Submit completed packet to: Office of Provider Services
Email: BHRecredentialing@cchealth.org - or - Fax: (925) 608-6794

Contra Costa County Behavioral Health

RECREDENTIALING APPLICATION

Current Agency/Employer Name:	List all Facility/Program IDs where the provider should be authorized:

Send credentialing confirmation to: Name: ______________________ Email: ______________________

Section I: Reason for Submission *To be completed by all providers*

This form is only intended for the actions listed below. For new providers, use the ShareCare ID Request Form and Credentialing/Privileging Form. All forms can be downloaded from: https://cchealth.org/mentalhealth/provider/

☐ **3 Year Recredentialing** – Check here if you are applying for recredentialing and complete all applicable section of the Recredentialing Application. Note: *Providers are required to be recredentialed every three years.*

☐ **Credentialing Category Change** – Check here if you are requesting a review of your credentialing information to apply for an updated credentialing category. Check the applicable box below and complete the sections indicated.

☐ **New LMFT, LCSW, LPCC, PhD, PsyD, or RN License-** *Complete Sections I, II, IV, IX & X*	☐ **New AMFT, ASW, or APCC Registration** *Complete Sections I, II, V, IX & X*	☐ **Additional Education** *(DMHW & MHRS only)* *Complete Section I, II, IX, & X*
☐ **Apply for Waivered Psychologist** *Complete Sections I, II, V, IX & X*	☐ **Apply for Trainee** *Complete Sections I, II, VI, IX & X*	☐ **Additional Work Experience** *(DMHW & MHRS only)* *Complete Section I, II, VIII, IX, & X*

☐ **Reactivation of ShareCare ID** – If your ShareCare ID was inactivated more than 30 days ago due to a change in your employment AND you are within your 3 year credentialing period, complete sections II, III, IV, V, VI, VII, VIII, IX, and X. If less than 30 days, use the Credentialing Change Form. If you are no longer within your 3 year credentialing period, use the Credentialing Form.

Section II: Provider Information *To be completed by all providers*

Provider Type:

☐ MD
☐ DO
☐ NP
☐ RN
☐ LPT

☐ LMFT
☐ LCSW
☐ LPCC
☐ Psychologist (PhD)
☐ Psychologist (PsyD)

☐ AMFT
☐ ASW
☐ APCC
☐ Pre-Doc Waivered
☐ PhD-Waivered
☐ PsyD-Waivered

☐ Trainee
☐ Unlicensed Worker
  ☐ *MHRS*
  ☐ *DMHW*
☐ Peer Support Specialist
☐ TFC Parent

First Name (please use full legal name)	Middle Name	Last Name	Jr., Sr., M.D., etc	ShareCare ID
Email Address	Previous Name (maiden name, etc)		Date of Birth (MM/DD/YYYY)	
Driver's License Number / State / Expiration Date		NPI Number	Taxonomy Code– *see codes on pg 1*	
Professional License or Registration # (if applicable) / Expiration Date		Medi-Cal# (if applicable)	Medicare # (if applicable)	

Gender: *(select one)* ☐ Female ☐ Male ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ Genderqueer ☐ Another Gender Identity ☐ Undisclosed

Section X: Attestation Questions (*continued*): **To be completed by all providers**	
I. Have you ever been convicted of any crime (other than a minor traffic violation)?	☐ Yes ☐ No
J. In the past (5) years, have you had a history of chemical dependency or substance abuse that might adversely affect your ability to competently and safely perform essential functions of a practitioner in your area of practice?	☐ Yes ☐ No
K. Do you have an ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without direct threat to the health and safety of others?	Yes No
L. Have any judgments/arbitration or claims been entered against you, or settlements been agreed to by you within the last (7) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitration's against you pending?	☐ Yes ☐ No
M. Are you currently engaged in the illegal use of drugs? ("Illegal use of drugs" means the use of controlled substances, obtained illegally, as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed health care practitioner. "Currently" does not mean on the day of or even the weeks preceding the completion of this application, rather, it means recently enough so that the illegal use may have an impact on one's ability to practice).	Yes No
N. Have you reviewed and completed the Contra Costa County Mental Health Plan Beneficiary Protection Training within the last 3 years? *The training must be completed at the time of initial credentialing and again every 3 years at recredentialing.* ***If you have not yet completed the training, please complete it before submitting your application.*** ***The training is available on the Provider Services Website.*** *https://cchealth.org/mentalhealth/provider/*	☐ Yes ☐ No
O. Do you always meet the continuing education requirements of your license as prescribed by the governing board of your discipline? **Check N/A if not applicable.** ***Unlicensed providers (DMHW & MHRS), Trainees, and Waivered Psychologists should select "N/A" here. Also, licensed providers and registered interns in their first year of licensure can check "N'A."***	☐ Yes ☐ No ☐ N/A
P. FOR UNLICENSED THERAPEUTIC BEHAVIORAL SERVICES (TBS) WORKERS ONLY Have you completed ongoing training related to providing TBS?	☐ Yes ☐ No
Q. FOR THERAPEUTIC FOSTER CARE (TFC) PARENTS ONLY Have you completed twenty-four hours of annual, ongoing training, related to providing TFC services? *This ongoing, annual training includes an emphasis on skill development and Specialty Mental Health Services knowledge acquisition, and can be provided in a variety of formats (video, readings, internet training, and webinars).*	☐ Yes ☐ No

