|  |
| --- |
| 1. PROVIDER INFORMATION
 |
| [ ]  | All fields are completed and or marked as N/A. |
| 1. IDENTIFYING INFORMATION
 |
| [ ]  | All fields are completed and or marked as N/A. Incomplete applications will be returned. |
| 1. LICENSE INFORMATION
 |
| [ ]  | **Attached** Copy of State Licensure from Board |
| 1. PROVIDER NUMERS
 |
| [ ]  | **Attached** Copy of DEA Registration (MDs Only) |
| 1. NATIONAL PROVIDER IDENTIFIER (NPI)
 |
| [ ]  | All fields completed and or marked as N/A. Incomplete applications will be returned. |
| 1. EMPLOYMENT/WORK HISTORY
 |
| [ ]  | Current and Previous employment for past ten (10) years. Noting “see resume” will not be accepted. |
| 1. PROFESSIONAL EDUCATION
 |
| [ ]  | Colleges and degrees obtained and clinical educational experience after college (residencies, clinical internships, etc.) |
| 1. BOARD CERTIFICATION
 |
| [ ]  | All fields completed and or marked as N/A. Incomplete applications will be returned. |
| 1. HOSPITAL PRIVILAGES
 |
| [ ]  | Hospital Privileges – Current and Previous if Applicable |
| 1. CONTINUING EDUCATION
 |
| [ ]  | Up to current or for past three (3) years if recredentialing. |
| 1. INSURANCE/MALPRACTICE LIABILITY
 |
| [ ]  | Provide current Information, do not leave blank. |
| 1. AVAILABILITY / ACCESSIBILITY
 |
| [ ]  | All fields completed and or marked as N/A. Incomplete applications will be returned. |
| 1. PROFESSIONAL ATTESTATION
 |
| [ ]  | Must be completed. Incomplete applications will be returned. |
| 1. ATTESTATION SIGNATURE
 |
| [ ]  | Sign and Date. Incomplete applications will be returned. |

**Please provide copies of:**

1. Government Issued Photo ID (Driver’s License, Identification Card, U.S. Passport, etc.)
2. Copies of professional licenses and certificates
3. DEA certificate (MDs Only)
4. Current malpractice liability coverage policy
5. Current Curriculum Vitae or Resume to include supplemental information stating areas of cultural expertise, training and foreign languages spoken, read, or written.
6. W-9 (Individual Provider licensed staff only)
7. Evidence of satisfaction of continuing education requirements (licensed staff only)

**NOTE**: Be prepared to provide PAVE/MedRx Enrollment upon request

**Send the completed application and any additional documents and/or explanation pages as follows:**

|  |  |  |
| --- | --- | --- |
| **Mail** | **In Person** | **Email** |
| Madera County Mental Health PlanAttn.: Credentialing CoordinatorP.O. Box 1288, Madera, CA 93639-1288 | Madera County Behavioral HealthAttn.: Credentialing Coordinator209 E. 7th Street, Madera, CA 93638 | Scanned Documents with original (pen to paper) signatures ONLY.BHSCredentialing@maderacounty.com  |

If you have any questions, please contact the credentialing coordinator at:

Phone: 559-673-3508

Fax: 559-675-7758 (Do not fax signed originals, instead, use the methods indicated above)

