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**FRESNO COUNTY BEHAVIORAL HEALTH SYSTEM OF CARE**

**INDIVIDUAL/GROUP PROVIDER APPLICATION INSTRUCTIONS**

**Section A - Identifying Information**

* Please type all information.
* All questions must be completed or marked as "N/A;" incomplete applications will be returned.
* If there is insufficient room for any question, additional sheets may be attached. In the attachment, reference the question being answered.
* If the group ismulti-specialty, an independent practice association, or a corporation, please provide a description of your role within the group under *Type of Practice: Group.*

**Section B – National Provider Identifier (NPI) & Taxonomy**

* Provide your NPI number. This is required of all applicants. Ensure that the practice address matches the “primary practice” or a “secondary practice” addressed as listed on the NPI form.
* Provide your taxonomy number.

**Section C – Office Locations**

* List your current practice location(s) information.
* Provide the names and disciplines of other providers in the group.

**Section D - Employment/ Work History**

* List your current and all previous employment for the last 10 (ten) years.
* List your most recent employment first.

**Section E - Professional Education**

* List colleges and degrees obtained and all significant clinical educational experience after college; e.g., degrees, fellowships, residencies, clinical internships, etc.
* List your most recent experience first.
* Please attach your Curriculum Vitae.

**Section F – Provider Numbers**

* Complete as applicable.

**Section G – Board Certifications**

* Please provide the name of the Board, certification date, and expiration date, if applicable.

**Section H – Hospital Privileges – Current and Previous**

* Please provide current and previous hospitals with dates.

**Section I – Insurance/Malpractice Liability Information**

* Please current and previous insurance companies within the past five (5) years.

**Section J – Accessibility/Availability**

* Please advise whether you are accepting new clients, and days and hours available.
* Indicate whether your facility is wheelchair accessible.

**Section K - Payment Information**

* Please provide your National Provider Identifier number (NPI), Tax ID number, and indicate who checks should be made out to.

**Section L - Professional Historical Data Attestation**

* Please answer all questions. Additional, detailed explanation is required for any “Yes” answer. (Questions #1-14 only)
* Definitions of “crimes of moral turpitude” can be found on page 12 of this application.

**Section M – Signature**

* Please read the included statement before signing.

**Please provide copies of:**

1. Government Issued Photo ID (Driver’s License, Identification Card, U.S. Passport, etc.).
2. Your DEA certificate (if applicable).
3. Copies of professional licenses & certificates.
4. Your current malpractice liability coverage policy.
5. Your current Curriculum Vitae or Resume. Also include supplemental information stating areas of cultural expertise, cultural training, and foreign languages spoken, read or written.
6. **FOR AMFT, ASW, APCC, and Registered Psychologists only:** Signed BBS *Responsibility Statement for Supervisors*, and provide copies of the supervisor’s current (most recent) supervision coursework.
7. **FOR AMFT, ASW, APCC, and Registered Psychologist applications only**: Provide a copy of the private practice employer’s current Worker’s Compensation insurance coverage policy.
8. Release of Information form.
9. CA 590 (Individual Provider licensed staff only).
10. W-9 (Individual Provider licensed staff only).
11. Clinical Profile and support material for any identified areas of specialty (licensed staff only).
12. Copy of EIN letter sent to you from the IRS to assign the EIN to you (Group Provider licensed staff only).
13. For **Nurse Practitioners and Medical Residents**, please provide a copy of your Standardized Procedures.
14. For **Physician Assistants**, please provide a copy of your Declarations.

Please send the completed Application, additional forms listed above, and, if applicable, explanation pages, via one of these methods:

***Hand Deliver:*** ***Mail:***

Fresno County Managed Care Credentialing Fresno County Managed Care Credentialing

1925 E Dakota Avenue, M/S 271 P.O. Box 45003

Fresno, CA 93726 Fresno, CA 93718-9886

***E-Mail:*** [mcare@FresnoCountyCA.gov](mailto:mcare@FresnoCountyCA.gov)

***Fax:*** 559-455-4633

If you have any questions regarding this application, please call Managed Care Credentialing at 559-600-4645.

**FRESNO COUNTY BEHAVIORAL HEALTH SYSTEM OF CARE**

INDIVIDUAL/GROUP PROVIDER APPLICATION

Please complete all sections; enter “N/A” if not applicable.

