KERN HEALTH SYSTEMS
BEHAVIORAL HEALTH APPLICATION

This application is submitted to**:** **Kern Health Systems** , herein, this Healthcare Organization[1]

I. INSTRUCTIONS:

Read all instructions before completing the application.
Type or print clearly, in ink.
Do not use abbreviations when completing the application.
If you must make corrections, please line through, date, and initial in ink.
Do not leave any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you.

Please return completed application to:
Kern Health Systems
Attn: Provider Relations
9700 Stockdale Hwy
Bakersfield, CA 93309

II. PROVIDER TYPE (check all that apply)

- ☐ Behavior Analyst (all levels)
- ☐ Licensed Marriage and Family Therapist
- ☐ Licensed Clinical Social Worker
- ☐ Nurse (RN, LPN, NA)
- ☐ Nurse Practitioner/Physician Assistant, Advance/Masters RN
- ☐ Psychiatrist/Physician/MD/DO
- ☐ Psychologist (PhD level)
- ☐ Substance Abuse Professional (all levels)
- ☐ Other (please specify)

III. IDENTIFYING INFORMATION

Last Name:	First:	Middle:
Is there any other name under which you have been known? Name (s):		
Home Mailing Address:	City:	
	State:	ZIP:
Home Telephone Number:	E-Mail Address:	
Home Fax Number:	Pager Number:	
Birth Date:	Social Security #:	
Birth Place (City/State/Country):	Citizenship (If not a United States citizen, please include copy of Alien Registration Card).	
Gender[2]: ☐ Male ☐ Female	Race/Ethnicity[2] (voluntary):	
Specialty:		
Subspecialties:		

[1] As used in the Information Release/Acknowledgments Section of this application, the term "this Healthcare Organization" shall refer to the entity to which this application is submitted as identified above.

[2] This information will be used for consumer information purposes only.

Applicant Name: _____

IV. PRACTICE INFORMATION

Practice Name (if applicable):	Department Name (If Hospital Based):	
PRIMARY OFFICE INFORAMTION		
Office Street Address:	City:	
	State:	ZIP:
Telephone Number:	Fax Number:	
Office Manager/Administrator:	Telephone Number:	
	Fax Number:	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
SECONDARY OFFICE INFORAMTION (if not applicable, enter N/A)		
Office Street Address:	City:	
	State:	ZIP:
Office Manager/Administrator:	Telephone Number:	
	Fax Number:	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
TERTIARY OFFICE INFORAMTION (if not applicable, enter N/A)		
Office Street Address:	City:	
	State:	ZIP:
Office Manager/Administrator:	Telephone Number:	
	Fax Number:	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
Other Medical Interests in Practice, Research, etc.:		

V. UNDERGRADUATE/PREMEDICAL EDUCATION - Applicants must submit proof of highest level of education with application. Attach additional sheets if necessary and reference this section.

College or University Name:	Degree Received:	Graduation date: (mm/yy)
Mailing Address:	City:	
	State/Country:	ZIP:

Applicant Name: _____

VI. MEDICAL/PROFESSIONAL EDUCATION - Applicants must submit <u>proof of highest level of education</u> with application. Attach additional sheets if necessary and reference this section.

Medical/Graduate School:	Degree Received:	Graduation date: (mm/yy)
Mailing Address:	City:	
	State/Country:	ZIP:
Medical/Professional School:	Degree Received:	Graduation date: (mm/yy)
Mailing Address:	City:	
	State/Country:	ZIP:

POSTGRADUATE TRAINING AND EXPERIENCE

VII. INTERNSHIP/PGYI - Attach additional sheets if necessary and reference this section. (if not applicable, enter N/A)

Institution:	Program Director:	
Mailing Address:	City:	
	State/Country:	ZIP:
Type of Internship :		
Specialty:	From: (mm/yy)	To: (mm/yy)

VIII. RESIDENCIES/FELLOWSHIPS - Attach additional sheets if necessary and reference this section. (if not applicable, enter N/A)

Include residencies, fellowships, preceptorships, teaching appointments (indicate whether clinical or academic), and postgraduate education in chronological order, giving name, address, city and ZIP code, and dates. Include **<u>all</u>** programs you attended, whether or not completed.

