Allied Health Provider Onboarding Packet

Thank you for your interest in joining the CenCal Health provider network. We greatly value your partnership in better serving our community. CenCal Health credentials all AHPs who provide care to our members. Enclosed is a credentialing application and additional documents required to begin the onboarding process. Please complete the packet in its entirety. **However, if you have a current and complete CAQH profile, you do not need to fill out the credentialing application portion**. Instead, please complete the Addendums and Information Release/Acknowledgement and provide your CAQH identifier below.

If you are a provider in CAQH, please provide your CAQH #: _____

The following must accompany your application:

- □ Completed Addendums A, B, and D
- □ Complete 5-year Work History with dates in MM/YYYY – MM/YYYY format (Include a brief explanation for any gaps 6 months or longer)
- □ Copy of current DEA Registration (ODs only. Include a brief explanation for any missing schedules)
- □ Signed and dated Information Release/Acknowledgement
- □ Signed and dated Attestation (Please take notice of Question L)
- □ Proof of Professional Liability coverage
- □ New Provider Training Orientation Attestation

Medi-Cal Enrollment is Separate and Required
Beginning January 1, 2018, federal law requires that all non-exempt providers of services to Medi-Cal recipients must be screened and enrolled as Medi-Cal providers by the Department of Health Care Services (DHCS). This is a requirement in addition to CenCal Health's onboarding and credentialing process. Please find more information about the Medi-Cal enrollment process on our website here.

All provider credentialing applications are reviewed by the CenCal Health Credentials and Peer Review Committee or a Medical Director. To ensure timely processing of your application, please complete and return all documents listed above as soon as possible. Forms may be submitted in the following ways:

Mail: CenCal Health, Attn: Provider Services Department
4050 Calle Real, Santa Barbara, CA 93110
Email: provideronboarding@cencalhealth.org
Fax: (805) 681-3033

We appreciate your cooperation during the onboarding process. If you have any questions, please contact us at the above email.

Thank You,

CenCal Health – Provider Services Department

Allied Health Professional Credentialing Application

INSTRUCTIONS
This form should be typed or legibly printed in black or blue ink. If more space is needed than provided on original, attach additional sheets and reference the question being answered. Please do not use abbreviations when completing the application.

IDENTIFYING INFORMATION			
Last Name:	First Name:		Middle:
Is there any other name under which you are known? Name(s):			
Home Mailing Address:	City:	State:	Zip:
Home Telephone Number:	Home Fax Number:		
Social Security Number:	Gender: ☐ Male ☐ Female		
Citizenship:	Date of Birth:		
Professional Type:			

PRACTICE INFORMATION				
Business Legal Name (as listed with IRS):				
Business Address:	City:	County:	State:	Zip Code:
Business Billing Address (if different):	City:	County:	State:	Zip Code:
Business Contract Address (if different):	City:	County:	State:	Zip Code:
Office Manager:	Business Telephone Number:		Business Fax Number:	
Email Address:	Tax ID # under which you bill:			
Please indicate what services you provide:				
Office Days and Hours:				
Number of blocks to nearest public transportation stop?				
Wheelchair Accessible: ☐ Yes ☐ No	Other special access arrangements?			

OTHER MEMBERS OF YOUR OFFICE:			
Name	Specialty	NPI Number	Medi-Cal Provider Number

ADDITIONAL LOCATION:				
Business Legal Name (as listed with IRS):				
Business Address:	City:	County:	State:	Zip Code:
Office Manager:	Business Telephone Number:	Business Fax Number:		
Email Address:	Tax ID # under which you bill:			
Please indicate what services you provide:				
Office Days and Hours:				
Number of blocks to nearest public transportation stop?				
Wheelchair Accessible: ☐ Yes ☐ No Other special access arrangements?				

