree was completed.

High School Diploma Or GED ☐Yes ☐No	School	From (mm/yy) To (mm/yy)	Year Graduated
Associate's Degree ☐Yes ☐No	School	From (mm/yy) To (mm/yy)	
	Discipline/Major	Year Degree Conferred	
Bachelor's Degree ☐Yes ☐No	School	From (mm/yy) To (mm/yy)	
	Discipline/Major	Year Degree Conferred	
Master's Degree ☐Yes ☐No	School	From (mm/yy) To (mm/yy)	
	Discipline/Major	Year Degree Conferred	
Doctoral Degree ☐Yes ☐No	School	From (mm/yy) To (mm/yy)	
	Discipline/Major	Year Degree Conferred	
Other training/certificate		Date Attended	

VI. EMPLOYMENT HISTORY: Start with Present Employment. A resume or supporting documentation may be attached but it may not be used as a substitute for completing this section. Mark the N/A box if you do not have any work experience in a mental health setting. ☐ N/A

Experience in a Mental Health Setting - #1:

From: _____

To: _____

Total: _____ _____

Years Months

Full Time ❑ Part Time ❑

*# hrs/week*_____

Employer's Name/Address

_____

_____

_____

Supervisor: _____

Phone: _____

Detail Typical Duties Performed for this job:

_____

_____

_____

_____

_____

_____

Employment History: *Experience in Mental Health Setting - #2:*

From: _____

To: _____

Total: _____ _____

Years Months

Full Time ❑ Part Time ❑

*# hrs/week*_____

Employer's Name/Address

_____

_____

_____

Supervisor: _____

Phone: _____

Detail Typical Duties Performed for this job:

_____

_____

_____

_____

_____

_____

Employment History: *Experience in Mental Health Setting - #3:*

From: _____

To: _____

Total: _____ _____

Years Months

Full Time ❑ Part Time ❑

*# hrs/week*_____

Employer's Name/Address

_____

_____

_____

Supervisor: _____

Phone: _____

Detail Typical Duties Performed for this job:

_____

_____

_____

_____

_____

_____

Employment History: *Experience in Mental Health Setting - #4:*

From: _____

To: _____

Total: _____ _____

Years Months

Full Time ❑ Part Time ❑

*# hrs/week*_____

Employer's Name/Address

_____

_____

_____

Supervisor: _____

Phone: _____

Detail Typical Duties Performed for this job:

_____

_____

_____

_____

_____

_____

I hereby affirm that the information submitted in this application and any addenda hereto is true, current, correct, and complete and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges or employment.

Print Name: _____ Signature: _____ Date: _____

(Stamped or Electronic Signature Is Not Acceptable)

If you need additional space, please use a blank page and include with this application.

VII. ATTESTATION QUESTIONS: Please answer the following questions "Yes" or No". If your answer is "yes" to any of the questions A through M, provide full details on a separate sheet of paper.

A. Has your license to practice in any jurisdiction, your Drug Enforcement Administration (DEA) registration or any applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions, or have you been fined or received a letter of reprimand or is such action pending?	☐Yes	☐No
B. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending?	☐Yes	☐No
C. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract or is any such action pending?	☐Yes	☐No
D. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?	☐Yes	☐No
E. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?	☐Yes	☐No
F. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending?	☐Yes	☐No
G. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank?	☐Yes	☐No
H. Have you been denied certification/recertification by a specialty board, or has your admissibility, certification or recertification status changed (other than changing from admissible to certified)	☐Yes	☐No

