PROVIDER CLINICAL APPLICATION

San Diego County Mental Health Plan & Optum Public Sector

Fee For Service (FFS) Medi-Cal Provider Network

Please mail, fax or email (secure) complete application packet to:

Optum Public Sector San Diego
Attention: Provider Services
P.O. Box 601370
San Diego, CA 92160-1370

Fax: 877- 309-4862

Email: sdu_providerserviceshelp@optum.com

Instructions and Frequently Asked Questions

CHECKLIST FOR MEDI-CAL PROVIDER APPLICATION

Please print or type your answers to all questions. If further space is needed for you to provide complete answers, please attach additional sheets of paper and indicate on the sheet the applicable question number.

A practitioner must meet basic Credentialing Criteria for inclusion in the Medi-Cal Network. Please check the requirements for each discipline on the link above to ensure you meet the minimum criteria.

Please use the following checklist to confirm you have included the following information with your application:

☐	**Credentialing Application Instructions**: To be completed and submitted on the Council for Affordable Quality Healthcare (CAQH) website. *Please review the FAQs on our website for additional information.*	
☐	**W-9:** A completed and signed W-9 form is required (*Please follow instructions carefully*)	
☐	**W-9 Verification:**	
	☐	**SSN**: If your Taxpayer Identification Number (TIN) is your social security number, **please provide a copy of your social security card.**
	☐	**EIN:** If your Taxpayer Identification Number (TIN) is an employer identification number (EIN), please submit a current Internal Revenue Service (IRS) generated document. **The only acceptable documents include:** a. IRS-generated Letter 147-C b. IRS-generated Form 941 (Employer's Quarterly Federal Tax Return) c. IRS-generated Form 8109-C (Deposit Coupon) d. IRS-generated Form SS-4 (only the official Confirmation Notification of FEIN/ITIN assignment) **Note:** The legal name of the applicant or provider on the application must match the exact name of the owner or officer of the entity listed on the IRS-generated document. For assistance in obtaining the above documents, please contact the IRS at (800) 829-4933.
☐	**Certificate of Professional Malpractice/Professional Liability Insurance:** • Limits of coverage (1 million per occurrence/3 million aggregate minimum) • Expiration date must cover the Dates of Services requested	
☐	**State Driver's License/ID Card:** • Active, valid copy (Color photocopy or scan required. Must be legible).	
☐	**State Professional License:** • Active pocket license or wall certificate required	
☐	**DEA License *(if applicable)*:** • Must be current/active	
☐	**Psychiatric Nurse Practitioners (PNP) and Physician Assistants (PA):** Must submit a copy of their Supervisory Agreement with an appropriate paneled/contracted FFS Psychiatrist (MD/DO)	

☐	**Medicare Provider Number:** • Providers intending to serve both Medicare and Medi-Cal beneficiaries must have a current Medicare Provider Number by visiting the Centers for Medicare and Medicaid Services (CMS) website https://www.cms.gov. *Medi-Cal will not reimburse you for services to a client with Medicare and Medi-Cal coverage unless you have a Medicare provider number.*
☐	**Resume or Curriculum Vitae (TERM):** It is very important that your resume be detailed including descriptions of populations, specialties, and disorders treated, and the theoretical orientation of the work. Include the dates and locations of education and post-graduate training. **Dates of employment must include the month and year. All gaps in employment of six (6) months or more require a written explanation.**
☐	**Medi-Cal Network Specialty Requirements:** Please carefully review the experience requirements on page 16-18 before you check an age or treatment specialty.
☐	**Child and Adolescent Needs and Strength Assessment (CANS):** • Provider must become CANS certified in order to render therapy services to clients ages 0-21. • Provider must be recertified every year. • Provider may be reimbursed for training, certification, recertification, and reports when the appropriate requirements are met. *Certification obtained prior to contract effective date cannot be reimbursed. Additional information and instructions will be provided during the contracting process.*
☐	**Verify Beneficiary's/Client's Med-Cal Eligibility:** Provider understands he/she will be provided a PIN Number to facilitate verifying a client's Medi-Cal eligibility. It is the provider's responsibility to ensure the client has active Medi-Cal coverage prior to rendering services. Additional information and instructions will be provided during the contracting process.
☐	**Provider Rights (page 19):** Provider understands that as an applicant for credentialing/re-credentialing, you have the right to review information obtained by Optum for the purpose of evaluating your credentialing or re-credentialing application. **Please print your name on this page.**
☐	**Clinician Specialty Requirements – Specialty Attestation Form (page 18):** Must be signed and dated.
☐	**All Pages of the Application must be Completed:** Please do not write "Refer to Resume/Curriculum Vitae" or "Refer to attached documents" as an answer to any questions on the application.
☐	**Home Office Standards:** The Optum Home Office Standards Attestation Addendum must be signed if you are rendering face-to-face services in your home office (not telehealth).

All documents and copies submitted must be clear and legible.

