PROVIDER CLINICAL APPLICATION

San Diego County Mental Health Plan & Optum Public Sector

Fee For Service (FFS) Medi-Cal Provider Network

Please mail, fax or email (secure) complete application packet to:

Optum Public Sector San Diego
Attention: Provider Services
P.O. Box 601370
San Diego, CA 92160-1370

Fax: (877) 309-4862

Email: sdu_providerserviceshelp@optum.com

Instructions and Frequently Asked Questions

CHECKLIST FOR MEDI-CAL PROVIDER APPLICATION

Please print or type your answers to all questions. If further space is needed for you to provide complete answers, please attach additional sheets of paper and indicate on the sheet the applicable question number.

A practitioner must meet basic credentialing standards for inclusion in the Medi-Cal Network. Please check the requirements for each discipline on the link above to ensure you meet the minimum criteria.

Please use the following checklist to confirm you have included the following information with your application:

☐	**Credentialing Application**: To be completed and submitted on the Council for Affordable Quality Healthcare (CAQH) website. *Please review the FAQs on our website for additional information.*
☐	**Resume/Curriculum Vitae:** It is very important that your resume be detailed including descriptions of populations, specialties, and disorders treated, and the theoretical orientation of the work. Include the dates and locations of education and post-graduate training. **Dates of employment must include the month and year. All gaps in employment of six (6) months or more require a written explanation.** **Curriculum Vitae is required with submission of a TERM application*
☐	**W-9:** A completed and signed W-9 form is required (*Please follow instructions carefully*)
☐	**W-9 Verification:**
	☐ **SSN**: If your Taxpayer Identification Number (TIN) is your social security number, **please provide a copy of your social security card.**
	☐ **EIN:** If your Taxpayer Identification Number (TIN) is an employer identification number (EIN), please submit a current Internal Revenue Service (IRS) generated document. **The only acceptable documents include:** a. IRS-generated Letter 147-C b. IRS-generated Form 941 (Employer's Quarterly Federal Tax Return) c. IRS-generated Form 8109-C (Deposit Coupon) d. IRS-generated Form SS-4 (only the official Confirmation Notification of FEIN/ITIN assignment) **Note:** The legal name of the applicant or provider on the application must match the exact name of the owner or officer of the entity listed on the IRS-generated document. For assistance in obtaining the above documents, please contact the IRS at (800) 829-4933.
☐	**Certificate of Professional Malpractice/Professional Liability Insurance:** • Limits of coverage (1 million per occurrence/3 million aggregate minimum) • Expiration date must cover the Dates of Services requested
☐	**State Driver's License/ID Card:** • Active, valid copy (Color photocopy or scan required. Must be legible).
☐	**State Professional License:** • Active pocket license or wall certificate required

☐	**DEA License *(if applicable)*:** • Must be current/active
☐	**Psychiatric Nurse Practitioners (PNP) and Physician Assistants (PA):** Must submit a copy of their Supervisory Agreement with an appropriate paneled/contracted FFS Psychiatrist (MD/DO)
☐	**Medicare Provider Number:** • Providers intending to serve both Medicare and Medi-Cal beneficiaries must have a current Medicare Provider Number by visiting the Centers for Medicare and Medicaid Services (CMS) website https://www.cms.gov *Medi-Cal will not reimburse you for services to a client with Medicare and Medi-Cal coverage unless you have a Medicare provider number.*
☐	**Medi-Cal Network – Clinician Specialty Requirements (pages 16-19):** Please carefully review the experience requirements before checking an age or treatment specialty.
☐	**Clinician Specialty Requirements – Specialty Attestation Form (page 20):** Must be signed and dated.
☐	**Provider Rights (page 21):** Provider understands that as an applicant for credentialing/re-credentialing, you have the right to review information obtained by Optum for the purpose of evaluating your credentialing or re-credentialing application. **Please print your name on this page.**
☐	**Child and Adolescent Needs and Strength Assessment (CANS):** ***Note: Reimbursement will not be granted for certifications obtained prior to the full execution of your contract. Please ensure that certification is pursued only after your contract's effective date. Further details and instructions will be provided with your fully executed contract.*** • Provider must become CANS certified in order to render therapy services to clients ages 0-21. • Provider must be recertified every year. • Provider may be reimbursed for training, certification, recertification, and reports when the appropriate requirements are met.
☐	**Verify Beneficiary's/Client's Med-Cal Eligibility:** Provider understands he/she will be provided a PIN Number to facilitate verifying a client's Medi-Cal eligibility. It is the provider's responsibility to ensure the client has active Medi-Cal coverage prior to rendering services. Additional information and instructions will be provided during the contracting process.
☐	**All Pages of the Application must be Completed:** Please do not write "Refer to Resume/Curriculum Vitae" or "Refer to attached documents" as an answer to any questions on the application.
☐	**Home Office Standards:** The Optum Home Office Standards Attestation Addendum must be signed if you are rendering face-to-face services in your home office (not telehealth).

All documents and copies submitted must be clear and legible.