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| **A - IDENTIFYING INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name (Last, First, M.I.): | | | | | | | | | | | | | | | | | | | | | | | | | DOB: | | | | |
| Practice Address: | | | | | | | | | | | | | | | | | | | Gender: | | | | | | | | | | |
| City: | | | | | | | | | | | State: | | | | | | | | ZIP: | | | | | | | | | | |
| Phone: | | | | | | | | | | | E-mail Address: | | | | | | | | | | | | | | | | | | |
| Website: | | | | | | | | | | | | Is site ADA Compliant? Choose an answer | | | | | | | | | | | | | | | | | |
| Social Security Number: | | | | | | | | | | | | Ethnicity: | | | | | | | | | | | | | | | | | |
| Previous (Full) Name(s) You’ve Worked Under: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Languages spoken fluently (besides English): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **MEDICAL STAFF-Prescribing**  *(add additional rows as needed)* | | | | | | | | Please choose one of the following | | | | | | | | | | | | | | | | | | | | | |
| **LICENSED/CERTIFIED CLINICAL STAFF**  *(add additional rows as needed)* | | | | | | | | Please choose one of the following | | | | | | | | | | | | | | | | | | | | | |
| **UNLICENSED/REGISTERED CLINICAL STAFF**  *(add additional rows as needed)* | | | | | | | | Please choose one of the following | | | | | | | | | | | | | | | | | | | | | |
| Licensing, Certifying or Registering Organization | | | | | Type of Licensure, Certification or Registration | | | | | | | | | | | Licensure, Certification or Registration Number | | | | | | | | | | State | Expiration Date | | |
|  | | | | |  | | | | | | | | | | |  | | | | | | | | | |  |  | | |
| *For all Unlicensed or Registered Clinical Staff: Please provide the name and license/certification information of your Supervisor.*  *Your Supervisor must be a BHSOC credentialed provider and be able to supervise according to your licensing/certifying organization.* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Supervisor’s Name:**        **Licensing/Certifying Organization and Number:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| B - National PROVIDER IDENTIFIER (npi) *– Practice address must match primary practice address* **AND TAXONOMY NUMBER** *(add additional rows as needed)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NPI Number: | | | | | | | | | | | | | | Taxonomy Number: Choose an item | | | | | | | | | | | | | | | | |
| c - PRACTICE LOCATION(S) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Office #1** | | | | | | | | | | | | | | **Office #2** | | | | | | | | | | | | | | | | |
| Street Address: | | | | | | | | | | | | | | Street Address: | | | | | | | | | | | | | | | | |
| City, State, ZIP: | | | | | | | | | | | | | | City, State, ZIP: | | | | | | | | | | | | | | | | |
| Phone: | | | Tax ID:  (if different from SSN) | | | | | | | | | | | Phone: | | | | | | Tax ID:  (if different from SSN) | | | | | | | | | | |
| Fax: | | | E-Mail: | | | | | | | | | | | Fax: | | | | | | E-Mail: | | | | | | | | | | |
| **Type of Practice:** | | | | | | | Please choose one of the following | | | | | | | | | | | | | | | | | | | | | | | |
| **Legal Name of Practice:** | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| Please provide the names and disciplines of other providers in the group: *(Add additional rows as needed)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name | | Discipline | | | | | | | | | | | | Name | | | | | | | | | Discipline | | | | | | | |
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| **D – EMPLOYMENT/WORK HISTORY** *Current and/or previous last 10 years (add additional rows as needed)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Organization | | Dates  From – To | | | | | | | | | | | | Reason for Leaving | | | | | | | | | Supervisor  Name, Title, Phone No. | | | | | | | |
