# PRACTITIONER CREDENTIALING APPLICATION

**San Diego County Mental Health Plan & Optum Public Sector**

**Fee For Service (FFS) Medi-Cal and/or**

**Treatment and Evaluation Resource Management (Optum TERM)**

**Provider Networks**

Prepared By:



#

**Re: Optum Application Process for County of San Diego Medi-Cal and/or TERM Networks**

Dear Provider:

Thank you for your interest in joining the County of San Diego Fee For Service (FFS) Medi-Cal Mental Health Plan (MHP) and/or Treatment and Evaluation Resource Management (Optum TERM) provider networks. Optum, as the County’s Administrative Services Organization, is responsible for contracting with individual providers who wish to join the Optum TERM and Medi-Cal Fee for Service (FFS) provider networks.

When you join the Optum TERM provider network, you are required to join the Medi-Cal FFS provider network as well when the services rendered are billable through Medi-Cal. Participation in both networks enables you to bill Medi-Cal for services you provide to Child Welfare Services (CWS) clients who have Medi-Cal coverage. In addition, you may choose to receive referrals of Medi-Cal clients who are not involved with the Juvenile Probation Department or CWS.

**Medi-Cal Network**

Clients of the Medi-Cal FFS network are eligible Medi-Cal beneficiaries in need of mental health services. You can obtain more information about the Medi-Cal FFS network by going to the Optum Public Sector website at https://[www.optumsandiego.com](http://www.optumsandiego.com). At this site you can access the FFS Provider Operations Handbook which describes the process for receiving referrals, authorization and payment from Optum for treating San Diego Medi-Cal clients.

**Optum TERM Network**

Optum TERM is a mental health program developed under the direction of the Board of Supervisors and managed by Optum Public Sector San Diego through a contract with the County of San Diego Health & Human Services Agency (HHSA) Behavioral Health Services. The Optum TERM mission is to improve the quality and appropriateness of mental health services provided to the clients of HHSA CWS and Juvenile Probation. In addition to contracting and credentialing providers Optum is responsible for monitoring the work of the TERM network providers through a quality review process. You can obtain additional information about Optum TERM at the website: <https://www.optumsandiego.com> or you can contact Optum TERM staff directly at 1-877-824-8376 (Option 4).

**Application Process** (*An Application Does Not Guarantee Acceptance to the Network)*

Enclosed is the Credentialing Application for all providers who want to join one or both the Optum Provider Networks. An application checklist is included to assist you in collecting all the required documentation. Please ensure your resume or curriculum vitae is current and includes the clinical experience and training necessary to support the specialties requested on your application. To begin the application process, please submit the completed application and supporting documentation to:

Optum Public Sector

Attention: Provider Services

P.O. Box 601370

San Diego, CA 92160-1370

Fax: 877-309-4862

Email: sdu\_providerserviceshelp@optum.com

You will receive an email from Optum Provider Services staff verifying the receipt of your application within 10 business days. If you do not receive an email please call 1-800-798-2254, Option 7 to follow up. Your application will be reviewed for completeness. If the application is incomplete, we will contact you to request the missing information. Completed applications are submitted to the County’s Credentialing Committee, which meets monthly. This Committee may approve or deny an application, or may request additional supporting documentation. We will notify you of the outcome within ten (10) business days of the committee’s decision.

**Pre-Credentialing Site Visit –** All FFS Medi-Cal applicants must complete a site review prior to being presented in the Credentialing Committee. While your application is being processed you will be contacted by a Quality Improvement (QI) Team member who will explain the procedure and make arrangements for the site visit.

**Please note:** The application requires all providers have a National Provider Identification (NPI) number. If you do not have an NPI, the NPI application can be completed online at [https://nppes.cms.hhs.gov/](https://nppes.cms.hhs.gov/%20). Alternatively, an application can be downloaded from the Centers for Medicare and Medicaid Services (CMS) website [www.cms.hhs.gov](http://www.cms.hhs.gov). From the CMS homepage, select ‘Regulations and Guidance’, then ‘National Provider Identifier Standard (NPI), How to Apply’.  This process should take less than ten (10) minutes to complete.

Providers will be registered by the County with State Medi-Cal and given a personal PIN number to facilitate verifying a client’s Medi-Cal eligibility. A request for a PIN number will be initiated at the point the contract/agreement is ready to execute.

If you have any questions, please contact **Provider Services at 1-800-798-2254, Option 7.** We appreciate the opportunity to work with you in serving the clients of the County of San Diego.

**Important Note:** Separate clinical applications for FFS Medi-Cal, TERM Therapist and/or Evaluator must be submitted with this Credentialing Application.