PROVIDER CLINICAL APPLICATION

San Diego County Mental Health Plan for Fee for Service (FFS) Medi-Cal Provider Network

Last Name: _____ **First Name:** _____ **MI:** __

Email Address: _____ **Phone Number:** _____

License Type: ☐ MD/DO ☐ Psychologist (☐ PhD ☐ PsyD) ☐ LMFT ☐ LCSW ☐ LPCC ☐ PNP ☐ PA

License Number: _____ **DEA Number** *(if applicable)*: _____

CAQH Provider ID#: _____

Date Credentialing Application completed at *CAQH: _____

***Council for Affordable Quality Healthcare**

Credentialing Rep Name *(if other than provider)*: _____ **Or** ☐ N/A

Email Address: _____ **Phone Number:** _____

Currently employed by the County of San Diego? ☐ **Yes** ☐ **No**

If "**Yes**" please include a letter from the County of San Diego Health and Human Services Compliance Office indicating their approval for your participation on this Network. Please email Amaris Sanchez, Health and Human Services Compliance Group Program Manager at Amaris.Sanchez@sdcounty.ca.gov for further information.

How did you hear about Optum Public Sector San Diego County Mental Health Plan for Medi-Cal and/or TERM Networks?

☐ Optum Recruiter ☐ FFS Medi-Cal Provider ☐ County Representative

☐ Other Optum Staff Member ☐ TERM Provider ☐ Other: _____

***Provider's Emergency Contact**

Name: _____ **Relationship to Provider:** _____

Phone: _____ **Email:** _____

**This is the person OPTUM must contact to implement your emergency plan if you were to become incapacitated and/or unable to fulfill your clinical obligations to your clients.*

Emergency 24 Hour Coverage of Clients

What arrangements do you have for 24-hour, 7-day emergency coverage for clients?

_____

Provider's Home Address *(Required and is confidential. Cannot be a PO Box.)*

Address: _____

Suite: _____

City: _____ **County:** _____

State: _____ **Zip:** _____

Confidential Mailing Address: ☐**N/A** *(When/If applicable: audit results, sensitive communications regarding your practice)*

Address: _____

Suite: _____

City: _____ **County:** _____

State: _____ **Zip:** _____

Phone: _____

Contact Name: _____

Fax #: _____ **Email:** _____

PRACTICE INFORMATION

Business Name: _____

DBA: _____

NPI Type 2 (Organization): _____

Mailing Address: ☐*Same as Confidential Mailing Address*

Address: _____

Suite: _____

City: _____ **County:** _____

State: _____ **Zip:** _____

Contact Name: _____ **Phone#:** _____

Fax #: _____ **Email:** _____

Billing Address: ☐*Same as Confidential Mailing Address* ☐*Same as Mailing Address*

Address: _____

Suite: _____

City: _____ **County:** _____

State: _____ **Zip:** _____

Contact Name: _____ **Phone#:** _____

Fax #: _____ **Email:** _____

Primary Treatment Location:

Select all that apply: ☐Telehealth ☐In-Person

Address: _____

Suite: _____

City: _____ **County:** _____

State: _____ **Zip:** _____

Contact Name: _____ **Phone#:** _____

Fax #: _____ **Email:** _____

TTY/TTD Phone#: _____
Does this office meet ADA (Americans with Disabilities Act) guidelines? ☐ Yes ☐ No

Is this office accessible to public transportation? ☐ Yes ☐ No
Is this a Home Office? ☐ Yes ☐ No

HOURS OF OPERATION: (Example: 9:00 AM to 5:00 PM)			
Sunday		**to**	
Monday		**to**	
Tuesday		**to**	
Wednesday		**to**	
Thursday		**to**	
Friday		**to**	
Saturday		**to**	

Hours per week serving: (*Estimate of all clients you may be rendering services to at this location. Numerical digits required*)

Children (0-20): ___

Adults (21+): ___

Maximum number of Medi-Cal clients you are willing to see at this location: *(Numerical digits required)*

Children (0-20): ___

Adults (21+): ___

Wait Times For:

- **Urgent Appointments (Hours):** ___
- **Non-Urgent Appointments (Hours):** ___

Emergent Appointments within 1 hour? ☐ Yes ☐ No

ADDITIONAL TREATMENT LOCATION: ☐ Yes ☐ No
If yes, please complete all sections below for Additional Treatment Location

Business Name: _____

DBA: _____

NPI Type 2 (Organization): _____

Mailing Address: ☐ *Same as Confidential Mailing Address*

Address: _____

Suite: _____

City: _____ **County:** _____

State: _____ **Zip:** _____

Contact Name: _____ **Phone#:** _____

Fax #: _____ **Email:** _____

Billing Address: ☐ *Same as Confidential Mailing Address* ☐ *Same as Mailing Address*

Address: _____

Suite: _____

City: _____ **County**: _____

State: _____ **Zip**: _____

Contact Name: _____ **Phone#**: _____

Fax #: _____ **Email**: _____

Additional Treatment Location:

Select all that apply: ☐ Telehealth ☐ In-Person

Address: _____

Suite: _____

City: _____ **County**: _____

State: _____ **Zip**: _____

Contact Name: _____ **Phone#**: _____

Fax #: _____ **Email**: _____

TTY/TTD Phone#: _____

Does this office meet ADA (Americans with Disabilities Act) guidelines? ☐ Yes ☐ No

Is this office accessible to public transportation? ☐ Yes ☐ No

Is this a Home Office? ☐ Yes ☐ No

HOURS OF OPERATION: (Example: 9:00 AM to 5:00 PM)			
Sunday		**to**	
Monday		**to**	
Tuesday		**to**	
Wednesday		**to**	
Thursday		**to**	
Friday		**to**	
Saturday		**to**	

Hours per week serving: (*This is an estimate of all clients you may be rendering services to at this location. Numerical digits required*)

Children (0-20): ___

Adults (21+): ___

Maximum number of Medi-Cal clients you are willing to see at this location: *(Numerical digits required)*

Children (0-20): ___

Adults (21+): ___

Wait Times For:

- **Urgent Appointments (Hours):** ___
- **Non-Urgent Appointments (Hours):** ___

Emergent Appointments within 1 hour? ☐Yes ☐No

Additional Treatment Location(s): ☐Yes ☐No

If yes, please complete the form at the end of the application to add additional treatment locations

OTHER TREATMENT MODES

A. Telehealth

Telehealth: ☐Yes ☐No
If "Yes" to the above: A Telehealth Requirements and Compliance Attestation will be required prior to being approved to render Telehealth services to Clients. Please submit the following with this application:

- Telehealth Attestation Form
- Copy of Business Associate Agreement (BAA) with chosen HIPAA compliant platform. Please contact your Telehealth platform to obtain a copy of the BAA.

B. Mobile/Field Based Services

Mobile Services including Home Visits (Provider will travel to the client's home or other location): ☐Yes ☐No

Skilled Nursing Facilities (SNF): ☐Yes ☐No

If "Yes" to either of the above, distance you are willing to travel to deliver services (miles): ___

C. Home Office - Services are rendered face-to-face in your personal residence (Not Telehealth)

Do you have a Home Office? ☐Yes ☐No
*If "Yes" please read and sign the **Optum Home Office Standards Attestation** included at the end of this application*

Home Office Address: _____

Suite: _____

City: _____ **County:** _____

State: _____ **Zip:** _____

INFORMATION FOR PSYCHIATRISTS, PSYCHIATRIC NURSE PRACTITIONERS, & PHYSICIAN ASSISTANTS WITH PRESCRIPTIVE AUTHORITY

Do you ONLY render services in an INPATIENT setting? ☐Yes ☐No

- **If "No" to the above**: Will you be rendering services in an OUTPATIENT (OP) setting other than Partial Hospitalization (PHP) or Intensive Outpatient (IOP)? ☐Yes ☐No
- **If "Yes" to the above**: Will you be *open to new referrals? ☐Yes ☐No

  ***Open to referrals means that you will accept any new Medi-Cal beneficiary patients referred to you through the Access and Crisis Line/Optum Public Sector.*

PSYCHIATRISTS (MD/DO) ONLY:

Board Certified/Eligible in Psychiatry and must meet the following criteria: Credentialing Criteria; Provider Handbook (Credentialing Standards pages 40 – 41)

- **Must be Board Certified/Eligible in Psychiatry:**
  - ☐ Board Certified
  - ☐ Board Eligible (*Proof of eligibility must be submitted with this application*)
  - ☐ Physicians who graduated from medical school prior to July 1, 1982, will be considered to have the equivalency of board certification requirement if he or she has completed an ACGME approved residency training program in psychiatry or a fellowship in addiction medicine

- **Must be Board Certified/Eligible for Child & Adolescent Psychiatry**:
  - ☐ Board Certified to treat children ages twelve (12) and under
  - ☐ Board Eligible to treat children ages twelve (12) and under *(Proof of eligibility must be submitted with this application)*

Second Opinions:

Are you available to provide second opinions? ☐ Yes ☐ No

Hospital Privileges (admitting privileges): N/A ☐

Please complete the section below to identify the County contracted hospitals where you currently have admitting privileges. Hospitals where you have admitting privileges must be provided for listing in the Provider Directory.

Hospitals			**Enter Date Privileged**
Alvarado Parkway Institute	☐ Yes	☐ No	
Aurora Hospital	☐ Yes	☐ No	
Palomar Hospital	☐ Yes	☐ No	
PH Bayview Hospital (A)	☐ Yes	☐ No	
PH Paradise Valley Hospital	☐ Yes	☐ No	
Pomerado Hospital	☐ Yes	☐ No	
Sharp Mesa Vista Hospital	☐ Yes	☐ No	
Scripps Mercy Healthcare	☐ Yes	☐ No	
Sharp Grossmont Hospital	☐ Yes	☐ No	
UCSD Medical Center	☐ Yes	☐ No	
Rady CAPS	☐ Yes	☐ No	

PSYCHIATRIC NURSE PRACTITIONERS (PNPs) ONLY:

American Nurse Credentialing Center (ANCC) Certification: (*As a Psychiatric Nurse Practitioner in Psychiatric/Mental Health Nursing*) ☐ Yes ☐ No

Supervising Psychiatrist Name & Phone Number:

Supervisor Name: _____

Phone Number: _____

Note: *Supervisor must be Board Certified or Eligible in Child and Adolescent Psychiatry if PNP is requesting to render services to children ages 0 - 12*

Will you accept referrals for Medi-Cal clients referred through the Access and Crisis Line (ACL) for Outpatient Services?
☐Yes ☐No

PSYCHIATRIC PHYSICIAN ASSISTANTS (PAs) ONLY:

Certificate of Added Qualifications (CAQ) in Psychiatry:
☐Yes – Certificate Number: _____
☐No – If no, must be eligible for the Exam *(Proof of eligibility must be submitted with this application)*

Supervising Psychiatrist Name & Phone Number:

Supervisor Name: _____

Phone Number: _____

Note: *Supervisor must be Board Certified or Eligible in Child and Adolescent Psychiatry if PA is requesting to render services to children ages 0 - 12*

Will you accept referrals for Medi-Cal clients referred through the Access and Crisis Line (ACL) for Outpatient Services?
☐Yes ☐No

CLINICAL PROFILE

Cultural Competency:

Delivering culturally competent clinical services means you have an understanding of: **1)** on-going social realities (e.g., racism, immigration patterns, acculturation) that can impact the mental health of culturally and linguistically distinct populations, **2)** differences between culturally acceptable behaviors and pathological characteristics, **3)** cultural beliefs around mental illness and help-seeking patterns, and **4)** have the ability to adapt your skills to fit the cultural context of a client.

If checking that you are culturally competent to deliver services to a group below, it means that you have experiences consistent with one or more of the statements:

- Have lived at least two (2) years or were raised in a community where this culture predominated; and/or
- Have completed formal training such as a degree emphasis area, specific university courses, multiple workshops or an internship focusing on culture and human behavior; and/or
- Have significant professional culture-based expertise (e.g., have provided cultural competence training to others and/or published peer-reviewed journal articles, book chapters, or major reports in this area); and/or
- Have provided clinical treatment or evaluations to more than ten (10) members of the cultural group.

From the following list, please identify the cultures in which you meet the Cultural Competency Criteria (to evaluate family dynamics and would like to provide treatment):

☐African American	☐Ethiopian	☐Jewish	☐Samoan
☐Amerasian	☐Filipino	☐Korean	☐Somali
☐Arab	☐Guamanian	☐Laotian	☐Sudanese
☐Asian Indian	☐Hawaiian Native	☐Mexican American/Chicano	☐Vietnamese
☐Cambodian	☐Hmong	☐Native American	☐Other Asian
☐Caucasian	☐Iranian	☐Pacific Islander	☐Other Hispanic
☐Chinese	☐Iraqi	☐Puerto Rican	☐Other Latin American
☐Cuban	☐Japanese	☐Salvadorian	☐Other South East Asian
☐Dominican	☐Other:		

INSURANCE PLANS

Please check all insurance plans you can accept:

☐Aetna PPO	☐Community Health Group	☐Medi-Cal	☐TriWest/TriCare
☐Anthem Blue Cross	☐Health Net	☐Medicare	☐Value Options
☐Blue Shield of CA	☐Kaiser	☐Molina	☐UnitedHealthcare
☐Care 1st	☐Magellan	☐Optum	
☐Cigna	☐Other:		

MEDICARE/MEDI-CAL PROVIDER

Are you a Medicare Provider? ☐Yes ☐No

- If yes, enter Medicare number: _____

Are you a Medi-Cal Provider? ☐Yes ☐No

- If yes, enter Medi-Cal number: _____

POPULATIONS AND SERVICES

Please check all the Populations and Services in which you have **clinical training and experience AND are currently willing to treat in your practice.**

Populations:	**Infants Toddlers 0 - 3**	**Preschool 3 - 5**	**Children 6 -12**	**Adolescents 13 - 17**	**Transitional Youth 18 - 22**	**Adults 23 - 59**	**Older Adults 60+**
Developmentally Delayed	☐	☐	☐	☐	☐	☐	☐
LGBTQIA	☐	☐	☐	☐	☐	☐	☐
Hearing Impaired			☐	☐	☐	☐	☐
Physically Disabled	☐	☐	☐	☐	☐	☐	☐
Veterans					☐	☐	☐
Visually Impaired	☐	☐	☐	☐	☐	☐	☐
Services/Modalities:							
Critical Incident Stress Debriefing		☐	☐	☐	☐	☐	☐
ECT (MD Only including consult)					☐	☐	☐
Spravato (MD Only)					☐	☐	☐
TMS (MD Only)					☐	☐	☐
Family Therapy	☐	☐	☐	☐	☐	☐	☐
Group Therapy			☐	☐	☐	☐	☐
Home Visits	☐	☐	☐	☐	☐	☐	☐
Individual Therapy (Non-prescriber)	☐	☐	☐	☐	☐	☐	☐
Inpatient Treatment	☐	☐	☐	☐	☐	☐	☐
Medication Evaluation & Management	☐	☐	☐	☐	☐	☐	☐
Neuropsychological Testing (MD/PhD/PsyD Only)	☐	☐	☐	☐	☐	☐	☐
Outpatient Treatment	☐	☐	☐	☐	☐	☐	☐
Psychological Testing (PhD/PsyD Only)	☐	☐	☐	☐	☐	☐	☐

AREAS OF CLINICAL EXPERTISE:

Check areas of expertise in which you have **clinical training and experience AND are currently willing to treat in your practice.** You may be requested to submit documentation to demonstrate expertise in these areas.