PROVIDER CLINICAL APPLICATION

San Diego County Mental Health Plan for Fee for Service (FFS) Medi-Cal Provider Network

Last Name: **First Name:** **MI:**

Email Address: **Phone Number:** **Ext:**

License Type: ☐ MD ☐ DO ☐ PhD ☐ PsyD ☐ LMFT ☐ LCSW ☐ LPCC ☐ PNP ☐ PA

License Number: **DEA Number** *(if applicable):*

NPI Number:

CAQH Provider ID: **Interested in Submitting Claims Electronically?** ☐ Yes ☐ No

*Council for Affordable Quality Healthcare (CAQH)

Credentialing Rep Name *(if other than provider)*: **Or** ☐ N/A

Email Address: **Phone Number:** **Ext:**

Currently employed by the County of San Diego? ☐ Yes ☐ No

If "**Yes**" please include a letter from the County of San Diego Health and Human Services Compliance Office indicating their approval for your participation on this Network. Please email Amaris Sanchez, Health and Human Services Compliance Group Program Manager at Amaris.Sanchez@sdcounty.ca.gov for further information.

How did you hear about Optum Public Sector San Diego County Mental Health Plan for Medi-Cal and/or TERM Networks?

☐ Optum Recruiter ☐ FFS Medi-Cal Provider ☐ County Representative

☐ Other Optum Staff Member ☐ TERM Provider ☐ Other:

***Provider's Emergency Contact**

Name: **Relationship to Provider:**

Phone#: **Ext:** **Email:**

**This is the person OPTUM must contact to implement your emergency plan if you were to become incapacitated and/or unable to fulfill your clinical obligations to your clients.*

Emergency 24 Hour Coverage of Clients

What arrangements do you have for 24-hour, 7-day emergency coverage for clients?

Provider's Home Address *(Required and is confidential. Cannot be a PO Box.)*

Address:

Suite:

City: **County:**

State: **Zip:**

Confidential Mailing Address: ☐ **N/A** *(When/If applicable: audit results, sensitive communications regarding your practice)*

Address:
Suite:
City: **County:**
State: **Zip:**

Contact Name: **Phone#:** **Ext:**
Fax #: **Email:**

PRACTICE INFORMATION

Business Name:
DBA:
NPI Type 2 (Organization):

Mailing Address: ☐ *Same as Confidential Mailing Address*
Address:
Suite:
City: **County:**
State: **Zip:**

Contact Name: **Phone#:** **Ext:**
Fax #: **Email:**

Billing Address: ☐ *Same as Confidential Mailing Address* ☐ *Same as Mailing Address*
Address:
Suite:
City: **County:**
State: **Zip:**

Contact Name: **Phone#:** **Ext:**
Fax #: **Email:**

Primary Treatment Location:

Select all that apply: ☐ Telehealth ☐ In-Person
Address:
Suite:
City: **County:**
State: **Zip:**

Contact Name: **Phone#:** **Ext:**
Fax#: **Email:**

TTY/TTD Phone#:
Does this office meet ADA (Americans with Disabilities Act) guidelines? ☐ Yes ☐ No

Is this office accessible to public transportation? ☐ Yes ☐ No
Is this a Home Office? ☐ Yes ☐ No

HOURS OF OPERATION: (Example: 9:00 AM to 5:00 PM)

Sunday		**to**	
Monday		**to**	
Tuesday		**to**	
Wednesday		**to**	
Thursday		**to**	
Friday		**to**	
Saturday		**to**	

Hours per week serving: (*Estimate of all clients you may be rendering services to at this location. Numerical digits required*)

Children (0-20):

Adults (21+):

Maximum number of Medi-Cal clients you are willing to see at this location: *(Numerical digits required)*

Children (0-20):

Adults (21+):

Wait Times For:

- **Urgent Appointments (Hours):**
- **Non-Urgent Appointments (Days):**

Emergent Appointments within 1 hour? ☐ Yes ☐ No

ADDITIONAL TREATMENT LOCATION: ☐ Yes ☐ No
If yes, please complete all sections below for Additional Treatment Location

Business Name:
DBA:
NPI Type 2 (Organization):

Mailing Address: ☐ *Same as Confidential Mailing Address*
Address:
Suite:
City: **County:**
State: **Zip:**

Contact Name: **Phone#:** **Ext:**
Fax #: **Email:**

Billing Address: ☐ *Same as Confidential Mailing Address* ☐ *Same as Mailing Address*

Address:

Suite:

City: **County**:

State: **Zip**:

Contact Name: **Phone#:** **Ext:**

Fax #: **Email**:

Additional Treatment Location:

Select all that apply: ☐ Telehealth ☐ In-Person

Address:

Suite:

City: **County**:

State: **Zip**:

Contact Name: **Phone#:** **Ext:**

Fax #: **Email**:

TTY/TTD Phone#:

Does this office meet ADA (Americans with Disabilities Act) guidelines? ☐ Yes ☐ No

Is this office accessible to public transportation? ☐ Yes ☐ No

Is this a Home Office? ☐ Yes ☐ No

HOURS OF OPERATION: (Example: 9:00 AM to 5:00 PM)			
Sunday		**to**	
Monday		**to**	
Tuesday		**to**	
Wednesday		**to**	
Thursday		**to**	
Friday		**to**	
Saturday		**to**	

Hours per week serving: (*This is an estimate of all clients you may be rendering services to at this location. Numerical digits required*)

Children (0-20):

Adults (21+):

Maximum number of Medi-Cal clients you are willing to see at this location: *(Numerical digits required)*

Children (0-20):

Adults (21+):

Wait Times For:

- **Urgent Appointments (Hours):**
- **Non-Urgent Appointments (Days):**

Emergent Appointments within 1 hour? ☐ Yes ☐ No

Additional Treatment Location(s): ☐ Yes ☐ No

If yes, please complete the form at the end of the application to add additional treatment locations

OTHER TREATMENT MODES

A. Telehealth

Telehealth: ☐ Yes ☐ No
If "Yes" to the above: A Telehealth Requirements and Compliance Attestation will be required prior to being approved to render Telehealth services to Clients. Please submit the following with this application:

- Telehealth Attestation Form
- Copy of Business Associate Agreement (BAA) with chosen HIPAA compliant platform. Please contact your Telehealth platform to obtain a copy of the BAA.