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| **E – PROFESSIONAL EDUCATION** *– Please attach Curriculum Vitae (add additional rows as needed)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Institution | | | | | | City/State | | | | | | | Type of Program | | | | | | | | | Graduation Year | | | | | | Degree | | |
|  | | | | | |  | | | | | | |  | | | | | | | | |  | | | | | |  | | |
| **F – PROVIDER NUMBERS** *- Complete only if applicable* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medi-Cal Provider No.: | | | | | | | Medicare UPIN: | | | | | | | | | | | Medicare Effective Date: | | | | | | | | | | | | |
| DEA Number: | | | | | | | DEA Issuance Date: | | | | | | | | | | | DEA Expiration Date: | | | | | | | | | | | | |
| ECFMG No.: | | | | | | | ECFMG Issuance Date: | | | | | | | | | | | ECFMG Recertification Date: | | | | | | | | | | | | |
| **G – BOARD CERTIFICATIONS -** Complete only if applicable (add additional rows as needed) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of Board | | | | | | | Certification Date | | | | | | | | | | | | | Expiration Date (if applicable) | | | | | | | | | | |
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| **H – HOSPITAL PRIVILEGES** – Current and Previous (add additional rows as needed) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hospital | | | City/State | | | | | | | | | | | Appointment Date | | | | | | Withdrawal Date (if applicable) | | | | | | | | | | |
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| **I – INSURANCE/MALPRACTICE LIABILITY INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Current Insurance Company and Coverage Information** - Please attach a copy of the current policy | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Carrier Name: | | | | | | | | | Phone No.: | | | | | | | | | | | | Fax No: | | | | | | | | |
| Street Address: | | | | | | | | | City/State/ZIP: | | | | | | | | | | | | Claim Limit: | | | | | | | | |
| Effective Date: | | | | | | | | | Expiration Date: | | | | | | | | | | | | Aggregate Limit: | | | | | | | | |
| **Previous Insurance Company** – Please list all Insurance Companies within the past five (5) years | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Carrier Name: | | | | | | | | | Phone No.: | | | | | | | | | | | | Fax No.: | | | | | | | | |
| Street Address: | | | | | | | | | City/State/ZIP: | | | | | | | | | | | | Claim Limit: | | | | | | | | |
| Effective Date: | | | | | | | | | Expiration Date: | | | | | | | | | | | | Aggregate Limit: | | | | | | | | |
| **J – AVAILABILITY/ACCESSIBILITY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Are you currently accepting new clients? | | | | | | | | | Yes  No | | | Wheelchair accessible? | | | | | | | | | Yes  No | | | | | | | | |
| Days Available | Monday | | | Tuesday | | | | | | Wednesday | | | | | Thursday | | Friday | | | | | | | Saturday | | | | | Sunday |
| Hours Available |  | | |  | | | | | |  | | | | |  | |  | | | | | | |  | | | | |  |
| **K – PAYMENT INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If I am approved to be a provider with the Fresno County Mental Health Plan, payments for services provided should be made to me as follows: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Checks made payable to: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mailing Address: | | | | | | | | | | | | City/State/ZIP: | | | | | | | | | | | | | | | | | |
| Tax ID: | | | | | | | | | | | | EIN No.: | | | | | | | | | | | | | | | | | |