Sincerely,

Judy A. Duncan-Sanford

Judy A. Duncan - Sanford, LMFT

Manager of Provider Services, Optum San Diego Public Sector

# COUNTY of SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY

# Checklist for Medi-Cal and/or TERM 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 on one of the Networks.

Please use this checklist to confirm that you have included all of the following information in your application packet.

|  |
| --- |
|[ ]  **Disclosure Questions** on pages 16-17 must be fully completed**.** |
|[ ]  **Standard Authorization, Attestation and Release Form** on page 19 must be signed |
|[ ]  **W-9 Form must be signed and dated.** A W9 form can be found on our website at [www.optumsandiego.com](http://www.optumsandiego.com) >County Staff and Providers>Fee For Service Providers>Applications>W9. Please follow the instructions included with the form and submit it with a completed application. Please contact Provider Services with questions, 1-800-798-2254, Option 7. |
|  |[ ]  If your Taxpayer Identification Number (TIN) is your social security number, please provide a **copy of your social security card**. |
|  |[ ]  If your Taxpayer Identification Number (TIN) is an employer identification number (EIN), please provide a **copy of form SS‐4** (IRS EIN assignment notification letter) |
|[ ]  **National Provider Identifier (NPI)** You must have an NPI. An NPI application may be completed on-line at <https://nppes.cms.hhs.gov/>. Alternatively, application may be downloaded from the Centers for Medicare and Medicaid Services (CMS) website [www.cms.hhs.gov](http://www.cms.hhs.gov). From the CMS homepage, select Regulations and Guidance, then National Provider Identifier Standard (NPI), How to Apply. This process can take less than 20 minutes to complete. |
|[ ]  **A Photocopy of State Professional License** with an expiration date clearly visible on the copy. The license may not have any marks on it that can interfere with reading the license number. **Please do not hand-write the license number on the copy.** |
|[ ]  **A Photocopy of State Driver’s License** with an expiration date clearly visible on the copy. The home address may be redacted; however, all other information including the photo must be clear. |
|[ ]  **Photocopy of Certificate of Insurance for your Professional Malpractice/Professional liability coverage** indicating limits of coverage and expiration date. ($1,000,000 per Occurrence; $3,000,000 in the Aggregate) (PA - must submit a copy of the supervising network physician’s malpractice rider that includes the oversight of the PA) |
|[ ]  **Curriculum Vitae (TERM) or Resume** It is very important that your resume or Vitae be detailed including descriptions of populations, specialties, and disorders treated, and the theoretical orientation of the work. This detail is required to approve you to treat various age groups or specialties. 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 6 months or more require a written explanation.** |
|[ ]  **Licensed Professional Clinical Counselor (LPCC)** (If applicable) CCR 1820.7 Requirement - LPCCs applying to treat couples and families must submit a copy of the Board confirmation of qualification. |
|[ ]  **Psychiatric Nurse Practitioners (PNP) and Physician Assistants (PA)** must submit a copy of their Supervisory Agreement with an appropriate paneled FFS Psychiatrist (MD/DO). |
|[ ]  Additional Application(s) – A separate clinical application for FFS Medi-Cal, TERM Therapist and/or Evaluator must be submitted with this Credentialing Application. These applications are available on our website at [www.optumsandiego.com](http://www.optumsandiego.com)  |
|[ ]  **All Pages of the Application must be Completed** (Please do not write “refer to Curriculum Vitae, resume or attached documents as an answer to any questions on the application.) |

**CREDENTIALING CRITERIA**

|  |
| --- |
| Psychiatrist  |
| 1. | Graduate degree from a school listed in the current AAMC Directory of American Medical Education, published by the American Association of Medical Colleges, or in the then-current World Directory of Medical Schools, published by the World Health Organization. |
| 2. | Board Certified/Eligible in Psychiatry. Physicians who graduated from medical school prior to July 1, 1982, will be considered to have the equivalency of board certification requirement if he or she has completed an ACGME approved residency training program in psychiatry or a fellowship in addiction medicine. |
| 3. | Current California licensure without material restrictions, conditions or other disciplinary action taken against applicant's license. Current and valid Drug Enforcement Agency or Controlled Dangerous Substance Certificate, unless the applicant's practice does not require it. |
| 4. | Medical Malpractice/Professional Liability with extended reporting option covering the licensed medical personnel providing health care services. 1. $1,000,000 per Occurrence (b) $3,000,000 in the Aggregate
 |
| 5. | Applicant has no history of denial or cancellation of professional liability insurance warranting denial of participation status. |
| 6. | No suspension of hospital privileges on three or more occasions during the past 12 months due to inappropriate, inadequate or tardy completion of medical records. |
| 7. | The absence of a history of professional disciplinary action or other sanction by a managed care plan, hospital, medical review board, licensing board or other administrative body or government agency that warrants the restriction or denial of participation status. |
| 8. | No conditions or other history of disciplinary action or sanctions taken against applicant in Medicare and/or Medicaid programs. |

|  |
| --- |
| Psychiatric Nurse Practitioner - (with prescriptive Authority) |
| 1. | Completion of an advanced Nursing Program and master’s degree in psychiatric/mental health nursing. |
| 2. | American Nurses Credentialing Center (ANCC) verification as a Psychiatric Nurse Practitioner in Psychiatric/Mental Health Nursing. |
| 3. | California RN License. Current California licensure without material restrictions, conditions or other disciplinary action taken against applicant's license. |
| 4. | Current and valid Furnishing Number. Current and valid Drug Enforcement Agency Certificate (DEA) unless the applicant’s practice does not require it. (Be authorized for prescriptive authority) |
| 5. | Be supervised by a **participating network behavioral health physician** (*A copy of the supervisory agreement must be submitted with the application)*. |
| 6. | Medical Malpractice/Professional Liability with extended reporting option covering the licensed medical personnel providing health care services. 1. $1,000,000 per Occurrence (b) $3,000,000 in the Aggregate
 |
| 7. | Applicant has no history of denial or cancellation of professional liability insurance warranting denial of participation status. |
| 8. | No suspension of hospital privileges on three or more occasions during the past 12 months due to inappropriate, inadequate or tardy completion of medical records. |
| 9. | The absence of a history of professional disciplinary action or other sanction by a managed care plan, hospital, medical review board, licensing board or other administrative body or government agency that warrants the restriction or denial of participation status. |
| 10. | No conditions or other history of disciplinary action or sanctions taken against applicant in Medicare and/or Medicaid programs. |