B. Mobile/Field Based Services

Mobile Services including Home Visits (Provider will travel to the client's home or other location): ☐ Yes ☐ No

Skilled Nursing Facilities (SNF): ☐ Yes ☐ No

If "Yes" to either of the above, distance you are willing to travel to deliver services (miles):

C. Home Office - Services are rendered face-to-face in your personal residence (Not Telehealth)

Do you have a Home Office? ☐ Yes ☐ No
*If "Yes" please read and sign the **Optum Home Office Standards Attestation** included at the end of this application.*

Home Office Address:

Suite:

City: **County:**

State: **Zip:**

INFORMATION FOR PSYCHIATRISTS, PSYCHIATRIC NURSE PRACTITIONERS, & PHYSICIAN ASSISTANTS WITH PRESCRIPTIVE AUTHORITY

Do you ONLY render services in an INPATIENT setting? ☐ Yes ☐ No

- **If "No" to the above**: Will you be rendering services in an OUTPATIENT (OP) setting other than Partial Hospitalization (PHP) or Intensive Outpatient (IOP)? ☐ Yes ☐ No
- **If "Yes" to the above**: Will you be *open to new referrals? ☐ Yes ☐ No

  ***Open to referrals means that you will accept any new Medi-Cal beneficiary patients referred to you through the Access and Crisis Line/Optum Public Sector.*

PSYCHIATRISTS (MD/DO) ONLY:

Must meet the following criteria: Credentialing Criteria; Provider Handbook (Credentialing Standards, page 12)

Psychiatry Board Certification Status

- **Psychiatry:**
  - ☐ I've completed an ACGME approved residency training program in psychiatry
  - ☐ Yes ☐ No - I am board certified in psychiatry
- **Child & Adolescent Psychiatry**:
  - ☐ I've completed an ACGME approved fellowship in child and adolescent psychiatry
  - ☐ Yes ☐ No - I am board certified in child and adolescent psychiatry

Second Opinions:

Are you available to provide second opinions? ☐ Yes ☐ No

Hospital Privileges (admitting privileges): N/A ☐

Please complete the section below to identify the County contracted hospitals where you currently have admitting privileges. Hospitals where you have admitting privileges must be provided for listing in the Provider Directory.

Hospitals			**Enter Date Privileged**
Aurora Hospital	☐ Yes	☐ No	
Palomar Hospital	☐ Yes	☐ No	
PH Bayview Hospital (A)	☐ Yes	☐ No	
PH Paradise Valley Hospital	☐ Yes	☐ No	
Pomerado Hospital	☐ Yes	☐ No	
Rady CAPS	☐ Yes	☐ No	
Scripps Mercy Healthcare	☐ Yes	☐ No	
Sharp Grossmont Hospital	☐ Yes	☐ No	
Sharp Mesa Vista Hospital	☐ Yes	☐ No	
UC San Diego Health East Campus Medical Center	☐ Yes	☐ No	
UC San Diego Medical Center	☐ Yes	☐ No	

PSYCHIATRIC NURSE PRACTITIONERS (PNPs) ONLY:

American Nurse Credentialing Center (ANCC) Certification: (*As a Psychiatric Nurse Practitioner in Psychiatric/Mental Health Nursing*) ☐ Yes ☐ No

Supervising Psychiatrist Name & Phone Number:

Supervisor Name:

Phone Number: **Ext:**

Email:

Will you accept referrals for Medi-Cal clients referred through the Access and Crisis Line (ACL) for Outpatient Services?
☐ Yes ☐ No

PSYCHIATRIC PHYSICIAN ASSISTANTS (PAs) ONLY:

Certificate of Added Qualifications (CAQ) in Psychiatry:
☐ Yes – Certificate Number:
☐ No – If no, must be eligible for the Exam *(Proof of eligibility must be submitted with this application)*

Supervising Psychiatrist Name & Phone Number:

Supervisor Name:

Phone Number: **Ext:**

Email:

Will you accept referrals for Medi-Cal clients referred through the Access and Crisis Line (ACL) for Outpatient Services?
☐ Yes ☐ No

CLINICAL PROFILE

Cultural Competency:

Please identify the cultures in which you meet the Cultural Competency Criteria below and are willing to treat in your practice. Delivering culturally competent clinical services means you have an understanding of: **1)** ongoing social realities (e.g., racism, immigration patterns, acculturation) that can impact the mental health of culturally and linguistically diverse populations, **2)** differences between culturally acceptable behaviors and pathological characteristics, **3)** cultural beliefs around mental illness and help-seeking patterns, and **4)** have the ability to adapt your skills to fit the cultural context of a client.