NOTE: **All Clinicians are designated to treat Depressive and Anxiety Disorders for all appropriate ages.

Areas of Clinical Expertise I:	Infants Toddlers 0 - 3	Preschool 3 - 5	Children 6 -12	Adolescents 13 - 17	Transitional Youth 18 - 22	Adults 23 - 59	Older Adults 60+
***** Anxiety Disorders***	☐	☐	☐	☐	☐	☐	☐
Attention Deficit/Hyperactivity Disorder		☐	☐	☐	☐	☐	☐
Bipolar and Related Disorders		☐	☐	☐	☐	☐	☐
Dissociative Disorders		☐	☐	☐	☐	☐	☐
Feeding and Eating Disorders		☐	☐	☐	☐	☐	☐
Factitious Disorders		☐	☐	☐	☐	☐	☐
Gender Dysphoria Disorders		☐	☐	☐	☐	☐	☐
Disruptive, Impulse-Control and Conduct Disorders		☐	☐	☐	☐	☐	☐
***** Depressive Disorders***	☐	☐	☐	☐	☐	☐	☐
Paraphilic Disorders		☐	☐	☐	☐	☐	☐
Personality Disorders		☐	☐	☐	☐	☐	☐
Autism Spectrum Disorder	☐	☐	☐	☐	☐	☐	☐
Trauma and Stress - Related Disorders	☐	☐	☐	☐	☐	☐	☐
Schizophrenia and Other Psychotic Disorders		☐	☐	☐	☐	☐	☐
Somatic Symptom and Related Disorders		☐	☐	☐	☐	☐	☐

Check areas below in which you have **clinical training and experience AND are currently willing to treat in your practice.** You may be requested to submit documentation to demonstrate expertise in these areas.

Documentation is required for some specialties as identified on the Clinician Specialty Requirements (pages 16-18).

Areas of Clinical Expertise II:	**Infants Toddlers 0 - 3**	**Preschool 3 - 5**	**Children 6 -12**	**Adolescents 13 - 17**	**Transitional Youth 18 - 22**	**Adults 23 - 59**	**Older Adults 60+**
ACA/Co-Dependency					☐	☐	☐
Adoption Pre/Post Issues	☐	☐	☐	☐	☐	☐	☐
ACA/Co-Dependency					☐	☐	☐
Adoption Pre/Post Issues	☐	☐	☐	☐	☐	☐	☐
Anger Management			☐	☐	☐	☐	☐
Domestic Violence Offender				☐	☐	☐	☐
Domestic Violence Victim	☐	☐	☐	☐	☐	☐	☐
Co-Occurring Disorders (MH/DD)	☐	☐	☐	☐	☐	☐	☐
Co-Occurring Disorders (MH/Medical)	☐	☐	☐	☐	☐	☐	☐
Co-Occurring Disorders (MH/SUD)			☐	☐	☐	☐	☐
Family or Relationship Issues	☐	☐	☐	☐	☐	☐	☐
Co-Parenting					☐	☐	☐
Grief/Loss	☐	☐	☐	☐	☐	☐	☐
HIV/AIDS	☐	☐	☐	☐	☐	☐	☐
Physical Abuse Offender			☐	☐	☐	☐	☐
Physical Abuse Non-Protecting Parent					☐	☐	☐

Check areas below in which you have **clinical training and experience AND are currently willing to treat in your practice.** You may be requested to submit documentation to demonstrate expertise in these areas.

Documentation is required for some specialties as identified on the Clinician Specialty Requirements (pages 16-18).

Areas of Clinical Expertise II:	**Infants Toddlers 0 - 3**	**Preschool 3 - 5**	**Children 6 -12**	**Adolescents 13 - 17**	**Transitional Youth 18 - 22**	**Adults 23 - 59**	**Older Adults 60+**
Political Refugee		☐	☐	☐	☐	☐	☐
Sexual Abuse Victims	☐	☐	☐	☐	☐	☐	☐
Sexual Abuse Non-Protecting Parent					☐	☐	☐
Sexual Abuse Offender			☐	☐	☐	☐	☐
Survivors of Torture	☐	☐	☐	☐	☐	☐	☐
Trauma	☐	☐	☐	☐	☐	☐	☐

CLINICIAN SPECIALTY REQUIREMENTS

Prescribers of Psychotropic Medication for Children and Youth In Out of Home Placement