PROFESSIONAL LICENSURE			
California License Number:	Type:	Issue Date:	Expiration Date:
Business License number:		Issue Date:	Expiration Date:
Medi-Cal License Number:			
NPI Number:	Taxonomy Code:		

ALL OTHER STATE PROFESSIONAL LICENSES				
State:	License Number:	Type:	Issue Date:	Expiration Date:
State:	License Number:	Type:	Issue Date:	Expiration Date:
State:	License Number:	Type:	Issue Date:	Expiration Date:

UNDERGRADUATE EDUCATION		
Undergraduate School:		
Mailing Address:		
City:	State:	Zip:
Degree Received:	Date of Graduation:	

ADVANCED DEGREE/TRAINING		
Institution:		
Mailing Address:		
City:	State:	Zip:
Degree Received:	Date of Graduation:	
Did you successfully complete the program? ☐ Yes ☐ No (If "No," please explain on separate sheet.)		
Institution:		
Mailing Address:		
City:	State:	Zip:
Degree Received:	Date of Graduation:	
Did you successfully complete the program? ☐ Yes ☐ No (If "No," please explain on separate sheet.)		
Institution:		
Mailing Address:		
City:	State:	Zip:
Degree Received:	Date of Graduation:	
Did you successfully complete the program? ☐ Yes ☐ No (If "No," please explain on separate sheet.)		

PROFESSIONAL LIABILITY			
Name of Insurance Company:			
Insurance Policy Number:	Date Policy Issued: (mm/dd/yyyy)	Expiration date of policy: (mm/dd/yyyy)	
Address:	City:	State:	Zip Code:
Insurance Policy Amount:	Occurrence: $	Aggregate: $	

If yes to any of the below, please provide details per the attached claims information sheet. Please explain any surcharges to your professional liability coverage on a separate sheet.
Have any judgments been made against you, settlements been agreed to, or are there any filed and served professional liability lawsuits against you pending? **Please include any cases pending or resolved through arbitration.** ☐ Yes ☐ No
Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance? ☐ Yes ☐ No

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WORK HISTORY		
Chronologically list all work history activities since the completion of professional training (use extra sheets if necessary). Please explain any gaps on a separate page.		
Current Practice/Employer:		
Mailing Address:		
City:	State:	Zip:
Telephone Number:	Fax Number:	
From:	To:	
Practice/Employer:		
Mailing Address:		
City:	State:	Zip:
Telephone Number:	Fax Number:	
From:	To:	
Practice/Employer:		
Mailing Address:		
City:	State:	Zip:
Telephone Number:	Fax Number:	
From:	To:	

HOSPITAL OR OTHER INSTITUTIONAL AFFILIATIONS				
Please list in reverse chronological order (with the current affiliation(s) first) all institutions where you have current affiliations and have had previous hospital affiliation. If more space is needed, attach additional sheet(s).				
Name of Hospital:	Department:			
Hospital Address:	City:	County:	State:	Zip Code:
Professional Designation and status:	From:		To:	
Name of Hospital:	Department:			
Hospital Address:	City:	County:	State:	Zip Code:
Professional Designation and status:	From:		To:	
Name of Hospital:	Department:			
Hospital Address:	City:	County:	State:	Zip Code:
Professional Designation and status:	From:		To:	

ATTESTATION QUESTIONS

Please answer the following questions "yes" or "no." If your answer to questions A through K is "yes," or if your answer to L is "no," please provide full details on separate sheet.

A. Has your license/certification to practice 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 certification, 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, professional 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 professional 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. Have you ever been convicted of any crime (other than a minor traffic violation)?

Yes ☐ No ☐

H. Do you presently use any drugs illegally?

Yes ☐ No ☐

I. Do you have a history of chemical dependency/substance abuse?

Yes ☐ No ☐

J. Have any judgments been entered against you, or settlements been agreed to by you within the last seven (7) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitrations against you pending?

Yes ☐ No ☐

K. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures?

Yes ☐ No ☐

L. Are you able to perform all the services required by your agreement with the Healthcare Organization to which you are applying, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients?

Yes ☐ No ☐

I hereby affirm that the information submitted to CenCal Health and any addenda thereto is true, current, and complete to the best of my knowledge and belief 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, employment or physician participation agreement.

