SACRAMENTO COUNTY MENTAL HEALTH PLAN
CREDENTIALING APPLICATION

INSTRUCTIONS: This form must be typed or legibly printed in black ink. If additional space is required, please attach additional pages and reference the question being answered.

I. IDENTIFYING INFORMATION

Last Name:	First Name:	MI/Name:	Date of Birth:

Gender:	Race/Ethnicity:

II. PRACTICE INFORMATION

Practice Name (if applicable):	Practitioner Website:

Primary Office Street Address:	City:	
	State:	Zip:
Telephone: ( )	Email:	Fax Number: ( )

Practice: ☐ **Solo** ☐ **Group/Corporation** ☐ **Other**

If other, please identify type of practice or group or corporate name:

List any employment in addition to private practice: ☐ **None**

III. PROFESSIONAL EDUCATION

Institution	City and State	Degree	Grad Date

IV. POSTGRADUATE TRAINING AND EXPERIENCE

INTERNSHIP/POSTGRADUATE YEAR (PGY): _____
(Attach additional sheets if necessary. Reference this section title and number.)

Institution:	Program Director:

Mailing Address:

City:	State:	Country:	Zip:

V. LICENSURE

State	License Number	Type of License	Expiration Date

COMPLETE ONLY IF APPLICABLE	Medi-Cal Provider Number:	National Provider ID Number:
Medicare UPIN:	**DEA Number:**	**DEA Expiration Date:**

VI. BOARD CERTIFICATION

Name of Board	Certification Date	Expiration Date (if applicable)

VII. HOSPITAL PRIVILEGES (CURRENT AND PAST)

Hospital	Mailing Address	Appointment Date	Reason for Leaving (if applicable)

VIII. COUNTY MENTAL HEALTH EXPERIENCE

Are you currently credentialed in any other county mental health plan?

☐ **Yes** ☐ **No** **(If yes, please list counties):**

IX. PROFESSIONAL REFERENCES

PLEASE HAVE THREE (3) PROFESSIONAL PEERS SUBMIT LETTERS OF REFERENCE DIRECTLY TO THE MHP.

Name: _____
Address: _____
Email: _____
Phone Number: _____

Name: _____
Address: _____
Email: _____
Phone Number: _____

Name: _____
Address: _____
Email: _____
Phone Number: _____

X. PROFESSIONAL LIABILITY

Minimum of $1,000,000/$3,000,000 professional liability/malpractice insurance required.

Name and Address Insurance Carrier	Policy Number	Per Claim Amount	Aggregate Amount	Expiration Date
		$	$	

XI. ATTESTATION QUESTIONS: "If you respond 'yes" to any of the questions below, please use the section at the bottom to provide an explanation."

☐ Yes ☐ No **1. Has your clinical license ever been revoked, suspended, or limited?**

☐ Yes ☐ No **2. Is there action pending?**

☐ Yes ☐ No **3. Within the past five years, have you ever been subject to disciplinary review action by any of the following?**

☐ Yes ☐ No **a. State Licensing Board: _____ Date: _____**

☐ Yes ☐ No **b. County or Professional Society: _____ Date: _____**

☐ Yes ☐ No **c. Hospital, Medical or Clinical Staff: _____ Date: _____**

☐ Yes ☐ No **4. Has your narcotics license ever been revoked, suspended or limited?**

☐ Yes ☐ No **5. Within the past five years:**

☐ Yes ☐ No **a. Have you been denied professional liability insurance, had your insurance been canceled, renewal refused or premiums surcharged because of claims?**

☐ Yes ☐ No **b. Have you been a party to a malpractice suit(s) which went to final disposition and resulted in payment to the plaintiff?**

☐ Yes ☐ No **c. Have any judgments been made against you, or settlements been agreed to, in professional liability cases, or are there any filed and served professional liability lawsuits pending against you?**

☐ Yes ☐ No **6. Have you ever been convicted of a felony?**

☐ Yes ☐ No **7. Do you have any physical or mental conditions which impair your ability to practice?**

Explain a "Yes" answer to any of the above questions:

I am hereby applying as a Sacramento County Mental Health Plan provider. I fully understand that any misstatement in or omission from the application will be cause for denial or revocation of provider eligibility status. I hereby affirm that the information provided is true and complete. I expect that the confidentiality and privacy of this information is preserved and will only be released or disclosed as part of current and future credentialing, peer review, and quality improvement processes.