**CREDENTIALING CRITERIA**

|  |
| --- |
| Psychiatric Physician Assistant - (with Prescriptive Authority) |
| 1. | Completion of a Physician Assistant Program. |
| 2. | Board certified through the National Commission of Certification of Physician Assistants (NCCPA) |
| 3. | Applicant must meet the following criteria for participation* 1. Active/unexpired Certificate of Added Qualifications (CAQ) in Psychiatry or eligible for the Exam
	2. Be supervised by a participating network behavioral health physician (*A copy of the supervisory agreement must be submitted with the application)*
 |
| 4. | California PA License: Current California licensure without material restrictions, conditions or other disciplinary action taken against applicant's license. |
| 5. | Current and valid Drug Enforcement Agency Certificate (DEA) unless the applicant’s practice does not require it. (Be authorized for prescriptive authority) |
| 6. | * Medical Malpractice/Professional Liability with extended reporting option covering the licensed medical personnel providing health care services.
1. $1,000,000 per Occurrence (b) $3,000,000 in the Aggregate
* The supervising network physician must have a malpractice rider that includes the oversight of the PA
 |
| 7. | Applicant has no history of denial or cancellation of professional liability insurance warranting denial of participation status. |
| 8. | No suspension of hospital privileges on three or more occasions during the past 12 months due to inappropriate, inadequate or tardy completion of medical records. |
| 9. | The absence of a history of professional disciplinary action or other sanction by a managed care plan, hospital, medical review board, licensing board or other administrative body or government agency that warrants the restriction or denial of participation status. |
| 10. | No conditions or other history of disciplinary action or sanctions taken against applicant in Medicare and/or Medicaid programs. |

|  |
| --- |
| Psychologist |
| 1. | A doctoral level degree in clinical psychology from an accredited college or university and direct provision of care to clients in a mental health setting. |
| 2. | If applicable, completion of a post-graduate training program appropriate for the type of services to be provided. |
| 3. | Current licensure at the highest level for independent practice granted within California. The license is without material restrictions, conditions or other disciplinary action taken against applicant's license. |
| 4. | Professional Malpractice/Professional Liability with extended reporting option covering the licensed medical personnel providing health care services.(a) $1,000,000 per Occurrence (b) $3,000,000 Aggregate |
| 5. | Applicant has no history of denial or cancellation of professional liability insurance warranting denial of participation status. |
| 6. | No suspension of hospital privileges on three or more occasions during the past 12 months due to inappropriate, inadequate or tardy completion of medical records. |
| 7.  | The absence of a history of professional disciplinary action or other sanction by a managed care plan, hospital, medical review board, licensing board or other administrative body or government agency that warrants the restriction or denial of participation status. |
| 8. | No conditions or other history of disciplinary action or sanctions taken against applicant in Medicare and/or Medicaid programs. |

|  |
| --- |
| Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT) orLicensed Professional Clinical Counselor (LPCC-special attestation required) |
| 1. | Current licensure at the highest level for independent practice granted within California. The license is without material restrictions, conditions or other disciplinary action taken against applicant's license. |
| 2. | Professional Malpractice/Professional Liability Insurance with extended reporting option covering the licensed medical personnel providing health care services.(a) $1,000,000 per Occurrence (b) $3,000,000 in the Aggregate |
| 3. | Applicant has no history of denial or cancellation of professional liability insurance warranting denial of participation status. |
| 4. | The absence of a history of professional disciplinary action or other sanction by a managed care plan, hospital, medical review board, licensing board or other administrative body or government agency that warrants the restriction or denial of participation status |
| 5. | Conditions or other history of disciplinary action or sanctions taken against applicant in Medicare and/or Medicaid programs. |

*Confidential*

### PRACTITIONER APPLICATION

**San Diego County Mental Health Plan for Medi-Cal and/or TERM Networks**

**Last Name**: Click here to enter text. **First Name**: Click here to enter text. **MI**: Click here to enter text.

**DOB**: Click here to enter a date.

**Gender:** [ ] Male [ ]  Female [ ]  Transgender **Ethnicity:** Click here to enter text.

Degree: [ ]  MD/DO [ ]  PhD [ ]  PsyD [ ]  MSW [ ]  MA [ ]  MSN [ ]  Other Click here to enter text.

License: [ ]  MD/DO [ ]  Psychologist [ ]  PNP [ ]  DNP [ ]  PA [ ]  LCSW [ ]  LMFT [ ]  LPCC

Social Security Number: Click here to enter text.