Print Name: _____

Signature: _____ **Date:** _____

INFORMATION RELEASE/ACKNOWLEDGEMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance ("credentialing information") by and between "this Healthcare Organization" and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations {IPAs}, health 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, "Healthcare Organizations"), for the purpose of evaluating this application and any recredentialing application regarding my professional training, 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 credentialing information from being further disclosed.

I am informed and acknowledge that federal and state[3] 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 this Healthcare Organization, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities providing credentialing information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in this Healthcare Organization, to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Healthcare Organization 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 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.

I also agree to notify this Healthcare Organization in writing, within five (5) days from the occurrence of receiving any written or oral notice of any adverse action, including, without limitation, any accusation filed, temporary restraining order or interim suspension order sought or obtained, public letter or reprimand, public approval, and any formal restriction, probation, suspension or revocation of licensure; any adverse action taken by any Healthcare Organization, or a report with the National Practitioner Data Bank; a conviction of any felony or a misdemeanor of moral turpitude; any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions; or any cancellation, non-renewal or material reduction in medical liability insurance policy coverage.

I hereby affirm that the information submitted in this application and any addenda thereto (including my curriculum vitae if attached) is current, correct, complete, and true to the best of my knowledge and belief 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, employment or physician participation agreement.

A photocopy of this document shall be as effective as the original.

Print Name: _____

Signature _____ **Date:** _____

3. The intent of this release is to apply at a minimum, protections comparable to those available in California to any action, regardless of where such action is

California Participating Practitioner Application

Addendum A

Practitioner Rights

Right to Review

The practitioner has the right to review information obtained by the Healthcare Organization for the purpose of evaluating that practitioner's credentialing or recredentialing application. This includes non-privileged information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards), but does not extend to review of information, references or recommendations protected by law from disclosure.

The practitioner may request to review such information at any time by sending a written request, via certified letter, to the Credentialing Department at the Healthcare Organization's offices. The Credentialing Department of the Healthcare Organization's offices, will notify the practitioner within 72 hours of the date and time when such information will be available for review at the Credentialing Department office.

Right to be Informed of the Status of Credentialing/Recredentialing Application

Practitioners may request to be informed of the status of their credentialing/recredentialing application. The practitioner may request this information by sending a written request by letter, email or fax to the Credentialing Department of the Healthcare Organization's offices.
The provider will be notified in writing by fax, email or letter no more than seven working days of the current status of the application with respect to outstanding information required to complete the application process.

Notification of Discrepancy

Practitioners will be notified in writing via fax, email or certified letter, 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 practitioner's malpractice claims history, actions taken against a practitioner's license/certificate, suspension or termination of hospital privileges or board certification expiration when one or more of these examples have not been self-reported by the practitioner on his/her application form. Practitioners will be notified of the discrepancy at the time of primary source verification. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

Correction of Erroneous Information

If a practitioner believes that erroneous information has been supplied to Healthcare Organization by primary sources, the practitioner may correct such information by submitting written notification to the Credentialing Department. Practitioners must submit a written notice, via certified letter, along with a detailed explanation to the Credentialing Department at the Healthcare Organization, within 48 hours of the Healthcare Organization's notification to the practitioner of a discrepancy or within 24 hours of a practitioner's review of his/her credentials file.

Upon receipt of notification from the practitioner, the Healthcare Organization 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 credentials file. The practitioner will be notified in writing, via certified letter, that the correction has been made to his/her credentials file. If, upon review, primary source information remains inconsistent with practitioner's notification, the Credentialing Department will so notify the practitioner via certified letter. The practitioner may then provide proof of correction by the primary source body to Healthcare Organization's Credentialing Department via certified letter at the address below within 10 working days. The Credentialing Department will re-verify primary source information if such documentation is provided.

Healthcare Organization's Credentialing Department Address:

Address: City: State: Zip:

APPLICANT SIGNATURE (Stamp is Not Acceptable)**:** _____
PRINTED NAME: _____
DATE:_____

California Participating Practitioner Application

Addendum B

Professional Liability Action Explained

This Addendum is submitted to _____ herein, this Healthcare Organization

Please complete this form for each pending, settled or otherwise conclude professional liability lawsuit or arbitration filed and served against you, in which you were named a party in the past seven (7) years, whether the lawsuit or arbitration is pending, settled or otherwise concluded, and whether or not any payment was made on your behalf by any insurer, company, hospital or other entity. All questions must be answered completely in order to avoid delay in expediting your application. If there is more than one professional liability lawsuit or arbitration action, please photocopy this Addendum B prior to completing, and complete a separate form for each lawsuit.