Institution:		Program Director:	
Mailing Address:		City:	
		State/Country:	ZIP:
Type of Training (e.g. residency, etc.):	Specialty:	From: (mm/yy)	To: (mm/yy)
Did you successfully complete the program? ☐Yes ☐No (If "No," please explain on separate sheet.)			
Institution:		Program Director:	
Mailing Address:		City:	
		State/Country:	ZIP:
Type of Training:	Specialty:	From: (mm/yy)	To: (mm/yy)
Did you successfully complete the program? ☐Yes ☐No (If "No," please explain on separate sheet.)			

Applicant Name: _____

Institution:		Program Director:	
Mailing Address:		City:	
		State/Country:	ZIP:
Type of Training:	Specialty:	From: (mm/yy)	To: (mm/yy)

Did you successfully complete the program? ☐Yes ☐No (If "No," please explain on separate sheet.)

IX. BOARD CERTIFICATION - Applicants must submit legible copies of each certification with application.
Attach additional sheets if necessary and reference this section. (if not applicable, enter N/A)

Include certifications by board(s) which are duly organized and recognized by:

- a member board of the American Board of Medical Specialties (ABMS)
- a board or association with equivalent requirements approved by the Medical Board of California
- a board or association with an Accreditation Council for Graduate Medical Education of American Osteopathic Association (AOA) approved postgraduate training that provides complete training in that specialty or subspecialty
- a member board of the Board of Psychology
- a member board of the Board of Behavioral Sciences
- a member board of the CA Board of Registered Nursing
- a member board of the Board Certified Behavior Analyst - Doctoral (BCBA-D), or Board Certified Behavior Analyst (BCBA), or Board Certified Assistant Behavior Analyst (BCaBA)

Name of Issuing Board:	Specialty:	Date Certified/Recertified:	Expiration Date: (if any)

Have you applied for board certification other than those indicated above? ☐Yes ☐ No

If so, list board(s) and date(s):

If not certified, describe your intent for certification, if any, and date of eligibility for certification on separate sheet.

X. OTHER CERTIFICATIONS (e.g. SBIRT, etc…) - Applicants must submit legible copies of each certification with application. Attach additional sheets if necessary and reference this section. (if not applicable, enter N/A)

Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:

XI. MEDICAL LICENSURE/REGISTRATIONS – Applicants must submit legible copies of each document with application.
(if not applicable, enter N/A)

Licensure/Registration	License Number	Effective date	Expiration Date
California State Medical License			
Drug Enforcement Administration (DEA)			
Medicare UPIN/National Physician Identifier (NPI)			

Applicant Name: _____

Licensure/Registration	License Number	Effective date	Expiration Date
Controlled Dangerous Substances Certificate (CDS)			
ECFMG Number (applicable to foreign medical graduates)			
Medi-Cal/Medicaid			

XII. ALL OTHER STATE MEDICAL LICENSES. List all Medical Licenses now or previously held. Applicants must <u>submit legible copies</u> of each document with application. Attach additional sheets if necessary and reference this section.

(if not applicable, enter N/A)

State:	License Number:	Expiration Date:
State:	License Number:	Expiration Date:
State:	License Number:	Expiration Date:

XIII. PROFESSIONAL LIABILITY – Applicants must <u>submit legible copies</u> of their certificate of insurance for business address.