E-mail: BHSCredentialing@maderacounty.com

|  |
| --- |
| Click or tap to enter a date. |
| 1. **PROVIDER INFORMATION**
 |
| Provider Name: |       | Type of Provider: | [ ]  MH [ ]  SUD [ ]  Both |
| Program Name: |       | Location: |       |
| 1. **IDENTIFYING INFORMATION**
 |
| Name (Last, First, M.I.): |       | DOB: |       |
| Practice Address: |       | Gender: |       |
| City: |       | State: |       | Zip: |       |
| Phone: |       | E-mail Address: |       |
| Website: |       | Is site ADA compliant? | [ ]  Yes [ ]  No |
| Social Security Number: |       | Ethnicity: |       |
| Languages spoken fluently (besides English): |       |
| 1. **LICENSE INFORMATION**
 |
| Medical Staff - Prescribing | [ ]  Psychiatrist [ ]  Physician (SUD Only) [ ]  Physician Assistant [ ]  Nurse Practitioner[ ]  Registered Pharmacist  |
| Licensed/Certified Clinical Staff | [ ]  Clinical Psychologist [ ]  LCSW [ ]  LMFT [ ]  LPCC [ ]  RN [ ]  LVN [ ]  LPT [ ]  OT [ ]  Certified SUD Counselor |
| Unlicensed/Registered Clinical Staff | [ ]  Associate/Registered Psychologist [ ]  ACSW [ ]  AMFT [ ]  APCC [ ]  Registered SUD Counselor |
| License Number | Type of License | Expiration Date | State |
|       |       |       |       |
|       |       |       |       |
| If unlicensed or registered, please provide the name and license/certification of your supervisor.Your supervisor must be an MCBHS credentialed provider and ale to supervise according to your licensing/certifying organization. |
| Supervisor’s Name: |       |
| Licensing/Certifying Organization and Number: |       |
| 1. **PROVIDER NUMERS**
 |
| Medi-Cal Provider No.: |       | Medicare UPIN: |       | Medicare Effective Date: |       |
| DEA Number: |       | DEA Issue Date: |       | DEA Expiration Date: |       |
| ECFMG No.: |       | ECFMG Issue Date: |       | ECFMG Recert. Date: |       |
| 1. **NATIONAL PROVIDER IDENTIFIER (NPI) – Practice address must match primary practice address**
 |
| **NPI Number:**  |       | **Taxonomy Number:** |  |
| 1. **EMPLOYMENT / WORK HISTORY –Current and previous ten (10) years. Most recent first.**
 |
| **Organization** | **Dates****From – To** | **Reason for Leaving** | **Supervisor****Name, Title, Phone No.** |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
| 1. **PROFESSIONAL EDUCATION – Attach Curriculum Vitae (add additional sheets as needed). Most recent first.**
 |
| **Institution** | **City/State** | **Type of Program** | **Graduation Year** | **Degree** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| 1. **BOARD CERTIFICATION – Complete only if applicable**
 |
| **Name of Board** | **Certification Date** | **Expiration Date (if applicable)** |
|       |       |       |
|       |       |       |
| 1. **HOSPITAL PRIVILEGES – Current and Previous**
 |
| **Hospital Name** | **Address, City, State** | **Appointment Date** | **Withdrawal Date (if applicable)** |
|       |       |       |       |
|       |       |       |       |
| 1. **CONTINUING EDUCATION (for past 3 years if applicable)**
 |
| **Course Title** | **Date Completed** |
|       |       |
|       |       |
| 1. **INSURANCE/MALPRACTICE LIABILITY INFORMATION – Current Insurance Company and Coverage – attach copy**
 |
| Carrier Name: |       | Phone No.: |       | Fax No.: |       |
| Street Address: |       | City/State/ZIP: |       | Claim Limit: |       |
| Effective Date: |       | Expiration Date: |       | Aggregate Limit: |       |
| 1. **AVAILABILITY/ACCESSIBILITY/SERVICES**
 |
| Are you currently accepting new clients? [ ]  Yes [ ]  No | Wheelchair accessible? [ ]  Yes [ ]  No |
| Ethnic, Racial & Culturally Specific Specialties: |       |
| Languages Spoken Other than English: |       |
| Days Available | [ ]  Monday | [ ]  Tuesday  | [ ]  Wednesday  | [ ]  Thursday | [ ]  Friday  | [ ]  Saturday  | [ ]  Sunday |
| Hours Available |       |       |       |       |       |       |       |
| Population Served: | [ ]  Children 5 & under | [ ]  Children 6 to 12 | [ ]  Adolescents | [ ]  Adults | [ ]  Older Adults 60+ |
| Services Provided: | [ ]  Individual | [ ]  Family | [ ]  Group | [ ]  Medications | [ ]  Psych Test | [ ]  Inpatient |
| Other (specify): |       |
| 1. **PROFESSIONAL ATTESTATION QUESTIONNAIRE**
 |
| Please answer questions #1-13. If you answer “Yes” to any question, please provide a detailed explanation on a separate page. Explanation should include dates, details of the incident, outcome, current disposition, etc. **In the past three (3) years:** |
| 1. | Have there been any disciplinary action or investigations against you by any state licensing board? | [ ]  Yes [ ]  No [ ]  N/A |
|  | a. | Are there any actions or investigations in progress? | [ ]  Yes [ ]  No [ ]  N/A |
|  | b. | Have you voluntarily surrendered your medical/clinical license? | [ ]  Yes [ ]  No [ ]  N/A |
| 2. | Has you DEA registration ever been denied, suspended, revoked, or limited in any other manner? | [ ]  Yes [ ]  No [ ]  N/A |
|  | a. | Are there any actions or investigations in progress? | [ ]  Yes [ ]  No [ ]  N/A |
|  | b. | Have you voluntarily surrendered your DEA registration? | [ ]  Yes [ ]  No [ ]  N/A |
| 3. | Has your professional liability insurance coverage ever been canceled, limited, denied or non-renewed? | [ ]  Yes [ ]  No [ ]  N/A |
|  | a. | Any malpractice claims filed against you? | [ ]  Yes [ ]  No [ ]  N/A |
| 4. | Have your privileges at any hospital ever been denied, suspended, reduced, revoked, or put on probation? | [ ]  Yes [ ]  No [ ]  N/A |
|  | a. | Are there any actions or investigations in progress? | [ ]  Yes [ ]  No [ ]  N/A |
|  | b. | Have you resigned from any hospital? | [ ]  Yes [ ]  No [ ]  N/A |
| 5. | Have you ever been investigated, suspended, sanctioned, or otherwise restricted from participating in a federal or State health insurance? | [ ]  Yes [ ]  No [ ]  N/A |
| 6. | Have there been any criminal proceedings against you including, but not limited to, gross misconduct, a felony, or a crime of moral turpitude? | [ ]  Yes [ ]  No [ ]  N/A |
| 7. | Do you suffer from any illness, injury, or health conditions (physical or mental) which limits or impairs your ability to safely provide medical services? This includes medication that may affect either your clinical judgment or motor skills. | [ ]  Yes [ ]  No [ ]  N/A |
| 9. | Have you ever had any of the following? | [ ]  Yes [ ]  No [ ]  N/A |
|  | a. | Lawsuits dismissed, dropped, or pending | [ ]  Yes [ ]  No [ ]  N/A |
|  | b. | Settlements including settled and dismissed with prejudice | [ ]  Yes [ ]  No [ ]  N/A |
|  | c. | Judgments | [ ]  Yes [ ]  No [ ]  N/A |
|  | d. | Reprimands or disciplinary action | [ ]  Yes [ ]  No [ ]  N/A |
|  | e. | Other, if marked yes, elaborate on a separate sheet. | [ ]  Yes [ ]  No [ ]  N/A |
| 10. | To your knowledge, has any information pertaining to you ever been reported to the National Practitioner data Bank? | [ ]  Yes [ ]  No [ ]  N/A |
| 11. | Have you voluntarily quit or involuntarily been terminated from any Managed Care Plan? | [ ]  Yes [ ]  No [ ]  N/A |
| 12. | Have you completed the continuing education requirements for license renewal per your State processional board? (Evidence may be requested by Credentialing Committee) | [ ]  Yes [ ]  No [ ]  N/A |
| 13. | Have you completed Cultural Competency Training? (Evidence of CEU completion may be requested by Credentialing Committee) | [ ]  Yes [ ]  No [ ]  N/A |
| 14. | For SUD Medical Directors only: I acknowledge that as part of the credentialing process I must be screened in accordance with 42 CFR 455.450(a) as a “limited” categorical risk within a year prior to serving as a SUD Medical Director. | [ ]  Yes [ ]  No [ ]  N/A |
| 15. | For SUD Medical Directors only: I have signed a Medicaid provider agreement with DHCS as required by 42 CFR 431.107. | [ ]  Yes [ ]  No [ ]  N/A |
| 16. | For SUD Medical Directors only: I hereby certify that I meet DUS medical director requirements as specified and will comply with duties as outlined in CCR Title 22, 51000.24.4, 51000.70 and 51341.1(b)(28). | [ ]  Yes [ ]  No [ ]  N/A |
| 1. **SIGNATURE – Please read this statement before signing:**
 |
| I attest that all the information I’ve provided on this application may be verified. My signature certifies that all the information on every section of this application and questionnaire is true, correct, and complete. I understand and agree that any misstatements or omissions of material facts herein may cause forfeiture on my part of my right to continued participation as a provider with the Madera County Mental Health Plan. |
| Signature: |  | Date: |  |

