

OUTPATIENT NETWORK PROVIDER APPLICATION

Note: No employee, director, agent, independent contractor or volunteer of the County is eligible to participate as an Outpatient Network Provider for the San Luis Obispo County Mental Health Plan.

A. Identifying Information

Last Name	First Name	Middle Initial	Professional Designation
Preferred Mailing Address (Line 1)	Preferred Mailing Address (Line 2)	City	Zip Code
Social Security Number (REQUIRED)	Date of Birth (REQUIRED)	Sex	

B. Primary Office Information (Please Identify if Private Residence: Yes ___ No ___)

After the Credentialing process is complete, a site visit will be conducted to meet and discuss the Program, Documentation and Billing Procedures

Practice Name		Office Manager (if applicable)	
Practice Address (Line 1)	Practice Address (Line 2)	City	Zip Code
Appointment Telephone	Fax Telephone	Email:	
Is this site near public transportation? (REQUIRED)		Is this site handicap accessible? (REQUIRED)	

Billing Information

Make Checks Payable to		Employer Identification Number (EIN)/Tax ID Number	
Billing Address (Line 1)		Billing Address (Line 2)	
City	Zip Code	Telephone Number	Medicare/UPIN Number (applicable for LCSW/PhD)

C. Secondary Office Information (Please Identify if Private Residence: Yes ___ No ___)

Practice Name		Office Manager (if applicable)	
Practice Address (Line 1)	Practice Address (Line 2)	City	Zip Code
Appointment Telephone	Fax Telephone	Voicemail Telephone	
Is this site near public transportation? (REQUIRED)		Is this site handicap accessible? (REQUIRED)	

Secondary Office Billing Information

Make Checks Payable to		Employer Identification Number/Tax ID Number	
Billing Address (Line 1)		Billing Address (Line 2)	
City	Zip Code	Telephone Number	Medicare/UPIN Number

D. Twenty-four (24) Hour Call Coverage

Note: It is Mental Health’s policy that each provider arrange for adequate 24-hour coverage. Mental Health defines the scope of 24-hour coverage by means of the following three (3) categories:

- (1) Preferred Coverage: consists of means leading to live contact with a licensed professional (i.e., answering service, call coverage group)
- (2) Acceptable Coverage: consists of voice message systems, beepers/pagers and cell phones leading to communication with a licensed professional
- (3) Unacceptable Coverage: Hotline, 911, County Mental Health and County Mental Health Crisis Team

After Hours: Please indicate how you can be reached after hours.

Answering Service Name	Telephone Number
Other	

Covering Practitioner(s): Please identify your covering practitioner(s) by name. It is strongly preferred that your covering practitioner(s) also participate in the San Luis Obispo County Mental Health Plan.

Call Coverage Practitioner	Licensure Level	Telephone Number
Call Coverage Practitioner	Licensure Level	Telephone Number

E. Hospital Privileges (physician’s only)

Primary Admitting Facility	Secondary Admitting Facility	Tertiary Admitting Facility
Address	Address	Address

SAN LUIS OBISPO COUNTY MENTAL HEALTH
 2178 JOHNSON AVENUE
 SAN LUIS OBISPO, CA 3401-4535
 PHONE NO. (800) 838-1381
 FAX NO. (805) 781-4176

F. Education Information

Undergraduate Institution	City/State	Degree	From	To
Graduate Institution	City/State	Degree	From	To
Internship	City/State		From	To
Residency	City/State		From	To
Fellowship	City/State		From	To

G. Licensure and Certification Information

Professional License(s)

Name of Issuing Board	Certificate Number	State	Original Date of Issue	Expiration Date
Name of Issuing Board	Certificate Number	State	Original Date of Issue	Expiration Date

National Provider Identifier (NPI) Number and Taxonomy Code

NPI Number	Taxonomy Code
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Board Certification/Specialty (if applicable)

Name of Issuing Board	Specialty	Original Date of Issue	Expiration Date (if applicable)
Name of Issuing Board	Specialty	Original Date of Issue	Expiration Date (if applicable)

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H. Professional Liability Insurance

Note: It is Mental Health’s policy that each provider procure professional liability insurance which has a Best’s rating of no less than B+VIII and are admitted insurance companies in the State of California. Each provider shall maintain coverage with limits of liability of not less than one million (\$1,000,000) dollars per claim or occurrence to cover all services rendered by provider. **Should Mental Health approve participation on the Network Provider Panel, the County of San Luis Obispo shall be named as additional insured under the provider’s professional liability policy.**

Carrier’s Name	Policy Certificate Number	Per Occurrence/Claim	Per Aggregate
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I. Comprehensive General Liability Insurance

Each provider shall maintain coverage with limits of liability of not less than one million (1,000,000) dollars per claim or occurrence to cover all services rendered by provider. **Should Mental Health approve participation on the Network Provider Panel, the County of San Luis Obispo shall be named as additional insured under the provider’s comprehensive general liability policy.**

Carrier’s Name	Policy Certificate Number	Per Occurrence/Claim	Per Aggregate
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J. Past Professional Liability Providers: List the name(s) and address(es) of the professional liability carrier(s) who has provided coverage for you in the most recent five (5) years. If there is more than one carrier, please indicate your reason for changing carriers. If additional space is needed, please use a separate sheet of paper.

Carrier’s Name	Policy Certificate Number	Per Occurrence/Claim	Per Aggregate
City/State	Dates of Coverage	Reason for Changing	
Carrier’s Name	Policy Certificate Number	Per Occurrence/Claim	Per Aggregate
City/State	Dates of Coverage	Reason for Changing	

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2178 JOHNSON AVENUE
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K. Work History

Note: This section may be used for work history and military experience. A current Curriculum Vitae, which **must specify month and year**, may be submitted. Please explain any gaps of six months or more on a separate piece of paper.