☐ *Please check here if there are no pending/ settled claims to report (and sign below to attest).*

I. Practioner Identifying Information

Last Name: _____ First Name: _____ Middle: _____

II. Case Information

Patient's Name: _____ Patient Gender ◯ Male ◯ Female Patient DOB: _____

City, County, State where lawsuit filed: _____ Court Case number, if known: _____ Date of alleged incident serving as basis for the lawsuit/ arbitration: _____ Date suit filed: _____

Location of incident:
☐ Hospital ☐ My Office ☐ Other doctor's office ☐ Surgery Center ☐ Other (specify) _____

Relationship to patient (Attending physician, Surgeon, Assistant, Consultant, etc.) _____

Allegation

_____

Is/was there an insurance company or other liability protection company or organization providing coverage/defense of the lawsuit or arbitration action? ◯ Yes ◯ No

If yes, please provide company name, contact person, phone number, location and carrier's claim identification number, or other liability protection company or organization.

_____

If you would like us to contact your attorney regarding any of the above, please provide attorney(s) name(s) and phone number(s). Please fax this document to your attorney as this will serve as your authorization:

Name: _____ Telephone Number: _____ Fax Number: _____

III. Status of Lawsuit/Arbitration (check one)

☐ Lawsuit/arbitration still ongoing, unresolved.

☐ Judgment rendered and payment was made on my behalf. Amount paid on my behalf: $

☐ Judgment rendered and I was found not liable.

☐ Lawsuit/arbitration settled and payment made on my behalf. Amount paid on my behalf: $

☐ Lawsuit/arbitration settled/dismissed, no judgment rendered, no payment made on my behalf.

Summarize the circumstances giving rise to the action. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. If more space is needed, attach additional sheets.

Please include:
1. Condition and diagnosis at the time of incident,
2. Dates and description of treatment rendered, and
3. Condition of patient subsequent to treatment.

SUMMARY

I certify that the information in this document and any attached documents is true and correct. I agree that "this Healthcare Organization", its representatives, and any individuals or entities providing information to this Healthcare Organization in good faith shall not be liable, to the fullest extent provided by law, for any act or occasion related to the evaluation or verification contained in this document, which is part of the California Participating Practitioner Application. In order for the participating healthcare organizations to evaluate my application for participation in and/or my continued participation in those organizations, I hereby give permission to release to this Healthcare Organization about my medical malpractice insurance coverage and malpractice claims history. This authorization is expressly contingent upon my understanding that the information provided will be maintained in a confidential manner and will be shared only in the context of legitimate credentialing and peer review activities. This authorization is valid unless and until it is revoked by me in writing. I authorize the attorney(s) listed on Page 1 to discuss any information regarding this case with "this Healthcare Organization".

APPLICANT SIGNATURE (Stamp is Not Acceptable) **PRINTED NAME** **DATE**

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CenCal Health Addendum D: Provider Application

Provider Name:_____ **Provider NPI:**_____

Provider Email:_____

Position (ie MD, DO, Psychiatrist, Physician Assistant, MFT, LCSW, Psychologist):_____

Date:_____

Are you accepting New Patients? ☐YES ☐NO
Exclude from Directory? ☐YES ☐NO

Do you provide: ☐In Person & Telehealth Appointments ☐Telehealth Only ☐In Person Only

What is the age range you are willing to accept? Min_____ Max ____

How many hours a week do you work? ☐ 40 hrs OR☐ ____hrs/week

Please list the languages you speak (other than English) and what level of fluency per language:
Language:_____Fluency: ☐Certified Fluent ☐ Good ☐ Fair ☐ Poor
Language:_____Fluency: ☐Certified Fluent ☐ Good ☐ Fair ☐ Poor
Language:_____Fluency: ☐Certified Fluent ☐ Good ☐ Fair ☐ Poor