I. Have you ever been convicted of any crime (other than a minor traffic violation)?	☐Yes	☐No
J. In the past (5) years, have you had a history of chemical dependency or substance abuse that might adversely affect your ability to competently and safely perform essential functions of a practitioner in your area of practice.	☐Yes	☐No
K. Do you have an ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without direct threat to the health and safety of others.	☐Yes	☐No
L. Have any judgments/arbitration or claims been entered against you, or settlements been agreed to by you within the last (7) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitration's against you pending?	☐Yes	☐No
M. Are you currently engaged in the illegal use of drugs? ("Illegal use of drugs" means the use of controlled substances, obtained illegally, as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed health care practitioner. "Currently" does not mean on the day of or even the weeks preceding the completion of this application, rather, it means recently enough so that the illegal use may have an impact on one's ability to practice.)	☐Yes	☐No
N. Have you reviewed and completed the Contra Costa County Mental Health Plan Beneficiary Protection Training within the past thirty (30) days? *The training must be completed at the time of initial credentialing and again every 3 years at recredentialing. The training is available on the Provider Services Website (https://cchealth.org/mentalhealth/provider/)*	☐Yes	☐No
O. FOR THERAPEUTIC BEHAVIORAL SERVICES (TBS) WORKERS ONLY Have you completed a training in functional behavioral analysis with an emphasis on positive behavioral interventions? *The training must be completed prior to being eligible to provide services as a TBS worker.*	☐Yes	☐No
P. FOR THERAPEUTIC FOSTER CARE (TFC) PARENTS ONLY Have you completed forty (40) hours of initial TFC parent training? *The training must be completed prior to being eligible to provide services as a TFC parent.*	☐Yes	☐No
Q. FOR ALL LICENSED PHYSICIANS, CLINICIANS AND NURSE PRACTITIONERS ONLY		
i. Are you currently enrolled in the Provider Application and Validation for Enrollment (PAVE) portal for Medi-Cal?	☐Yes	☐No
ii. Have you also completed an Ordering/Referring/Prescribing (ORP) application or has someone done so on your behalf? *As of 4/1/21, all Physicians (MD and DO), Nurse Practitioners, Licensed Psychologists, LMFTs, LCSWs, and LPCCs are required to be enrolled in the PAVE Portal and have ORP enrollment in order to work within the Medi-Cal system.*	☐Yes	☐No

R. FOR ALL PHYSICIANS (MD AND DO) AND NURSE PRACTITIONERS ONLY

Have you enrolled in the Medi-Cal Rx portal or has someone done so on your behalf? ☐Yes ☐No

As of 4/1/21 all MDs, DOs and NPs are required to be enrolled in MC Rx partnered with Magellan to administer Medi-Cal Pharmacy benefits. All prescribers must be enrolled in this portal to provide services.

I hereby affirm that the information submitted in the Attestation Questions, and any addenda thereto is true, current, correct and complete to the best of my knowledge and belief and is furnished in good faith. I understand that intentionally withholding or omitting material information or intentionally submitting material false or misleading information may result in denial of my application or termination of my privileges or employment.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

_____

Print Full Name Here

Signature: _____Date _____

(Stamped or Electronic Signature Is Not Acceptable)

CONTRA COSTA
HEALTH SERVICES

Submit completed form to: Office of Provider Services

For New Providers (Initial Credentialing):
Email: provider.services@cchealth.org - or - Fax: (925) 608-6794

For Existing Providers (Recredentialing):
Email: bhrecredentialing@cchealth.org - or - Fax: (925) 608-6794

Contra Costa County Behavioral Health

SSN Consent Form

(for Provider Credentialing and Recredentialing)

Contra Costa Mental Health Plan (CCMHP) is required to conduct federal exclusion database checks at the time of credentialing and recredentialing providers. This includes querying the Social Security Administration's Death Master File and National Practitioner Data Bank. These two database checks require the provider's Social Security number.

Below is a form to authorize the Provider Services Staff of the Contra Costa County Behavioral Health Division to use your Social Security number for these two required federal exclusion database checks.

Section I: Identifying Information

Provider's Legal Name:

Last: _____ *First:* _____ *Middle:* _____

Birth Date: _____ **NPI Number:** _____ **ShareCare ID:** _____
(MM/DD/YYYY) *(if known)*

Social Security Number: _____

Section II: Signature

I authorize CCMHP to use my Social Security Number for purposes of identification when corresponding with the National Practitioner Data Bank and checking the Social Security Administration's Death Master File.

Print Name: _____

Signature: _____ **Date:** _____
(Stamped or Electronic Signature Is Not Acceptable)