From (Month/Year)	To (Month/Year)	Name & Address of Employer	Description of Activities

Note: On a separate sheet of paper, please explain in full any answers which you have marked “YES” Documentation is REQUIRED if you have any malpractice claims pending or settling (include any settlement(s)/adjudication(s), original complaint(s) and final disposition(s)). In the event of a pending case, a signed statement from you regarding the alleged incident will suffice.

(Please mark appropriate box)

Attestation		YES	NO	N/A
1.	Health Status: Do you currently have any physical, mental or emotional condition, which may impair your ability to render the professional services which are the subject of this application?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Do you currently use illegal drugs or abuse drugs or alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Professional Liability Coverage: Has your professional liability coverage ever been denied, canceled, or non-renewed or initially refused upon application?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Licensure: Has your medical or professional license in any state ever been revoked, suspended, placed on probation, conditional status, or limited?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Have you ever voluntarily surrendered your license?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Are formal charges pending against you at this time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	DEA Certificate: Has your DEA Registration Certificate ever been suspended, revoked, subjected to probation, placed on conditional status, or limited?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Hospital Privileges: Has any hospital ever dismissed you from its staff?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Has any hospital ever revoked, suspended, or limited your privileges?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	Has any hospital initiated either type of aforementioned action by formal notice to you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	Has any hospital refused or denied you privileges?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.	Have you ever voluntarily surrendered your hospital privileges?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.	Hospital Sanctions: Have you ever surrendered your clinical privileges upon threat censure, restriction, suspension, or revocation of such privileges?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.	Professional Membership(s): Has your membership in any professional society or association ever been canceled, revoked, or censured?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15.	Medicare/Medicaid: Have you ever been fined, had an arrangement suspended, been expelled from participation or had criminal charges brought against you by Medicare or Medicaid?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16.	Criminal Offenses: Have you ever been convicted of a felony involving charges of moral or ethical turpitude?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17.	Board Discipline: Have you ever been the subject of disciplinary proceedings by any professional association or organization (i.e. state licensing board; county; state or national professional society, hospital medical or clinical staff)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18.	Malpractice Action: Has any malpractice action against you been brought or settled in the last five (5) years, or has there been any unfavorable judgment(s) against you in a malpractice action?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19.	To your knowledge, is any malpractice action against you currently pending?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I hereby attest that the information above is true and correct to the best of my knowledge.

Signature: _____

Print Name: _____

Date: _____

Participation Statement

I fully understand that if any matter stated in this application is or becomes false, San Luis Obispo County Mental Health will be entitled to terminate my provider agreement for breach. All information submitted by me in this application is warranted to be true, correct and complete.

I authorize San Luis Obispo County Mental Health and/or its Credentials Verification Organization (CVO) to consult with the National Practitioners Data Bank (NPDB), the Healthcare Integrity and Protection Data Bank (HIPDB), state licensing board(s), educational institutions, specialty boards, malpractice insurance carriers, Educational Council for Foreign Medical Graduates, hospitals, professional references and any other person or entity from whom/which information may be needed to complete the credentialing process or to obtain and verify information concerning my membership, professional competence, character and moral and ethical qualifications, and I also authorize all of them to release such information to San Luis Obispo County Mental Health and/or its CVO. I release San Luis Obispo County Mental Health and its employees and/or its CVO and all those whom San Luis Obispo County Mental Health and/or its CVO contacts from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluation of my application.

I consent to the release by any person to San Luis Obispo County Mental Health and/or its CVO of all information that may reasonably be relevant to an evaluation of my professional competency, character and moral and ethical qualification, including any information in relation to any disciplinary action/suspension or curtailment of privileges, and hereby release any such person providing such information from any and all liability for doing so.

I consent to the release by San Luis Obispo County Mental Health and its employees of all information that may reasonably be relevant to an evaluation of my professional competency, including any information concerning any disciplinary action/suspension or curtailment of privileges, and hereby release any such person providing such information to other Counties or appropriate agencies/facilities from any and all liability for doing so.

Signature:

Printed Name:

Date:

RETURN COMPLETED APPLICATION WITH REQUIRED DOCUMENTATION

- Professional State Licensure
- Curriculum Vitae
- Drug Enforcement Administration (DEA) Certificate (if applicable)
- Professional Liability face sheet
- Board Certificate (if applicable)
- Business License
- When applicable, verification of training, clinical experience/background, and/or certification of specialty(ies)

TO:

San Luis Obispo County Mental Health
Credentialing/Managed Care
2178 Johnson Avenue
San Luis Obispo, CA 3401-4535

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 2178 JOHNSON AVENUE
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PROFESSIONAL PEER REFERENCE FORM

A. Identifying Information

Last Name	First Name	Middle Initial	Professional Designation
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B. Reference #1

Note: It is Mental Health's policy that each applicant provide the names of two peer references that are licensed professionals, not related to applicant, that we may contact. Due to a possible conflict of interest, no employee, director, or agent of the County, is eligible to participate as a peer reference.

Last Name	First Name	Professional Designation	Sex
Mailing Address (Line 1)	Mailing Address (Line 2)	City	Zip Code
Telephone Number	Fax Number		

C. Reference #2

Last Name	First Name	Professional Designation	Sex
Mailing Address (Line 1)	Mailing Address (Line 2)	City	Zip Code
Telephone Number	Fax Number		