If you endorse cultural competency in the ability to deliver services to one of the groups listed below, you **must also** have experiences consistent with one or more of the statements below:

- By adopting systematic practices that align behaviors, attitudes, and policies, I have worked effectively in cross-cultural situations, showcasing cultural competence and diversity. All services provided have been tailored to meet the unique linguistic and cultural needs of our diverse clients. I honor the diversity of cultures, address the complexities within and between them, and ensure our services are accessible and relevant.
- Have completed formal training, such as a degree emphasis area, specific university courses, multiple workshops, or an internship focusing on culture and human behavior
- Have significant professional culture-based expertise (e.g., have provided cultural competence training to others and/or published peer-reviewed journal articles, book chapters, or major reports in this area)

- Have provided clinical treatment or evaluations to more than ten (10) members of the cultural group

Please check any groups from the table below for which you are competent to evaluate family dynamics and provide treatment:

☐ African American	☐ Dominican	☐ Iraqi	☐ Puerto Rican
☐ Amerasian	☐ Ethiopian	☐ Japanese	☐ Salvadorian
☐ Arab	☐ Filipino	☐ Jewish	☐ Samoan
☐ Asian Indian	☐ Guamanian	☐ Korean	☐ Somali
☐ Cambodian	☐ Haitian	☐ Laotian	☐ Sudanese
☐ Caucasian	☐ Hawaiian Native	☐ Mexican American/Chicano	☐ Vietnamese
☐ Chinese	☐ Hmong	☐ Native American	
☐ Cuban	☐ Iranian	☐ Pacific Islander	
☐ Other:			

INSURANCE PLANS

Please check all insurance plans you can accept:

☐ Aetna PPO	☐ Cigna	☐ Magellan	☐ TriWest/TriCare
☐ Blue Cross	☐ Community Health Group	☐ Medi-Cal	☐ Value Options
☐ Blue Shield of CA	☐ Health Net	☐ Medicare	☐ United Behavioral Health/ Optum
☐ Care 1st	☐ Kaiser	☐ Molina	
☐ CHIP	☐ Other:		

MEDICARE/MEDI-CAL PROVIDER

Are you a Medicare Provider? ☐ Yes ☐ No

- If yes, enter Medicare number:

Are you a Medi-Cal Provider? ☐ Yes ☐ No

- If yes, enter Medi-Cal number:

POPULATIONS AND SERVICES

Please check all the Populations and Services in which you have **clinical training and experience AND are currently willing to treat in your practice.**

**Documentation is required for some specialties as identified on the Clinician Specialty Requirements (pages 16-19)*

Populations:	Infants Toddlers 0 - 3	Preschool 3 - 5	Children 6 -12	Adolescents 13 - 17	Transitional Youth 18 - 22	Adults 23 - 59	Older Adults 60+
Developmentally Delayed	☐	☐	☐	☐	☐	☐	☐
LGBTQIA	☐	☐	☐	☐	☐	☐	☐
Hearing Impaired			☐	☐	☐	☐	☐
Physically Disabled	☐	☐	☐	☐	☐	☐	☐
Veterans					☐	☐	☐
Visually Impaired	☐	☐	☐	☐	☐	☐	☐
Services/Modalities:							
Critical Incident Stress Debriefing		☐	☐	☐	☐	☐	☐
ECT (MD Only, including consult)					☐	☐	☐
*Spravato (Prescribers)					☐	☐	☐
*TMS (Prescribers)					☐	☐	☐
Family Therapy	☐	☐	☐	☐	☐	☐	☐
Group Therapy			☐	☐	☐	☐	☐
Home Visits	☐	☐	☐	☐	☐	☐	☐
Individual Therapy (Non-prescribers)	☐	☐	☐	☐	☐	☐	☐
Inpatient Treatment	☐	☐	☐	☐	☐	☐	☐
Medication Evaluation & Management	☐	☐	☐	☐	☐	☐	☐
*Neuropsychological Testing (MD/PhD/PsyD Only)	☐	☐	☐	☐	☐	☐	☐
Outpatient Treatment	☐	☐	☐	☐	☐	☐	☐
Psychological Testing (PhD/PsyD Only)	☐	☐	☐	☐	☐	☐	☐

AREAS OF CLINICAL EXPERTISE:

Check areas of expertise in which you have **clinical training and experience AND are currently willing to treat in your practice.** You may be requested to submit documentation to demonstrate expertise in these areas.

Areas of Clinical Expertise I:	Infants Toddlers 0 - 3	Preschool 3 - 5	Children 6 -12	Adolescents 13 - 17	Transitional Youth 18 - 22	Adults 23 - 59	Older Adults 60+
Anxiety Disorders	☐	☐	☐	☐	☐	☐	☐
Attention Deficit/Hyperactivity Disorder		☐	☐	☐	☐	☐	☐
Bipolar and Related Disorders		☐	☐	☐	☐	☐	☐
Dissociative Disorders		☐	☐	☐	☐	☐	☐
Feeding and Eating Disorders		☐	☐	☐	☐	☐	☐
Factitious Disorders		☐	☐	☐	☐	☐	☐
Gender-Affirming Care		☐	☐	☐	☐	☐	☐
Gender Dysphoria Disorders		☐	☐	☐	☐	☐	☐
Disruptive, Impulse-Control and Conduct Disorders		☐	☐	☐	☐	☐	☐
Depressive Disorders	☐	☐	☐	☐	☐	☐	☐
Paraphilic Disorders		☐	☐	☐	☐	☐	☐
Personality Disorders		☐	☐	☐	☐	☐	☐
Autism Spectrum Disorder	☐	☐	☐	☐	☐	☐	☐
Trauma and Stress - Related Disorders	☐	☐	☐	☐	☐	☐	☐
Schizophrenia and Other Psychotic Disorders		☐	☐	☐	☐	☐	☐
Somatic Symptom and Related Disorders		☐	☐	☐	☐	☐	☐

Check areas below in which you have **clinical training and experience AND are currently willing to treat in your practice.** You may be requested to submit documentation to demonstrate expertise in these areas.

