

 **TERM Network**

**Therapist**

**Provider Application**

[Instructions and Frequency Asked Questions](https://www.optumsandiego.com/content/dam/san-diego/documents/ffsproviders/applications/1_Instructions_and_FAQs_Credentialing_and_Contracting.pdf)

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

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PRACTITIONER APPLICATION

San Diego County Mental Health Plan for TERM Network **(Therapist)**

**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 CFWB 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 on the following website: [www.optumsandiego.com](https://www.optumsandiego.com/) or you can contact the **Optum TERM Provider Line at 1-877-824-8376.**

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

Included is the application for providers who would like to join the Optum TERM Provider Network as a Therapist. An application checklist is provided to assist you in collecting all the required documents. Please ensure your curriculum vita 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 complete application and supporting documents by mail, fax or email 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

If you have any questions, please contact the **TERM Provider Line at 1-877-824-8376, Option 3.** We appreciate the opportunity to work with you in serving the clients of the County of San Diego.

**IMPORTANT NOTE:** All providers that render any service(s) that may be billable to Medi-Cal must also apply to the San Diego Fee for Service Medi-Cal Network. Only providers whose services cannot be billed under Medi-Cal may apply to be TERM Only Providers.

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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](https://www.optumsandiego.com/content/dam/san-diego/documents/ffsproviders/applications/Credentialing%20Criteria.pdf) for inclusion in the TERM Network. Please check the requirements for each discipline on the link above to ensure you meet the minimum criteria.

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

|  |  |
| --- | --- |
|  |  **Application Checklist** |
|[ ]  [**Credentialing Application**](https://www.optumsandiego.com/content/dam/san-diego/documents/ffsproviders/applications/Credentialing%20Application%20Instructions.pdf) **–** To be completed and submitted on the [Council for Affordable Quality Healthcare](https://proview.caqh.org/Login/Index?ReturnUrl=%2f) (CAQH) website. *Please see the* [*FAQs*](https://www.optumsandiego.com/content/dam/san-diego/documents/ffsproviders/applications/1_Instructions_and_FAQs_Credentialing_and_Contracting.pdf) *on our website for additional information.*  |
|[ ]  **W-9** **–** A completed and signed [W-9 form](https://www.optumsandiego.com/content/dam/san-diego/documents/ffsproviders/applications/W9%20-%20Blank.pdf) is required. (P*lease follow instructions carefully.)* |
|[ ]  **W-9 Verification –** |
|  |[ ]  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 submit a current Internal Revenue Service (IRS) generated document. The only acceptable documents include: * 1. IRS-generated Letter 147-C
	2. IRS-generated Form 941 (Employer’s Quarterly Federal Tax Return)
	3. IRS-generated Form 8109-C (Deposit Coupon)
	4. 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 (*1million per occurrence / 3million aggregate minimum)*
* Expiration date *must cover the Dates of Services requested*
 |
|[ ]  **State Driver’s License/ID Card** **–**  * Current, valid copy
* Expiration date and photo must be clearly visible (Color copy via e-mail is preferred)
 |
|[ ]  **State Professional License** **–**  * Active, valid copy
* Copy must be of current pocket license or original wall certificate
 |
| [ ]  | **Curriculum Vitae (CV) -** It is very important that your CV be detailed. These details are required to approve you to treat various age groups or specialties. **Dates of employment must include the month and year. All gaps in employment of 6 months or more require written explanation.**Please include the following:* Descriptions of populations, specialties, and disorders treated
* Theoretical orientation of the work
* Dates and locations of education and post-graduate training
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San Diego County Mental Health Plan for TERM Network **(Therapist)**

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| **Application Checklist – (*Continued)*** |
| [ ]  | **Writing Sample (required):** Part of the application and must be included in order for your application packet to be considered complete. * The Therapist Writing Sample Packet is available at [www.optumsandiego.com](http://www.optumsandiego.com) (BHS Provider à Resources à TERM Providers à Join the Provider Network à TERM Therapist Applications). Please see the attached Exhibit “A” for instructions.
 |
| [ ]  | **Certification:** Certificate must be submitted when required by the specialty criteria as stated in this application. |
| [ ]  | **Attestation: Optum Application Process - Page #9 (required):*** Please sign and date page #9 attesting to your review and understanding of the Optum Application Process.
 |
| [ ]  | **Attestation: TERM Clinician Specialty Requirements (CEUs) - Page #16 (if applicable):*** Page #16 must be signed and dated (if applicable)
 |
| [ ]  |  **Application Attestation: Page #18 (required):*** Please sign and date page #18 attesting to the accuracy of the information submitted
 |
|[ ]  **Continuing Education:** Applicant understands that CEU certificates that are not required with the original application may be required at the first (1st) and subsequent recredentialing (every 3 years). Applicant must be aware of the Continuing Education requirements for each of the specialties being requested and plan accordingly to complete them and maintain the certificates for possible future submittal if required. |
| [ ]  | **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.
 |