National Provider Identifier (NPI) Number: Click here to enter text.

|  |  |
| --- | --- |
| **Are you currently employed by the County of San Diego or public agencies for which the County of San Diego Board of Supervisors is the governing body?** | [ ]  **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 Christy Carlson, Health and Human Services Compliance Group Program Manager at** **christy.carlson@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 (Angelina Noel) | [ ]  FFS Medi-Cal Provider | [ ]  County Representative |
| [ ]  Other Optum Staff Member | [ ]  TERM Provider | [ ]  Other: Click here to enter text. |

 |

|  |
| --- |
| **Provider’s Emergency Contact**:  |
| **Provider’s Emergency Contact**: (*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)* Name: Click here to enter text. Phone: Click here to enter text.Email: Click here to enter text. |

|  |
| --- |
| 1. **TREATMENT LOCATION(S) / OFFICE(S):** *Continued***:** *The office(s) below reflect the location(s) where services will be rendered to Medi-Cal and/or TERM clients.*
 |
| 1. **Mobile Services**
 |
| * **Home Visits:**  [ ]  Yes [ ]  No
* **Additional Mobile Services Including Home Visits:** [ ]  Yes [ ]  No
* If “Yes: to either of the above:

List all San Diego County zip codes served Click here to enter text.  |
| **Treatment Location(s) / Offices – *Continued on the next page*** |

|  |
| --- |
| 1. **TREATMENT LOCATION(S) / OFFICE(S):** *Continued****:*** *The office(s) below reflect the location(s) where services will be rendered to Medi-Cal and/or TERM clients.*
 |
| 1. \*\* **Primary Office** : **Home Office:** [ ]  **No** [ ]  **Yes - *The address below is in a personal residence***
 |
| * Business Name (*If Applicable):* Click here to enter text. (*This name must match the name the IRS has on file for the social security or tax identification number listed on the W-9)*
 |
| * DBA: [ ]  No [ ]  Yes DBA Name: Click here to enter text.
 |
| * Address: Click here to enter text. [ ]  **N/A - Mobile Services Only**
 |
| * City: Click here to enter text. County: Click here to enter text.
 |
| * State: Click here to enter text. Zip: Click here to enter text.
 |
| * Daytime Phone**:** Click here to enter text. Fax: Click here to enter text.
 |
| * Emergency / After Hours: Click here to enter text.
 |
| * TTY/TDD: Click here to enter text.
 |
| * E-mail Address (Client Use): Click here to enter text.
 |
| * E-mail Address (Business Use): Click here to enter text.
 |
| * Federal Tax I.D. or Social Security Number: Click here to enter text. (*This number must match the number listed on your W-9*)
 |
| * Office Manager Name: Click here to enter text.
 | * Contract Person: Click here to enter text.
 |
| * + Is office accessible to public transportation?
 | [ ]  Yes | [ ]  No | [ ]  N/A - Mobile Services Only |
| * + Does office meet ADA guidelines?

(*\* Americans with Disabilities Act*) | [ ]  Yes | [ ]  No | [ ]  N/A - Mobile Services Only |
| * + Is your office wheelchair accessible?
 | [ ]  Yes | [ ]  No | [ ]  N/A - Mobile Services Only |
| * **Hours of Operation:**

|  |  |
| --- | --- |
|[ ]  Monday | Click here to enter text. to Click here to enter text. |
|[ ]  Tuesday | Click here to enter text. to Click here to enter text. |
|[ ]  Wednesday | Click here to enter text. to Click here to enter text. |
|[ ]  Thursday | Click here to enter text. to Click here to enter text. |
|[ ]  Friday | Click here to enter text. to Click here to enter text. |
|[ ]  Saturday | Click here to enter text. to Click here to enter text. |
|[ ]  Sunday | Click here to enter text. to Click here to enter text. |

 |
| 1. **Mailing Address:** *This is the address Optum mails all correspondence, excluding payments.*

[ ]  Same as Primary Office |
| * Address: Click here to enter text.
 |
| * City: Click here to enter text. State: Click here to enter text.
 |
| * Zip: Click here to enter text. Daytime Phone: Click here to enter text.
 |

|  |
| --- |
| 1. **TREATMENT LOCATION(S) / OFFICE(S):** *Continued****:***
 |
| 1. **Billing Address:** *This is the address that all Medi-Cal and TERM payments will be sent.*

[ ]  Same as Primary Office [ ]  Same as Mailing Address |
| **Note:** *There can only be one (1) Billing Address and it must correspond to the address on the W9****.*** |
| * Address: Click here to enter text.
 |
| * City: Click here to enter text. State: Click here to enter text.
 |
| * Zip: Click here to enter text. Daytime Phone: Click here to enter text.
 |
| * Contract Person: Click here to enter text.
 |
| 1. \*\* **N/A** [ ]  **Additional Office Location(s):** List all office locations where services will be rendered to Medi-Cal and/or TERM Clients (Attach additional pages if you will have additional treatment locations)
 |
| * Address: Click here to enter text.
 |
| * City: Click here to enter text. County: Click here to enter text.
 |
| * State: Click here to enter text. Zip: Click here to enter text.
 |
| * Daytime Phone: Click here to enter text. Fax: Click here to enter text.
 |
| * Emergency / After Hours: Click here to enter text.
 |
| * TTY/TDD: Click here to enter text.
 |
| * E-mail Address (Client Use): Click here to enter text.
 |
| * E-mail Address (Business Use): Click here to enter text.
 |
| * Office Manager Name: Click here to enter text.
 |
| * Is office accessible to public transportation? [ ]  Yes [ ]  No
 |
| * + Does office meet \*ADA guidelines? [ ]  Yes [ ]  No