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| **L – PROFESSIONAL HISTORICAL DATA ATTESTATION** | | | |
| You must answer all questions below. **If you answer “Yes” to any question with the exception of # 15 - 18, please provide a detailed explanation on a separate page.** The explanation should include dates, circumstances of the incident, final outcome, current disposition, etc. | | | |
| 1 | Yes  No  N/A | Any professional license ever denied, revoked, limited, suspended or voluntarily surrendered. | |
| 2 | Yes  No  N/A | DEA registration ever suspended, revoked, or otherwise limited in any state? | |
| 3 | Yes  No  N/A | Has your professional liability insurance coverage ever been terminated by action of an insurance company? | |
| 4 | Yes  No  N/A | Have you ever been denied professional liability insurance coverage or rated in a high-risk class for your professional specialty? | |
| 5 | Yes  No  N/A | Do you suffer from any physical or psychological illness, problem, injury or health condition that may limit, impair, or affect your ability to practice? | |
| 6 | Yes  No  N/A | To your knowledge, has any information pertaining to you ever been reported to the National Practitioner Data Bank? | |
| 7 | Yes  No  N/A | Have you ever been denied membership or renewal thereof, or been subject to probation, reprimand, censure, sanction, under investigation or disciplined by any health care organization, including but not limited to: Fresno County or another county mental health plan*,* hospitals, health care facilities*,* HMOs, PPOs, independent practitioner associations, professional associations, groups or societies, ethics committee, state licensing boards, certification boards or examiners, professional standards review organization (PSRO), peer-review organization (PRO), or educational/training institution? | |
| 8 | Yes  No  N/A | Are you currently or have you ever been excluded, debarred, suspended or otherwise ineligible to participate in the Federal (Medicare & Medi-Cal) health care programs; i.e., are you considered an “ineligible person” for billing Federal health care programs? | |
| 9 | Yes  No  N/A | Have you been convicted of a criminal offense that will make you an “ineligible person,” but you are not yet excluded from participating in Federal health care programs? | |
| 10 | Yes  No  N/A | Have you ever been convicted, suspended or assessed a civil penalty under the anti-fraud and abuse provision of the Medicare or Medicaid program? | |
| 11 | Yes  No  N/A | Are you currently under investigation by the Medicare and/or Medicaid programs? | |
| 12 | Yes  No  N/A | Have any malpractice claims been filed against you during the past seven (7) years? | |
| 13 | Yes  No  N/A | Have you ever been convicted of gross misconduct, a felony, or a crime of moral turpitude? | |
| 14 | Yes  No  N/A | Are you presently using any illegal drugs? | |
| 15 | Yes  No  N/A | Have you completed the continuing education requirements for license renewal per your State professional board? (Evidence of CEU completion may be requested for auditing purposes by the Credentialing Committee) | |
| 16 | Yes  No  N/A | Have you completed Cultural Competency Training? (Evidence of CEU completion may be requested for auditing purposes by the Credentialing Committee). | |
| 17 | Yes  No  N/A | **For medical residents only:**  If you are not Board eligible, are you working under the direction of a Board certified physician?  Name of this physician: | |
| 18 | Yes  No  N/A | **For medical residents only:**  Are you a medical resident in Fresno County? Choose an item. If “No,” List State & County: | |
| **M – SIGNATURE** *– Please read this statement before signing:* | | | |
| Information provided on this application may be verified, including but not limited to, by contacting former employers. My signature certifies that all the information on this Application, the Clinical Profile and any attached explanation page(s) is true, correct and complete. I understand and agree that any misstatements or omissions of material facts herein may cause forfeiture on my part of my right to participate as a provider with the Fresno County Mental Health Plan. | | | |
| Signature: | | | Date: |

