**PROVIDER CLINICAL APPLICATION**

**San Diego County Mental Health Plan & Optum Public Sector**

**Fee For Service (FFS) Medi-Cal Provider Network**

Prepared By:



**Please mail, fax or email (secure) complete application packet to:**

Optum Public Sector

Attention: Provider Services

P.O. Box 601370

San Diego, CA 92160-1370

Fax: 877- 309-4862

Email: [sdu\_providerserviceshelp@optum.com](mailto:sdu_providerserviceshelp@optum.com)

[Instructions and Frequency Asked Questions](https://www.optumsandiego.com/content/dam/san-diego/documents/ffsproviders/applications/1_Instructions_and_FAQs_Credentialing_and_Contracting.pdf)

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**PRACTITIONER APPLICATION**

**San Diego County Mental Health Plan for FFS Medi-Cal Network**

**COUNTY of SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY**

**Checklist for Medi-Cal Provider Application**

Please print or type your answers to all questions. If further space is needed for you to provide complete answers, please attach additional sheets of paper, and indicate on the sheet the applicable question number.

A practitioner must meet basic [credentialing standards](https://www.optumsandiego.com/content/dam/san-diego/documents/ffsproviders/applications/Credentialing_Criteria_1.29.20.pdf) for inclusion in the Medi-Cal Network. Please check the requirements for each discipline on the link above to ensure you meet the minimum criteria.

Please use this checklist to confirm that you have included all of the following information in your application packet.

|  |  |  |
| --- | --- | --- |
|  | [**Credentialing Application**](https://www.optumsandiego.com/content/dam/san-diego/documents/ffsproviders/applications/3_Credentialing_Application_Instructions.pdf) completed and submitted at [Council for Affordable Quality Healthcare](https://proview.caqh.org/Login/Index?ReturnUrl=%2f) (CAQH) *Please see* [*FAQs*](https://www.optumsandiego.com/content/dam/san-diego/documents/ffsproviders/applications/0_Instructions_and_FAQs_Credentialing_and_Contracting.pdf) *on our website for additional information.* | |
|  | \* Copy of **Active Professional License** (*this must be your current pocket license or a copy of your original wall certificate)* | |
|  | \* Copy of **DEA License,** if applicable (*this must be your current/active)* | |
|  | **W-9** A completed and signed [W-9 form](https://www.optumsandiego.com/content/dam/san-diego/documents/ffsproviders/applications/W9%20-%20Blank.pdf) (*Please follow instructions carefully)* | |
|  | **W-9 Verification** | |
|  |  | \*If your Taxpayer Identification Number (TIN) is your social security number, please provide a **copy of your social security card**. |
|  | \*If your Taxpayer Identification Number (TIN) is an employer identification number (EIN), please submit a current Internal Revenue Service (IRS) generated document. The only acceptable documents include:   * 1. IRS-generated Letter 147-C   2. IRS-generated Form 941 (Employer’s Quarterly Federal Tax Return)   3. IRS-generated Form 8109-C (Deposit Coupon)   4. IRS-generated Form SS-4 (only the official Confirmation Notification of FEIN/ITIN assignment)   5. Note: The legal name of the applicant or provider on the application must exactly match the name on the IRS-generated document; and the applicant/provider must be an owner or officer of the entity listed on the IRS document. For further information, please check with the IRS or call them at (800) 829-4933. |
|  | ***(If applicable*) Recorded/stamped Fictitious Business Name Statement (FBNS),** issued by the county where the principal place of business is located, if using a fictitious business name AND the business name is different from the legal name on your application. For example, in the case of a corporation, any name other than the corporation’s name on record with the Secretary of State requires a FBNS. To determine the applicable county agency where fictitious business names are filed, please visit the California State Association of Counties http://www.counties.org/) and click on the "California’s Counties" link and select "County Web Sites." | |
| **\* All documents and copies submitted must be clear and legible.** | | |

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**PRACTITIONER APPLICATION**

