

**PLEASE RETURN THIS CHECK-LIST WITH YOUR APPLICATION**

**BEHAVIORAL HEALTH APPLICATION CHECKLIST**

Please complete the KHS Behavioral Health application, with addendums, relevant to your licensure or certification, and clinic practice. Upon receipt, all primary source verifications will be validated. Allow 60-120 days for completion of all primary source verifications to be completed including approval by the Physician Advisory Committee who will provide written notification of their decision and if approved, an effective date will also be provided. **\*\*Prospective applicants should not see any KFHC members until receipt of written notification.**

You are entitled to the following considerations in this application process:

- You may review information submitted to us by primary sources in support of your application.
- You may correct erroneous information other than that protected by peer review laws, references and recommendations that we receive from any of the sources we use to verify your credentials. Corrections must be submitted in writing with documentation supporting the correction. You must request the correction prior to your records being reviewed by the Practitioner Advisory Committee if the information may affect the Committee’s decision regarding your participation in the network.
- Upon request, we will inform you of the status of your application prior to being finalized.

I have enclosed the following CURRENT copies of:

|   | YES                      | NO                       | If not enclosed, expected date |
|---|--------------------------|--------------------------|--------------------------------|
| 1) Medical/Professional License   | <input type="checkbox"/> | <input type="checkbox"/> | _____                          |
| Or Professional Certification/Registration  | <input type="checkbox"/> | <input type="checkbox"/> | _____                          |
| 2) DEA Certificate, if applic.  | <input type="checkbox"/> | <input type="checkbox"/> | _____                          |
| 3) Board/Training Certificates  | <input type="checkbox"/> | <input type="checkbox"/> | _____                          |
| 4) Professional Liability   | <input type="checkbox"/> | <input type="checkbox"/> | _____                          |
| 5) General liability (office premise)   | <input type="checkbox"/> | <input type="checkbox"/> | _____                          |
| 6) CV/Resume (month/year format)  | <input type="checkbox"/> | <input type="checkbox"/> | _____                          |
| 7) DHCS Medi-Cal FFS Enrollment Confirmation, if applicable*  | <input type="checkbox"/> | <input type="checkbox"/> | _____                          |
| 8) Completed BH Application:<br>(Sign & date applicable pages even if Not Applicable)   | <input type="checkbox"/> | <input type="checkbox"/> | _____                          |
| a. Addendum A   | <input type="checkbox"/> | <input type="checkbox"/> | _____                          |
| b. Addendum B   | <input type="checkbox"/> | <input type="checkbox"/> | _____                          |
| c. Behavioral Health Questionnaire  | <input type="checkbox"/> | <input type="checkbox"/> | _____                          |
| d. Attachment C   | <input type="checkbox"/> | <input type="checkbox"/> | _____                          |
| e. Attachment E   | <input type="checkbox"/> | <input type="checkbox"/> | _____                          |
| 9) QAS Supervisor Agreement(s)<br>(A QAS Supervisor Agreement is required for each QAS Professional and/or Paraprofessionals you supervise) | <input type="checkbox"/> | <input type="checkbox"/> | _____                          |

Comments:

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\*DHCS Medi-Cal required enrollment types include: Psychiatry, Licensed Clinical Social Worker, Licensed Marriage/Family Therapist, NP/PA (Supervised), Psychologist.