Important note: Signature on the Optum Public Sector Specialty Attestation on page #18 is required of all applicants

Authorized Prescribers of Psychotropic Medication: Because of the complex medical and psychiatric needs of children in out of home placements (which include foster, kinship, NREFM care; group homes; and the juvenile justice systems), it is recommended that psychotropic medications for children be prescribed by board certified or board eligible specialists in one of the following areas of expertise:

- Psychiatry (specialization in child and adolescent psychiatry recommended)
- Neuro-developmental pediatrics
- Developmental-Behavioral pediatrics
- Pediatric neurology
- Pediatrics or family practice with specialized training in children who are at high risk or who had in utero exposure to illicit drugs or alcohol

PSYCHOLOGISTS, NURSES, & MASTER'S LEVEL CLINICIANS SPECIALTY REQUIREMENTS

Domestic Violence Treatment - Victim

- Documented completion of an approved (40) hour training program in Domestic Violence that fulfills California State's requirement for domestic violence victim counselors
  AND both of the following:
- Fifteen (15) hours CEU in Domestic Violence Victim training in the last thirty-six (36) month months
- Evidence of recent practice experience in Domestic Violence Victim treatment

Domestic Violence Treatment - Offender

- Documented completion of the forty (40) hour basic domestic violence training from a Facilitator Training Committee (FTC) approved provider
- Evidence of recent practice experience in Domestic Violence Batterers treatment

Sexual Offender and Sexual Abuse Non-Protecting Parent Treatment

- **Must be approved by CA State Sex Offender Management Board (CASOMB)** ***http://www.casomb.org*** and continue to meet CASOMB requirements.

Psychiatric Nurse Practitioners Requesting Prescriptive Authority Must:

- Possess a currently valid license as a Registered Nurse in California
- Be authorized for prescriptive authority in California
- Meet California specific mandates regarding DEA and/or Furnishing license and physician supervision
- Attest that you meet California's collaborative or supervisory agreement requirements
- Specifically request prescriptive privileges on the Optum Public Sector application below

Psychiatric Physician Assistants Requesting Prescriptive Authority Must:

- Possess a currently valid license as a Registered Nurse in California
- Be authorized for prescriptive authority in California
- Meet California specific mandates regarding DEA and physician supervision
- Attest that you meet California's collaborative or supervisory agreement requirements
- Specifically request prescriptive privileges on the Optum Public Sector application below

CLINICIAN SPECIALTY REQUIREMENTS

Optum Public Sector San Diego Specialty Attestation

You must sign this document even if you are not requesting any of these specialty designations in your provider record. Additional training, experience, requirements, and/or outside agency approval is required for the following populations, professional certifications, and specialties. **Please review Specialty Requirements on pages 16-18**.

If you are not requesting a specialty designation, please check the "No Specialties" box at the bottom of the list to indicate you have read this form and acknowledge that you have not requested these specialties.

I have reviewed the Optum Specialty Requirements criteria that a Clinician must meet to be considered a specialist in the following treatment areas. After reviewing the criteria, I hereby attest that by placing a check next to a specialty or specialties, I meet Optum's requirements for that treatment area.

Physician Specialties	Non-Physician Specialties
☐ Child /Adolescent (Please specify all the ages that you treat) ☐ Infant Mental Health (0 – 3) ☐ Preschool (3 - 5) ☐ Children (6 – 12) ☐ Adolescents (13 - 17) ☐ Children and youth in out of home placements ☐ Geriatrics (60+) ☐ Neuropsychological Testing ☐ Transcranial Magnetic Stimulation (TMS) ☐ Spravato Treatment (**Proof of certification required)**	☐ Child /Adolescent (Please specify all the ages that you treat) ☐ Infant Mental Health (0 – 3) ☐ Preschool (3 - 5) ☐ Children (6 – 12) ☐ Adolescents (13 - 17) ☐ Neuropsychological Testing – *Psychologist Only* ☐ Psychiatric Nurses – Prescriptive Privileges (**Submit ANCC certificate, Prescriptive Authority, DEA Certificate and/or Controlled Substance certificate, based on CA State requirements.** ☐ Transcranial Magnetic Stimulation (TMS) *- Psychiatric Nurse Practitioners and Physician Assistants only* ☐ Spravato Treatment - **(Proof of certification required)** *- Psychiatric Nurse Practitioners and Physician Assistants only* ☐ Domestic Violence Victim – (**Submit proof of 40 hr. CA approved DV Training**) ☐ Domestic Violence Offender – (**Submit proof of 40 hr. DV Training from a Facilitator Training {FTC} approved provider.**) ☐ Sexual Offender AND Sexual Abuse Non-Protecting Parent (**Must be approved by CA State Sex Offender Management Board (CASOMB) http://www.casomb.org and continue to meet CASOMB requirements**.) ☐ DBT (Certification attests the ability to provide individual/group services.) Please submit copy of certification.