**IMPORTANT: Review of the CV is completed by TERM clinicians based on the following:**

**Glossary of Application Terminology and Requirements**

**Training:** For the purpose of completing the TERM Panel Application, the word “training” refers to any Continuing Education Units (CEUs) that you acquire in effort to stay current with the specialty you are requesting approval for. Training can also include formal, didactic learning that is obtained by attending courses that are specific to the specialty.

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**Supervision/Consultation:** For the purpose of completing the TERM Panel Application, “Supervision and/or Consultation” refer to obtaining clinical supervision and/or in consultation with peers who have experience with the specialty you are attesting to.

**Experience:** Refers to any direct practice, therapeutic treatment, and/or psychological evaluations of children and/or adults in the areas of competence and/or diagnoses you are attesting to, as the *primary* focus of treatment and/or evaluation.

**Clarification:** Clarification of your experience, training and/or supervision/consultation may be requested during the application process. If “clarification” is requested under any area of competence and/or diagnoses, TERM is requesting specific, detailed information of your experience, training and/or supervision/consultation.

**Curriculum Vitae (CV):** A record of your academic and professional achievements. A CV is a thorough account of your professional training and experience. Please include a CV with your TERM Panel Application and ensure it includes detailed information of your training, supervision/consultation, and experience treating and/or performing psychological evaluations in each of the areas of competence and diagnoses to which you are attesting.

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

**Email Address:** Click here to enter text. **Phone Number:**  Click here to enter text.

**License Type**: [ ]  MD/DO [ ]  Psychologist ([ ]  PhD [ ]  PsyD) [ ]  LMFT [ ]  LCSW [ ]  LPCC [ ]  PNP [ ]  PA

**License Number**: Click here to enter text. **CAQH Provide ID #**: Click here to enter text.

**Date Credentialing Application completed at \*CAQH**: Click here to enter a date.

\* [Council for Affordable Quality Healthcare](https://proview.caqh.org/Login/Index?ReturnUrl=%2f)

**Credentialing Rep** (*If other than provider*): [ ]  **N/A** or Click here to enter text.

**Email Address:** Click here to enter text. **Phone Number:**  Click here to enter text.

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|  |  |
| **Are you 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 Office Team Member 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: Click here to enter text. |

 |
| **Provider’s Emergency Contact (***Required Information)* |
| **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. |
|  |
| **Emergency 24 Hour Coverage of Clients:** |
| What arrangements do you have for 24-hour, 7-day emergency coverage for clients? Click here to enter text. |
|  |
| 1. **Applicant/Provider Home Address** (*REQUIRED AND IS CONFIDENTIAL*)
 |
| Address: Click here to enter text.  |
| Suite: 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. |

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| **II. CONFIDENTIAL MAILING ADDRESS:**[ ]  **N/A (***When/If applicable: audit results, sensitive communications regarding your practice*) |
| Address: Click here to enter text.  |
| Suite: 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. |
| 1. **Mailing Address:** [ ] *Same as Confidential Mailing Address*
 |
| Address: Click here to enter text.  |
| Suite: 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. |
| 1. **Billing Address:** [ ] *Same as Confidential Mailing Address* [ ] *Same as Mailing Address*
 |
| Address: Click here to enter text.  |
| Suite: 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. |
| **V. TREATMENT LOCATION /OFFICE – Offices** (Office Locations where *services will be rendered to clients face-to-face)* |
| 1. **PRIMARY TREATMENT LOCATION**
 |
| Address: Click here to enter text.  |
| Suite: 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. |
| **B. ADDITIONAL TREATMENT LOCATION(S):** [ ]  **N/A** (Additional Office Locations where *services will be rendered to clients face-to-face)* |
| Address: Click here to enter text.  |
| Suite: 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. |

|  |  |
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| 1. **ADDITIONAL TREATMENT LOCATION(S):**

***If “Yes”: Please complete the form at the end of the application to add additional offices*** | [ ] Yes - I have additional office locations to add[ ]  No |

