CONTRA COSTA HEALTH

Contra Cost County Behavioral Health
Credentialing Application Checklist

Please review prior to submitting to Provider Services
Incomplete application may result in a delay

I. All Providers: Please include the following with the completed packet

- ☐ **Credentialing Form (MHA22)**- Provide your full legal name. ***Do not use nicknames, initials or abbreviations!*** All applicable sections of the form must be complete. Also, if you answered "yes" to any of the attestation questions A-M, provide full details on a separate sheet of paper.
- ☐ **ShareCare ID Request Form (MHA12) -** Provide your full legal name. ***Do not use nicknames, initials or abbreviations.***
- ☐ **SSN Consent Form (MHA22c) -** Provide your full legal name. ***Do not use nicknames, initials or abbreviations.***
- ☐ **Copy of current valid government issued photo identification (Driver's License or Passport)**
- ☐ **Copy of NPI registration with valid taxonomy** (Note: Taxonomy code must be designated as primary. Name in NPPES needs to match the legal name on identification.)
- ☐ **274 Report Provider Information** (Completed by Manager/Supervisor)

Valid Taxonomy Codes

Psychiatrist – 2084P0800X

NP – 363LP0808X or 363LF0000X

RN – 163W00000X, 163WP0807X, 163WP0808X or 163WP0809X

Psych Tech – 167G00000X

Psychologist – 103TC0700X

LCSW – 1041C0700X

LMFT – 106H00000X

LPCC – 101YM0800X

Waivered Psychologist – 103TC1900X

ASW – 104100000X

AMFT – 106H00000X

APCC – 101YM0800X

Trainee – 390200000X

MHRS – 171M00000X

DMHW or TFC Parent – 172V00000X

Certified Peer Support Specialist – 175T00000X

II. If you are a MD, DO or NP, please submit the following:

- ☐ All documents listed in Section I
- ☐ Copy of current Professional License
- ☐ Copy of current Unrestricted DEA Registration
- ☐ Peer Reference Form (MHA22g)- *one reference needs to be a current or former supervisor*
- ☐ Proof of ORP enrollment (Approval Letter or screenshot from your PAVE account showing the "approved" status of your application). If you are still waiting for approval, please submit a screenshot from your PAVE account showing that you have submitted your application.

III. If you are an RN or LPT, please submit the following:

- ☐ All documents listed in Section I
- ☐ Copy of current Professional License

IV. If you are an LMFT, LCSW, LPCC or Licensed Psychologist, please submit the following:

- ☐ All documents listed in Section I
- ☐ Copy of current Professional License
- ☐ Proof of ORP enrollment (Approval letter or screenshot from your PAVE account showing the "approved" status of your application) If you are still waiting for approval, please submit a screenshot from your PAVE account showing that you have submitted your application.

V. If you are an AMFT, ASW, or APCC, please submit the following:

- ☐ All documents listed in Section I
- ☐ Copy of current Registration

VI. If you are a Pre-Doctoral or Post-Doctoral Intern, please submit the following:

Pre-Doctoral Intern

- ☐ All documents listed in Section I
- ☐ Curriculum Vitae or resume
- ☐ **Most current official transcript** demonstrating that you have completed a minimum of 48 semester/trimester or 72 quarter units of graduate coursework in (not including thesis, internship or dissertation).

Post-Doctoral Intern (You need to be in the status of collecting hours)

- ☐ All documents listed in Section I
- ☐ Curriculum Vitae or resume
- ☐ A copy of your degree and official transcript. The official transcript must demonstrate that you have completed the doctoral program.

VII. If you are a Trainee, please submit the following:

- ☐ All documents listed in Section I
- ☐ Executed agreement or contract between the agency and school
- ☐ Field placement agreement signed by the student, individual supervisor and/or training coordinator and the school field placement liaison

VIII.If you are an Unlicensed Worker (DMHW or MHRS), please submit the following:

- ☐ All documents listed in Section I
- ☐ Proof of highest level of education (Provide ONE of the following): *Note: LVNs will be credentialed as a DMHW*
  - High School Diploma, GED, Degree or **Official** Transcript
    ..... OR .....
  - School verification letter that degree was completed.

IX. If you are a Certified Peer Support Specialist, please submit the following:

- ☐ All documents listed in Section I
- ☐ Proof of highest level of education (Provide ONE of the following:)
  - High School Diploma, GED, Degree or **Official** Transcript
    ..... OR .....
  - School verification letter that degree was completed
- ☐ Peer Support Specialist Certificate
- ☐ Supervisor must submit verification of completion of Supervisor training

Online Supervisor training is available at: https://www.capeercertification.org/supervisor-training/

Do Not Submit with Application

Reset Form

Print

CONTRA COSTA HEALTH

Contra Costa County Mental Health

SHARECARE ID REQUEST FORM

PLEASE COMPLETE ALL SECTIONS AS APPLICABLE TO PREVENT DELAYS IN PROCESSING

Section I. To be completed by staff

FULL LEGAL NAME: _____ _____ _____
First Name Middle Name Last Name

DOB: _____ **NPI:**_____ **Taxonomy:** _____ **Email Address:**_____

Gender: ☐ Female ☐ Male ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ Genderqueer ☐ Another Gender Identity ☐ Undisclosed

DISCIPLINE: _____ LICENSE #: _____

EXP DATE: _____ STATE: _____

YOU MUST ATTACH A COPY OF YOUR LICENSE OR OTHER DOCUMENTATION REQUIRED FOR YOUR LICENSE

PHYSICIAN DEA#: _____ EXP DATE: _____

PHYSICIAN UPIN:_____

YOU MUST ATTACH A COPY OF YOUR DEA REGISTRATION

Employment Start Date:

_____

STAFF LANGUAGES	Please check one:
English	☐ Certified ☐ Fluent
Other Languages:	
	☐ Certified ☐ Fluent
	☐ Certified ☐ Fluent

ETHNICITY:

☐	White	☐	Mexican American/Chicano	☐	Chinese	☐	Cambodian	☐	Other Non-White
☐	Black	☐	Latin American	☐	Vietnamese	☐	Japanese	☐	Other Southeast Asian
☐	Native American	☐	Other Spanish	☐	Laotian	☐	Filipino	☐	Unknown

STAFF SIGNATURE _____ Date: _____

(Stamped or Electronic Signature Is Not Acceptable)

Section II. To be completed by supervisor/manager

Staff Type: ☐ Direct Service Provider ☐ TBS Worker ☐ TFC Parent ☐ Certified Peer Support Specialist ☐ Administrative Staff

Contractor/Supervisor/Manager: _____ Program Name: _____

Notification of Staff # Assignment to: _____ Phone Number: _____

EMAIL: _____

Facility Authorization Requested for the following:

Facility ID #_____Program ID #_____ Facility ID #_____Program ID #_____

Facility ID #_____Program ID #_____ Facility ID #_____Program ID #_____

Section III. To be completed by Contra Costa Provider Services Unit

FOR CCC PROVIDER SERVICES USE ONLY

APPROVED START DATE:

_____

Psychiatrist:
☐ DO ☐ MD

Nursing:
☐ Nurse Practitioner ☐ Registered Nurse ☐ Psychiatric Technician

Licensed Mental Health Professional:
☐ Marriage & Family Therapist ☐ Social Worker ☐ Psychologist [☐ PhD ☐ PsyD] ☐ LPCC

Intern:
☐ Associate Marriage & Family Therapist ☐ Associate Social Worker ☐ Psychologist Intern ☐ Associate Prof Clinical Counselor

Trainees:
☐ Marriage & Family Therapist Trainee ☐ Social Work Trainee ☐ Psychologist Trainee

☐ Mental Health Rehabilitation Specialist ☐ Designated Mental Health Worker ☐ TFC Parent
☐ Certified Peer Support Specialist ☐ Administrative Staff

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

Print Form

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) 608- 6794 **EMAIL:** Provider.Services@cchealth.org

PLEASE COMPLETE ALL SECTIONS AS APPLICABLE TO PREVENT DELAYS IN PROCESSING

I. IDENTIFYING INFORMATION

FIRST NAME (FULL 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 ABPN Certificate Number: _____

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, official transcript and degree, and complete questions #1 and #2 below.

If you are pre-graduation, you must complete a minimum of 48 semester/trimester units or 72 quarter units of graduate coursework, not including thesis, internship, or dissertation. A current official transcript reflecting completion of this coursework requirement must be submitted with your credentialing application.

1. *How many hours of supervised professional experience have you completed?* _____
2. *Have you previously applied for and been approved for waiver in Contra Costa County or any other county? (Check one)*

   ☐ *Yes If yes, which county?* _____ Waiver Effective Date: _____

   ☐ *No*

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 and complete this section continued on the next page.

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.

IV. For Trainees Only (Continued)	
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. You are required to complete this section. Provide the name of your school, discipline/major, dates attended, and year degree was conferred.

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:

_____

_____

_____

_____

_____

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

VII. CERTIFICATION

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 Full Legal Name: _____ Signature:_____ Date: _____
(Stamped or Electronic Signature Is Not Acceptable)

VIII. 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	☐Yes ☐No

your area of practice, or unable to perform those essential functions without direct threat to the health and safety of others.

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? ☐Yes ☐No

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/*

O. **FOR THERAPEUTIC BEHAVIORAL SERVICES (TBS) WORKERS ONLY** ☐Yes ☐No

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. To request TBS Training from the County, email: CCMH.Training@cchealth.org*

P. **FOR THERAPEUTIC FOSTER CARE (TFC) PARENTS ONLY** ☐Yes ☐No

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.

Q. **FOR ALL LICENSED PHYSICIANS (MDs & DOs), NURSE PRACTITIONERS, LICENSED PSYCHOLOGISTS, LMFTs, LCSWs, and LPCCs ONLY.**

i. Are you currently enrolled in the Provider Application and Validation for Enrollment (PAVE) portal for Medi-Cal? (Required for all provider types listed above) ☐Yes ☐No

ii. Have you also completed an Ordering/Referring/Prescribing (ORP) application or has someone done so on your behalf? (Required for all provider types listed above) ☐Yes ☐No
To confirm your ORP enrollment status, you can go to this website and enter your NPI number https://www.medi-cal.ca.gov/ORPEnroll/ORPEnroll.aspx

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.

For the PAVE Step-by-Step Enrollment Guide, you can go to the Provider Services Website https://cchealth.org/mentalhealth/provider/

R. **FOR ALL PHYSICIANS (MDs AND DOs) AND NURSE PRACTITIONERS ONLY**

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

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.

For the Medi-Cal Rx Step-by-Step Enrollment Guide, you can go to the Provider Services Website https://cchealth.org/mentalhealth/provider/

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 Legal Name

Signature: _____ Date _____

(Stamped or Electronic Signature Is Not Acceptable)

Print Form

Submit completed form to the Provider Services Unit
Email: provider.services@cchealth.org - or - Fax: (925) 608-6794

Contra Costa County Behavioral Health

SSN Consent Form

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: _____ *(MM/DD/YYYY)*

NPI Number: _____

ShareCare ID: _____ *(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, checking the Social Security Administration's Death Master File and the DEA Diversion Control Data base.

Print Name: _____

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