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CONTRA COSTA HEALTH

*Contra Costa County Mental Health*

# SHARECARE ID REQUEST FORM

**PLEASE COMPLETE ALL SECTIONS AS APPLICABLE TO PREVENT DELAYS IN PROCESSING**

## Section I. To be completed by staff

**FULL LEGAL NAME:** _____ _____ _____
First Name Middle Name Last Name

**DOB:** _____ **NPI:**_____ **Taxonomy:** _____ **Email Address:**_____

**Gender:** ☐ Female ☐ Male ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ Genderqueer ☐ Another Gender Identity ☐ Undisclosed

DISCIPLINE: _____ LICENSE #: _____

EXP DATE: _____ STATE: _____

**YOU MUST ATTACH A COPY OF YOUR LICENSE OR OTHER DOCUMENTATION REQUIRED FOR YOUR LICENSE**

PHYSICIAN DEA#: _____ EXP DATE: _____

PHYSICIAN UPIN:_____

**YOU MUST ATTACH A COPY OF YOUR DEA REGISTRATION**

**Employment Start Date:**

_____

| **STAFF LANGUAGES** | Please check one: |
|---|---|
| English | ☐ Certified ☐ Fluent |
| Other Languages: | |
| | ☐ Certified ☐ Fluent |
| | ☐ Certified ☐ Fluent |

**ETHNICITY:**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| ☐ | White | ☐ | Mexican American/Chicano | ☐ | Chinese | ☐ | Cambodian | ☐ | Other Non-White |
| ☐ | Black | ☐ | Latin American | ☐ | Vietnamese | ☐ | Japanese | ☐ | Other Southeast Asian |
| ☐ | Native American | ☐ | Other Spanish | ☐ | Laotian | ☐ | Filipino | ☐ | Unknown |

**STAFF SIGNATURE** _____ Date: _____

**(Stamped or Electronic Signature Is Not Acceptable)**

## Section II. To be completed by supervisor/manager

Staff Type: ☐ Direct Service Provider ☐ TBS Worker ☐ TFC Parent ☐ Certified Peer Support Specialist ☐ Administrative Staff

Contractor/Supervisor/Manager: _____ Program Name: _____

Notification of Staff # Assignment to: _____ Phone Number: _____

EMAIL: _____

**Facility Authorization Requested for the following:**

Facility ID #_____Program ID #_____ Facility ID #_____Program ID #_____

Facility ID #_____Program ID #_____ Facility ID #_____Program ID #_____

## Section III. To be completed by Contra Costa Provider Services Unit

**FOR CCC PROVIDER SERVICES USE ONLY**

**APPROVED START DATE:**

_____

**Psychiatrist:**
☐ DO ☐ MD

**Nursing:**
☐ Nurse Practitioner ☐ Registered Nurse ☐ Psychiatric Technician

**Licensed Mental Health Professional:**
☐ Marriage & Family Therapist ☐ Social Worker ☐ Psychologist [ ☐ PhD ☐ PsyD ] ☐ LPCC

**Intern:**
☐ Associate Marriage & Family Therapist ☐ Associate Social Worker ☐ Psychologist Intern ☐ Associate Prof Clinical Counselor

**Trainees:**
☐ Marriage & Family Therapist Trainee ☐ Social Work Trainee ☐ Psychologist Trainee

☐ Mental Health Rehabilitation Specialist ☐ Designated Mental Health Worker ☐ TFC Parent
☐ Certified Peer Support Specialist ☐ Administrative Staff

**SEND TO:** Behavioral Health Administration 1340 Arnold Dr., Ste. 200, Martinez, CA 94553 **FAX:** (925) 957-5217 **EMAIL:** Provider.Services@cchealth.org