**San Diego County Mental Health Plan for FFS Medi-Cal Network**

**COUNTY of SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY**

**Checklist for Medi-Cal Provider Application - *Continued***

|  |  |
| --- | --- |
|  | **Photocopy of Certificate of Professional Malpractice/Professional Liability Insurance**  indication limits of coverage and expiration date (*1mil/3mil and must cover the Dates of*  *Services Requested)* |
|  | **\*A Photocopy of State Driver’s License** with an expiration date clearly visible on the copy. The home address and all other information including the photo must be clear. |
|  | **\*Psychiatric Nurse Practitioners (PNP) and Physician Assistants (PA)** must submit a copy of their Supervisory Agreement with an appropriate paneled FFS Psychiatrist (MD/DO) |
|  | **Medicare Provider Number** Providers intending to serve both Medicare and Medi-Cal beneficiaries must have a current Medicare Provider Number by visiting the Centers for Medicare and Medicaid Services (CMS) website [www.cms.hhs.gov](http://www.cms.hhs.gov). **(Medi-Cal will not reimburse you for services to a client with Medicare and Medi-Cal coverage unless you have a Medicare provider number.)** |
|  | **\*Licensed Professional Clinical Counselor (LPCC)** (If applicable) CCR 1820.7 Requirement - LPCCs applying to treat couples and families must submit a copy of the Board confirmation of qualification. |
|  | **\*Curriculum Vitae (TERM) or Resume** It is very important that your resume or Vitae be detailed including descriptions of populations, specialties, and disorders treated, and the theoretical orientation of the work. This detail is required to approve you to treat various age groups or specialties. Include the dates and locations of education and post-graduate training. **Dates of employment must include the month and year. All gaps in employment of 6 months or more require a written explanation.** |
|  | **Medi-Cal Network Specialty Requirements:** Please carefully review the experience requirements on page 15 before you check an age or treatment specialty. |
|  | **Child and Adolescent Needs and Strength Assessment (CANS):** Provider understands that all providers who render therapy services to clients ages 0 - 21 must become CANS certified and then be recertified every year. Provider may be reimbursed for training, certification, recertification, and reports when the appropriate requirements are met. Additional information and instructions will be provided during the contracting process. |
|  | **Verify Beneficiary’s/Client’s Med-Cal Eligibility:** Provider understands he/she will be provided a PIN Number to facilitate verifying a client’s Medi-Cal eligibility. It is the provider’s responsibility to ensure the client has active Medi-Cal coverage prior to rendering services. Additional information and instructions will be provided during the contracting process. |
|  | **Provider Rights (pg. 13):** Provider understandsthat as an applicant for credentialing/re-credentialing, you have the right to review information obtained by Optum for the purpose of evaluating your credentialing or re-credentialing application. **Please print your name on this page.** |
|  | **Clinical Specialty Requirements Form** on **page 14 must be signed and dated** |
|  | **\*All Pages of the Application must be Completed** Please do not write “refer to Resume/Curriculum Vitae or attached documents as an answer to any questions on the application. |
|  | **Home Office Standards** the attestation addendum must be signed if you are rendering face – to -face services in your home office (not telehealth) |

**\* All documents and copies submitted must be clear and legible.**

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**PRACTITIONER APPLICATION**

**San Diego County Mental Health Plan for FFS Medi-Cal Network**

**Last Name**: Click here to enter text. **First Name**: Click here to enter text. **MI**: Click here to enter text.

**Email Address:** Click here to enter text. **Phone Number:**  Click here to enter text.

**Credentialing Rep** (*If other than provider*):  **N/A** or Click here to enter text.

**Email Address:** Click here to enter text. **Phone Number:**  Click here to enter text.

**License Type**:  MD/DO  Psychologist ( PhD  PsyD)  LMFT  LCSW  LPCC  PNP  PA

**License Number**: Click here to enter text. **DEA Number** (*if applicable)*: Click here to enter text.

**CAQH Provide ID #**: Click here to enter text.

**NPI Number:** Click or tap here to enter text.

\* [Council for Affordable Quality Healthcare](https://proview.caqh.org/Login/Index?ReturnUrl=%2f)

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|  |  |
| **Are you currently employed by the County of San Diego or public agencies for which the County of San Diego Board of Supervisors is the governing body?** | **YES  NO** |
| **If “Yes” please include a letter from the County of San Diego Health and Human Services Compliance Office indicating their approval for your participation on this Network.  Please email Amaris Sanchez, Health and Human Services Compliance Group Program Manager at** [**Amaris.Sanchez@sdcounty.ca.gov**](mailto:Amaris.Sanchez@sdcounty.ca.gov) **for further information.** | |
| **How did you hear about Optum Public Sector San Diego County Mental Health Plan for Medi-Cal and/or TERM Networks?**   |  |  |  | | --- | --- | --- | | Optum Recruiter | FFS Medi-Cal Provider | County Representative | | Other Optum Staff Member | TERM Provider | Other: Click here to enter text. | | |
|  | |
| **Provider’s Emergency Contact**: *Required Information* | |
| **Provider’s Emergency Contact**: (*This is the person OPTUM must contact to implement your emergency plan if you were to become incapacitated and/or unable to fulfill your clinical obligations to your clients)*  Name: Click here to enter text. Phone: Click here to enter text.  Email: Click here to enter text. | |
| **Emergency 24 Hour Coverage of Clients:** | |
| What arrangements do you have for 24-hour, 7-day emergency coverage for clients? Click here to enter text. | |
| 1. **Applicant/Provider Home Address** (Required and is Confidential Cannot be a P.O. Box) | |
| Address: Click here to enter text. | |
| Apt: Click here to enter text. | |
| City: Click here to enter text. County: Click here to enter text. | |
| State: Click here to enter text. Zip: Click here to enter text. | |

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**PRACTITIONER APPLICATION**

**San Diego County Mental Health Plan for FFS Medi-Cal Network**

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| 1. **CONFIDENTIAL MAILING ADDRESS:  N/A (***When/If applicable: audit results, sensitive communications regarding your practice*) | | | |
| Address: Click here to enter text. | | | |
| Suite: Click here to enter text. | | | |
| City: Click here to enter text. County: Click here to enter text. | | | |
| State: Click here to enter text. Zip: Click here to enter text. | | | |
| 1. **Mailing Address:** *Same as Confidential Mailing Address* | | | |
| Address: Click here to enter text. | | | |
| Suite: Click here to enter text. | | | |
| City: Click here to enter text. County: Click here to enter text. | | | |
| State: Click here to enter text. Zip: Click here to enter text. | | | |
| 1. **Billing Address:** *Same as Confidential Mailing Address* *Same as Mailing Address* | | | |
| Address: Click here to enter text. | | | |
| Suite: Click here to enter text. | | | |
| City: Click here to enter text. County: Click here to enter text. | | | |
| State: Click here to enter text. Zip: Click here to enter text. | | | |
|  | | | |
| 1. **TREATMENT LOCATION – OFFICES** (Office Location(s) where *services will be rendered to clients face-to-face)* | | | |
| 1. **PRIMARY TREATMENT LOCATION** | | | |
| Address: Click here to enter text. | | | |
| Suite: Click here to enter text. | | | |
| City: Click here to enter text. County: Click here to enter text. | | | |
| State: Click here to enter text. Zip: Click here to enter text. | | | |
| Hours per week serving: (*This is an estimate of all clients you may be rendering services to at this location*) | | | |
| Children (0 – 20): Click or tap here to enter text. Adults (21+): Click or tap here to enter text. | | | |
| Maximum number of Medi-Cal clients you are willing to see at this location | | | |
| Children (0 – 20): Click or tap here to enter text. Adults (21+): Click or tap here to enter text. | | | |
| **Hours of Operations: Example- 9:00 AM to 5:00 PM** | | | |
| Sunday | Click or tap here to enter text. | to | Click or tap here to enter text. |
| Monday | Click or tap here to enter text. | to | Click or tap here to enter text. |
| Tuesday | Click or tap here to enter text. | to | Click or tap here to enter text. |
| Wednesday | Click or tap here to enter text. | to | Click or tap here to enter text. |
| Thursday | Click or tap here to enter text. | to | Click or tap here to enter text. |
| Friday | Click or tap here to enter text. | to | Click or tap here to enter text. |
| Saturday | Click or tap here to enter text. | to | Click or tap here to enter text. |