☐ No Specialties (Must be checked if none of the above specialties are being designated)

CLINICIAN SPECIALTY REQUIREMENTS

Optum Public Sector San Diego Specialty Attestation

I understand that Optum may require documentation to verify that I meet the criteria outlined under Specialty Requirements pertaining to the specialty or specialties I have designated above. I will cooperate with an Optum documentation audit, if requested, to verify that I meet the required criteria.

I hereby attest that all of the information above is true and accurate to the best of my knowledge. I understand that any information provided pursuant to this attestation that is subsequently found to be untrue and/or incorrect could result in my termination from the Optum network.

Please note that standard credentialing criteria must be met before specialty designation can be considered.

All clinicians must sign this form whether specialties are applicable or not. Failure to sign this form may cause a delay in the processing of your initial credentialing file.

Printed Name of Applicant: _____

Signature of Applicant: _____
(Electronic Signatures and Signature Stamps are not accepted)

Date: _____

PROVIDER RIGHTS

I. RIGHT TO REVIEW

As an applicant for credentialing/re-credentialing, you have the right to review information obtained by Optum for the purpose of evaluating your credentialing or re-credentialing application. This includes non-privileged information obtained from any outside source (e.g., Malpractice insurance carriers, state licensing boards, National Practitioner Data Bank) but does not extend to review of information, references, or recommendations protected by law from disclosure. You may request to review such information at any time by sending a written request via email at sdu_providerserviceshelp@optum.com to the Provider Services (PS) Manager. The PS Manager, or designee, will notify you within 72 hours of the date and time when such information will be available at the OPTUM Credentialing Department located in San Diego, California.

II. RIGHT, UPON REQUEST, TO BE INFORMED OF STATUS OF CREDENTIALING/RECREDENTIALING APPLICATION

You have the right to be informed, upon request, of the status of your credentialing and/or re-credentialing application. You may request such information by sending a written request via email to the Credentialing Manager at the above cited email address. You will be notified in writing and within no more than ten (10) working days of receiving your fax or letter, by return fax or letter, of the current status of your application with respect to outstanding information required to complete the application process.

III. NOTIFICATION OF DESCREPENCY

Practitioners will be notified when information obtained by primary sources varies substantially from information provided on the practitioner's application. Examples of information at substantial variance include reports of a practitioner's malpractice claims history, actions taken against a practitioner's license/certification, suspension or termination of hospital privileges or board certification expiration when one or more of these examples have not been reported by the practitioner on his/her application. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

CORRECTION OF ERRONEOUS INFORMATION

If a practitioner believes that erroneous information has been supplied to OPTUM by primary sources, the practitioner may correct such information by submitting written notification to the Credentialing Manager. Practitioners must submit a written notice along with a detailed explanation to the Manager of Credentialing at sdu_providerserviceshelp@optum.com Notification to OPTUM must occur within 48 hours of OPTUM notification to the practitioner of a discrepancy as provided in Section II or within 24 hours of a practitioner's review of his/her credential file as provided in Section I.

Upon receipt of notification from the practitioner, OPTUM will re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the practitioner's credential file. If, upon re-review, primary source information remains inconsistent with practitioner's notification, Credentialing Manager will so notify the practitioner via fax or letter. The practitioner may then provide proof of correction by the primary source body to OPTUM Director of Medical Services via fax or letter at the email address above within ten (10) working days. The Credentialing Manager will re-verify primary source information if such documentation is provided. If, after ten (10) working days, primary source information remains in dispute, the practitioner will be subject to Adverse Action, up to administrative denial/termination.

Printed Name of Applicant: _____

APPLICATION ADDENDUM

Additional Treatment Location

Provider Name: _____

ADDITIONAL TREATMENT LOCATION: ☐ Yes ☐ No
If yes, please complete all sections below for Additional Treatment Location

Business Name: _____
DBA: _____
NPI Type 2 (Organization): _____

Mailing Address: ☐ *Same as Confidential Mailing Address*
Address: _____
Suite: _____
City: _____ **County:** _____
State: _____ **Zip:** _____

Contact Name: _____ **Phone#:** _____
Fax #: _____ **Email:** _____

Billing Address: ☐ *Same as Confidential Mailing Address* ☐ *Same as Mailing Address*
Address: _____
Suite: _____
City: _____ **County:** _____
State: _____ **Zip:** _____

Contact Name: _____ **Phone#:** _____
Fax #: _____ **Email:** _____

Additional Treatment Location:

Select all that apply: ☐ Telehealth ☐ In-Person
Address: _____
Suite: _____
City: _____ **County:** _____
State: _____ **Zip:** _____

Contact Name: _____ **Phone#:** _____
Fax #: _____ **Email:** _____

TTY/TTD Phone#: _____
Does this office meet ADA (Americans with Disabilities Act) guidelines? ☐ Yes ☐ No

Is this office accessible to public transportation? ☐ Yes ☐ No
Is this a Home Office? ☐ Yes ☐ No

HOURS OF OPERATION: (Example: 9:00 AM to 5:00 PM)			
Sunday		**to**	
Monday		**to**	
Tuesday		**to**	
Wednesday		**to**	
Thursday		**to**	
Friday		**to**	
Saturday		**to**	

