SANTA CLARA COUNTY
Behavioral Health Services

Clinician Credentialing Form

This form should only be filled out by clinicians providing direct services

8328230

** If filling out by hand, please use a black pen. No markers please.*

** Use CAPITAL letters. Do not let the writing touch the edges of the boxes:* A B C D

** Write numerals like this:* 1 2 3 4 5 6 7 8 9 0

1 ○ New ○ Update ○ Removal

2 ○ Temporary Absence — Absence Start Date (Y Y . M M . D D) — Absence Return Date (Y Y . M M . D D)

3 Provider's (Clinician's) Last Name

4 Provider's (Clinician's) First Name

5 Provider's (Clinician's) Middle Name

6 Hire Date (.Y Y . M M . D D)

7 Manager Last Name

8 Manager First Name

9 DEA Number (if applicable)

10 UniCare Provider Code

11 NPI Number - Type 1 (Clinician)

12 Taxonomy Code

13 Taxonomy / NPI Enumeration Date (Y Y . M M . D D)

14 Provider's (Clinician's) Email

15 California Professional Certification Number

16 Professional Cert. Effective Date (Y Y . M M . D D)

17 Professional Cert. Expiration Date (Y Y . M M . D D)

18 **Mark the license you have**

○ APCC	○ LPCC	○ ASW	○ LCSW	○ AMFT	○ LMFT	○ Reg Psy	○ Lic Psy	○ Psy Tech	○ NP ○ MD
○ RADT	○ RADT II	○ CADC I	○ CADC II	○ CADS-CAS	○ CATC	○ CATC I	○ CATC II	○ CATC III	○ CATC IV
○ CATC V	○ CATC N	○ LAADC	○ LAADC-S	○ CA ODC	○ CA ODC-A	○ CA ODC-CS	○ RAC	○ SUDCC-CS	○ SUDRC

19 List any board certification, special training, experience or specialization:

20 List any cultural capabilities (i.e. TAY, Veterans, etc.)

21 Language Capacity ○ American Sign Language ○ Arabic ○ Armenian ○ Cambodian ○ Cantonese ○ English ○ Farsi ○ Hmong ○ Korean ○ Mandarin ○ Other Chinese ○ Russian ○ Spanish ○ Tagalog ○ Vietnamese

22 Other 1 Lang. / Other 2 Lang. / Other 3 Lang.

23 Cultural Competency Training (hrs) (Within past 24 months)

24 Telehealth Provider ○ Yes ○ No

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25	Have you ever had any suspension or curtailment of hospital or clinic privileges?	○ Yes ○ No	If yes, please attach a list.
26	Have you ever had any liability claims filed against you?	○ Yes ○ No	If yes, please attach a list.
27	Have you ever had any sanctions from participating in Medicare/Medicaid/Medi-Cal?	○ Yes ○ No	If yes, please attach a list.
28	Have you ever had any sanctions, limitations or revocation of your license by any state agency or licensing board?	○ Yes ○ No	If yes, please attach a list.

29 **Organization Name (select ONE):**

Contractors: ○ AACI ○ Advent ○ BAART ○ Caminar/FCS ○ HR360 ○ Parisi

30 ○ Pathway ○ Proyecto ○ Momentum ○ TeleCare ○ Starlight

	L-Codes for locations where you provide services	Start Date (Y Y M M D D)	End Date (Y Y M M D D)	Full Time Equivalent (# of hours/week)
31	LC 1 L-000	. .	. .	
32	LC 2 L-000	. .	. .	
33	LC 3 L-000	. .	. .	
34	LC 4 L-000	. .	. .	

35 **Exit Date** . . (Y Y M M D D)

36 **Comments**

I attest that as a network provider who delivers services for the Behavioral Health Services Department that:

1. I do not have any limitations or inabilities that affect my capacity to perform any of the position's essential functions, with or without accommodation;
2. I have never lost my license / credential or had a felony conviction; 3. I have never lost or had any limitation of privileges or disciplinary action;
4. I do not use illicit substances. 5. I attest to the accuracy and completeness of the information provided.

37 **Enter your name in lieu of your signature**

38 **Date** . . (Y Y M M D D)