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**San Diego County Mental Health Plan for FFS Medi-Cal Network**

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| 1. **TREATMENT LOCATION/OFFICE – Offices** (*Office Locations where services will be rendered to clients face-to-face) - Continued* | | | |
| **B. ADDITIONAL TREATMENT LOCATION(S):  N/A** (Additional Office Locations where *services will be rendered to clients face-to-face)* | | | |
| Address: Click here to enter text. | | | |
| Suite: Click here to enter text. | | | |
| City: Click here to enter text. County: Click here to enter text. | | | |
| State: Click here to enter text. Zip: Click here to enter text. | | | |
| Hours per week Serving: (*This is an estimate of all clients you may be rendering services to at this location*) | | | |
| Children (0 – 20): Click or tap here to enter text. Adults (21+): Click or tap here to enter text. | | | |
| Maximum Number of Medi-Cal clients you are willing to see at this location | | | |
| Children (0 – 20): Click or tap here to enter text. Adults (21+): Click or tap here to enter text. | | | |
| **Hours of Operations: Example- 9:00 AM to 5:00 PM** | | | |
| Sunday | Click or tap here to enter text. | to | Click or tap here to enter text. |
| Monday | Click or tap here to enter text. | to | Click or tap here to enter text. |
| Tuesday | Click or tap here to enter text. | to | Click or tap here to enter text. |
| Wednesday | Click or tap here to enter text. | to | Click or tap here to enter text. |
| Thursday | Click or tap here to enter text. | to | Click or tap here to enter text. |
| Friday | Click or tap here to enter text. | to | Click or tap here to enter text. |
| Saturday | Click or tap here to enter text. | to | Click or tap here to enter text. |
| 1. **ADDITIONAL TREATMENT LOCATION(S):**   ***If Yes: Please complete the form at the end of the application to add additional offices***  **Yes** - I have additional office locations to add  **No** | | | |

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| 1. **OTHER TREATMENT MODES** |
| 1. **Telemental Health** |
| * **Telemental Health:**   Yes  No * If “Yes: to the above: A Virtual Visits Telemental Health Compliance Attestation will be required prior to being approved to render Telemental Health services to Clients. * Please download and submit the [Telemental Health Attestation](https://www.optumsandiego.com/content/dam/san-diego/documents/ffsproviders/provider-services-info/telehealth-attestation-standards/Telemental_Health_Attestation.pdf) with this application |
|  |
| 1. **Mobile/Field Based Services** |
| * **Mobile Services including Home Visits (**Provider will travel to the client’s home or other location)**:**  Yes  No * **Skilled Nursing Facilities (SNF):**    Yes  No * If “Yes: to either of the above: **Distance you will travel to deliver services,** Click or tap here to enter text. |

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| 1. **OTHER TREATMENT MODES***) - Continued* |
| 1. **HOME OFFICE -** *The services are rendered face-to-face in your personal residence (****NOT TELEHEALTH****)* |
| **Do you have a Home Office?**   No  \*Yes |
| Address: Click here to enter text. |
| Suite: Click here to enter text. |
| City: Click here to enter text. County: Click here to enter text. |
| State: Click here to enter text. Zip: Click here to enter text. |
| \* If Yes, please read and sign the **Optum Home Office Standards** attestation included at the end of this application |

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| 1. **Licensed Professional Clinical Counselor (LPCC):** |
| Are you a Licensed Professional Clinical Counselor (LPCC)?  Yes  No |
| If yes, are you applying to assess or treat couples or families?  Yes  No |
| If “Yes” above, you must submit a copy of the BBS confirmation of qualifications to treat couples and families must be submitted with this application |