**Documentation is required for some specialties as identified on the Clinician Specialty Requirements (pages 16-19)*

Areas of Clinical Expertise II:	**Infants Toddlers 0 - 3**	**Preschool 3 - 5**	**Children 6 -12**	**Adolescents 13 - 17**	**Transitional Youth 18 - 22**	**Adults 23 - 59**	**Older Adults 60+**
ACA/Co-Dependency					☐	☐	☐
Adoption Pre/Post Issues	☐	☐	☐	☐	☐	☐	☐
Anger Management			☐	☐	☐	☐	☐
*Domestic Violence Offender				☐	☐	☐	☐
*Domestic Violence Victim	☐	☐	☐	☐	☐	☐	☐
Co-Occurring Disorders (MH/DD)	☐	☐	☐	☐	☐	☐	☐
Co-Occurring Disorders (MH/Medical)	☐	☐	☐	☐	☐	☐	☐
Co-Occurring Disorders (MH/SUD)			☐	☐	☐	☐	☐
Family or Relationship Issues	☐	☐	☐	☐	☐	☐	☐
Co-Parenting					☐	☐	☐
Grief/Loss	☐	☐	☐	☐	☐	☐	☐
HIV/AIDS	☐	☐	☐	☐	☐	☐	☐
Physical Abuse Offender			☐	☐	☐	☐	☐
Physical Abuse Non-Protecting Parent					☐	☐	☐

Check areas below in which you have **clinical training and experience AND are currently willing to treat in your practice.** You may be requested to submit documentation to demonstrate expertise in these areas.

**Documentation is required for some specialties as identified on the Clinician Specialty Requirements (pages 16-19)*

Areas of Clinical Expertise II:	**Infants Toddlers 0 - 3**	**Preschool 3 - 5**	**Children 6 -12**	**Adolescents 13 - 17**	**Transitional Youth 18 - 22**	**Adults 23 - 59**	**Older Adults 60+**
Political Refugee		☐	☐	☐	☐	☐	☐
Sexual Abuse Victims	☐	☐	☐	☐	☐	☐	☐
*Sexual Abuse Non-Protecting Parent					☐	☐	☐
*Sexual Abuse Offender			☐	☐	☐	☐	☐
Survivors of Torture	☐	☐	☐	☐	☐	☐	☐
Trauma	☐	☐	☐	☐	☐	☐	☐

CLINICIAN SPECIALTY REQUIREMENTS

Important note: Signature on the Optum Public Sector Specialty Attestation on page #20 is required of all applicants

PHYSICIAN SPECIALTY REQUIREMENTS

Child/Adolescent

- Completion of an ACGME approved Child and Adolescent Fellowship ***OR*** recognized certification in Adolescent Psychiatry. This specialty includes Infants/Toddlers, Preschool, Children and Adolescents (twelve (12) years old and younger)

Geriatrics

- Completion of an ACGME approved Geriatric Fellowship ***OR*** recognized certification in Geriatric Psychiatry

Neuropsychological Testing

- Recognized certification in Neurology through the American Board of Psychiatry and Neurology ***OR***
- Accreditation in Behavioral Neurology and Neuropsychiatry through the American Neuropsychiatric Association

AND all the following criteria:

- State medical licensure does not include provisions that prohibit neuropsychological testing service;
- Evidence of professional training and expertise in the specific tests and/or assessment measures for which authorization is requested;
- Physician and supervised psychometrician adhere to the prevailing national professional and ethical standards regarding test administration, scoring, and interpretation.

Prescribers of Psychotropic Medication for Children and Youth in Out of Home Placement

Authorized Prescribers of Psychotropic Medication: Because of the complex medical and psychiatric needs of children in out of home placements (which include foster, kinship, NREFM care; group homes; and the juvenile justice systems), it is recommended that psychotropic medications for children be prescribed by board certified or board eligible specialists in one of the following areas of expertise:

- Psychiatry (specialization in child and adolescent psychiatry recommended)
- Neuro-developmental pediatrics
- Developmental-Behavioral pediatrics
- Pediatric neurology
- Pediatrics or family practice with specialized training in children who are at high risk or who had in utero exposure to illicit drugs or alcohol

PSYCHOLOGISTS, NURSES, & MASTER'S LEVEL CLINICIANS SPECIALTY REQUIREMENTS

Infants/Toddlers: 0 - 3 Years

- Completion of an APA approved or other accepted training/certification program in Child Psychology or Infant Mental Health

AND one (1) or more of the following:

- Fifteen (15) hours of CEU in topics relevant to Infant and Early Childhood Mental Health in the last thirty-six (36) month period
- Documented certification in treatment of infants 0-3 years
- Evidence of work experience with infants 0-3 years at an agency that provides treatment to this age group