(*\* Americans with Disabilities Act*) |
| * + Is your office wheelchair accessible? [ ]  Yes [ ]  No
 |
| * **Hours of Operation:**

|  |  |
| --- | --- |
|[ ]  Monday | Click here to enter text. to Click here to enter text. |
|[ ]  Tuesday | Click here to enter text. to Click here to enter text. |
|[ ]  Wednesday | Click here to enter text. to Click here to enter text. |
|[ ]  Thursday | Click here to enter text. to Click here to enter text. |
|[ ]  Friday | Click here to enter text. to Click here to enter text. |
|[ ]  Saturday | Click here to enter text. to Click here to enter text. |
|[ ]  Sunday | Click here to enter text. to Click here to enter text. |

 |
|  |
| 1. **LICENSE INFORMATION:** *A current copy of the professional license must to be submitted with the application*
 |
| **Please complete the following for each professional license currently or previously held:** |
| * + Professional License Type: Choose an item. License #: Click here to enter text.
 |
| * + Original Independent License Issue Date: Click here to enter a date.
	+ Expiration Date: Click here to enter a date.
 |
| * + Professional License Type: Choose an item. License #: Click here to enter text.
 |
| * + Original Independent License Issue Date: Click here to enter a date.
	+ Expiration Date: Click here to enter a date.
 |
| * + Professional License Type: Choose an item. License #: Click here to enter text.
 |
| * + Original Independent License Issue Date: Click here to enter a date.
	+ Expiration Date: Click here to enter a date.
 |

|  |
| --- |
| 1. **INSURANCE INFORMATION:** *Requirement:* ($1M per occurrence, $3M in the aggregate required) –

*A current copy of the Professional Liability Insurance (PLI) must to be submitted with the application.*  |
| * + Name of Current Insurance Carrier: Choose an item.
 |
| * + Mailing Address: Click here to enter text.
 |
|

|  |
| --- |
| * City: Click here to enter text.
 |
| * State: Click here to enter text. Zip: Click here to enter text.
 |

 |
| * Policy #: Click here to enter text.
 |
| * Start Date: Click here to enter a date. Expiration Date: Click here to enter a date.
 |

|  |
| --- |
| 1. **Licensed Professional Clinical Counselor (LPCC):**
 |
| * + Are you a Licensed Professional Clinical Counselor (LPCC)? [ ]  Yes [ ]  No
 |
| * + If yes, are you applying to assess or treat couples or families? [ ]  Yes [ ]  No
 |
| * + If “Yes” above, you must submit a copy of the BBS confirmation of qualifications to treat couples and families must be submitted with this application
 |

|  |
| --- |
| 1. **EDUCATION:**
 |
| **Graduate School Information:** |
| * + Degree: Click here to enter text. University/College: Click here to enter text.
 |
|

|  |
| --- |
| * City: Click here to enter text. State: Click here to enter text.
 |
| * Date Issued: Click here to enter a date.
 |

 |
| * Degree: Click here to enter text. University/College: Click here to enter text.
 |
|

|  |
| --- |
| * City: Click here to enter text. State: Click here to enter text.
 |
| * Date Issued: Click here to enter a date.
 |

 |
| **Education – *Continued on the next page*** |
| 1. **EDUCATION:** *Continued*
 |
| **Graduate School Information:** *Continued* |
| * Degree: Click here to enter text. University/College: Click here to enter text.
 |
|

|  |
| --- |
| * City: Click here to enter text. State: Click here to enter text.
 |
| * Date Issued: Click here to enter a date.
 |

 |
| * Degree: Click here to enter text. University/College: Click here to enter text.
 |
|

|  |
| --- |
| * City: Click here to enter text. State: Click here to enter text.
 |
| * Date Issued: Click here to enter a date.
 |

 |
| **Post Graduate Training and Experience (Attach additional pages if necessary)** |
| * **Internship**: Click here to enter text. Institution: Click here to enter text.
 |
| * Address: Click here to enter text.
 |
| * City: Click here to enter text. State: Click here to enter text.
 |
| * Specialty: Click here to enter text. Date Issued: Click here to enter a date.
 |
| * **Residency**: Click here to enter text. Institution: Click here to enter text.
 |
| * Address: Click here to enter text.
 |
| * City: Click here to enter text. State: Click here to enter text.
 |
| * Specialty: Click here to enter text. Date Issued: Click here to enter a date.
 |
| * **Post-Doctoral**: Click here to enter text. Institution: Click here to enter text.
 |
| * Address: Click here to enter text.
 |
| * City: Click here to enter text. State: Click here to enter text.
 |
| * Specialty: Click here to enter text. Date Issued: Click here to enter a date.
 |
| **Psychiatric Nurse Practitioner (PNP) Only:** |
| * Supervised Clinical Experience Location: Click here to enter text.
 |
| * Supervisor: Click here to enter text.
 |
| * Specialty: Click here to enter text.
 |
| * Address: Click here to enter text.
 |
| * City: Click here to enter text. State: Click here to enter text.
 |
| * Date Completed: Click here to enter a date.
 |
| **Physician’s Assistant (PA) Only:** |
| Supervised Clinical Experience Location: Click here to enter text. |
| Supervisor: Click here to enter text. |
| Specialty: Click here to enter text. |
| Address: Click here to enter text.  |
| City: Click here to enter text. State: Click here to enter text.  |
| Date Completed: Click here to enter a date. |