**FRESNO COUNTY BEHAVIORAL HEALTH SYSTEM OF CARE**

**RELEASE OF INFORMATION**

**INDIVIDUAL/GROUP PROVIDERS**

**CERTIFICATION**

I, the undersigned, hereby attest that the information given in or attached to this Application is accurate and complete. I specifically authorize you and your authorized representatives to consult with any third party which may have information bearing on the subject matter addressed by this Application, and to inspect or obtain any reports, records, recommendations, or other documents or disclosures from third parties that may be material to the questions in the Application. I also specifically authorize any third party to release information to you and/or your authorized representatives upon request.

I hereby release you and/or your authorized representatives and any third parties, from any liability for any reports, records, recommendations, or other documents or disclosures involving me that are made, requested, or received by you and/or your authorized representatives to, from, or by third parties, including otherwise privileged or confidential information, made or given in good faith and relating to the subject matter addressed by this Application.

I warrant that I am authorized to sign this Application, on behalf of any entity or organization for which I am signing in a representative capacity. I understand that if this Application is accepted by the Fresno County Mental Health Plan, I will be bound by current State and Federal regulations.

**Your signature is required to complete this Application.**

**Stamped signatures are not acceptable.**

Provider Name:

Printed Name:

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title:

*Fresno County is an equal opportunity, disabilities, affirmative action organization that does not discriminate in regards to race, color, religion, sex, national origin, age (40 or older), disability (physical or mental), medical condition, pregnancy, genetic information, ancestry, sexual orientation, marital status, veteran/military status, or any other basis protected by Federal or State law.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Clinical Profile for MDs** (Page 1 of 2) | | | |
| Please mark with an X all areas in which you have been trained, are clinically experienced, and are willing to treat. "**Standard**" areas do not require explanation, but for each area under "**Specialties / Specialized Experience**" you must provide **specific information** on the education, training and/or experience you have in that specialty, including Board eligibility, Board certification, residency, and fellowships, as applicable. Specialties indicate **extensive knowledge and practice** in the area. **Use page 2 to provide this information**. | | | |
| **I. Populations Treated/Cultural Focus** | | | |
| Standard | Specialty / Subspecialty | | |
| Infants/Toddlers (0-5)  Children (6-11)  Adolescents (12-17)  Adults (18-64)  Senior Adults (65+)  African American  Latino-Hispanic  Asian / Pacific Islander  Men  Women  Physical Disability (Severe)  Other: | Infants/Toddlers (0-5)  Children (6-11)  Adolescents (12-17)  Adults (18-64)  Senior Adults (65+)  Blind  Deaf & Hard of Hearing  Families  Couples  Gay/Lesbian/Bisexual/Transgender  Other: | | |
| **II. Problems/Disorders** | | | |
| Standard | Specialty / Subspecialty | | |
| Adjustment Disorders  Anxiety Disorders  Attention Deficit Disorders  MH w/ Substance Abuse Disorders  Impulse Control Disorders  Job Stress  Mood Disorders  Personality Disorders  Psychotic Disorders  Somatoform Disorders  Acute & Post Traumatic Disorders  Other: | ACA/Co-Dependency  Addiction Psychiatry  Dual Diagnosis  Domestic Violence  MH w/Developmental Delay  Eating Disorders  Forensic  Gender Dysphoria  HIV / AIDS  Pain Management  Sexual Abuse - Victim  Sexual Abuse – Offender  Dissociative Disorders  Neurodevelopmental Disabilities  Psychosomatic Medicine  Other: | | |
| **III. Service Areas/Techniques** | | | |
| Standard | Specialty / Subspecialty | | |
| Psychopharmacology  Crisis Intervention  Group Therapy  Inpatient  Individual Therapy  Family Therapy  Other: | Cognitive Behavioral Therapy  EMDR  Biofeedback  Hypnosis  Play Therapy  Other: | | |
| **Signature/Title:** | | **Date:** |  |
|  |  | | |

**MD Clinical Profile - Additional Information** (Page 2 of 2)

From each section on page 1, for each item marked under the "Specialties" columns, please provide additional information below regarding your clinical training and/or experience for each item. Attach additional sheets if needed.

|  |  |  |
| --- | --- | --- |
| **Section I - Populations Treated/Cultural Focus** | | |
| Specialty | Provide your education, clinical training/experience, Board eligibility, Board Certification, residency and fellowships, as applicable, for each specialty. (add additional rows as needed) |
|  |  |

|  |  |  |
| --- | --- | --- |
| **Section II - Problems/Disorders Treated** | | |
| Specialty | Provide your education, clinical training/experience, Board eligibility, Board Certification, residency and fellowships, as applicable, for each specialty. (add additional rows as needed) |
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| **Section III - Service Areas/Techniques** | | |
| Specialty | Provide your education, clinical training/experience, Board eligibility, Board Certification, residency and fellowships, as applicable, for each specialty. (add additional rows as needed) |
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| **Signature/Title:** | **Date:** |