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| **VI. OTHER TREATMENT MODES** |
| 1. **TELEMENTAL HEALTH**
 |
| * **Telemental Health:**  [ ]  Yes [ ]  No
* If “Yes” to the above: A Virtual Visits Telemental Health Compliance Attestation will be required prior to being approved to render Telemental Health services to TERM Clients.
* Please download and submit the [Telemental Health Attestation](https://www.optumsandiego.com/content/dam/san-diego/documents/ffsproviders/provider-services-info/telehealth-attestation-standards/Telehealth%20Attestation.pdf) with this application
 |
| 1. **MOBILE SERVICES/FIELD BASED**
 |
| * **Mobile Services including Home Visits (***Provider will travel to the client’s home or other location*)**:**

 [ ]  Yes [ ]  No * **If “Yes”, enter distance you will travel to deliver services** Click or tap here to enter text.
 |
| 1. **HOME OFFICE -** *The services are rendered face-to-face in your personal residence (****NOT TELEHEALTH****)*
 |
| **Do you have a Home Office?**  [ ]  No [ ]  \*Yes  |
| Address: Click here to enter text.  |
| Suite: 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. |
| \* If yes, please read and sign the **Optum Home Office Standards** attestation included with the addendums |

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| 1. **Licensed Professional Clinical Counselor (LPCC):**
 |
| * + Are you a Licensed Professional Clinical Counselor (LPCC)? [ ]  Yes [ ]  No
 |
| * + If “Yes” above, 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 with this application
 |

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| 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 |

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| 1. **Clincal PRofile:** *Please identify the cultures in which you meet the Cultural Competency Criteria below and currently want to treat in your practice*
 |
| **\*\* 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; 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 | [ ]  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: Click here to enter text. |

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**Optum Application Process for the County of San Diego TERM Network Attestation**

**Curriculum Vitae (CV):** Must be current and include the clinical experience and training necessary to support the specialties requested on this application. Include descriptions of populations, specialties, and disorders treated, and the theoretical orientation of the work. These details are 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 written explanation.**

* **Important:** The CV submitted with theapplication will be reviewed for the education, clinical experience, and training to support the specialties requested on this application.
	+ If the CV does not support the education, clinical experience, and training for the specialties requested on this application, you will receive notification that your application has been removed from further consideration. You are welcome to reapply in 6 months

**Application:**

* TERM Clinician Specialty Requirements (Therapist) on page 16 must be signed and dated (if applicable).
* Optum may require documentation to verify you meet the criteria outlined under TERM Clinician Specialty Requirements pertaining to the specialty or specialties designated.
* Review and complete the application in its entirety. Only select the age ranges and specialties in which you have the experience and training and are willing to treat in your practice.
* CV must be included with the application at the time of submittal.
* Signatures are required on pages #9, #16 (*if applicable)* and #18.

Writing Sample(s):Please see the attached Exhibit “A” for instructions. Writing Sample packets are located at [www.optumsandiego.com](http://www.optumsandiego.com) (BHS Provider Resources à TERM Providers à Applications).

* A Writing Sample is a required part of the application and must be submitted with your application for it to be considered complete.
* A TERM Team Clinician will review the Writing Sample and contact you if additional documentation is needed. **Note:** Only one (1) revision will be accepted.
* If the Writing Sample revision does not meet TERM Documentation Guidelines, you will receive a letter advising you that your application has been removed from further consideration. You are welcome to reapply in 6 months.

**Continuing Education**: Some CEU certificates are required with this application and/or with the first (1st) and subsequent recredentialing (every 3 years). Please ensure you are aware of the Continuing Education requirements for each of the specialties you are requesting and plan accordingly to complete them and maintain the certificates for possible future submittal if required.

We will notify you of the outcome within ten (10) business days of the decision.

I have read and understand the Optum Application Process for the County of San Diego TERM Network.

**Printed Name of Applicant**: Click here to enter text. **Date**: Click here to enter a date.

**Signature** *(Required)*

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**PROVIDER CLINICAL APPLICATION: Child Welfare Services Plan for TERM Network 03/06/202020**

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The **TERM** Network is a specialized panel focusing on evaluation and treatment of children and families referred through the dependency and delinquency systems. Due to the forensic and high-risk nature of the referrals, specialized treatment and evaluation experience is required. While completing this application, please **ONLY** check those specialties to which you meet the criteria.