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| 1. **INFORMATION FOR MD/DOs, NURSE PRACTITIONERS & Physicians Assistants WITH PRESCRIPTIVE AUTHORITY**: |
| * Do you ONLY render services in an INPATIENT setting:  Yes  No * If NO above: Will you be rendering services in an OUTPATIENT (OP) setting other than Partial Hospitalization (PHP) or Intensive Outpatient (IOP)?  Yes  No * If YES above: Will you be OPEN to new referrals? (*OPEN to referrals means that you will accept* ***any new Medi-Cal beneficiary patients*** *referred to you through the Access and Crisis Line /Optum Public Secto*r. |
| **These Questions apply to MDs only:** [Credentialing Criteria](https://www.optumsandiego.com/content/dam/san-diego/documents/ffsproviders/applications/Credentialing_Criteria_1.29.20.pdf); [Provider Handbook](https://www.optumsandiego.com/content/dam/san-diego/documents/ffsproviders/manuals/FFS_Operations_Handbook.pdf) (Credentialing Standards pages 40 – 41) |
| * Board Certified/ Eligible in Psychiatry:  Certified  Board Eligible (*Proof of eligibility must be submitted with this application*) * Physicians who graduated from medical school prior to July 1, 1982, will be considered to have the equivalency of board certification requirement if he or she has completed an ACGME approved residency training program in psychiatry or a fellowship in addiction medicine * Board Certified/Eligible for Child & Adolescent Services:  Certified  Board Eligible (*Proof of eligibility must be submitted with this application*) * Psychiatrists who treat 12 years old children and under, must be board certified or eligible in Child & Adolescent Psychiatry |

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| ***continued* - These Questions apply to MDs only:** | | | |
| **Hospital Privileges (admitting privileges)**: **N/A** | | | |
| *Please complete the section below to identify the county contracted hospitals where you currently have admitting privileges:* | | | |
| Hospitals where you have admitting privileges must be provided for listing in the Directory | | | |
|  |  |  | If Yes - Date Privileged Here |
| Alvarado Parkway Institute | Yes | No | Click here to enter a date. |
| Aurora Hospital | Yes | No | Click here to enter a date. |
| Palomar Hospital | Yes | No | Click here to enter a date. |
| PH Bayview Hospital (A) | Yes | No | Click here to enter a date. |
| PH Paradise Valley Hospital | Yes | No | Click here to enter a date. |
| Pomerado Hospital | Yes | No | Click here to enter a date. |
| Sharp Mesa Vista Hospital | Yes | No | Click here to enter a date. |
| Scripps Mercy Healthcare | Yes | No | Click here to enter a date. |
| Sharp Grossmont Hospital | Yes | No | Click here to enter a date. |
| UCSD Medical Center | Yes | No | Click here to enter a date. |
| Rady CAPS | Yes | No | Click here to enter a date. |

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| 1. INFORMATION FOR MD/DOs, NURSE PRACTITIONERS & Physicians Assistants WITH PRESCRIPTIVE AUTHORITY: *Continued* |
| These questions apply to PSYCHIATRIC NURSE PRACTITIONERS (PNP) ONLY: |
|  |
| * American Nurse Credentialing Center (ANCC) Certification (*As a Psychiatric Nurse Practitioner in Psychiatric/ Mental Health Nursing*) No. Click here to enter text. |
| * Name & telephone number of supervising psychiatrist:   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Click here to enter text. Click here to enter text.  Supervisor Name Phone Number  Note: Supervisor must be Board Certified or Eligible in Child and Adolescent Psychiatry if PNP is requesting to render services to children ages 0 - 12 |
| * Will you accept referrals for Med-Cal clients through the Access in Crisis Line for Outpatient Services?  Yes  No |

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| **These questions apply to PSYCHIATRIC PHYSICIAN’S ASSISTANTS (pas) ONLY:** |
| * Certificate of Added Qualifications (CAQ) in Psychiatry:  Yes - Certificate Number: Click here to enter text. * No – If No, Must be eligible for the Exam (Proof of eligibility must be submitted with this application) |
| * Name & telephone number of supervising psychiatrist:   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Click here to enter text. Click here to enter text.  Supervisor Name Phone Number  **Note**: Supervisor must be Board Certified or Eligible in Child and Adolescent Psychiatry if PNP is requesting to render services to children ages 0 - 12 |
| * Will you accept referrals for Med-Cal clients through the Access in Crisis Line for Outpatient Services?  Yes  No |

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| 1. **Clincal PRofile:** *Please identify the cultures in which you meet the Cultural Competency Criteria below and currently want to treat in your practice* | | | |
| **\*\* Cultural Competency:**  Delivering ***culturally competent clinical services*** means you have an understanding of: 1) on-going social realities (e.g., racism, immigration patterns, acculturation) that can impact the mental health of culturally and linguistically distinct populations, 2) differences between culturally acceptable behaviors and pathological characteristics, 3) cultural beliefs around mental illness and help-seeking patterns, and 4) have the ability to adapt your skills to fit the cultural context of a client. | | | |
| **\*\*** If you check that you are culturally competent to deliver services to a group below it means that you have experiences consistent with one or more of the statements below: | | | |
| * Have lived at least 2 years or were raised in a community where this culture predominated; and/or | | | |
| * Have completed formal training such as a degree emphasis area, specific university courses, multiple workshops or an internship focusing on culture and human behavior; and/or | | | |
| * Have significant professional culture-based expertise (e.g., have provided cultural competence training to others and/or published peer-reviewed journal articles, book chapters, or major reports in this area); and/or | | | |
| * Have provided clinical treatment or evaluations to more than 10 members of the cultural group. | | | |
| ***From the following list please check any group for which you are competent to evaluate family dynamics and provide treatment.*** | | | |
| African American | Filipino | Korean | Somali |
| Amerasian | Guamanian | Laotian | Sudanese |
| Arab | Hawaiian Native | Mexican American/Chicano | Vietnamese |
| Asian Indian | Hmong | Native American | Caucasian |
| Cambodian | Iranian | Pacific Islander | Other Asian |
| Chinese | Iraqi | Puerto Rican | Other Hispanic |
| Cuban | Japanese | Salvadorian | Other Latin American |
| Dominican | Jewish | Samoan | Other South East Asian |
| Ethiopian | Other Click here to enter text. | | |