Section X: Attestation Questions (*continued*): **To be completed by all providers**	
R. ***FOR PHYSICIANS, NURSE PRACTITIONERS, PSYCHOLOGISTS, LMFTs, LCSWs, and LPCCs ONLY***	
i. Are you currently enrolled in the Provider Application and Validation for Enrollment (PAVE) portal for Medi-Cal? *(required for all provider types listed above)*	☐ Yes ☐ No
ii. Have you also completed an Ordering/Referring/Prescribing (ORP) application or has someone done so on your behalf? *(required for all provider types listed above*). To confirm your ORP enrollment status, you can go to this website and enter your NPI number: *https://www.medi-cal.ca.gov/ORPEnroll/ORPEnroll.aspx*	☐ Yes ☐ No
All Physicians, Nurse Practitioners, Licensed Psychologists, LMFTs, LCSWs, and LPCCs are required to be enrolled in the PAVE Portal and have ORP enrollment in order to work within the Medi-Cal system. *For the PAVE Step-by Step Enrollment Guide, you can go to the Provider Services Website: https://cchealth.org/mentalhealth/provider/*	
S. ***FOR ALL LICENSED PHYSICIANS (MD and DO) AND NURSE PRACTITIONERS ONLY*** Have you enrolled in the Medi-Cal Rx portal or has someone done so on your behalf? *All MDs, DOs and NPs are required to be enrolled in MC Rx partnered with Magellan to administer Medi-Cal Pharmacy benefits. All prescribers must be enrolled in this portal to provide services.* *For the Medi-Cal Rx Step-by Step Enrollment Guide, you can go to the Provider Services Website: https://cchealth.org/mentalhealth/provider/*	☐ Yes No

I hereby affirm that the information submitted in the Attestation Questions, and any addenda thereto is true, current, correct and complete to the best of my knowledge and belief and is furnished in good faith. I understand that intentionally withholding or omitting material information or intentionally submitting material false or misleading information may result in denial of my application or termination of my privileges or employment.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

Print Full Name: ____

Signature: ______________________________ **Date:** ____________

(Stamped or Electronic Signature Is Not Acceptable)

Contra Costa County Behavioral Health

274 Report Provider Information

This form must be completed for <u>each</u> facility where the provider will be available to provide services.

Contra Costa County Mental Health Services must submit the 274 Report to DHCS to demonstrate that it complies with the network adequacy requirements. This form provides us with some of the provider information that is included in our monthly 274 Report submission. Please complete a copy of this form for each facility where the provider will be available to provide services. Additional copies of the form are available here: https://cchealth.org/mentalhealth/provider/

Section I: Provider and Facility Information

This form must be completed for each facility where the provider will be available to provide services.

Provider Name: ____ ShareCare ID *(if known)*: __________

Facility Name: ____ Facility ID: ____________

Section II: Contact Information

This form should be completed by the 274 Report Contact Person for the organization/clinic.

Please list the person we can contact for questions regarding the information you list in this form:

Name: __________________________________ Phone: ___________________ Email: _______________________

Section III: Inclusion in 274 Report

Will the person listed in Section I be providing outpatient mental health services, targeted case management, crisis intervention, medication support services, intensive care coordination, or intensive home-based services on a regular basis at the facility listed in Section I?

Please select one:

- ☐ **<u>Yes</u>**- Provider will be available to provide direct services to beneficiaries on a regular basis at the facility above.
  Please complete the remainder of this form and return to the Provider Services Unit.

- ☐ **<u>No</u>**- The person listed in Section 1 is an Administrative Staff Member, Supervisor, and/or member of leadership and will not have the capacity to serve clients on a regular and on-going basis at this facility.
  You can stop here and return form to Provider Service Unit. You do not need to complete the remainder of the form.

- ☐ **<u>No</u>**- The person listed in Section 1 is <u>only</u> providing inpatient, hospital, and/or residential services at this facility.
  You can stop here and return form to Provider Service Unit. You do not need to complete the remainder of the form.

