

**TERM Network**

**TERM Psychotherapy Provider:**

**Specialty Addition Application**

This application is only for paneled TERM Provider requesting to add a Specialty (i.e., Modality, Age Range, Area of Competence and General Clinical Expertise and/or Safety Threats and Risk Factors).

**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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TERM THERAPIST SPECIALTY ADDITION APPLICATION

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

Dear TERM Therapist:

This application is intended for providers who are currently contracted and paneled on the Optum Public Sector Treatment and Evaluation Resource Management (TERM) Network as a 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 Child and Family Well-Being (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 at the 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 the Addition of New Specialties)*

Included is the application for providers who are requesting the addition of a Specialty that includes a modality, age range, area of competence, and general clinical expertise and/or safety threats and risk factors to his/her provider profile for services that may be rendered to San Diego County CFWB TERM clients. An application checklist is provided to assist you in collecting all the required documents. Please ensure your 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 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](mailto: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.

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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 submitting this application must be contracted and paneled on the Optum Public Sector Treatment Evaluation and Resource Management (TERM) Network.

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

|  |  |
| --- | --- |
| **Application Checklist** | |
|  | **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. 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 |
|  | **CEUs:** Copies of all required CEUs that support the specialty criteria that you are requesting must be included with this application. |
|  | **Certification:** Certificate must be submitted when required by the specialty criteria as stated in this application. |
|  | **Child and Adolescent Needs and Strengths Training (CANS):**   * 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. |
|  | **Attestation: Optum Application Process - Page #5 (required):**  Please sign and date page #5 attesting to your review and understanding of the Optum Application Process. |
|  | **Attestation: Sexual Abuse Non-Protecting Parent Treatment Page #13 (if applicable):**   * Page #13 must be signed and dated |
|  | **Application Attestation: Page #15 (required):**   * Please sign and date page #15 attesting to the accuracy of the information submitted |
|  | **Pages #7-15:** Only complete the pages that contain the specialty information you’re requesting to add. |

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

**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.

**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 you are attesting to.

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TERM THERAPIST SPECIALTY ADDITION APPLICATION

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

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

**License Type:**  MD/DO  Psychologist ( PhD  PsyD)  LCSW  LMFT  LPCC

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

**License Number**: Click here to enter text.

**Optum Application Process for the County of San Diego TERM Network (Therapist)**

**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, 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.**

* **Important:** The CV submitted with the application 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 #12 (*if applicable*) and page #14 must be signed and dated.
* Optum will require documentation to verify you meet the criteria outlined under TERM Clinician Specialty Requirements pertaining to the specialty or specialties designated.
* CEU Certificates *(if required)* – Copies of the required CEUs must be submitted with this application.
* 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 requesting to add to your practice.
* CV must be included with the application at the time of submittal.
* **Signatures are required on pages #5, #12 (*if applicable)* and #14.**

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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TERM THERAPIST SPECIALTY ADDITION APPLICATION

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

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 ***AND*** are currently requesting to add in your practice.

**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. 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 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 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.**

**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 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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TERM THERAPIST SPECIALTY ADDITION APPLICATION

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

|  |
| --- |
| 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)** On-going social realities (e.g., racism, immigration patterns, acculturation) that can impact the mental health of culturally and linguistically diverse populations, **2)** Differences between culturally acceptable behaviors and pathological characteristics, **3)** Cultural beliefs around mental illness and help-seeking patterns, and **4)** Have the ability to adapt your skills to fit the cultural context of a client. |
| If you endorse cultural competency in the ability to deliver services to one of the groups listed below, you **must also** have experiences consistent with one or more of the statements below:   * By adopting systematic practices that align behaviors, attitudes, and policies, I have worked effectively in cross-cultural situations, showcasing cultural competence and diversity. All services provided have been tailored to meet the unique linguistic and cultural needs of our diverse clients. I honor the diversity of cultures, address the complexities within and between them, and ensure our services are accessible and relevant. * Have completed formal training, such as a degree emphasis area, specific university courses, multiple workshops, or an internship focusing on culture and human behavior * Have significant professional culture-based expertise (e.g., have provided cultural competence training to others and/or published peer-reviewed journal articles, book chapters, or major reports in this area) * Have provided clinical treatment or evaluations to more than ten (10) members of the cultural group |
| ***Please check any groups from the table below for which you are competent to evaluate family dynamics and provide treatment:*** |

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

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**Specific Criteria for Age Ranges:**

Please only check areas in which you meet the criteria ANDare currently requesting to **add** in your practice**.**

|  |  |
| --- | --- |
| **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**) | |

|  |  |
| --- | --- |
| **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 experience 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 for Clinical Criteria Specialties:** *(Prerequisite: Must meet age range specialty criteria)*

Please only check areas in which you meet the criteria ANDare currently requesting to **add** in your practice

|  |  |
| --- | --- |
| **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 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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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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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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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) <http://www.casomb.org> **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) <http://www.casomb.org>   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 years. At least twenty (20) of those thirty hours must be in the Core Areas described on the Approved Training Topics list. | |
| * **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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San Diego County Mental Health Plan for TERM Network **(Therapist)**

Please complete the following grids. Only check areas in which you specialize, have experience, ***AND*** are currently requesting to **add** 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 | |  |  |  |  |  |  |  |
| Post-Traumatic Stress Disorder (PTSD) | |  |  |  |  |  |  |  |
| Serious Emotional Disturbance (SED) | |  |  |  |  |  |  |  |
| Born Positive Toxicity (Pos Tox) | |  |  |  |  |  |  |  |

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**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 here to enter a date.

**Signature** *(Required)*