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| **Clinical Profile for LMFTs, LCSWs, LPCCs, Certified AOD Counselors & Licensed Psychologists** (page 1 of 2) | | |
| Please mark with an X all areas in which you have been trained, are clinically experienced, and are willing to treat. "**Standard**" areas do not require explanation, but for each area under "**Specialties / Specialized Experience**" you must provide **specific information**, including details such as **where**, **when** and **time spent (part time = 16-31 hrs/wk) (full time = 32+ hrs/wk)**. Specialties indicate **extensive practice** in the area substantiated by a credential, certification and/or documented clinical experience. **Use page 2 to provide this information**.  Please **attach supporting documentation of your specialty in addition to your resume.** | | |
| **I. Populations Treated/Cultural Focus** | | |
| Standard | Specialties / Specialized Experience | |
| Children (6-11)  Adolescents (12-17)  Adults (18-64)  Senior Adults (65+)  African American  Latino-Hispanic  Asian / Pacific Islander  Men  Women  Lesbian/Gay/Bisexual/Transgender  Deaf & Hard of Hearing  Other: | Infants/Toddlers (0-5) (certification)  Developmental Delay/Cognitive Impaired  Autism Spectrum Disorder (BCBA)  Sexual Abuse - Victim/Survivor  Sexual Abuse - Offender  Other:  *\* When not specified, to claim any "Specialty" area, the professional must be licensed and demonstrate a minimum of 32 hours training and a minimum of 6 months full-time or 1 year part-time post-licensure experience.* | |
| **II. Problems/Disorders Treated** | | |
| Standard | Specialties / Specialized Experience | |
| Adjustment Disorders  Anxiety Disorders  Attention Deficit Disorders  Acute & Post Traumatic Disorders  ACA/Co-Dependency  Dissociative Disorders  Mood Disorders  Personality Disorders  Psychotic Disorders  Attachment  Impulse Control Disorders  Gender Identity Disorders  HIV / AIDS  Aging  Substance Use Disorders  Other: | Domestic Violence (40hr training)  MH w/Substance Abuse Disorders CADAC  Eating Disorders  Pain Management (40hr training or certification)  Forensic (40training or certification)  Anger Management  Medication Monitoring  Other:  *\* When not specified, to claim any "Specialty" area, the professional must be licensed and demonstrate a minimum of 32 hours training and a minimum of 6 months full-time or 1 year part-time post-licensure experience.* | |
| **III. Service Areas/Techniques** | | |
| Standard | Specialties / Specialized Experience | |
| Individual Therapy  Family Therapy  Couples Therapy  Group Therapy  Targeted Case Management  Cognitive Behavioral Therapy  Religious/Spiritual  Court Services  Motivational Interviewing  Relapse Prevention  Psychoeducation  Trauma-informed Treatment  Other: | Trauma-Focused CBT (certification)  Play Therapy/Theraplay (certification)  Biofeedback (certification)  Hypnosis (certification)  EMDR (certification)  Psychological Testing (Psychologist license accepted;  LMFT/LCSW/LPCC must justify)  Neuropsychological Testing (Psychologist license  accepted; LMFT/LCSW/LPCC must justify)  Other:  *\* When not specified, to claim any "Specialty" area, the professional must be licensed and demonstrate a minimum of 32 hours training and a minimum of 6 months full-time or 1 year part-time post-licensure experience.* | |
| **Requirement for all Licensed Professional Clinical Counselors (LPCC)** - Effective January 1, 2017, LPCCs **must** obtain written **Confirmation of Qualifications to Assess and Treat Couples and Families** from the Board of Behavioral Sciences. *A copy of the written confirmation from the Board must be provided along with a copy of current BBS licensure certificate prior to credentialing approval regardless of any Standard or Specialty areas claimed for all LPCC applicants.* | | |
| **Signature/Title:** | | **Date:** |

**Clinical Profile for LMFTs, LCSWs, LPCCs, Certified AOD Counselors & Licensed Psychologists** (Page 2 of 2)

For each item marked under the "Specialties" columns on Page 1, please provide additional information below regarding your clinical training and/or experience for each item. **Attach copies of certifications/verification of training when appropriate.**

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| **Section I - Populations Treated/Cultural Focus** | | |
| Specialty | Provide your education, clinical training/experience and # of hours for each specialty. (add additional rows as needed) |
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| **Section II - Problems/Disorders Treated** | | |
| Specialty | Provide your education, clinical training/experience and # of hours for each specialty. (add additional rows as needed) |
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| **Section III - Service Areas/Techniques** | | |
| Specialty | Provide your education, clinical training/experience and # of hours for each specialty. (add additional rows as needed) |
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| **Signature/Title:** | **Date:** |

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| **Clinical Profile for PAs, NPs, RNs, LVNs and LPTs** | | |
| Please mark all areas in which you have been  trained, are clinically experienced, and are willing to treat. | For each area marked, please specify:  **1) where you received your clinical experience** AND  **2) The number of hours worked per week to achieve this experience** (full time = 32 hours or more per week/Part time = 16 to 31 hours per week). **Attach certification or verification of training as appropriate.** | |
| **I. Populations Treated/Cultural Focus** | | |
| Infants/Toddlers (0-5)  Children (6-11)  Adolescents (12-17)  Adults (18-64)  Senior Adults (65+)  African American  Latino-Hispanic  Asian / Pacific Islander  Men  Women  Lesbian/Gay/Bisexual/Transgender  Deaf & Hard of Hearing  Other: |  | |
| **II. Problems/Disorders Treated** | | |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Adjustment Disorders  Anxiety Disorders  Attention Deficit Disorders  Acute & Post Traumatic Disorders  ACA/Co-Dependency  Dissociative Disorders  Mood Disorders  Personality Disorders  Psychotic Disorders  Attachment  Impulse Control Disorders  Gender Identity Disorders  HIV / AIDS  Aging  MH w/Substance Use Disorders  Other: |  | |
| **III. Service Areas/Techniques** | | |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date**: |
| Psychopharmacology  Crisis Intervention  Group Therapy  Inpatient Individual Therapy  Other: |  | |
| **Signature/Title**: | | **Date**: |