CLINICIAN SPECIALTY REQUIREMENTS

PSYCHOLOGISTS, NURSES, & MASTER'S LEVEL CLINICIANS SPECIALTY REQUIREMENTS - *Continued*
Preschool: 3 - 5 Years
• Completion of an APA approved or other accepted training program in Child Psychology **AND one (1) or more of the following:** • Fifteen (15) hours of CEU in topics relevant to Child Development in the last thirty-six (36) month period • Evidence of practice experience in treating preschool aged children
Children: 6 - 12 Years
• Completion of an APA approved or other accepted training program in Child Psychology **AND one (1) or more of the following:** • Fifteen (15) hours of CEU in topics relevant to Child Development in the last thirty-six (36) month period • Evidence of practice experience in treating children
Adolescents: 13 - 17 Years
• Completion of an APA approved or other accepted training program in Adolescent Psychology **AND one (1) or more of the following:** • Fifteen (15) hours of CEU in topics relevant to Child Development in the last thirty-six (36) month period • Evidence of practice experience in treating adolescents
Older Adults: 60+ Years
• Completion of an APA approved or other accepted training program in Geriatric Psychology **AND one (1) or more of the following:** • Fifteen (15) hours of CEU in topics relevant to Older Adults in the last thirty-six (36) month period • Evidence of practice experience in treating older adult
Neuropsychological Testing (Psychologists Only)
• Member of the American Board of Clinical Neuropsychology OR the American Board of Professional Neuropsychology **OR** • Completion of courses in Neuropsychology including: Neuroanatomy, Neuropsychological testing, Neuropathology, or Neuropharmacology • Completion of an internship, fellowship, or practicum in Neuropsychological Assessment at an accredited institution **AND** • Two (2) years of supervised professional experience in Neuropsychological Assessment
Domestic Violence Treatment - Victim
• Documented completion of an approved (40) hour training program in Domestic Violence that fulfills California State's requirement for domestic violence victim counselors **AND both of the following:** • Fifteen (15) hours CEU in Domestic Violence Victim training in the last thirty-six (36) month months • Evidence of recent practice experience in Domestic Violence Victim treatment
Domestic Violence Treatment - Offender
• Documented completion of the forty (40) hour basic domestic violence training from a Facilitator Training Committee (FTC) approved provider • Evidence of recent practice experience in Domestic Violence Batterers treatment

CLINICIAN SPECIALTY REQUIREMENTS

PSYCHOLOGISTS, NURSES, & MASTER'S LEVEL CLINICIANS SPECIALTY REQUIREMENTS - *Continued*
Sexual Offender and Sexual Abuse Non-Protecting Parent Treatment
• **Must be approved by CA State Sex Offender Management Board (CASOMB)** ***https://www.casomb.org*** and continue to meet CASOMB requirements.
Psychiatric Nurse Practitioners Requesting Prescriptive Authority Must:
• Possess a currently valid license as a Registered Nurse in California • Be authorized for prescriptive authority in California • Meet California specific mandates regarding DEA and/or Furnishing license and physician supervision • Attest that you meet California's collaborative or supervisory agreement requirements • Specifically request prescriptive privileges on the Optum Public Sector application below
Psychiatric Physician Assistants Requesting Prescriptive Authority Must:
• Possess a currently valid license as a Registered Nurse in California • Be authorized for prescriptive authority in California • Meet California specific mandates regarding DEA and physician supervision • Attest that you meet California's collaborative or supervisory agreement requirements • Specifically request prescriptive privileges on the Optum Public Sector application below

CLINICIAN SPECIALTY REQUIREMENTS

Optum Public Sector San Diego Specialty Attestation

You must sign this document even if you are not requesting any of these specialty designations in your provider record. Additional training, experience, requirements, and/or outside agency approval is required for the following populations, professional certifications, and specialties. **Please review Specialty Requirements on pages 16-19**.

If you are not requesting a specialty designation, please check the "No Specialties" box at the bottom of the list to indicate you have read this form and acknowledge that you have not requested these specialties.

I have reviewed the Optum Specialty Requirements criteria that a Clinician must meet to be considered a specialist in the following treatment areas. After reviewing the criteria, I hereby attest that by placing a check next to a specialty or specialties, I meet Optum's requirements for that treatment area.

Physician Specialties	Non-Physician Specialties
☐ Child /Adolescent (Please specify all the ages that you treat) ☐ Infant Mental Health (0 – 3) ☐ Preschool (3 - 5) ☐ Children (6 – 12) ☐ Adolescents (13 - 17) ☐ Children and youth in out of home placements ☐ Geriatrics (60+) ☐ Neuropsychological Testing ☐ Spravato Treatment **(Proof of certification required)** ☐ Transcranial Magnetic Stimulation (TMS) - (**Proof of certification required)**	☐ Child /Adolescent (Please specify all the ages that you treat) ☐ Infant Mental Health (0 – 3) ☐ Preschool (3 - 5) ☐ Children (6 – 12) ☐ Adolescents (13 - 17) ☐ DBT (**Submit copy of certification. Certification attests the ability to provide individual/group services.**) ☐ Domestic Violence Offender – (**Submit proof of 40 hr. DV Training from a Facilitator Training {FTC} approved provider.**) ☐ Domestic Violence Victim – (**Submit proof of 40 hr. CA approved DV Training**) ☐ Neuropsychological Testing – *Psychologist Only* ☐ Psychiatric Nurses – Prescriptive Privileges (**Submit ANCC certificate, Prescriptive Authority, DEA Certificate and/or Controlled Substance certificate, based on CA State requirements.** ☐ Sexual Offender AND Sexual Abuse Non-Protecting Parent (**Must be approved by CA State Sex Offender Management Board (CASOMB) https://www.casomb.org and continue to meet CASOMB requirements**.) ☐ Spravato Treatment **(Proof of certification required**) ☐ Transcranial Magnetic Stimulation (TMS) - *Psychiatric Nurse Practitioners and Physician Assistants Only* - **(Proof of certification required)**