|  |
| --- |
| 1. **INFORMATION FOR PSYCHIATRISTS, NURSE PRACTITIONERS & Physicians Assistants WITH PRESCRIPTIVE AUTHORITY**:
 |
| **These Questions apply to MDs only:** |
| * DEA (BNDD) No.: Click here to enter text. Expiration Date: Click here to enter a date.
 |
| * Successfully completed AMA approved residency in psychiatry: [ ]  Yes [ ]  No
 |
| * Board Eligible for Child & Adolescent Services: [ ]  Yes [ ]  No
 |
| * *(If yes above, please provide proof of completion of Fellowship)*
 |
|  |  |  | If Yes - Date of Board Certification: |
| * **Board Certification N/A** [ ]
 | [ ]  Yes | [ ]  No | Click here to enter a date. |
| * Psychiatry & Neurology
 | [ ]  Yes | [ ]  No | Click here to enter a date. |
| * Addiction Psychiatry
 | [ ]  Yes | [ ]  No | Click here to enter a date. |
| * Child & Adolescent Psychiatry
 | [ ]  Yes | [ ]  No | Click here to enter a date. |
| * Geriatric Psychiatry
 | [ ]  Yes | [ ]  No | Click here to enter a date. |
| * Other: Click here to enter text.
 | [ ]  Yes | [ ]  No | Click here to enter a date. |
| * Other: Click here to enter text.
 | [ ]  Yes | [ ]  No | Click here to enter a date. |
| **Hospital Privileges (admitting privileges)**: **N/A** [ ] Hospitals where you have admitting privileges must be provided for listing in the Directory |
| *Please complete the section below to identify the county contracted hospitals where you currently have admitting privileges:* |
|  | If Yes - Date Privileged Here |
| Alvarado Parkway Institute | [ ]  Yes | [ ]  No | Click here to enter a date. |
| Aurora Hospital | [ ]  Yes | [ ]  No | Click here to enter a date. |
| Palomar Hospital | [ ]  Yes | [ ]  No | Click here to enter a date. |
| PH Bayview Hospital (A) | [ ]  Yes | [ ]  No | Click here to enter a date. |
| PH Paradise Valley Hospital | [ ]  Yes | [ ]  No | Click here to enter a date. |
| Pomerado Hospital | [ ]  Yes | [ ]  No | Click here to enter a date. |
| Sharp Mesa Vista Hospital | [ ]  Yes | [ ]  No | Click here to enter a date. |
| Scripps Mercy Healthcare | [ ]  Yes | [ ]  No | Click here to enter a date. |
| Sharp Grossmont Hospital | [ ]  Yes | [ ]  No | Click here to enter a date. |
| UCSD Medical Center | [ ]  Yes | [ ]  No | Click here to enter a date. |
| Rady CAPS | [ ]  Yes | [ ]  No | Click here to enter a date. |
| **Information for Psychiatrists & Nurse Practitioners with Prescriptive Authority: *Continued on the next page*** |

|  |
| --- |
| 1. **INFORMATION FOR PSYCHIATRISTS, NURSE PRACTITIONERS & Physicians Assistants WITH PRESCRIPTIVE AUTHORITY**: *Continued*
 |
| **These questions apply to PNPs ONLY:** |
| * American Nurse Credentialing Center (ANCC) Certification (*As a Psychiatric Nurse Practitioner in Psychiatric/ Mental Health Nursing*) No. Click here to enter text.
 |
| * Furnishing Number: Click here to enter text.
 |
| * Do you have a DEA No.?
 | [ ]  Yes | [ ]  No |
| * If Yes above: DEA (BNDD) No. Click here to enter text.
* Expiration Date: Click here to enter a date.
 |
| * Name & telephone number of supervising psychiatrist: Click here to enter text.
 |
| * Do you provide Outpatient Treatment? [ ]  Yes [ ]  No
 |
| **These questions apply to PAs ONLY:** |
| * Certificate of Added Qualifications (CAQ) in Psychiatry: [ ]  Yes - Certificate Number:
* [ ]  No – If No, Must be eligible for the Exam
* [ ]  Yes, I am eligible for the Exam
 |
| Do you have a DEA No.? [ ]  Yes [ ]  No |
| * If Yes above: DEA (BNDD) No. Click here to enter text.