**Curriculum Vitae:** It is very important that your Curriculum Vitae be detailed including descriptions of populations served, clinical specialties, diagnoses 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 and employment. Please note that you may be asked to testify in Court to support the treatment you have provided. At that time, your Curriculum Vitae will be used by the Court to determine your expertise to treat and/or evaluate clients in the Juvenile Court System.

**Individual and Group Treatment Specialty Criteria:**

**Provider must maintain competency in the specialty through ongoing relevant training, supervision/consultation, experience and/or Continuing Education Units (CEUs).**

**Provider shall maintain a record of her/ his training and continuing education hours as applicable to requirements. Provider is required to sign an attestation under penalty of perjury that training requirements for Specialties that they are approved for have been fulfilled.**

**Some CEU certificates are required with this application and/or the first (1st) and subsequent recredentialing (every 3 years). Applicant must be aware of the Continuing Education requirements for each of the specialties being requested and plan accordingly to complete them and maintain the certificates for possible future submittal if required.**

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Please check the boxes for the age ranges and specialties you are requesting be privileged. The appropriate Age Range Criteria is a prerequisite for all other specialties requested.

**Specific Criteria for Age Ranges:**

|  |  |
| --- | --- |
| **Infant –Toddler: 0 months – 3 years**  [ ]  Yes [ ]  No | **TERM Use Only:*** Meets Specialty Criteria
* DOES NOT Meet Specialty Criteria
 |
| * Licensed Psychologist, LMFT, LCSW or LPCC
* Completion of didactic training and clinical expertise treating infants and toddlers as evidenced by documentation of various combinations of education, training, supervised experience, consultation, study, and professional experience (**Documentation to be reflected on Curriculum Vitae/Resume**)
* Experience to include EITHER:
* A minimum of two (2) years treating infants and toddlers within the last five (5) years (**Documentation to be reflected on Curriculum Vitae/Resume**)

OR * Post-licensure certification as an infant-family and early childhood mental health specialist prenatal to 3 years endorsement or prenatal to 5 years endorsement (**Copy of Certificate Required**)
 |

|  |  |
| --- | --- |
| **Preschool: 3 - 5 years** [ ]  Yes [ ]  No | **TERM Use Only:*** Meets Specialty Criteria
* DOES NOT Meet Specialty Criteria
 |
| * Licensed Psychologist, LMFT, LCSW or LPCC
* Completion of didactic training and clinical expertise treating children between the ages of 3-5 years as evidenced by documentation of various combinations of education, training, supervised experience, consultation, study, and professional experience (**Documentation to be reflected on Curriculum Vitae/Resume**)
* Experience to include EITHER:
* Post-licensure certification as an Infant-Family and Early Childhood Mental Health Specialist prenatal as 3 - 5 years endorsement or prenatal to 5 years endorsement (**Copy of Certificate Required**)

OR* A minimum of two (2) years treating children between the ages of 3 - 5 years within the last five (5) years (**Documentation to be reflected on Curriculum Vitae/Resume**)
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| --- | --- |
| **Children: 6 - 12 years** [ ]  Yes [ ]  No | **TERM Use Only:*** Meets Specialty Criteria
* DOES NOT Meet Specialty Criteria
 |
| * Licensed Psychologist, LMFT, LCSW or LPCC
* Completion of didactic training and clinical expertise treating children between the ages 6-12 years as evidenced by documentation of various combinations of education, training, supervised experience, consultation, study, and professional experience (**Documentation to be reflected on Curriculum Vitae/Resume**)
* A minimum of two (2) years within the last five (5) years of practice treating children ages 6-12 (**Documentation to be reflected on Curriculum Vitae/Resume**)
 |

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| **Adolescents: 13 - 17 years** [ ]  Yes [ ]  No | **TERM Use Only:*** Meets Specialty Criteria
* DOES NOT Meet Specialty Criteria
 |
| * Licensed Psychologist, LMFT, LCSW or LPCC
* Completion of didactic training and clinical expertise treating children between the ages 13-17 years as evidenced by documentation of various combinations of education, training, supervised experience, consultation, study, and professional experience (**Documentation to be reflected on Curriculum Vitae/Resume**)
* A minimum of two (2) years within the last five (5) years of practice treating children ages 13 and older (**Documentation to be reflected on Curriculum Vitae/Resume**)
 |