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| **Explanation for “Crime of Moral Turpitude” from Question 13 of the Professional Historical Data Attestation** |
| **Crimes Against Property** |
| **Crimes involving moral turpitude**  Fraud: Making false representation; Knowledge of such false representation by the perpetrator; Reliance on the false representation by the person defrauded; An intent to defraud; The actual act of committing fraud  Evil Intent: Arson; Blackmail; Burglary; Embezzlement; Extortion; False pretenses; Forgery; Fraud; Larceny (grand or petty); Malicious destruction of property; Knowingly Receiving stolen goods; Robbery; Theft (when it involves the intention of permanent taking); Transporting stolen property (with guilty knowledge) |
| **Crimes not involving moral turpitude**  Damaging private property (where intent to damage not required); Breaking and entering (requiring no specific or implicit intent to commit a crime involving moral turpitude); Passing bad checks (where intent to defraud not required); Possessing stolen property (if guilty knowledge is not essential); Joy riding (where the intention to take permanently not required); Juvenile delinquency; Trespassing |
| **Crimes Against Governmental Authority** |
| **Crimes involving moral turpitude**  Bribery; Counterfeiting; Fraud against revenue or other government functions; Mail and wire fraud; Perjury; Harboring a fugitive from justice (with guilty knowledge); Tax evasion (willful) |
| **Crimes not involving moral turpitude**  Black market violations; Breach of the peace; Carrying a concealed weapon; Desertion from the Armed Forces; Disorderly conduct; Drunk or reckless driving; Driving while license suspended or revoked; Driving without insurance; Drunkenness; Escape from prison; Failure to report for military induction; False statements (not amounting to perjury or involving fraud); Firearm violations; Gambling violations; Immigration violations; Liquor violations; Loan sharking; Lottery violations; Minor traffic violations; Operating a pirate radio or television station; Possessing burglar tools (without intent to commit burglary); Smuggling and customs violations (where intent to commit fraud is absent); Tax evasion (without intent to defraud); Vagrancy |
| **Crimes Against Person, Family Relationship and Sexual Morality** |
| **Crimes involving moral turpitude**  Abandonment of a minor child (if willful and resulting in the destitution of the child); Adultery (see INA 101\*\* repealed by Public Law 97-116); Assault (this crime is broken down into several categories, which involve moral turpitude): Assault with intent to kill, commit rape, commit robbery or commit serious bodily harm / Assault with a dangerous or deadly weapon; Bigamy; Paternity fraud; Contributing to the delinquency of a minor (where sexual); Gross indecency; Incest (if the result of an improper sexual relationship); Kidnapping; Lewdness; Manslaughter: Voluntary / Involuntary (where the statute requires proof of recklessness, which is defined as the awareness and conscious disregard of a substantial and unjustified risk which constitutes a gross deviation from the standard that a reasonable person would observe in the situation. A conviction for the statutory offense of vehicular homicide or other involuntary manslaughter requires only a showing of negligence will not involve moral turpitude even if it appears the defendant in fact acted recklessly); Mayhem; Murder; Pandering; Prostitution; Rape (including "Statutory rape" by virtue of the victim's age) |
| **Crimes not involving moral turpitude**  Assault (simple) (any assault, which does not require an evil intent or depraved motive, although it may involve the use of a weapon, which is neither dangerous nor deadly); Bastardy (the offense of begetting a bastard child); Creating or maintaining a nuisance (where knowledge that premises were used for prostitution is not necessary); Incest (when a result of a marital status prohibited by law); Involuntary manslaughter (when killing is not the result of recklessness); Libel; Failure to register as a sex offender[14]; Mailing an obscene letter; Mann Act violations (where coercion is not present); Riot; Sexual harassment; Suicide (attempted) |
| **Attempts, Aiding and Abetting, Accessories and Conspiracy** |
| **Crimes involving moral turpitude**  An attempt to commit a crime deemed to involve moral turpitude; Aiding and abetting in the commission of a crime deemed to involve moral turpitude; Being an accessory (before or after the fact) in the commission of a crime deemed to involve moral turpitude; Taking part in a conspiracy (or attempting to take part in a conspiracy) to commit a crime involving moral turpitude where the attempted crime would itself constitute moral turpitude. |
| **Crimes not involving moral turpitude – N/A** |