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| 1. IDENTIFYING INFORMATION | |
|  | All fields are completed and or marked as N/A. Incomplete applications will be returned. |
| 1. NATIONAL PROVIDER IDENTIFIER (NPI) | |
|  | All fields completed and or marked as N/A. Incomplete applications will be returned. |
| 1. PROFESSIONAL EDUCATION | |
|  | Colleges and degrees obtained and clinical educational experience after college (residencies, clinical internships, etc.) |
| 1. PROFESSIONAL ATTESTATION | |
|  | Must be completed. Incomplete applications will be returned. |
| 1. ATTESTATION SIGNATURE | |
|  | Sign and Date. Incomplete applications will be returned. |

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

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| **Mail** | **In Person** | **Email** |
| Madera County Mental Health Plan  Attn.: Credentialing Coordinator  P.O. Box 1288, Madera, CA 93639-1288 | Madera County Behavioral Health  Attn.: Credentialing Coordinator  209 E. 7th Street, Madera, CA 93638 | Scanned Documents with original (pen to paper) signatures ONLY.  [BHSCredentialing@maderacounty.com](mailto: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](mailto:BHSCredentialing@maderacounty.com)

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| Click or tap to enter a date. | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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): | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Previous Name(s) you’ve worked under: | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Clinical Supervisor’s Name & Discipline: | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Hire Date: | | |  | | | | | | | Job Title: | |  | | | | | | | | | | | | | |
| 1. **NATIONAL PROVIDER IDENTIFIER (NPI) – Practice address must match primary practice address** | | | | | | | | | | | | | | | | | | | | | | | | | |
| **NPI Number:** | | | |  | | | | | | | | | | **Taxonomy Number:** | | | | | | Choose an item. | | | | | |
| 1. **PROFESSIONAL EDUCATION – Attach Curriculum Vitae (add additional sheets as needed). Most recent first.** | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Institution** | | | | | | | | **City/State** | | | **Type of Program** | | | | | | **Graduation Year** | | | | | **Degree** | | | |
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| 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.