Expiration Date: Click here to enter a date. |
| Name & telephone number of supervising psychiatrist: Click here to enter text. |
| Do you provide Outpatient Treatment? [ ]  Yes [ ]  No |

|  |
| --- |
| 1. **Clincal PRofile:** *Please complete the following information so that you may receive appropriate referrals.*
 |
| * What arrangements do you have for 24-hour, 7 day emergency coverage for clients? Click here to enter text.
 |
| * **List ALL Languages other than English** in which you are able to conduct treatment **fluently:**

**CRITERIA:** Fluent means that you are able to effectively and effortlessly speak and conduct a clinical evaluation and treatment in the language(s) checked below. For most individuals, formal classes in school or university will not produce this level of competence without other experience with the language. |
| [ ]  American Sign Language | [ ]  French | [ ]  Laotian | [ ]  Samoan |
| [ ]  Arabic | [ ]  Hebrew | [ ]  Mandarin Chinese | [ ]  Somali |
| [ ]  Armenian | [ ]  Hmong | [ ]  Mien | [ ]  Spanish |
| [ ]  Cambodian | [ ]  Ilocano | [ ]  Other Sign Language | [ ]  Tagalog |
| [ ]  Cantonese Chinese | [ ]  Italian | [ ]  Polish | [ ]  Thai |
| [ ]  Chinese | [ ]  Japanese | [ ]  Portuguese | [ ]  Turkish |
| [ ]  Farsi | [ ]  Korean | [ ]  Russian | [ ]  Vietnamese |
| [ ]  Filipino Dialect | [ ]  Other Click here to enter text. |
| 1. **Clincal PRofile:** *Continued*
 |
| **Ethnic/Cultural Identity: *Optional*** – Clinicians self-identified information |
| [ ]  African American | [ ]  Filipino | [ ]  Laotian | [ ]  Samoan |
| [ ]  Amerasian | [ ]  Guamanian | [ ]  Mexican American/Chicano | [ ]  Somali |
| [ ]  Asian Indian | [ ]  Hawaiian Native | [ ]  Native American | [ ]  Sudanese |
| [ ]  Cambodian | [ ]  Hmong | [ ]  Other Asian | [ ]  Vietnamese |
| [ ]  Chinese | [ ]  Iranian | [ ]  Other Latin American  | [ ]  White |
| [ ]  Cuban | [ ]  Iraqi | [ ]  Pacific Islander | [ ]  Unknown |
| [ ]  Dominican | [ ]  Japanese | [ ]  Puerto Rican |
| [ ]  Ethiopian | [ ]  Korean | [ ]  Salvadoran |
| [ ]  Other Click here to enter text. |
| *This information below is* ***optional***and will not limit referrals to only these populations |
| Sexual Orientation:[ ]  Bisexual [ ]  Gay/Lesbian [ ]  Heterosexual |
| **\*\* Cultural Competency:** Delivering ***culturally competent clinical services*** means you have an understanding of: 1) on-going social realities (e.g., racism, immigration patterns, acculturation) that can impact the mental health of culturally and linguistically distinct 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 check that you are culturally competent to deliver services to a group below it means that you have experiences consistent with one or more of the statements below: |
| * Have lived at least 2 years or were raised in a community where this culture predominated; and/or
 |
| * Have completed formal training such as a degree emphasis area, specific university courses, multiple workshops or an internship focusing on culture and human behavior;  and/or
 |
| * 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); and/or
 |
| * Have provided clinical treatment or evaluations to more than 10 members of the cultural group.
 |
| ***From the following list please check any group for which you are competent to evaluate family dynamics and provide treatment.*** |
| [ ] African American | [ ]  Filipino | [ ]  Korean | [ ]  Somali |
| [ ]  Amerasian | [ ]  Guamanian | [ ]  Laotian | [ ]  Sudanese |
| [ ]  Arab | [ ]  Hawaiian Native | [ ]  Mexican American/Chicano | [ ]  Vietnamese |
| [ ]  Asian Indian | [ ]  Hmong | [ ]  Native American | [ ]  White |
| [ ]  Cambodian | [ ]  Iranian | [ ]  Pacific Islander | [ ]  Other Asian |
| [ ]  Chinese | [ ]  Iraqi | [ ]  Puerto Rican | [ ]  Other Hispanic |
| [ ]  Cuban | [ ]  Japanese | [ ]  Salvadorian | [ ]  Other Latin American |
| [ ]  Dominican | [ ]  Jewish | [ ]  Samoan | [ ]  Other South East Asian |
| [ ]  Ethiopian | [ ]  Other Click here to enter text. |
| 1. **Clincal PRofile:** *Continued*
 |
| **Religious Affiliation:** At times clients may request a provider with a particular religious affiliation. This information is **optiona**l, and will not limit referrals to these populations. This information is used only to assist in meeting client requests for referrals. Please check those that apply. |
| [ ]  Buddhist | [ ]  Other | [ ]  Jewish  | [ ]  Other Christian |
| [ ]  Catholic | [ ]  Hindu | [ ]  Lutheran | [ ]  Not Applicable |
| [ ]  Episcopal | [ ]  Islam | [ ]  Methodist |

|  |
| --- |
| 1. **PLEASE CHECK ALL INSURANCE PLANS YOU CAN ACCEPT**
 |
| [ ]  Aetna PPO | [ ]  Health Net | [ ]  TriWest/TriCare | [ ]  Care 1st |
| [ ]  Anthem Blue Cross | [ ]  Magellan | [ ]  Optum | [ ]  Kaiser |
| [ ]  Community Health Group | [ ]  Medi-Cal | [ ]  Value Options | [ ]  Cigna |
| [ ]  Other Click here to enter text. | [ ]  Medicare | [ ]  Molina | [ ]  UnitedHealth Care |
|  |
| **Available to provide Second Opinions (MD ONLY)** [ ]  Yes [ ]  No |