|  |  |
| --- | --- |
| **Older Adults: 60 years and older** [ ]  Yes [ ]  No | **TERM Use Only:*** Meets Specialty Criteria
* DOES NOT Meet Specialty Criteria
 |
| * Licensed Psychologist, LMFT, LCSW or LPCC
* Completion of didactic training and clinical expertise treating older adults as evidenced by documentation of various combinations of education, training, supervised experience, consultation, study, and professional experience (**Documentation to be reflected on Curriculum Vitae/Resume**)
* A minimum of two (2) years within the last five (5) years of practice treating older adults (**Documentation to be reflected on Curriculum Vitae/Resume**)
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**Specific Criteria for Clinical Specialties:** (Prerequisite: *must meet age range specialty criteria*)

|  |  |
| --- | --- |
| **Adults with Serious Mental Illness (SMI): CFWB - Involved Parents** [ ]  Yes [ ]  No | **TERM Use Only:*** Meets Specialty Criteria
* DOES NOT Meet Specialty Criteria
 |
| * Licensed Psychologist, LMFT, LCSW or LPCC
* Completion of didactic training and clinical expertise in treating adults with serious mental illness as evidenced by documentation of various combinations of education, training, supervised experience, consultation, study, and professional experience (**Documentation to be reflected on Curriculum Vitae/Resume**)
* A minimum of two (2) years within the last five (5) years of practice treating adults with serious mental illness (**Documentation to be reflected on Curriculum Vitae/Resume**)
 |
| **Below mark age groups you are willing to treat in your practice:**[ ]  18-22 years old [ ]  23 – 59 years old [ ]  60+ years old |

|  |  |
| --- | --- |
| **Child Physical Abuse:** **Individual Treatment** [ ]  Yes [ ]  No | **TERM Use Only:*** Meets Specialty Criteria
* DOES NOT Meet Specialty Criteria
 |
| * Licensed Psychologist, LMFT, LCSW or LPCC
* Minimum of two (2) years practice experience working in Child Physical Abuse Treatment in the last five (5) years (**Documentation to be reflected on Curriculum Vitae/Resume**)
* Documentation of completion of forty (40) hours of initial training that include topics related to child abuse and neglect, parenting, maladaptive client response styles such as denial and cognitive distortions, substance abuse, domestic violence, anger management, law and ethics, psychopathology including personality disorders, differential diagnosis, and risk assessments related to suicidality, homicidality, and training in actuarial risk assessment tools, if validated for intended purpose. This requirement may be satisfied by graduate level training or BBS/BOP approved continuing education units (CEUs) (**Copy of CEU Certificate Required**)
* (Must submit at recredentialing) All treatment providers must complete seven (7) hours of continuing education yearly, with subject matter related to child maltreatment and its prevention or amelioration. Continuing education must be BBS/BOP approved.
 |
| **Below mark age groups you are willing to treat in your practice:**[ ]  18-22 years old [ ]  23 – 59 years old [ ]  60+ years old  |

|  |  |
| --- | --- |
| **Child Physical Abuse:** **Group Treatment** [ ]  Yes [ ]  No | **TERM Use Only:*** Meets Specialty Criteria
* DOES NOT Meet Specialty Criteria
 |
| * Approved by the County of San Diego Adult Probation Department as a Child Abuse Group Treatment Provider
 |
| **Below mark age groups you are willing to treat in your practice:**[ ]  18-22 years old [ ]  23 – 59 years old [ ]  60+ years old |

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PRACTITIONER APPLICATION

San Diego County Mental Health Plan for TERM Network **(Therapist)**

|  |  |
| --- | --- |
| **Domestic Violence Treatment - Victim:** **Group & Individual Treatment** [ ]  Yes [ ]  No | **TERM Use Only:*** Meets Specialty Criteria
* DOES NOT Meet Specialty Criteria
 |
| * + Licensed Psychologist, LMFT, LCSW or LPCC
	+ Completion of an approved forty (40) hour training program in Domestic Violence that fulfills California State’s requirement for domestic violence victim counselors (**Copy of CEU Certificate Required**)
	+ Minimum of six (6) months supervised training experience working with Domestic Violence Victims and topics relevant to the CFWB population (**Documentation to be reflected on Curriculum Vitae/Resume**)
	+ Evidence of a minimum of two (2) years practice experience in Domestic Violence Victim treatment within the last five (5) years(**Documentation to be reflected on Curriculum Vitae/Resume**)
	+ (Must be submitted with this application) Minimum of fifteen (15) hours continuing education in topics relevant to Domestic Violence Victim treatment in the last three (3) years
 |
| **Below mark age groups you are willing to treat in your practice:**[ ]  18-22 years old [ ]  23 – 59 years old [ ]  60+ years old |