- ☐ **<u>No</u>**- The person listed in Section 1 is <u>ONLY</u> providing substance use disorder services and is not providing outpatient mental health services at this facility.
  You can stop here and return form to Provider Service Unit. You do not need to complete the remainder of the form.

- ☐ **<u>No</u>**- For a reason other than those listed above, the person should be excluded on the 274 Report (please specify reason): ____
  You can stop here and return form to Provider Service Unit. You do not need to complete the remainder of the form.

Provider Name: ______________________________

Contra Costa County Behavioral Health

274 Report Provider Information

Section IV: Area of Expertise

Select all Areas of Expertise

☐ Child/Adolescent (ages 0-20) ☐ Adult (ages 21+)

☐ Geriatric ☐ Substance Abuse

Section V: Service Types

Select up to 5 Service Types the provider is qualified to provide

☐ **Mental Health Services-** assessment, evaluation, plan development, rehabilitation, individual psychotherapy, group psychotherapy, group rehab, or collateral.

☐ **Targeted Case Management-** placement, linkage, or case management plan development.

☐ **Crisis Intervention-** crisis intervention.

☐ **Medication Support-** evaluation/RX, RN/LPT injection, education, medication plan development, or medication group.

☐ **Intensive Care Coordination-** Check this box if this facility is approved to provide Katie-A services and the services are within the provider's scope of practice.

☐ **Intensive Home-Based Services-** Check this box if this facility is approved to provide Katie-A services and the services are within the provider's scope of practice.

Section VI: Practice Focus

Select up to 5 Practice Focus Areas

☐ Disorders usually first diagnosed in infancy, childhood, or adolescence (1D)

☐ Delirium, Dementia, and Amnestic and other Cognitive Disorders (CD)

☐ Mental Disorders Due to a General Medical Condition Not Elsewhere Categorized (GM)

☐ Substance-Related Disorders (SR)

☐ Schizophrenia and Other Psychotic Disorders (PS)

☐ Depressive Disorders (DS)

☐ Bi-Polar Disorders (BP)

☐ Mood Disorders (MD)

☐ Anxiety Disorders (AD)

☐ Somatoform Disorders (SD)

☐ Factitious Disorders (FD)

☐ Dissociative Disorders (DD)

☐ Sexual and Gender Identity Disorders (SG)

☐ Eating Disorders (ED)

☐ Sleep Disorders (SL)

☐ Impulse-Control Disorders not otherwise elsewhere categorized (IC)

☐ Adjustment Disorders (AJ)

☐ Personality Disorders (PD)

Section VII: FTE

FTE is dedicated time available to serve the Medi-Cal beneficiaries (including assessment, plan development, treatment, documentation, chart review, etc). For Administrative Staff, do not include percent of time spent on administrative functions. For example, if a Program Manager is needed for administrative functions 90% of the time, they can only be included in the 274 Report at a maximum of 10% FTE.

100% = 40 hours/week
87% = 35 hours/week
80% = 32 hours/week
75% = 30 hours/week
62% = 25 hours/week
50% = 20 hours/week
40% = 16 hours/week
37% = 15 hours/week
25% = 10 hours/week
20% = 8 hours/week

FTE % Children's Services (0-20): ______% **FTE % Adult Services (21+): ______%**

Total FTE at all facilities for an individual provider should not exceed 100% (40 hours/week).

Section VIII: Caseload

Enter the Maximum & Current Caseload for each age group. Or, enter "N/A" if the provider does not work with the specified age group.

For providers that do not carry a caseload (such as nursing staff and staff at mobile crisis units and transitional teams), estimate the Max Caseload based on the maximum number of beneficiaries the provider could serve during the amount of time specified in the FTE section above. Estimate the Current Caseload based on average/range of encounters per month.

Current Caseload (Children 0-20): _______ **Maximum Caseload (Children 0-20):** _______

Current Caseload (Adult 21+): _____ **Maximum Caseload (Adult 21+):** _____

Section IX: Telehealth

How are the services provided for this provider at this facility?

☐ Services provided through telehealth only

☐ Services provided both in-person & through telehealth

☐ Services provided in-person only

Section X: Field Based Services

Does provider travel to beneficiaries' home and/or community settings to deliver services?

☐ Yes - Maximum miles provider will travel: _______

☐ No

Section XI: Cultural Competency Training

Has the provider completed Cultural Competency Training in the past 12 months?

☐ Yes- Total Training Hours in Last 12 Months: ______

☐ No

Prov. Serv. Unit Use Only: Provider Start Date: ___________ ☐ S.P. 274 Record Created ☐ S.P. 274 Monthly Record Created Date Complete: ___________