Please list your primary race:		
White ☐	Japanese ☐	Alaskan Native or American Indian ☐
Hispanic ☐	Hawaiian ☐	Korean ☐
Black ☐	Cambodian ☐	Vietnamese ☐
Filipino ☐	Samoan ☐	Chinese ☐
Asian or Pacific Islander ☐	Laotian ☐	Other:
Asian Indian ☐	Guamanian ☐	Decline to state ☐

Please list your gender:			
Male ☐	Female ☐	Genderqueer neither male or female ☐	Transgender male trans man/female-to male (FTM) ☐
Decline to state ☐	Other ☐		Transgender female trans woman/male-to female (MTF) ☐

Program/Specialty Participation:	**Yes**	**No**	**Effective Date**
Child Health and Disability Prevention Program (CHDP)	☐	☐	
California Children Services (CCS)	☐	☐	
Medi-Cal Certified	☐	☐	
HIV Specialist	☐	☐	

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Please list your primary ethnicity from the list below:			
Afghanistani ☐	Chinese ☐	Korean ☐	Pohnpeian ☐
African ☐	Chuukese ☐	Kosraean ☐	Polish ☐
African American ☐	Colombian ☐	Kurdish ☐	Polynesian ☐
Alaska Native ☐	Costa Rican ☐	La Raza ☐	Portuguese ☐
American Indian ☐	Criollo ☐	Laotian ☐	Puerto Rican ☐
Andalusian ☐	Cuban ☐	Latin American ☐	Punjabi (India) ☐
Arab ☐	Dominica Islander ☐	Lebanese ☐	Russian ☐
Argentinean ☐	Dominican ☐	Maldivian ☐	Saipanese ☐
Armenian ☐	Ecuadorian ☐	Mariana Islander ☐	Salvadoran ☐
Asian Indian ☐	Egyptian ☐	Marshallese ☐	Samoan ☐
Assyrian ☐	English ☐	Melanesian ☐	Scottish ☐
Asturian ☐	Ethiopian ☐	Mexican ☐	Singaporean ☐
Bahamian ☐	European ☐	Mexican American ☐	Solomon Islander ☐
Bangladeshi ☐	Fijian ☐	Mexican American Indian ☐	South American ☐
Barbadian ☐	Filipino ☐	Mexicano ☐	South American Indian ☐
Belearic Islander ☐	French ☐	Micronesian ☐	Spaniard ☐
Bengalese (India) ☐	Gallego ☐	Middle Eastern or North African ☐	Spanish Basque ☐
Bhutanese ☐	German ☐	Mixtec (Mexican Indian) ☐	Sri Lankan ☐
Black ☐	Guamanian ☐	Namibian ☐	Syrian ☐
Bolivian ☐	Guamanian or Chamorro ☐	Native Hawaiian ☐	Tahitian ☐
Bosnian ☐	Guatemalan ☐	Nepalese ☐	Taiwanese ☐
Botswanan ☐	Haitian ☐	New Hebrides ☐	Thai ☐
Brazilian ☐	Hindu ☐	Nicaraguan ☐	Tobagoan ☐
Burmese ☐	Hmong ☐	Nigerian ☐	Tokelauan ☐
Cambodian ☐	Honduran ☐	Okinawan ☐	Tongan ☐
Canal Zone ☐	Indonesian ☐	Other Hispanic ☐	Trinidadian ☐
Canarian ☐	Iranian ☐	Other Latino ☐	Uruguayan ☐
Carolinian ☐	Iraqi ☐	Pakistani ☐	Valencian ☐
Castilian ☐	Irish ☐	Palauan ☐	Venezuelan ☐
Catalonian ☐	Israeli ☐	Palestinian ☐	Vietnamese ☐
Central American ☐	Italian ☐	Panamanian ☐	West Indian ☐
Central American Indian ☐	Iwo Jiman ☐	Papua New Guinean ☐	Yao (Mien) ☐
Chamorro ☐	Jamaican ☐	Paraguayan ☐	Yapese ☐
Chicano ☐	Japanese ☐	Peruvian ☐	Zairean ☐
Chilean ☐	Kiribati ☐	Other (not on list)	Decline to state ☐

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For Mental Health Providers ONLY:
Put a check in the box next to the following areas in which you specialize with your patients as well as the treatment modalities. For those areas with an asterisk, please provide a copy of any certificates obtained in this area.