|  |  |
| --- | --- |
| **Domestic Violence Treatment – Offender: Group Treatment** [ ]  Yes [ ]  No | **TERM Use Only:*** Meets Specialty Criteria
* DOES NOT Meet Specialty Criteria
 |
| * Approved by the County of San Diego Adult Probation Department as a Domestic Violence Offender Group Treatment Provider
 |
| **Below mark age groups you are willing to treat in your practice:**[ ]  18-22 years old [ ]  23 – 59 years old [ ]  60+ years old  |

|  |  |
| --- | --- |
| **Domestic Violence Treatment – Offender:****Individual Treatment** [ ]  Yes [ ]  No | **TERM Use Only:*** Meets Specialty Criteria
* DOES NOT Meet Specialty Criteria
 |
| * Licensed Psychologist, LMFT, LCSW or LPCC
* Completion of the forty (40) hour basic domestic violence training from Facilitator Training Committee (FTC) approved provider, pursuant to PC1203.098(a)(1) (**Copy of CEU Certificate Required**)
* Minimum of three (3) years practice experience working in Domestic Violence Offender Treatment in the last five (5) years (**Documentation to be reflected on Curriculum Vitae/Resume**)
* Attendance at the San Diego Domestic Violence Council Treatment and Intervention Committee meetings; minimum attendance is three (3) per calendar year (**Documentation to be reflected on Curriculum Vitae/Resume**)
* (Must submit at recredentialing) Sixteen (16) hours annually (calendar year) of continuing education in either domestic violence or a related field with a minimum of eight (8) hours in domestic violence
 |
| **Below mark age groups you are willing to treat in your practice:**[ ]  18-22 years old [ ]  23 – 59 years old [ ]  60+ years old |

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PRACTITIONER APPLICATION

San Diego County Mental Health Plan for TERM Network **(Therapist)**

|  |  |
| --- | --- |
| **Child Sexual Abuse Victim Treatment: CFWB - Involved** [ ]  Yes [ ]  No | **TERM Use Only:*** Meets Specialty Criteria
* DOES NOT Meet Specialty Criteria
 |
| * + Licensed Psychologist, LMFT, LCSW or LPCC
	+ Clinical expertise working with Child Sexual Abuse Victims and topics relevant to the CFWB population as evidenced by documentation of various combinations of education, training, supervised experience, consultation, study, and professional experience (**Documentation to be reflected on Curriculum Vitae/Resume**)
	+ Training in evidence-supported treatment for sexual victimization (**Documentation to be reflected on Curriculum Vitae/Resume**)
	+ Evidence of a minimum of two (2) years practice experience in Child Sexual Abuse Victim treatment within the last five (5) years (**Documentation to be reflected on Curriculum Vitae/Resume**)
 |
| **Below mark age groups you are willing to treat in your practice:**[ ]  0-3 years old [ ]  3-5 years old [ ]  6-12 years old [ ]  13-17 years old |

|  |  |
| --- | --- |
| **Youth with Sexual Behavior Problems Treatment: CFWB - Involved Youth** [ ]  Yes [ ]  No | **TERM Use Only:*** Meets Specialty Criteria
* DOES NOT Meet Specialty Criteria
 |
| * + Licensed Psychologist, LMFT, LCSW or LPCC
	+ Clinical expertise working with Youth with Sexual Behavior Problems as evidenced by documentation of various combinations of education, training, supervised experience, consultation, study, and professional experience (**Documentation to be reflected on Curriculum Vitae/Resume**)
	+ Training in evidence-supported treatment for sexual behavior problems (**Documentation to be reflected on Curriculum Vitae/Resume**)
	+ Evidence of a minimum of two (2) years practice experience in youth with Youth with Sexual Behavior Problems treatment within the last five (5) years (**Documentation to be reflected on Curriculum Vitae/Resume**)
 |
| **Below mark age groups you are willing to treat in your practice:**[ ]  6-12 years old [ ]  13-17 years old |