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| **Available to provide Second Opinions (MD ONLY)**  Yes  No |

* **Are you a Medicare Provider**:  Yes  No
* If Yes, Medicare Number: Click here to enter text.
* **Medi-Cal Provider Number**: (*if available*) Click here to enter text.

|  |  |  |  |
| --- | --- | --- | --- |
| 1. **PLEASE CHECK ALL INSURANCE PLANS YOU CAN ACCEPT** | | | |
| Aetna PPO | Health Net | TriWest/TriCare | Care 1st |
| Anthem Blue Cross | Magellan | Optum | Kaiser |
| Community Health Group | Medi-Cal | Value Options | Cigna |
| Other Click here to enter text. | Medicare | Molina | UnitedHealth Care |

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| 1. **POPULATIONS AND SERVICES** | | | | | | | |
| Please check all Populations and Services in which you have clinical training and experience ***AND* are currently willing to treat in your practice.** | | | | | | | |
| **Populations:** | **Infants**  **Toddlers**  **0 - 3** | **Preschool**  **3 - 5** | **Children**  **6 -12** | **Adolescents**  **13 - 17** | **Transitional**  **Youth**  **18 - 22** | **Adults**  **23 - 59** | **Older Adults**  **60+** |
| Developmentally Delayed |  |  |  |  |  |  |  |
| Hearing Impaired |  |  |  |  |  |  |  |
| LGBTQIA |  |  |  |  |  |  |  |
| Physically Disabled |  |  |  |  |  |  |  |
| Veterans |  |  |  |  |  |  |  |
| Visually Impaired |  |  |  |  |  |  |  |
| **Services/Modalities:** |  |  |  |  |  |  |  |
| Critical Incident Stress Debriefing |  |  |  |  |  |  |  |
| ECT (MD Only including consult) |  |  |  |  |  |  |  |
| Family Therapy |  |  |  |  |  |  |  |
| Group Therapy |  |  |  |  |  |  |  |
| Home Visits |  |  |  |  |  |  |  |
| Individual Therapy |  |  |  |  |  |  |  |
| Inpatient Treatment |  |  |  |  |  |  |  |
| Medication Evaluation  & Management |  |  |  |  |  |  |  |
| Neuropsychological Testing |  |  |  |  |  |  |  |
| Outpatient Treatment |  |  |  |  |  |  |  |
| Psychological Testing |  |  |  |  |  |  |  |

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**Areas of Clinical Expertise:**

* + - ***Check*** areas of expertise in which you have clinical training and experience ***AND* are currently willing to treat in your practice.** You may be requested to submit documentation to demonstrate expertise in these areas.

***Note: \*\****All Clinicians are **designated** to treat Depressive and Anxiety Disorders for all appropriate ages

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Areas of Clinical Expertise I:** | | **Infants**  **Toddlers**  **0 - 3** | | **Preschool**  **3 - 5** | | | **Children**  **6 -12** | | **Adolescents**  **13 - 17** | **Transitional**  **Youth**  **18 - 22** | **Adults**  **23 - 59** | **Older Adults**  **60+** |
| ***\*\* Anxiety Disorders*** |  | |  | | |  | | |  |  |  |  |
| Attention Deficit/Hyperactivity Disorder | |  | |  | | |  | |  |  |  |  |
| Bipolar and Related Disorders | |  | |  | | |  | |  |  |  |  |
| Dissociative Disorders | |  | |  | | |  | |  |  |  |  |
| Feeding and Eating Disorders | |  | |  | | |  | |  |  |  |  |
| Factitious Disorders | |  | |  | | |  | |  |  |  |  |
| Gender Dysphoria Disorders | |  | |  | | |  | |  |  |  |  |
| Disruptive, Impulse-Control and Conduct Disorders | |  | |  | | |  | |  |  |  |  |
| ***\*\* Depressive Disorders*** |  | |  | |  | | |  | |  |  |  |
| Paraphilic Disorders | |  | |  | | |  | |  |  |  |  |
| Personality Disorders | |  | |  | | |  | |  |  |  |  |
| Autism Spectrum Disorder | |  | |  | | |  | |  |  |  |  |
| Trauma and Stress - Related Disorders | |  | |  | | |  | |  |  |  |  |
| Schizophrenia and Other Psychotic Disorders | |  | |  | | |  | |  |  |  |  |
| Somatic Symptom and Related Disorders | |  | |  | | |  | |  |  |  |  |

*Confidential*

**PRACTITIONER APPLICATION**

**San Diego County Mental Health Plan for FFS Medi-Cal Network**

Check **ALL** areas below in which you have clinical training and experience ***AND are currently* willing to treat in your practice.**

Documentation is required for some specialties as identified on the Clinician Specialty Requirements (pg. 15).

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Areas of Clinical Expertise II:** | **Infants**  **Toddlers**  **0 - 3** | **Preschool**  **3 - 5** | **Children**  **6 -12** | **Adolescents**  **13 - 17** | **Transitional**  **Youth**  **18 - 22** | **Adults**  **23 - 59** | **Older Adults**  **60+** |
| Physical Abuse Parent Non-Protecting Parent |  |  |  |  |  |  |  |
| Political Refugee |  |  |  |  |  |  |  |
| Sexual Abuse Victims |  |  |  |  |  |  |  |
| Sexual Abuse Non-Protecting Parent |  |  |  |  |  |  |  |
| Sexual Abuse Offender |  |  |  |  |  |  |  |
| Survivors of Torture |  |  |  |  |  |  |  |
| Trauma |  |  |  |  |  |  |  |

|  |  |
| --- | --- |
| 1. ***PROVIDER RIGHTS*** | |
| 1. **RIGHT TO REVIEW**   As an applicant for credentialing/re-credentialing, you have the right to review information obtained by Optum for the purpose of evaluating your credentialing or re-credentialing application. This includes non-privileged information obtained from any outside source (e.g., Malpractice insurance carriers, state licensing boards, National Practitioner Data Bank) but does not extend to review of information, references, or recommendations protected by law from disclosure. You may request to review such information at any time by sending a written request via email at [**sdu\_providerservices**](mailto:sdu_providerservices)**help@optum.com** to the Provider Services (PS) Manager. The PS Manager, or designee, will notify you within 72 hours of the date and time when such information will be available at the OPTUM Credentialing Department located in San Diego, California.   1. **RIGHT, UPON REQUEST, TO BE INFORMED OF STATUS OF CREDENTIALING/RECREDENTIALING APPLICATION**   You have the right to be informed, upon request, of the status of your credentialing and/or re-credentialing application. You may request such information by sending a written request via email to the Credentialing Manager at the above cited email address. You will be notified in writing and within no more than ten (10) working days of receiving your fax or letter, by return fax or letter, of the current status of your application with respect to outstanding information required to complete the application process.   1. **NOTIFICATION OF DESCREPENCY**   Practitioners will be notified when information obtained by primary sources varies substantially from information provided on the practitioner's application. Examples of information at substantial variance include reports of a practitioner's malpractice claims history, actions | taken against a practitioner's license/certification, suspension or termination of hospital privileges or board certification expiration when one or more of these examples have **not** been reported by the practitioner on his/her application. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.   1. **CORRECTION OF ERRONEOS INFORMATION**   If a practitioner believes that erroneous information has been supplied to OPTUM by primary sources, the practitioner may correct such information by submitting written notification to the Credentialing Manager. Practitioners must submit a written notice along with a detailed explanation to the Manager of Credentialing at [**sdu\_providerservices**](mailto:sdu_providerservices)**help@optum.com** Notification to OPTUM must occur within 48 hours of OPTUM notification to the practitioner of a discrepancy as provided in Section II or within 24 hours of a practitioner's review of his/her credential file as provided in Section I.  Upon receipt of notification from the practitioner, OPTUM will re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the practitioner's credential file. If, upon re-review, primary source information remains inconsistent with practitioner's notification, Credentialing Manager will so notify the practitioner via fax or letter. The practitioner may then provide proof of correction by the primary source body to OPTUM Director of Medical Services via fax or letter at the email address above within ten (10) working days. The Credentialing Manager will re-verify primary source information if such documentation is provided. If, after ten (10) working days, primary source information remains in dispute, the practitioner will be subject to Adverse Action, up to administrative denial/termination. |
|  |
| Print Name: Click here to enter text. |

***CLINICIAN SPECIALTY REQUIREMENTS***

***Optum Public Sector San Diego Specialty Attestation***

**You must sign this document even if you are not requesting any of these specialty designations in your provider record.** Additional training, experience, requirements, and/or outside agency approval is required for the following populations, professional certifications, and specialties. **Please review Specialty Requirements on pages 12 - 13**.

If you are not requesting a specialty designation, please check the “No Specialties” box at the bottom of the list to indicate you have read this form and acknowledge that you have not requested these specialties.

*I have reviewed the Optum Specialty Requirements criteria that a Clinician must meet to be considered a specialist in the following treatment areas. After reviewing the criteria, I hereby attest that by placing a check next to a specialty or specialties, I meet Optum requirements for that treatment area.*

|  |  |
| --- | --- |
| **Physician Specialties** | **Non-Physician Specialties** |
| Child /Adolescent (Please specify all the ages that you treat)  Infant Mental Health (0 – 3)  Preschool (3 - 5)  Children (6 – 12)  Adolescents (13 - 18)  Geriatrics (60+)  Neuropsychological Testing | Child /Adolescent (Please specify all the ages that you treat)  Infant Mental Health (0 – 3)  Preschool (3 - 5)  Children (6 – 12)  Adolescents (13 - 18)  Neuropsychological Testing – *Psychologist only*  Psychiatric Nurses – Prescriptive Privileges (**Submit ANCC certificate, Prescriptive Authority, DEA Certificate and/or Controlled Substance certificate, based on CA State requirements.**  Domestic Violence Victim – (**Submit proof of 40 hr. CA approved DV Training**)  Domestic Violence Offender – (**Submit proof of 40 hr. DV Training from a Facilitator Training {FTC} approved provider.**)  Sexual Offender AND Sexual Abuse Non-Protecting Parent (**Must be approved by CA State Sex Offender Management Board (CASOMB)** [***http://www.casomb.org***](http://www.casomb.org) **and continue to meet CASOMB requirements**.) |
| **No Specialties (Must be checked if no other specialties are being designated)** | |

I understand that Optum may require documentation to verify that I meet the criteria outlined under Specialty Requirements pertaining to the specialty or specialties I have designated above. I will cooperate with an Optum documentation audit, if requested, to verify that I meet the required criteria.

I hereby attest that all of the information above is true and accurate to the best of my knowledge. I understand that any information provided pursuant to this attestation that is subsequently found to be untrue and/or incorrect could result in my termination from the Optum network.

**Please note that standard credentialing criteria must be met before specialty designation can be considered.**

**All clinicians must sign this form whether specialties are applicable or not. Failure to sign this form may cause a delay in the processing of your initial credentialing file.**

# Printed Name of Applicant: \_\_\_\_ Click here to enter text. \_\_\_\_\_\_\_\_\_\_\_\_\_

# Signature of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date Click here to enter Date

Signature Stamps or Electronic Signature are not accepted

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***CLINICIAN SPECIALTY REQUIREMENTS***

**Important Note: Signature on the Optum Public Sector Specialty Attestation page #11 is required of all applicants**

|  |
| --- |
| ***PSYCHOLOGISTS, NURSES & MASTER’S LEVEL CLINICIANS SPECIALTY REQUIREMENTS (cont.)*** |
| **DOMESTIC VIOLENCE TREATMENT – VICTIM**  **▪** Documented completion of an approved (40) hour training program in Domestic Violence that fulfills California State’s requirement for domestic violence victim counselors  **AND both of the following:**   * Fifteen (15) hours CEU in Domestic Violence Victim training in the last thirty-six (36) month months * Evidence of recent practice experience in Domestic Violence Victim treatment |
| **DOMESTIC VIOLENCE TREATMENT – OFFENDER**   * + Documented completion of the forty (40) hour basic domestic violence training from a Facilitator Training Committee (FTC) approved provider   + Evidence of recent practice experience in Domestic Violence Batterers treatment |
| **SEXUAL OFFENDER AND SEXUAL ABUSE NON-PROTECTING PARENT TREATMENT**  ▪ **Must be approved by CA State Sex Offender Management Board (CASOMB)** [***http://www.casomb.org***](http://www.casomb.org) and continue to meet CASOMB requirements. |
| **PSYCHIATRIC NURSES REQUESTING PRESCRIPTIVE AUTHORITY MUST:**   * Possess a currently valid license as a Registered Nurse in California * Be authorized for prescriptive authority in California * Meet California specific mandates regarding DEA and/or Furnishing license and physician supervision * Attest that you meet California’s collaborative or supervisory agreement requirements * Specifically request prescriptive privileges on the Optum Public Sector application above |
| **PSYCHIATRIC PHYSICIAN ASSISTANTS REQUESTING PRESCRIPTIVE AUTHORITY MUST:**   * Possess a currently valid license as a Registered Nurse in California * Be authorized for prescriptive authority in California * Meet California specific mandates regarding DEA and physician supervision * Attest that you meet California’s collaborative or supervisory agreement requirements * Specifically request prescriptive privileges on the Optum Public Sector application above |

|  |  |  |
| --- | --- | --- |
|  | ***LICENSED PROFESSIONAL CLINICAL COUNSELOR REQUIREMENTS*** |  |
| **Signature for the following Attestation page is required of all LPPC applicants who are applying to assess or treat couples or families which includes the treatment of children. Effective January 1, 2016 CCR 1820.7 - A copy of the Board confirmation of qualifications to treat couples and families must be submitted with this application.**  **LPCCs are not permitted to assess or treat couples or families unless the LPCC has completed all of the required coursework on this subject as specified in California Business and Professions Code section 4999.20:**   * Six (6) semester units or nine (9) quarter units specifically focused on the theory and application of marriage and family therapy OR a named specialization or emphasis area on the qualifying degree in marriage and family therapy; marital and family therapy; marriage family and child counselling; or couple and family therapy.   **AND:**   * No less than 500 hours of documented supervised experience working directly with couples, family, or children.   **AND:**   * A minimum of six (6) hours of continuing education specific to marriage and family therapy, completed in each license renewal cycle. | |

**Application Addendum: Additional Office Location(s)**

**Provider Name:** Click or tap here to enter text.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **ADDITIONAL TREATMENT LOCATION(S):** (Additional Office Locations where *services will be rendered to clients face-to-face) – Continued from page # 5 of 13* | | | | | |
| **C. Add Office Location** | | | | | |
| Address: Click here to enter text. | | | | | |
| Suite: Click here to enter text. | | | | | |
| City: Click here to enter text. County: Click here to enter text. | | | | | |
| State: Click here to enter text. Zip: Click here to enter text. | | | | | |
| Hours per week serving: (*This is an estimate of all clients you may be rendering services to at this location*) | | | | | |
| Children (0 – 20): Click or tap here to enter text. Adults (21+): Click or tap here to enter text. | | | | | |
| Maximum Number of Medi-Cal clients you are willing to see at this location | | | | | |
| Children (0 – 20): Click or tap here to enter text. Adults (21+): Click or tap here to enter text. | | | | | |
| **Hours of Operations: Example- 9:00 AM to 5:00 PM** | | | | | |
| Sunday | Click or tap here to enter text. | | to | Click or tap here to enter text. | |
| Monday | Click or tap here to enter text. | | to | Click or tap here to enter text. | |
| Tuesday | Click or tap here to enter text. | | to | Click or tap here to enter text. | |
| Wednesday | Click or tap here to enter text. | | to | Click or tap here to enter text. | |
| Thursday | Click or tap here to enter text. | | to | Click or tap here to enter text. | |
| Friday | Click or tap here to enter text. | | to | Click or tap here to enter text. | |
| Saturday | Click or tap here to enter text. | | to | Click or tap here to enter text. | |
|  |  | |  |  | |
| **D. Add Office Location** | | | | | |
| Address: Click here to enter text. | | | | | |
| Suite: Click here to enter text. | | | | | |
| City: Click here to enter text. County: Click here to enter text. | | | | | |
| State: Click here to enter text. Zip: Click here to enter text. | | | | | |
| Hours per week serving: (*This is an estimate of all clients you may be rendering services to at this location*) | | | | | |
| Children (0 – 20): Click or tap here to enter text. Adults (21+): Click or tap here to enter text. | | | | | |
| Maximum Number of Medi-Cal clients you are willing to see at this location | | | | | |
| Children (0 – 20): Click or tap here to enter text. Adults (21+): Click or tap here to enter text. | | | | | |
| **Hours of Operations: Example- 9:00 AM to 5:00 PM** | | | | | |
| Sunday | Click or tap here to enter text. | to | | | Click or tap here to enter text. |
| Monday | Click or tap here to enter text. | to | | | Click or tap here to enter text. |
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| Friday | Click or tap here to enter text. | to | | | Click or tap here to enter text. |
| Saturday | Click or tap here to enter text. | to | | | Click or tap here to enter text. |

