Contra Costa County Behavioral Health

Recredentialing Application

Incomplete applications may result in a delay in the recredentialing process

I. All Providers: Please include the following with the completed packet:

☐ **Recredentialing Form (MHA22b)**- All applicable sections of the form must be complete.
Note: If you answered "yes" to any of the attestation questions A-M, provide full details on a separate sheet of paper.

☐ **Copy of valid government issued photo identification (Driver's License or Passport)**

☐ **Copy of Degree (if a new degree was obtained since your last credentialing)**

☐ **274 Report Provider Information (MHA22h)** (To be completed by Manager/Supervisor)

☐ **Copy of NPI registration with valid taxonomy**
(Note: Taxonomy code must match the applicable code below AND be designated as primary)

Valid Taxonomy Codes

Psychiatrist- 2084P0800X

NP- 363LP0808X or 363LF0000X

RN- 163W00000X, 163WP0807X, 163WP0808X, or 163WP0809X

Psych Tech- 167G00000X

Psychologist- 103TC0700X

LCSW- 1041C0700X

LMFT- 106H00000X

LPCC- 101YP2500X

Waivered Psychologist- 390200000X

ASW- 390200000X or 1041C0700X

AMFT- 390200000X or 106H00000X

APCC- 390200000X or 101YP2500X

Trainee- 390200000X

MHRS, DMHW, or TFC Parent- 101YM0800X

Certified Peer Support Specialist– 175T00000X

II. If you are a **MD, DO or NP**, please submit the following:

☐ All documents listed in Section I

☐ Copy of current DEA Registration

☐ Peer Reference Form

☐ Copy of current Professional License

☐ Proof of ORP enrollment
(approval letter or screen shot from your PAVE account showing the "Approved" status of your application)

III. If you are an **RN or LPT**, please submit the following:

☐ All documents listed in Section I

☐ Copy of current Professional License

IV. If you are an **LMFT, LCSW, LPCC, PhD-Licensed, or PsyD-Licensed**, please submit the following:

☐ All documents listed in Section I

☐ Copy of current Professional License

☐ Proof of ORP enrollment
(approval letter or screen shot from your PAVE account showing the "Approved" status of your application)

V. If you are an **AMFT, ASW or APCC**, please submit the following:

- ☐ All documents listed in Section I
- ☐ Copy of current Registration

VI. If you are a **newly qualified Pre-Doctoral or Post-Doctoral Intern**, please submit the following:

- ☐ All documents listed in Section I
- ☐ Copy of Curriculum Vita or Resume
- ☐ Copy of Official Transcript

Note: If you are recredentialing as a PsyD- Waivered or PhD- Waivered, or Pre-Doctoral-Waivered, your recredentialing period will be set to three years or the end of your waiver, whichever is sooner.

VII. If you are a **newly qualified Trainee**, please submit the following:

- ☐ All documents listed in Section I
- ☐ Executed agreement or contract between the agency and school
- ☐ Field placement agreement signed by the student, individual supervisor and/or training coordinator and school field placement liaison

VIII. If you are a **Certified Peer Support Specialist**, please submit the following:

Newly Certified Peer Support Specialist

- ☐ All documents listed in Section I
- ☐ Proof of highest level of education:
  (Provide ONE of the following)
  - High School Diploma, GED, Degree or Official Transcript

    - OR -

  - School verification letter that degree was completed.
- ☐ Peer Support Specialist Certificate

Existing Certified Peer Support Specialist

- ☐ All documents listed in Section I
- ☐ Certificate or other documentation showing that you have completed twenty (20) hours of continuing education within the last two years.

Cover Sheet (for your reference only). Do not return with your application.

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

Note: this section is continued on the next page...

Section II: Provider Information *(continued)* — ***To be completed by all providers***

Current Home Address	City	State	Zip	Date Range:

List all languages you can speak fluently: ____

County employees only– are you certified for any of the languages listed above? ______________________

Section III: For Licensed Psychiatrists and Nurse Practitioners Only ☐ N/A

Please answer the questions below and *attach a copy of your professional license, DEA certificate, and NPI registration.*

DEA Number: ________________ DEA Expiration Date: _________________

Psychiatrists Only: Are your hospital and clinic privileges currently in good standing? ☐ Yes ☐ No

Psychiatrists Only: Are you board certified or board eligible in Psychiatry? ☐ Yes ☐ No

Section IV: For LMFT, LCSW, LPCC, Ph-D Licensed, Psy-D Licensed, and RNs Only ☐ N/A

Have you become licensed since your last credentialing? If yes, check the appropriate box and *attach a copy of your professional license and NPI registration*.