☐ No Specialties (Must be checked if none of the above specialties are being designated)

CLINICIAN SPECIALTY REQUIREMENTS

Optum Public Sector San Diego Specialty Attestation

I understand that Optum may require documentation to verify that I meet the criteria outlined under Specialty Requirements pertaining to the specialty or specialties I have designated above. I will cooperate with an Optum documentation audit, if requested, to verify that I meet the required criteria.

I hereby attest that all of the information above is true and accurate to the best of my knowledge. I understand that any information provided pursuant to this attestation that is subsequently found to be untrue and/or incorrect could result in my termination from the Optum network.

Please note that standard credentialing criteria must be met before specialty designation can be considered.

All clinicians must sign this form whether specialties are applicable or not. Failure to sign this form may cause a delay in the processing of your initial credentialing file.

Printed Name of Applicant: _____

Signature of Applicant: _____

(Electronic Signatures and Signature Stamps are not accepted)

Date:

PROVIDER RIGHTS

I. RIGHT TO REVIEW

As an applicant for credentialing/re-credentialing, you have the right to review information obtained by Optum for the purpose of evaluating your credentialing or re-credentialing application. This includes non-privileged information obtained from any outside source (e.g., Malpractice insurance carriers, state licensing boards, National Practitioner Data Bank) but does not extend to review of information, references, or recommendations protected by law from disclosure. You may request to review such information at any time by sending a written request via email at sdu_providerserviceshelp@optum.com to the Provider Services (PS) Manager. The PS Manager, or designee, will notify you within 72 hours of the date and time when such information will be available at the OPTUM Credentialing Department located in San Diego, California.

II. RIGHT, UPON REQUEST, TO BE INFORMED OF STATUS OF CREDENTIALING/RECREDENTIALING APPLICATION

You have the right to be informed, upon request, of the status of your credentialing and/or re-credentialing application. You may request such information by sending a written request via email to the Credentialing Manager at the above cited email address. You will be notified in writing and within no more than ten (10) working days of receiving your fax or letter, by return fax or letter, of the current status of your application with respect to outstanding information required to complete the application process.

III. NOTIFICATION OF DESCREPENCY

Practitioners will be notified when information obtained by primary sources varies substantially from information provided on the practitioner's application. Examples of information at substantial variance include reports of a practitioner's malpractice claims history, actions taken against a practitioner's license/certification, suspension or termination of hospital privileges or board certification expiration when one or more of these examples have not been reported by the practitioner on his/her application. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

CORRECTION OF ERRONEOUS INFORMATION

If a practitioner believes that erroneous information has been supplied to OPTUM by primary sources, the practitioner may correct such information by submitting written notification to the Credentialing Manager. Practitioners must submit a written notice along with a detailed explanation to the Manager of Credentialing at sdu_providerserviceshelp@optum.com Notification to OPTUM must occur within 48 hours of OPTUM notification to the practitioner of a discrepancy as provided in Section II or within 24 hours of a practitioner's review of his/her credential file as provided in Section I.

Upon receipt of notification from the practitioner, OPTUM will re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the practitioner's credential file. If, upon re-review, primary source information remains inconsistent with practitioner's notification, Credentialing Manager will so notify the practitioner via fax or letter. The practitioner may then provide proof of correction by the primary source body to OPTUM Director of Medical Services via fax or letter at the email address above within ten (10 working days. The Credentialing Manager will re-verify primary source information if such documentation is provided. If, after ten (10 working days, primary source information remains in dispute, the practitioner will be subject to Adverse Action, up to administrative denial/termination.

Printed Name of Applicant: _____

Date:

APPLICATION ADDENDUM

Additional Treatment Location

Provider Name:

ADDITIONAL TREATMENT LOCATION: (Additional office location where services will be rendered to clients face-to-face and/or telehealth) – *Continued from pages 5 – 7*

Business Name:
DBA:
NPI Type 2 (Organization):

Mailing Address: ☐ *Same as Confidential Mailing Address*
Address:
Suite:
City: **County:**
State: **Zip:**

Contact Name: **Phone#:** **Ext:**
Fax #: **Email:**

Billing Address: ☐ *Same as Confidential Mailing Address* ☐ *Same as Mailing Address*
Address:
Suite:
City: **County:**
State: **Zip:**

Contact Name: **Phone#:** **Ext:**
Fax #: **Email:**

Additional Treatment Location:

Select all that apply: ☐ Telehealth ☐ In-Person
Address:
Suite:
City: **County:**
State: **Zip:**

Contact Name: **Phone#:** **Ext:**
Fax #: **Email:**

TTY/TTD Phone#:
Does this office meet ADA (Americans with Disabilities Act) guidelines? ☐ Yes ☐ No