Current Insurance Carrier:	Policy Number:	Original effective date:	
Mailing Address:		City:	
		State:	ZIP:
Per Claim Amount $	Aggregate Amount: $	Expiration Date:	
Please explain any surcharges to your professional liability coverage on a separate sheet and reference this section			

Please list all of your professional liability carriers within the <u>past seven years</u>, other than the one listed above:

Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State:	ZIP:
Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State:	ZIP:
Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State:	ZIP:
Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State:	ZIP:

Applicant Name: _____

XIV. GENERAL LIABILITY – Applicants must submit legible copies of their certificate of insurance for business address.

Current Insurance Carrier:	Policy Number:	Original effective date:
Mailing Address:		City:
		State: / ZIP:
Per Claim Amount $	Aggregate Amount: $	Expiration Date:

XV. PEER REFERENCES

List three professional references, preferably from your specialty area, not including relatives, current partners or associates in practice. If possible, include at least one member from the Medical Staff of each facility at which you have privileges.

NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through close working relations.

Name of Reference:	Specialty:	Contact Number:
Mailing Address:		City:
		State: / ZIP:
Name of Reference:	Specialty:	Contact Number:
Mailing Address:		City:
		State: / ZIP:
Name of Reference:	Specialty:	Contact Number:
Mailing Address:		City:
		State: / ZIP:

XVI. PROFESSIONAL HISTORY - Attach additional sheets if necessary and reference this section.

Chronologically list all work history activities since completion of postgraduate training (use extra sheets if necessary). This information must be complete. Curriculum vitae are sufficient provided it is current and contains all information requested below. Please explain any gaps in professional work history on a separate page.

Current Practice:	From: (mm/yy)	Telephone Number:
	To: (mm/yy)	Fax Number:
Mailing Address:		City:
		State: / ZIP:
Contact Name:	Contact Number:	
Name of Practice /Employer:	From: (mm/yy)	Telephone Number:
	To: (mm/yy)	Fax Number:

Applicant Name: _____

Mailing Address:		City:	
		State:	ZIP:
Contact Name:	Contact Number:		
Name of Practice /Employer:	To: (mm/yy)	Telephone Number:	
	To: (mm/yy)	Fax Number:	
Mailing Address:		City:	
		State:	ZIP:
Contact Name:	Contact Number:		

Applicant Name: _____

XVI. 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 to practice medicine in any jurisdiction, your Drug Enforcement Administration (DEA) registration or any applicable narcotic registration 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 registration 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, medical 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 internship, residency, fellowship, preceptorship, or other clinical 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 been denied certification/recertification by a specialty board, or has your eligibility, certification or recertification status changed (other than changing from eligible to certified)?

Yes ☐ No ☐

H. Have you ever been convicted of any crime (other than a minor traffic violation)?

Yes ☐ No ☐

I. Do you presently use any drugs illegally?

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, or the professional staff bylaws of, 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 in this Section XVI, Attestation Questions, and any addenda thereto is true, current, correct, 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 Here: _____

Physician Signature_____ _____Date_____

(Stamped Signature Is Not Acceptable)

INFORMATION RELEASE/ACKNOWLEDGMENTS

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.

In addition to any notice required by any contract with a Healthcare Organization, I agree to notify this Healthcare Organization immediately in writing of the occurrence of any of the following: (i) the unstated suspension, revocation or nonrenewal of my license to practice medicine in California; (ii) any suspension, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellation or nonrenewal of my professional liability insurance coverage.

I further agree to notify this Healthcare Organization in writing, promptly and no later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me by the Medical Board of California taken or pending, including but not limited to, any accusation filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action against me by any Healthcare Organization which has resulted in the filing of a Section 805 report with the Medical Board of California, or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding minor traffic violations); or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I hereby affirm that the information submitted in this application and any addenda thereto (including my curriculum vitae if attached) is true, current, correct, 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. A photocopy of this document shall be as effective as the original; however, original signatures and current dates are required on pages 8 and 9.

Print Name Here_____

Physician Signature_____ Date_____
(Stamped Signature Is Not Acceptable)

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

Addenda Submitting (Please check the following):	*This Application and Addenda A and B were created and are endorsed by:*
☐ Addendum A - Health Plan and IPA/Medical Group ☐ Addendum B - Professional Liability Action Explanation	• American Medical Group Association - (310/430-1191 x223) • California Association of Health Plans - (916/552-2910) • California Healthcare Association - (916/552-7574) • California Medical Association - (415/882-5166) • National IPA Coalition - (510/267/1999) • The Medical Quality Commission - (310/936-1100 x230)

Individual healthcare organizations may request additional information or attach supplements to this form. They are not part of the Kern Health Systems Behavioral Health Application nor have they been endorsed by the above organizations. Any questions about supplements should be addressed to the health care organization from which it was provided.

Applicant Name: _____

KERN HEALTH SYSTEMS
ADDENDUM A
HEALTH PLANS AND IPA'S/MEDICAL GROUPS

This application is submitted to**:** **Kern Health Systems** , herein, this Healthcare Organization[1]

I. TYPE OF ENTITY (check all that apply)

☐ Solo Practice ☐ Group Practice ☐ Single Specialty ☐ Multi Specialty

II. IDENTIFYING INFORMATION

Last Name:	First:	Middle:
Medical Group(s)/IPA(s) Affiliation:		

Do you intend to serve as a primary care provider? ☐ Yes ☐ No

So you intend to serve as a specialist? ☐ Yes ☐ No

If yes, please list specialty(s):

III. BILLING INFORMATION

Billing Company Name:

Mailing Address:	City:	
	State:	ZIP:
Contact Person:	Telephone Number:	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	

IV. PRACTICE INFORMATION

So you employ any allied health professionals (AHP) (e.g. nurse practitioners, psychologists, etc.)? ☐ Yes ☐ No

If yes, please list all AHP(s) below:

STAFF MEMBER NAME	TYPE OF PROVIDER	LICENSE NUMBER

If you are a Physician Assistant Supervisor, please include State License Number:

[1] As used in the Information Release/Acknowledgments Section of this application, the term "this Healthcare Organization" shall refer to the entity to which this application is submitted as identified above.

Applicant Name: _____

Do you personally employ any physicians? ☐ Yes ☐ No

If yes, please list all AHP(s) below:

STAFF MEMBER NAME	CALIFORNIA MEDICAL LICENSE NUMBER

Please list any clinical services you perform that are not typically associated with your specialty:

Please list any clinical services **you do not** perform that are typically associated with your specialty:

Is your practice limited to certain age groups? If yes, specify limitations:	☐ Yes	☐ No
Are you a Certified Qualified Medical Examiner (QME) of the Sate Industrial Medical Council?	☐ Yes	☐ No
Do you participate in electronic data interchange (EDI)? If yes, which Network?	☐ Yes	☐ No
Do you use practice management systems/software? If yes, which system/software?	☐ Yes	☐ No

What type of anesthesia do you provide in your group/office?

☐ Local ☐ Regional ☐ Conscious Sedation ☐ General ☐ None ☐ Other (please specify)

Has your office received any of the following accreditations, certifications or licensures?

☐ American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
☐ California Department of Health Services Licensure
☐ Institute for Medical Quality – Accreditation Association for Ambulatory Health Care (IMQ-AAAHC)
☐ Medicare Certification
☐ The Medical Quality Commission (TMQC)
☐ Other

V. OFFICE HOURS (please indicate the hours your office is open)

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

Please indicate which Holidays your office is closed or have fluctuating hours:

VI. COVERAGE OF PRACTICE – List your answering service and covering physicians by name. (Attach additional sheets if necessary)

Answering Service Company:	Phone Number:	Fax Number:

Mailing Address:

Applicant Name: _____

City:	State:	ZIP:

COVERING PHYSICIAN'S NAME	CONTACT NUMBER

If you do not have hospital privileges, please provide written plan for continuity of care:

VII. FOREIGN LANGUAGES SPOKEN

Fluently by Physician:	Fluently by Staff:

VIII. LABORATORY SERVICES

If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. Applicants must **submit legible copies** of CLIA certificate or waiver, if applicable.

Tax ID#:	Billing Name:	Type of Service Provided:

Do you have a CLIA certificate? ☐ Yes ☐ No

CLIA Certificate Number:	CLIA Expiration Date:

IX. PROFESSIONAL ORGANIZATIONS

Please list county, state or national medical societies or other professional organizations or societies of which you are a member or applicant.

ORGANIZATION NAME	APPLICANT	MEMBER

I certify that the information in this document and any attached documents is true and correct

Print Name Here _____

Physician Signature_____ **Date**_____
(Stamped Signature Is Not Acceptable)

Applicant Name: _____

KERN HEALTH SYSTEMS
ADDENDUM B
PROFESSIONAL LIABILITY ACTION EXPLANATION

This application is submitted to**: Kern Health Systems** , herein, this Healthcare Organization[1]

Please complete this form for each pending, settled or otherwise concluded 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.

I. IDENTIFYING INFORMATION

Last Name:	First:	Middle:
Mailing Address:	City:	
	State:	ZIP:

II. CASE INFORMATION - where lawsuit(s) filed

City:	County:	State:
Date of alleged incident serving as basis for the lawsuit/arbitration:	Case Number, if known:	
Date Suit Filed:	Sex of Patient: ☐ Male ☐ Female	Age of Patient:

Location of Incident: ☐ Hospital ☐ Office ☐ Surgery Center ☐ Other Doctor's Office ☐ Other (please specify below):

Your relationship to Patient (e.g. 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, below please provide the following information for the insurance company, or other liability protection company or organization:

Company Name:	Carrier's Claim ID Number:
City/State:	Contact Number

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:

Attorney Name:	Contact Number:
Attorney Name:	Contact Number:

[1] As used in the Information Release/Acknowledgments Section of this application, the term "this Healthcare Organization" shall refer to the entity to which this application is submitted as identified above.

Applicant Name: _____

III. WHAT IS THE STATUS OF THE LAWSUIT/ARBITRATION DESCRIBED ABOVE? (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 behalf:
- ☐ Lawsuit/arbitration settled, 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 sheet(s). Include 1) condition and diagnosis at 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 Physician Application. In order for participating healthcare organization 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 information 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 attorneys listed on Page 1 to discuss any information regarding this case with —this Healthcare Organization."

Print Name Here _____

Physician Signature_____ Date_____
(Stamped Signature Is Not Acceptable)

Applicant Name: _____

CONFIDENTIAL/PROPRIETARY

KERN HEALTH SYSTEMS
MEDI-CAL BEHAVIORAL HEALTH NETWORK QUESTIONNAIRE

I. BEHAVIORAL HEALTH PROVIDER INFORMATION

Last Name:	First:	Middle:

Type of Licensure: (mark all that apply)

- ☐ Behavior Analyst (all levels)
- ☐ Marriage and Family Therapist (MFT)/Licensed MFT
- ☐ Master of Social Work (SW)/Licensed Clinical SW
- ☐ Nurse (RN, LPN, NA)
- ☐ Nurse Practitioner/Physician Assistant/Advance/Masters RN
- ☐ Professional Clinical Counselor (LPCC)
- ☐ Psychiatrist/Physician/MD/DO
- ☐ Psychologist (PhD level)
- ☐ Substance Abuse Professional (all levels)
- ☐ Other (please specify)

Full-Time Equivalent (FTE): ☐ Yes ☐ No	Accepting New Medi-Cal Members/Referrals: ☐ Yes ☐ No
Total Number of Medi-Cal Members Provider Will Accept from KHS:	Current Number of KHS Medi-Cal Members Assigned to Provider:

Do you offer Autism Behavioral Health services?
☐ Yes ☐ No

Do you provide In-Home Support Services? ☐ Yes ☐ No

Please indicate which Autism BHT services you provide: (mark all that apply)
☐ ASD Screening ☐ Comprehensive Diagnostic Exam (CDE)
☐ Behavioral Analytic Assessment/Treatment Plan ☐ Behavioral Health Therapy Services

II. TREATMENT LOCATION(s) – attach additional sheets if necessary and reference this section.

Name and Location of Clinic Where Services are Provided:

Do you provide Tele-Health services? ☐ Yes ☐ No
If so, please list all the site locations below. Please use additional sheets if needed.

Clinic Name	Location Site

Are you exclusive Tele-Health provider? ☐ Yes ☐ No ☐ N/A

III. SPECIALITY/AREA OF EXPERTISE

Specialty/Area of Expertise **(mark all that apply)**
☐ Child/Adolescent ☐ Adult ☐ Geriatric ☐ Substance Abuse ☐ Other (please specify)

Are you Board Certified in your Specialty /Area of Expertise? If so, please **submit a legible copy** of each certification with this application.
☐ Yes ☐ No

Do you provide individual/group mental health evaluation and treatment (psychotherapy)?
☐ Yes ☐ No

Do you provide psychological testing when clinically indicated to evaluate mental health condition?
☐ Yes ☐ No

Applicant Name: _____

Primary Practice Focus: **(select all that apply)**

- ☐ Qualified Autism Services Provider (BCBA)
- ☐ Qualified Autism Services Professional (Only BCaBA or RBT)
- ☐ Qualified Autism Services Paraprofessional (Non-Certified)
- ☐ Adjustment Disorders
- ☐ Anxiety disorders (e.g. Panic Disorder, Obsessive-Compulsive Disorder)
- ☐ Delirium, dementia, amnestic and other cognitive disorders
- ☐ Disorders usually first diagnosed in Infancy, Childhood, or Adolescence (e.g. Pervasive Developmental Disorders, Autistic Disorder,
- ☐ Attention-Deficit and Disruptive Behavior Disorder)
- ☐ Dissociative disorders
- ☐ Eating disorders (e.g. Bulimia Nervosa, Anorexia Nervosa)
- ☐ Factitious disorders
- ☐ Impulse-Control disorders not otherwise elsewhere categorized
- ☐ Mental disorders due to a general medical condition not elsewhere categorized
- ☐ Mood disorders (e.g. Depressive Disorders, Bipolar Disorders)
- ☐ Personality Disorders
- ☐ Schizophrenia and other psychotic disorders (e.g. Schizoaffective Disorder)
- ☐ Sexual and gender identity disorders
- ☐ Sleep disorders
- ☐ Somatoform disorder
- ☐ Substance-related disorders

I certify that the information in this document and any attached documents is true and correct.

Print Name _____

Provider Signature_____ Date_____
(Stamped Signature Is Not Acceptable)

Applicant Name: _____

ADDITIONAL INFORMATION for _____

PRIMARY **Payment Address** *(if different from practice location)*

Practice Name		**Name***	
Address		**Address**	
Suite		**Suite**	
City/State/Zip		**City/State/Zip**	
Phone No.		**Phone No.**	
Fax No.		**Contact Person**	
Office Day/Hours		**Name Affiliated with Tax ID Number**	
Contact Person		**Tax ID Number**	

FTE Percentage of a forty-hour workweek this provider is available to see patients at this location	☐ **100%** ☐ **80%** ☐ **75%** ☐ **60%** ☐ **50%**	☐ **40%** ☐ **30%** ☐ **25%** ☐ **20%** ☐ **Other _____**	**The sum of percentages for one provider located at different sites should not exceed 100%.**

ALTERNATE (2nd Location) **Payment Address** *(if different from practice location)*

Practice Name		**Name***	
Address		**Address**	
Suite		**Suite**	
City/State/Zip		**City/State/Zip**	
Phone No.		**Phone No.**	
Fax No.		**Contact Person**	
Office Day/Hours		**Name Affiliated with Tax ID Number**	
Contact Person		**Tax ID Number**	

FTE Percentage of a forty-hour workweek this provider is available to see patients at this location	☐ **100%** ☐ **80%** ☐ **75%** ☐ **60%** ☐ **50%**	☐ **40%** ☐ **30%** ☐ **25%** ☐ **20%** ☐ **Other _____**	**The sum of percentages for one provider located at different sites should not exceed 100%.**

ADDITIONAL INFORMATION for _____

ALTERNATE (3rd Location) **Payment Address** *(if different from practice location)*

Practice Name		**Name***	
Address		**Address**	
Suite		**Suite**	
City/State/Zip		**City/State/Zip**	
Phone No.		**Phone No.**	
Fax No.		**Contact Person**	
Office Day/Hours		**Name Affiliated with Tax ID Number**	
Contact Person		**Tax ID Number**	

FTE Percentage of a forty-hour workweek this provider is available to see patients at this location	☐ **100%** ☐ **80%** ☐ **75%** ☐ **60%** ☐ **50%**	☐ **40%** ☐ **30%** ☐ **25%** ☐ **20%** ☐ **Other _____**	**The sum of percentages for one provider located at different sites should not exceed 100%.**

ALTERNATE (4th Location) **Payment Address** *(if different from practice location)*

Practice Name		**Name***	
Address		**Address**	
Suite		**Suite**	
City/State/Zip		**City/State/Zip**	
Phone No.		**Phone No.**	
Fax No.		**Contact Person**	
Office Day/Hours		**Name Affiliated with Tax ID Number**	
Contact Person		**Tax ID Number**	

FTE Percentage of a forty-hour workweek this provider is available to see patients at this location	☐ **100%** ☐ **80%** ☐ **75%** ☐ **60%** ☐ **50%**	☐ **40%** ☐ **30%** ☐ **25%** ☐ **20%** ☐ **Other _____**	**The sum of percentages for one provider located at different sites should not exceed 100%.**

Attachment E

Physician and Staff Language Capabilities Form

Provider/Clinic Name:____

Site Address:____

If English is the only language spoken by you and your staff, please check this box: ☐ **English only**

STAFF NAME	POSITION	LANGUAGE(S)	SPEAKING	READING	WRITING
	☐ Physician ☐ RN/NP ☐ Staff	1. 2. 3.	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5
	☐ Physician ☐ RN/NP ☐ Staff	1. 2. 3.	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5
	☐ Physician ☐ RN/NP ☐ Staff	1. 2. 3.	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5
	☐ Physician ☐ RN/NP ☐ Staff	1. 2. 3.	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5
	☐ Physician ☐ RN/NP ☐ Staff	1. 2. 3.	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5	1 2 3 4 5 1 2 3 4 5 1 2 3 4 5

If you need additional pages, please photocopy this form.

Evaluation Guidelines

(1) Poor — Satisfies elementary needs and minimum courtesy requirements. Able to understand and respond to 2-3 word entry level questions. May require slow speech and repetition.

(2) Fair — Meets basic conversational needs. Able to understand and respond to simple questions. Can handle casual conversation about work, school, and family. Has difficulty with vocabulary and grammar.

(3) Good — Able to speak the language with sufficient accuracy and vocabulary to have effective formal and informal conversations on most familiar topics.

(4) Very Good — Able to use the language fluently and accurately on all levels related to work needs. Can understand and participate in any conversation within the range of his/her experience with a high degree of fluency and precision of vocabulary. Unaffected by rate of speech.

(5) Excellent — Speaks proficiently equivalent to that of an educated native speaker. Has complete fluency in the language such that speech in all levels is fully accepted by educated native speakers in all its features, including breadth of vocabulary and idioms, colloquialism, and pertinent cultural preferences. Usually has received formal education in target language.