**Disclosure Questions** Answer all questions. For any “Yes” response, provide an explanation on page 18.

|  |  |
| --- | --- |
|  |  **Disclosure Questions** |
| 1. [ ] Yes [ ]  No | **LICENSURE**Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board? |
| 2. [ ] Yes [ ]  No | Has there been any challenge to your licensure, registration or certification? |
| 3. [ ] Yes [ ]  No | **HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS**Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board including TERM – approved or Juvenile Court panels? |
| 4. [ ] Yes [ ]  No | Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation? |
| 5. [ ] Yes [ ]  No | Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMO’s, PPO’s, or provider organizations such as IPAs, PHOs)? |
| 6. [ ] Yes [ ]  No | **EDUCATION, TRAINING AND BOARD CERTIFICATION**Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign? |
| 7. [ ] Yes [ ]  No | Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program? |
| 8. [ ] Yes [ ]  No | Have any of your board certifications or eligibility ever been revoked? |
| 9. [ ] Yes [ ]  No | Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation? |
| 10. [ ] Yes [ ]  No | **DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION**Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished? |
| 11. [ ] Yes [ ]  No | **MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PROGRAM PARTICIPATION**Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs? |
| 12. [ ] Yes [ ]  No | **OTHER SANCTIONS OR INVESTIGATIONS**Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or sexual offense or sexual misconduct? |
| 13. [ ] Yes [ ]  No | To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?  |
|  |  **Disclosure Questions – Continued** |
| 14. [ ] Yes [ ]  No | Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)? |
| 15. [ ] Yes [ ]  No | Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchanged for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct? |
| 16. [ ] Yes [ ]  No | Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchanged for no investigation by a hospital or healthcare facility or any military agency? |
| 17. [ ] Yes [ ]  No | **PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY**Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history? |
| 18. [ ] Yes [ ]  No | Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history? |
| 19. [ ] Yes [ ]  No | **MALPRACTICE CLAIMS HISTORY**Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years? If yes, provide information for each case.  |
| 20. [ ] Yes [ ]  No | **CRIMINAL/CIVIL HISTORY** Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony? |
| 21. [ ] Yes [ ]  No | In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct? |
| 22. [ ] Yes [ ]  No | Have you ever been court-martialed for actions related to your duties as a medical professional? |
| 23. [ ] Yes [ ]  No | Has a true finding ever been made against you, your spouse, or an adult member of your household in a Juvenile Court dependency action?  |
| 24. [ ] Yes [ ]  No | Have you, your spouse, or an adult member of your household ever been investigated by a Child Protective Agency? |
| 25. [ ] Yes [ ]  No | **ABILITY TO PERFORM JOB**Are you currently engaged in the illegal use of drugs?(“Currently” means sufficiently recent to justify a reasonable belief that the use of drugs may have any ongoing impact on one’s ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. “Illegal use of drugs” refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C.§ 812.22. It “does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal Law.” The term does include, however, the unlawful use of prescription controlled substances.) |
| 26. [ ] Yes [ ]  No | Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety? |
| 27. [ ] Yes [ ]  No | Do you have any reason to believe that you would pose a risk to the safety or wellbeing of your patients? |
| 28. [ ] Yes [ ]  No | Are you unable to perform the essential functions of a practitioner in your area even with reasonable accommodation? |

**Standard Authorization, Attestation and Release**

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as “Participation”) at or with each healthcare organization indicated on the “List of Authorized Organizations” that accompanies this Provider Application (hereinafter, each healthcare organization on the “List of Authorized Organizations” is individually referred to as the “Entity”), and any of the Entity’s affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

 I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

**Authorization of Investigation Concerning Application for Participation:** I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity’s affiliated entities and their representatives, employees, and/or designated agents; and the Entity’s designated professional credentials verification organization (collectively referred to as “Agents”), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

**Authorization of Third-Party Sources to Release Information Concerning Application for Participation:** I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data bank, and the Health Care Integrity and Protection Data Bank, and Child Protection Agencies to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

**Authorization of Release an Exchange of Disciplinary Information:** I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party’s agents to release “Disciplinary Information,” as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, “Disciplinary Information” means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have acknowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

**Release from Liability**: I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, is Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity’s medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide consent may be grounds for termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration: denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature Name (print) Date Signed

|  |
| --- |
| The National Practitioner Data Bank requires Health Care Entities to report: (1) professional review actions that are based on reasons related to professional competence or conduct and that adversely affect clinical privileges for a period longer than 30 days; or, (2) the voluntary surrender or restriction of clinical privileges while under investigation, or to avoid investigation. If you suspect you may not be accepted through our credentialing process for the reasons listed above, you may not want to apply since a denial of you application may require a report to the National Practitioner Data Bank if the denial is for reasons related to profession competence or conduct. |

If you answered “yes” to any Disclosure Questions, please provide an explanation here: Click here to enter text.

**\* Please complete and include the appropriate FFS Medi-Cal and/or TERM Clinical Application(s) as explained in the checklist on** [**page 3**](#_Checklist_for_Medi-Cal) **of this Credentialing Application.**