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| --- |
| **RELEASE OF INFORMATION** |
| **CONFIDENITIAL CERTIFICATION** |
| I, the undersigned, hereby attest that the information given in or attached to this Application is accurate, complete, and fairly represents the current level of my training, experience, capability, and competence to practice at the level requested. I specifically authorize you and your authorized representatives to consult with any third party which may have information bearing on the subject matter addressed by this Application and to inspect or obtain any reports, records, recommendations, or other documents or disclosures from third parties that may be material to the questions in the Application. I also specifically authorize any third parties to release information to you and/or your authorized representatives upon request. I hereby release you and/or your authorized representatives, and any third parties, from any liability for any reports, records, recommendations, or other documents or disclosures involving me that are made, requested, or received by you and/or your authorized representatives to, from, or by any third parties, including otherwise privileged or confidential information, made or given in good faith and relating to the subject matter addressed by this Application.I warrant that I have the authorization to sign this Application, on my own behalf, or on behalf of any entity or organization for which I am signing in a representative capacity. I understand that if this Application is accepted by the Madera County Mental Health Plan, I will be bound by the terms of the Mental Health Plan, of which this Application is a part.**ANY INFORMATION ENTERED INTO THIS APPLICATION WHICH SUBSEQUENTLY IS FOUND TO BE FALSE COULD RESULT IN REFUSAL OF APPROVED CREDENTIALING STATUS WITH MADERA COUNTY BEHAVIORAL HEALTH SERVICES.****YOUR SIGNATURE IS REQUIRED TO COMPLETE THIS APPLICATION. STAMPED SIGNATURES ARE NOT ACCEPTABLE.** |
| Print Name: |       | Title: |       |
| Signature: |  | Date: |  |

MADERA COUNTY IS AN EQUAL OPPORTUNITY, DISABILITIES, AFFIRMATIVE ACTION ORGANIZATION THAT DOES NOT DISCRIMINATE IN REGARD TO AGE, GENDER, COLOR, RACE, RELIGION, NATIONAL ORIGIN, HANDICAP OR SEXUAL ORIENTATION.