Reset Form

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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