☐ LMFT ☐ LCSW ☐ LPCC ☐ Ph-D Licensed ☐ Psy-D Licensed ☐ RN

Section V: For Registered Interns (AMFT, ASW, and APCC) and Waivered Psychologists Only ☐ N/A

Have you become an intern since your last credentialing? If yes, check the appropriate box and attach applicable documentation.
Note: Waivered Psychologists must obtain a DHCS waiver through the Provider Services Unit.

☐ Registered AMFT, ASW or APCC - Attach a copy of your BBS registration.

☐ Waivered Psychologist (PhD or PsyD) – Attach a copy of your resume and official transcript or degree, and complete questions 1 and 2 below. *Note: If you are pre-graduation, you must complete a minimum of 48 semester/trimester units or 72 quarter units of graduate work, not including thesis, internship, or dissertation. An official transcript reflecting completion of this coursework requirement must be submitted with your credentialing application.*

1. *How many hours of supervised professional experience have you completed?* __________
2. *Have you previously applied for and been approved for a waiver in Contra Costa County or any other county? If yes, which county?* ______________________

Section VI: For Trainees Only ☐ N/A

Have you enrolled in a Master/Doctoral degree program in a Mental Health or closely related field since your last credentialing? If yes, check the appropriate box and attach a copy of:

☐ Executed agreement or contract between agency and school – and –

☐ Field placement agreement signed by (a) student, (b) supervisor and/or training coordinator, and (c) school field placement liaison.

Currently enrolled in: ☐ Master's Degree Program *- or -* ☐ Doctoral Degree Program

School: ____

Major: ______________________________ Start Date of Enrollment: _____________

Section VII: For Unlicensed Workers Only– Education and Employment ☐ N/A

Unlicensed staff are privileged based on both education and level of experience. Please complete information below.

EDUCATION: Have you obtained additional education or training since your last credentialing? If yes, complete the section below and attach a copy of an official degree, transcript, or school verification letter for education completed in a mental health or a closely related field. You may also include information on any relevant training or certificates.

☐ Associate's Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ Doctoral Degree

School Name	Date Range of Enrollment
Major	Year Degree Conferred

Other training or certificate	Date Attended

EMPLOYMENT: Have you obtained additional work experience in a mental health setting since your last credentialing that may change your credentialing status? If yes, complete the section below. Note: *A resume or supporting documentation may be attached, but may not be used as a substitute for completing this section.*

Employer Name		Job Title
Employer Address (Street Address, City, State, Zip)		
Supervisor Name	Supervisor Phone	☐ Full Time ☐ Part Time
Date Range of Employment From: To:	Total Time in Position (Years/Months)	*If part time, how many hours worked per week:* ___________
Typical Duties:		

Section IX: Signature *To be completed by all providers*

I hereby affirm that the information submitted in this application and any addenda hereto is true, current, correct, and complete and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges or employment.

Print Full Name: ____

Signature: ____ **Date:** _________________

(*Stamped or Electronic Signature Is Not Acceptable)*

Section X: Attestation Questions:	***To be completed by all providers***
Please answer the following questions. ***If your answer is "yes" to any of the questions A-M, please provide full details on a separate sheet of paper.***	
A. Has your license to practice in any jurisdiction, your Drug Enforcement Administration (DEA) registration or any applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions, or have you been fined or received a letter of reprimand or is such action pending?	☐ Yes No
B. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending?	☐ Yes No
C. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract or is any such action pending?	☐ Yes No
D. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?	☐ Yes No
E. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?	Yes No
F. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending?	Yes No
G. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank?	Yes No
H. Have you been denied certification/recertification by a specialty board, or has your admissibility, certification or recertification status changed (other than changing from admissible to certified)?	Yes No

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 each 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:

☐ **Yes**- 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.

☐ **No**- 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.

☐ **No**- The person listed in Section 1 is only 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.

☐ **No**- The person listed in Section 1 is ONLY 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.

☐ **No**- 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: ___________