Printed Name:	Signature:	Date:

SACRAMENTO COUNTY MENTAL HEALTH PLAN
PRACTITIONER PRACTICE INFORMATION

Please complete the following practice information survey so that we might best match beneficiary clinical needs with characteristics of your practice. Your resume should reflect your training and expertise in the areas you select.

Last Name:	First Name:	MI/Name:

POPULATIONS:

I provide service to the following client populations:

- ☐ **Children 0-3**
- ☐ **Children 4-11**
- ☐ **Adolescents 12-18**
- ☐ **Young Adult 19-20**
- ☐ **Adult 21-65**
- ☐ **Older Adult 65+**

SPECIALITY AREAS:

- ☐ **Adjustment Disorders**
- ☐ **Attention Deficit Disruptive Behaviors**
- ☐ **Domestic/Non-Domestic Violence**
- ☐ **Dissociative Disorders**
- ☐ **Eating Disorders**
- ☐ **Historical Trauma**
- ☐ **Mood Disorders**
- ☐ **Medication Services**
- ☐ **Psychotic Disorders**
- ☐ **Racial Trauma**
- ☐ **Sexual Abuse**
- ☐ **Somatoform Disorders**
- ☐ **Substance Abuse Issues**

☐ **Training/experience serving Black and African/American Communities:**

_____

_____

☐ **Other:**

_____

_____

LANGUAGES:

Please identify languages, including American Sign Language, in which you can provide services, other than English?

☐ **None** ☐ **Specify Language(s):** _____

Are you certified? ☐ **Yes** ☐ **No** **If yes, please attach certificate.**

ADDITIONAL INFORMATION YOU WANT THE SCMHP TO KNOW:

SACRAMENTO COUNTY MENTAL HEALTH PLAN

INFORMATION RELEASE/ACKNOWLEDGMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials and qualifications (peer review information) by and between the Sacramento County Mental Health Plan (SCMHP) and other Healthcare Organizations (e.g., individual professionals, hospital medical staffs, medical groups, independent practice associations [IPAs], health care providers and plans, health maintenance organizations [HMOs], preferred provider organizations [PPOs], other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies (with respect to certification of coverage and claims history}, licensing authorities, and businesses and individuals acting as their agents-collectively SCMHP) for the purpose of evaluating this application and any recredentialing application regarding my professional training, qualifications, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect peer review information from being further disclosed.

I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including the SCMHP, engaged in quality assessment, peer review and credentialing on behalf of the SCMHP, and all persons and entities providing peer review information to such representative of the SCMHP, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in the SCMHP, to the extent that those acts and/or communication are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in the SCMHP as may be required by state and federal law and regulation, including but not limited to, California Business and Professions Code Section 809 et seq., if applicable.

I understand and agree that I, as an applicant, have the burden of producing all requested information and any additional information needed 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.

I also agree to notify the SCMHP in writing, within five (5) days of receiving any written or oral notice of any adverse action, including, without limitation, any filed and served malpractice suit or arbitration action; any adverse action by a licensing authority taken or pending, including but not limited to, any accusation filed, temporary restraining order or interim suspension order sought or obtained, public letter or reprimand, public reproval, and any formal restriction, probation, suspension or revocation of licensure; any adverse action taken by any Healthcare Organization, which has resulted in the filing of a Business & Professions Code Section 805 report with the Medical Board of California, or a report with the National Practitioner Data Bank; any revocation of DEA license; a conviction of any felony or a misdemeanor; any action against any certification under the Medicare or Medi-Cal programs; or any cancellation, non-renewal or material reduction in medical liability insurance policy coverage.

I hereby declare **under penalty of perjury** under the laws of the State of California that the information submitted in this application and any addenda thereto is true to the best of my knowledge and belief and is furnished in good faith. I understand that significant omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement. A photocopy of this document shall be as effective as the original.

Print Name Here: _____

Signature: _____ Date: _____
(Electronic Signature Is Acceptable)