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PRACTITIONER APPLICATION

San Diego County Mental Health Plan for TERM Network **(Therapist)**

|  |  |
| --- | --- |
| **Sexual Offender Treatment:****Group & Individual Treatment** [ ]  Yes [ ]  No | **TERM Use Only:*** Meets Specialty Criteria
* DOES NOT Meet Specialty Criteria
 |
| * Approved by the California State Sex Offender Management Board (CASOMB) [https://casomb.org](https://casomb.org/index.cfm?pid=1211) **AND** continue to meet CASOMB requirements for treating sex offenders at the independent or Associate level
 |
| **Below mark age groups you are willing to treat in your practice:**[ ]  13-17 years old [ ]  18-22 years old [ ]  23 – 59 years old [ ]  60+ years old  |

|  |  |
| --- | --- |
| **Sexual Abuse Non-Protecting Parent Treatment: Group & Individual Treatment** [ ]  Yes [ ]  No | **TERM Use Only:*** Meets Specialty Criteria
* DOES NOT Meet Specialty Criteria
 |
| **Below mark age groups you are willing to treat in your practice:**[ ]  18-22 years old [ ]  23 – 59 years old [ ]  60+ years old  |
| * + Approved by the California State Sex Offender Management Board (CASOMB) [https://casomb.org](https://casomb.org/index.cfm?pid=1211)

OR* Licensed Psychologist, LMFT, LCSW or LPCC
	+ A Minimum of seven hundred and fifty (750) hours within the preceding two years treating Sexual Abuse Non-Protective Parents; five hundred (500) of those hours were provided face to face or providing supervision, OR two thousand (2000) hours over lifetime (**Documentation to be reflected on Curriculum Vitae/Resume**)
	+ The Independent Practitioner shall attest that he or she has completed a minimum of thirty (30) hours of continuing education and training over the course of the previous two (2) years. At least twenty (20) of those thirty hours must be in the Core Areas described on the Approved Training Topics.
 |
| * **I attest that I have completed a minimum of thirty (30) hours of continuing education and training over the course of the previous two years. At least twenty (20) of those thirty (30) hours are in the Core Areas described on the** [**Approved Training Topics list**](http://casomb.org/docs/REVISION%20OF%20PROVIDER%20CERTIFICATION%20REQUIREMENTS%20-%20TOPICS%208-23-13.pdf)**.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: Click here to enter a date.**Signature** *(Signature* *required when requesting to render this specialty*) |

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PRACTITIONER APPLICATION

San Diego County Mental Health Plan for TERM Network **(Therapist)**

Please complete the following grids. Only check areas in which you specialize, have experience, andare willing to treat in your practice.

**Clinical Experience:** *(Not included under the Specialty Criteria)*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Modality:** | **Infants****0 - 3** | **Preschool****3 - 5** | **Children****6 - 12** | **Adolescents****13 - 17** | **Transitional Youth****18 - 22** | **Adults 23- 59** | **Older Adults****60+** |
| Conjoint Therapy | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Family Therapy | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Individual Therapy |  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Areas of Clinical Expertise:** | **Infants****0 - 3** | **Preschool****3 - 5** | **Children****6 - 12** | **Adolescents****13 - 17** | **Transitional Youth****18 - 22** | **Adults 23- 59** | **Older Adults****60+** |
| Adoption Related Issues |[ ]  [ ]  | [ ]  | [ ]  |  |  |  |
| Attachment Issues | [ ]  | [ ]  | [ ]  | [ ]  |  |  |  |
| Autism Spectrum | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Blind/Vision Impaired | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Chemical Dependency/ Substance Abuse Treatment |  |  |  | [ ]  | [ ]  | [ ]  | [ ]  |
| Commercial Sexual Exploitation of Children (CSEC) | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Deaf Hearing Impaired | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Developmentally Delayed | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Co-Occurring Disorders-Mental Health/Substance Abuse |  |  |  | [ ]  | [ ]  | [ ]  | [ ]  |
| LGBTQIA |  |  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Gender-Affirming Care |  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Medically Fragile | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Depressive Disorders |  | [ ]  | [ ]  | [ ]  |[ ] [ ] [ ]
| Parenting Skills |  |  |  | [ ]  | [ ]  | [ ]  | [ ]  |
| Trauma and Stress Related Disorder | [ ]  | [ ]  | [ ]  | [ ]  |[ ] [ ] [ ]
| Serious Emotional Disturbance (SED) |  |  |[ ] [ ]   |  |  |
| Born Positive Toxicity (Pos Tox) | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |

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PRACTITIONER APPLICATION

San Diego County Mental Health Plan for TERM Network **(Therapist)**

**Safety Threats and Risk Factors:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Infants****0 - 3** | **Preschool****3 - 5** | **Children****6 - 12** | **Adolescents****13 - 17** | **Transitional Youth****18 - 22** | **Adults 23- 59** | **Older Adults****60+** |
| Domestic Violence – Exposed | [ ]  | [ ]  | [ ]  | [ ]  |  |  |  |
| Emotional Abuse Victim  | [ ]  | [ ]  | [ ]  | [ ]  |  |  |  |
| Emotional Abuse – Offender/Non-Protector |  |  |  |  | [ ]  | [ ]  |[ ]
| Neglect – Offender/Non-Protector |  |  |  |  | [ ]  | [ ]  | [ ]  |
| Neglect – Victim | [ ]  | [ ]  | [ ]  | [ ]  |  |  |  |
| Child Physical Abuse – Victim | [ ]  | [ ]  | [ ]  | [ ]  |  |  |  |

**Evidence Based Practices:**

|  |  |  |
| --- | --- | --- |
| **\* Proof of CEU’s and/or training certificate may be requested** |  | **Certification** |
| Behavioral |[ ]   |
| \* CBT |[ ]  [ ]  Yes Date: Click here to enter a date. [ ]  No |
| \* Child Parent Psychotherapy (CPP) |[ ]  [ ]  Yes Date: Click here to enter a date. [ ]  No |
| \* DBT (Certification attests the ability to provide individual/group services) | [ ]  Ind[ ]  Grp | [ ]  Yes Date: Click here to enter a date. [ ]  No |
| \* EMDR |[ ]  [ ]  Yes Date: Click here to enter a date. [ ]  No |
| \* PCAT |[ ]  [ ]  Yes Date: Click here to enter a date. [ ]  No |
| \* PCIT |[ ]  [ ]  Yes Date: Click here to enter a date. [ ]  No |
| \* Play Therapy |[ ]  [ ]  Yes Date: Click here to enter a date. [ ]  No |
| \* TF-CBT |[ ]  [ ]  Yes Date: Click here to enter a date. [ ]  No |

**Signature on this page is required of all TERM Network applicants. Failure to sign this form will cause a delay in the processing of your application.**

I hereby attest that all the information in this application is true and accurate to the best of my knowledge.

I shall maintain proficiency in all specialty areas I selected on my application to the TERM network.

I understand that Optum may require documentation to verify that I meet the criteria outlined under the TERM Clinical Specialty Requirements pertaining to the specialty or specialties I have selected on this application. I agree to cooperate with an Optum TERM Network audit, if requested, to verify that I meet the required criteria.

**Printed Name of Applicant**: Click here to enter text.

 **Date**: Click or tap to enter a date.

|  |  |
| --- | --- |
| **Signature** *(Required)* |  |

**Exhibit “A”**

# Writing Sample Packet

**Psychotherapy Treatment**

The Writing Sample Packet can be found on our website at [www.optumsandiego.com](https://www.optumsandiego.com/)

(BHS Provider Resources 🡪 TERM Providers 🡪 Join the Provider Network 🡪 TERM Therapist Applications à Writing Sample Packet for Therapist).

 

1 of 1

EXIBIT “A” - PROVIDER CLINICAL APPLICATION: Child and Family Well-Being Plan for TERM Network 02/28/2025

**Application Addendum: Additional Office Location(s)**

**Provider Name:** Click or tap here to enter text.

|  |
| --- |
| **ADDITIONAL TREATMENT LOCATION(S):** (Additional Office Locations where *services will be rendered to clients face-to-face) – Continued from page # 6 of 18* |
| **C. Add Office Location** |
| Address: Click here to enter text.  |
| Suite: 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. |
|  |
| **D. Add Office Location** |
| Address: Click here to enter text.  |
| Suite: 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. |
|  |
| **E. Add Office Location** |
| Address: Click here to enter text.  |
| Suite: 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. |
|  |
| 1. **Add Office Location**
 |
| Address: Click here to enter text.  |
| Suite: 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. |

**1 of 1**

**Application Addendum: Additional Office Location(s)**



**Application Addendum: Home Office Standards**

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)

**1 of 3**

**Application Addendum: Home Office Standards Attestation**

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/for-professionals/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.

**2 of 3**

**Application Addendum: Home Office Standards Attestation**

**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:** Click here to enter text.**Provider Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*(Electronic Signatures and Signature Stamps are not accepted)***Date:** Click here to enter a date. |

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**Application Addendum: Home Office Standards Attestation**

**3 of 3**

**Application Addendum: Home Office Standards Attestation**