Area of expertise (check all that apply):

- ☐ Child/Adolescent
- ☐ Adult
- ☐ Geriatric Substance Abuse

Mental Health Practice Focus		
ADHD (1D)		☐
Anxiety (AD)		☐
Autism Spectrum Disorder (1D)*	*	☐
Bipolar Disorder (BP)		☐
Borderline Personality Disorder (PD)		☐
Dementia (CD)		☐
Depression (MD)		☐
Dissociative Disorders (DD)		☐
Eating Disorder (ED)*	*	☐
Families with Children with Serious Illnesses (AJ)		☐
Gambling (IC)		☐
Gender Dysphoria/LGBTQI (SG)		☐
Grief (AJ)		☐
Hoarding (AD)		☐
Illness Anxiety/Somatic Symptom Disorder (SD)		☐
Narcolepsy (SL)		☐
OCD (AD)*	*	☐
Phobias (AD)*	*	☐
Perinatal Mental Health (MD)* including	*	☐
PTSD/Trauma (AD)		☐
Schizophrenia/Schizo-affective Disorder (PS)		☐
Separation Anxiety (ID)		☐
Sexual Dysfunctions (SG)		☐
Skin-picking/Trichotillomania (IC)		☐
Substance Abuse (SR)		☐
Traumatic Brain Injury (GM)		☐

Treatment Modalities	
Child-parent Psychotherapy (CPP)	☐
Cognitive Behavioral Therapy (CBT)	☐
Couples Counseling	☐
Dialectical Behavior Therapy (DBT)	☐
Eye Movement Desensitization and Reprocessing (EMDR)	☐
Family Therapy (FMTPY)	☐
Group Therapy (GRTPY)	☐
Hypnotherapy	☐
Parent-Child Interaction Therapy (PCIT)	☐
Play Therapy (PLTPY)	☐
Positive Parenting Program (Triple P)	☐
Trauma-focused Cognitive Behavioral Therapy (TF-CBT)	☐
PSYCHOLOGISTS ONLY – Psychological testing	☐
PSYCHOLOGISTS ONLY – Neuro-psych testing	☐

Spravato/Ketamine Treatment ☐

New Provider Training

Attestation Form

Provider Group Name: _____

By signing below, I _____ attest that I have received and reviewed CenCal Health's New Provider Operations Guide, and watched the New Provider Orientation training videos located online at www.cencalhealth.org/providers/welcome-to-the-network on the following subjects:

- About the CenCal Health Provider Network
- Key Contacts
- CenCal Health Programs
- Eligibility
- Access to Care
- Covered Medi-Cal Benefits
- Referrals & Prior Authorization
- Member Rights, including the right to full disclosure of healthcare information and the right to actively participate in healthcare decisions
- Member Complaints and Grievances
- Provider Complaints and Grievances
- Behavioral Health & Mental Health Services
- Initial Health Assessment (IHA)
- Staying Healthy Assessment (SHA)
- Coordination of Care for Medi-Cal Members
- Health Education
- Cultural and Linguistics Training
- Seniors and Persons with Disabilities

_____ _____
Signature Date

_____ _____
Print Name Group Billing NPI#

_____
Title

_____
Address, City, St, Zip

☐ Our practice, including Providers and Medical Staff, acknowledges and confirms to have received Cultural Competency & Linguistics training and Seniors and Persons with Disabilities (SPD) Sensitivity training resources located within the New Provider Operations Guide or online Cultural Competency and Health Literacy | CenCal Health Insurance Santa Barbara and San Luis Obispo Counties

Please list all Rendering Physicians within your organization that received these training resources below:

_____ _____
Signature Date

_____ _____
Print Name Physician NPI#

_____
Title

_____ _____
Signature Date

_____ _____
Print Name Physician NPI#

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Title

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Title