Is this office accessible to public transportation? ☐ Yes ☐ No
Is this a Home Office? ☐ Yes ☐ No

HOURS OF OPERATION: (Example: 9:00 AM to 5:00 PM)			
Sunday		**To**	
Monday		**To**	
Tuesday		**To**	
Wednesday		**To**	
Thursday		**To**	
Friday		**To**	
Saturday		**To**	

Hours per week serving: (*Estimate of all clients you may be rendering services to at this location. Numerical digits required*)

Children (0-20):

Adults (21+):

Maximum number of Medi-Cal clients you are willing to see at this location: *(Numerical digits required)*

Children (0-20):

Adults (21+):

Wait Times For:

- **Urgent Appointments (Hours):**
- **Non-Urgent Appointments (Days):**

Emergent Appointments within 1 hour? ☐ Yes ☐ No

APPLICATION ADDENDUM

Optum Home Office Standards

Clinicians who practice in a home office setting are required to meet the following standards listed below. A Provider with a home office that does not meet these standards shall be required to remediate the identified deficiencies, relocate their office to a setting that meets standards, or face disciplinary action up to an including contract termination.

1. Clinicians will inform all clients in advance that the therapy office is located in a home and if the office is not Americans with Disabilities Act compliant. If the client requires an ADA compliant location or is not comfortable with a home office setting, the provider shall refer the client back to the Access and Crisis Line for alternative referrals that better meet the client's preference.

2. When a clinician has any animals, clients must be told in advance that there is/are an animal(s) in the house and the clinician should isolate them from the office area. If an animal(s) is/are kept in the therapy office area they must have special training or be a certified pet therapy animal.

3. Off street or separate parking for clients should be offered. If off street parking is not available, then clients must be informed in advance where to park. The home should be clearly identified with a house number or sign and the entrance to the home must have adequate lighting. Exits and entrances must be clearly identified with exit signs. Exit doors must be unlocked on the inside.

4. The therapy office is designed so that family members, friends, or other clients cannot enter the office while therapy is in session and must be soundproof. Soundproofing may include a white noise machine, and/or structural soundproofing.

5. The clinician should offer a waiting area for clients. If s/he does not, it is expected that clients be informed in advance of the process for arrival to appointments and where to wait.

6. The office setting should be free from personal effects (i.e., medications, personal papers, and intimate pictures). Office furnishings need to be permanent and professional.

7. The office space should contain a separate bathroom for client use only. The bathroom utilized by clients must be free from personal effects (i.e., medications and intimate pictures/items).

8. Office, waiting room, and bathroom areas must be maintained in a neat, clean, and sanitary manner with no unpleasant odors; and be in good repair.

9. Office, waiting area and bathrooms must be compliant with applicable fire/safety regulations for businesses in that jurisdiction.

10. Medications and medication samples must be stored in a locked cabinet in a secure area. (MD and ARPN's Only)

11. Safeguards must be in place to ensure that no one other than the treating clinician has access to the office equipment that contains confidential information. Computers must be password protected.

12. The clinician must screen for high risk and/or potentially violent clients prior to first session. If the clinician does not have an alternative non-home setting to see high risk and/or potentially violent clients, the clinician should refer those clients back to Optum/Access and Crisis Line for appropriate referrals to offices that are not home based.

13. The Clinician is required to have a business license if required by the city/town in which the office is located.

14. If a complaint is received about the home office of a clinician contracted with Optum, a site audit and treatment record review request may be referred to County Quality Management. In such cases, the results of the review are forwarded to the requesting committee (e.g., Credentialing, Quality of Care Committee, Peer Review Committee) for determination about the need for further actions.

15. Treatment records storage is required to meet HIPAA privacy and security requirements in order to protect the view of client personal health information (PHI) by others. Detailed information about HIPAA privacy and security regulations can be located at the following website: https://www.hhs.gov/hipaa/index.html

16. The following beneficiary materials must be available to clients:
    - Client and Family Handbooks is given to the client in the first meeting
    - Client Grievance/Appeal Posters in the threshold languages are visibly posted.
    - Grievance/Appeal brochures and forms are available without requiring the client to request them form the provider
    - Limited English Proficiency (LEP) posters in the threshold languages are prominently displayed.
    - The Access and Crisis Line phone number is visibly posted.

Referral Screening Tool

Not all clients are comfortable with, or appropriate to be seen in, a home office setting. Please discuss the following topics and items with client prior to first appointment.

☐	Discuss with client the home office setting. If the client requires an ADA compliant location or is not comfortable with a home office setting, the provider shall refer the client back to the Access and Crisis Line for alternative referrals that better me the client's preference.
☐	Parking: inform where to park or if parking is not available
☐	Office is/is not ADA compliant
☐	Entrance: how to enter office
☐	Waiting Room: where to wait if there is no waiting room
☐	Screen client for history of violence (notify ACL and refer back to ACL if client has history of violence.)
☐	Inform client if there are animals in the home and inquire about client concerns (e.g., allergies, fears of animals, etc.)
☐	Document in phone call assessment or first intake note that these items were discussed with client

Attestation

- I understand and will abide by the Optum Public Sector Home Office Standards
- My home office meets these standards

Provider Printed Name: _____

Provider Signature: _____
(Electronic Signatures and Signature Stamps are not accepted)

Date: