KERN HEALTH SYSTEMS

PLEASE RETURN THIS CHECK-LIST WITH YOUR APPLICATION

ACSW – AMFT – APCC – PSYCH ASSISTANT ATTESTATION CHECK-LIST

1. Section I. Personal Information - Select one provider type:

   ☐ Associate Clinical Social Worker ☐ Associate Marriage/Family Therapist

   ☐ Associate Psychology Assistant ☐ Associate Professional Clinical Counselor

2. ☐ Section II. Education/Training/Experience
3. ☐ Section III. Current Employment or Volunteer Work
4. ☐ Section IV Attestation – **Sign and Date required by Associate/Assistant**
5. ☐ Section V. Agreement – **Sign and Date required by Associate/Assistant**
6. ☐ Section VI. Supervising Provider-**Sign and Date required by Licensed Supervisor**

NOTIFICATIONS:

- ***KEEP A COPY OF ALL MATERIALS SUBMITTED FOR YOUR RECORDS AS THE SUPERVISING PROVIDER AND SUPERVISEE MUST MAINTAIN EVIDENCE SUPERVISORY AGREEMENT, OVERSIGHT PLAN AND WEEKLY EXPERIENCE LOGS.***
- ***EMPLOYERS ARE RESPONSIBLE FOR VERIFICATION OF APPLICANTS' PERSONAL OR BACKGROUND INFORMATION.***
- ***YOU HAVE THE RIGHT TO REQUEST AND BE INFORMED ABOUT INFORMATION THAT KHS COLLECTS ABOUT YOU OTHER THAN PROTECTED BY PEER REVIEW LAWS. YOU ARE ENTITLED TO CORRECT ERRONEOUS INFORMATION UPON REQUEST. YOU ALSO HAVE THE RIGHT TO ASK THE STATUS OF YOUR APPLICATION.***

661-664-5000
661-664-5151
kernhealthsystems.com
2900 Buck Owens Boulevard, Bakersfield, CA 93308-6316

Section I. Personal Information (Please *Print* or *Type* all information in ink)

Last Name | First Name | Middle Name

Home Address (Street Address) | Apt.# | City | State | Zip Code | County

Mailing Address (if different from home address) | City | State | Zip Code | County

Social Security Number | Mobile/Cell Phone

Date of Birth (Month/Day/Year) | **Gender:** ☐ **Female** ☐ **Male**

☐ **No personal email address**

Personal email address

Race/Ethnicity (Opional/Voluntary)

☐ **American Indian/Alaskan** ☐ **Asian** ☐ **Black/African American** ☐ **Hispanic/Latino** ☐ **White**

☐ **Native Hawaiian/Other Pacific Islander** ☐ **Other (Specify)** _____

☐ **Decline to Disclose**

Language(s) used

English:	☐ **Speak**	☐ **Read**	☐ **Write**	**Preferred Language for Correspondence:** ☐ **English**	☐ **Spanish**
Spanish:	☐ **Speak**	☐ **Read**	☐ **Write**	**(Specify Other Language)**	
Other:	☐ **Speak**	☐ **Read**	☐ **Write**		

Section II. Education (United States or Other Country)

Highest Level of Education Completed (Check One)

☐ Elementary – 12th Grade

☐ High School Graduate or General Education Development (GED)

☐ Junior College or Technical Degree

☐ Some College

☐ College/University Degree

☐ Advanced Degree such as Master's or Doctoral

Other current State of CA Professional National or License / Certificate ☐Yes ☐No

Certificate Agency: | Certificate Number:

Section III. Current Employment or Volunteer Work

☐ **Employment** ☐ **Volunteer** ☐ **None**

Is your supervisor employed, contracted, or an owner of this practice?
☐ **Yes** ☐ **No**

Name of Organization (Volunteer or Employment)

Address (Street address) | City | State | Zip Code | County

Supervisor's Name | **Supervisor's Degree** (LCSW/LMFT/LPCC/Clinical PsyD, or MD Psychiatrist)

Current Job Title | Applicant's Work Phone

Work Status: ☐ Full Time ☐ Part Time ☐ Volunteer

Work E-mail Address

Section IV. Attestation

☐ **Supervision Agreement**: Any licensed mental health professional who provides supervision (whether as a primary supervisor or other supervisor) to any person gaining hours of experience toward LMFT, LCSW or LPCC licensure is required by law, along with the supervisee, to complete all parts of the agreement within 60 days of the commencement of supervision. The supervisee shall retain the signed form and provide the original agreement when applying for licensure. ***Attest Only - Supervision Agreement available upon request.***

☐ **Verification of Employment:** The actual letter submitted to Board of Behavioral Health must be written on the employer's letterhead. The supervisee is required to submit this letter with the application for licensure and shall retain copy of signed form. ***Attest only - Verification of Employment available upon request only.***

☐ **Oversight / Supervisory Plan:** The supervisor and supervisee are required by law to collaboratively develop a supervisory plan that describes the goals and objectives of supervision – the supervisee shall retain copy of the signed oversight/supervisory plan and make available upon request, if necessary.

☐ **Weekly Summary Log:** The supervisor and supervisee are required by law to keep a weekly summary and experience log – the supervisee shall retain copies of the signed weekly summary logs and make available upon request, if necessary.

☐ **Statutes and Regulations:** The supervisor and supervisee must abide by all California Board's Statutes and Regulations contained in the official legal Business and Professions Code applicable sections. KHS strongly encourages both supervisor and supervisee to thoroughly read the Statutes and Regulations pertaining to your professional scope of practice.

Associate/Assistants Signature: **(Electronic or Digital Signatures Accepted / Stamped or Changed Font Signatures are NOT ACCEPTABLE)**	**Date**

Section V. Associate/Assistant Application Signature

Please read the following statements carefully. Sign or type your name below to indicate your understanding and acceptance of these statements in the space provided.

- I certify that all the information provided by me in connection with this application is true and complete. I understand providing false or misleading information, material omissions or misrepresentations which is used in determining my qualifications may result in the voiding of the application and failure to be granted network participation.
- I agree to abide by Kern Health Systems (KHS) Policy and Procedures, KHS provider service agreement, the Department of Health Care Services Provider Manual and All Plan Letters as applicable to Dyadic Care Services, Non-Specialty Mental Health Services and Psychiatric and Psychological Services.
- I give KHS permission to verify any information, work or volunteer experience, and references, which are important in determining my qualifications.
- I understand the application and supporting documentation submitted become the property of KHS and are nonreturnable.
- I shall advise KHS PNM-Credentialing Department of and changes to my current address immediately, but no later than 10-days, of any changes of address or within 1-day of other significant changes in my work, volunteer status and/or certification.
- I understand my employer is responsible for verification of applicants' personal or background information.
- I acknowledge that this Application is not a contract between me and Kern Health Systems and does not make me an employee, agent, contractor, or representative of Kern Health Systems.

Associate/Assistants Signature: **(Electronic or Digital Signatures Accepted / Stamped or Changed Font Signatures are NOT ACCEPTABLE)**	**Date**

Mail, email or fax complete application to:

Mail to:	**Email to:**
Kern Health Systems Attn: PNM-Credentialing 2900 Buck Owens Blvd Bakersfield CA 93309	credentialing@khs-net.com **Fax to:** 661-716-9619

Section VI. Supervising Provider / Attestation & Acknowledgement

TO BE COMPLETED BY SUPERVISOR(S) LISTED IN SECTION III
Form must be submitted with Application

- I attest that as the Supervising Provider, I meet the qualification as a licensed provider in California or another state for at least two (2) years out of the last five (5) years prior to the commencement of supervison;
- Have practiced psychotherapy during at least two (2) years out of the last five (5) years prior to the commencement of supervision (or, if an LEP, has provided psychological counseling pursuant to Business and Professions Code (BPC) section 4989.14) OR Provided direct supervision to ASWs, Associate Professional Clinical Counselors, Marriage and Family Therapist Trainees, or Associate Marriage and Family Therapists who perform psychotherapy during at least two (2) years out of the last five (5) years prior to the commencement of supervision. Supervision of psychotherapy performed by a student shall be accepted if substantially equivalent to the supervision required for registrants;
- I have completed a minimum of 15 hours of supervision training that meets the course provider and course content requirements specified in regulation within 60 days of the commencement of supervision. Six hours of continuing professional development in supervision is required each renewal cycle thereafter.

  NOTE: Licensed Clinical Psychologists and Psychiatrists are exempt from these requirements
- I have signed and will comply with the required supervision-related agreement, oversight plan and weekly logs;

  Note: *LEPs may only supervise the provision of educationally related mental health services consistent with the LEP scope of practice described in BPC section 4989.14, up to a maximum of 1,200 hours
- I agree to ensure that the associate/assistant provider meets the qualification listed in the KHS Policy and Procedures, KHS provider service agreement, the Department of Health Care Services All Plan Letter 22-029, and any subsequent updates, if applicable.
- I agree to ensure that the associate/assistant provider meets the qualification listed in the Non-Specialty Mental Health Services; 4 Part 2, Psychiatric and Psychological Services from the DHCS Provider Manual, if applicable.
- I agree to adhere to the supervisory agreement plan, and/or responsibility statement provided to the California Board of Behavioral Sciences and provide necessary copies upon request.
- I understand that I must immediately notify KHS and my supervisees of any disciplinary action, including revocation, suspension (even if stayed), probation terms, inactive license status, or any lapse in licensure that affects my ability or right to supervise immediately, but no later than 10-days, including any changes of address.

Supervisor Name:		**Supervisor's Degree:**	
Supervisor's Signature **(Electronic or Digital Signatures Accepted / Stamped or Changed Font Signatures are NOT ACCEPTABLE)**		**Date**	