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**1 of 1**

**Application Addendum: Additional Office Location(s)**

**Application Addendum: Home Office Standards**

**Application Addendum: Home Office Standards**



                                          San Diego Public Sector

Home Office Standards

Clinicians who practice in a home office setting are required to meet the following standards listed below. A Provider with a home office that does not meet these standards shall be required to remediate the identified deficiencies, relocate their office to a setting that meets standards, or face disciplinary action up to an including contract termination.

1. Clinicians will inform all clients in advance that the therapy office is located in a home and if the office is not Americans with Disabilities Act compliant**.** If the client requires an ADA compliant location or is not comfortable with a home office setting, the provider shall refer the client back to the Access and Crisis Line for alternative referrals that better meet the client’s preference.

2. When a clinician has any animals, clients must be told in advance that there is/are an animal(s) in the house and the clinician should isolate them from the office area. If an animal(s) is/are kept in the therapy office area they must have special training or be a certified pet therapy animal.

3. Off street or separate parking for clients should be offered. If off street parking is not available, then clients must be informed in advance where to park. The home should be clearly identified with a house number or sign and the entrance to the home must have adequate lighting. Exits and entrances must be clearly identified with exit signs. Exit doors must be unlocked on the inside.

4. The therapy office is designed so that family members, friends, or other clients cannot enter the office while therapy is in session and must be soundproof. Soundproofing may include a white noise machine, and/or structural soundproofing.

5. The clinician should offer a waiting area for clients. If s/he does not, it is expected that clients be informed in advance of the process for arrival to appointments and where to wait.

6. The office setting should be free from personal effects (i.e., medications, personal papers, and intimate pictures). Office furnishings need to be permanent and professional.

7. The office space should contain a separate bathroom for client use only. The bathroom utilized by clients must be free from personal effects (i.e., medications and intimate pictures/items).

8. Office, waiting room, and bathroom areas must be maintained in a neat, clean, and sanitary manner with no unpleasant odors; and be in good repair.

9. Office, waiting area and bathrooms must be compliant with applicable fire/safety regulations for businesses in that jurisdiction.

10. Medications and medication samples must be stored in a locked cabinet in a secure area. (MD

and ARPN's Only)

11.Safeguards must be in place to ensure that no one other than the treating clinician has access to the office equipment that contains confidential information. Computers must be password protected.

**1 of 3**

**Application Addendum: Home Office Standards Attestation**

12. The clinician must screen for high risk and/or potentially violent clients prior to first session. If the clinician does not have an alternative non-home setting to see high risk and/or potentially violent clients, the clinician should refer those clients back to Optum/Access and Crisis Line for appropriate referrals to offices that are not home based.

13. The Clinician is required to have a business license if required by the city/town in which the office is located.

14. If a complaint is received about the home office of a clinician contracted with Optum, a site audit and treatment record review request may be referred to County Quality Management. In such cases, the results of the review are forwarded to the requesting committee (e.g., Credentialing, Quality of Care Committee, Peer Review Committee) for determination about the need for further actions.

15. Treatment records storage is required to meet HIPAA privacy and security requirements in order to protect the view of client personal health information (PHI) by others. Detailed information about HIPAA privacy and security regulations can be located at the following website: <http://www.hhs.gov/ocr/privacy/>

16. The following beneficiary materials must be available to clients:

* + - Client and Family Handbooks is given to the client in the first meeting
    - Client Grievance/Appeal Posters in the threshold languages are visibly posted.
    - Grievance/Appeal brochures and forms are available without requiring the client to request them form the provider
    - Limited English Proficiency (LEP) posters in the threshold languages are prominently displayed.
    - The Access and Crisis Line phone number is visibly posted.

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**Application Addendum: Home Office Standards Attestation**

**2 of 3**

**Application Addendum: Home Office Standards Attestation**

**2 of 3**

**Application Addendum: Home Office Standards Attestation**

**Referral Screening Tool**

Not all clients are comfortable with, or appropriate to be seen in, a home office setting.

Please discuss the following topics and items with client prior to first appointment.

Discuss with client the home office setting. If the client requires an ADA compliant location or

is not comfortable with a home office setting, the provider shall refer the client back to the Access and Crisis Line for alternative referrals that better me the client’s preference.

Parking: inform where to park or if parking is not available

Office is/is not ADA compliant

Entrance: how to enter office

Waiting Room: where to wait if there is no waiting room

Screen client for history of violence (notify ACL and refer back to ACL if client has history of

violence.)

Inform client if there are animals in the home and inquire about client concerns (e.g., allergies, fears

of animals, etc.)

Document in phone call assessment or first intake note that these items were discussed with client

**Attestation**

* I understand and will abide by the Optum Public Sector Home Office Standards
* My Home Office meets these Standards

Click or tap here to enter text.

|  |
| --- |
| Provider Name |

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**Application Addendum: Home Office Standards Attestation**