Hours per week serving: (*This is an estimate of all clients you may be rendering services to at this location. Numerical digits required*)

Children (0-20): ___

Adults (21+): ___

Maximum number of Medi-Cal clients you are willing to see at this location: *(Numerical digits required)*

Children (0-20): ___

Adults (21+): ___

Wait Times For:

- **Urgent Appointments (Hours):** ___
- **Non-Urgent Appointments (Hours):** ___

Emergent Appointments within 1 hour? ☐ Yes ☐ No

APPLICATION ADDENDUM

Optum Home Office Standards

Clinicians who practice in a home office setting are required to meet the following standards listed below. A Provider with a home office that does not meet these standards shall be required to remediate the identified deficiencies, relocate their office to a setting that meets standards, or face disciplinary action up to an including contract termination.

1. Clinicians will inform all clients in advance that the therapy office is located in a home and if the office is not Americans with Disabilities Act compliant. If the client requires an ADA compliant location or is not comfortable with a home office setting, the provider shall refer the client back to the Access and Crisis Line for alternative referrals that better meet the client's preference.

2. When a clinician has any animals, clients must be told in advance that there is/are an animal(s) in the house and the clinician should isolate them from the office area. If an animal(s) is/are kept in the therapy office area they must have special training or be a certified pet therapy animal.

3. Off street or separate parking for clients should be offered. If off street parking is not available, then clients must be informed in advance where to park. The home should be clearly identified with a house number or sign and the entrance to the home must have adequate lighting. Exits and entrances must be clearly identified with exit signs. Exit doors must be unlocked on the inside.

4. The therapy office is designed so that family members, friends, or other clients cannot enter the office while therapy is in session and must be soundproof. Soundproofing may include a white noise machine, and/or structural soundproofing.

5. The clinician should offer a waiting area for clients. If s/he does not, it is expected that clients be informed in advance of the process for arrival to appointments and where to wait.

6. The office setting should be free from personal effects (i.e., medications, personal papers, and intimate pictures). Office furnishings need to be permanent and professional.

7. The office space should contain a separate bathroom for client use only. The bathroom utilized by clients must be free from personal effects (i.e., medications and intimate pictures/items).

8. Office, waiting room, and bathroom areas must be maintained in a neat, clean, and sanitary manner with no unpleasant odors; and be in good repair.

9. Office, waiting area and bathrooms must be compliant with applicable fire/safety regulations for businesses in that jurisdiction.

10. Medications and medication samples must be stored in a locked cabinet in a secure area. (MD and ARPN's Only)

11. Safeguards must be in place to ensure that no one other than the treating clinician has access to the office equipment that contains confidential information. Computers must be password protected.

12. The clinician must screen for high risk and/or potentially violent clients prior to first session. If the clinician does not have an alternative non-home setting to see high risk and/or potentially violent clients, the clinician should refer those clients back to Optum/Access and Crisis Line for appropriate referrals to offices that are not home based.

13. The Clinician is required to have a business license if required by the city/town in which the office is located.

14. If a complaint is received about the home office of a clinician contracted with Optum, a site audit and treatment record review request may be referred to County Quality Management. In such cases, the results of the review are forwarded to the requesting committee (e.g., Credentialing, Quality of Care Committee, Peer Review Committee) for determination about the need for further actions.

15. Treatment records storage is required to meet HIPAA privacy and security requirements in order to protect the view of client personal health information (PHI) by others. Detailed information about HIPAA privacy and security regulations can be located at the following website: https://www.hhs.gov/hipaa/index.html

16. The following beneficiary materials must be available to clients:
    - Client and Family Handbooks is given to the client in the first meeting
    - Client Grievance/Appeal Posters in the threshold languages are visibly posted.
    - Grievance/Appeal brochures and forms are available without requiring the client to request them form the provider
    - Limited English Proficiency (LEP) posters in the threshold languages are prominently displayed.
    - The Access and Crisis Line phone number is visibly posted.

Referral Screening Tool

Not all clients are comfortable with, or appropriate to be seen in, a home office setting. Please discuss the following topics and items with client prior to first appointment.

☐	Discuss with client the home office setting. If the client requires an ADA compliant location or is not comfortable with a home office setting, the provider shall refer the client back to the Access and Crisis Line for alternative referrals that better me the client's preference.
☐	Parking: inform where to park or if parking is not available
☐	Office is/is not ADA compliant
☐	Entrance: how to enter office
☐	Waiting Room: where to wait if there is no waiting room
☐	Screen client for history of violence (notify ACL and refer back to ACL if client has history of violence.)
☐	Inform client if there are animals in the home and inquire about client concerns (e.g., allergies, fears of animals, etc.)
☐	Document in phone call assessment or first intake note that these items were discussed with client

Attestation

- I understand and will abide by the Optum Public Sector Home Office Standards
- My home office meets these standards.

Provider Printed Name: _____

Provider Signature: _____
(Electronic Signatures and Signature Stamps are not accepted)

Date: _____