San Mateo County Behavioral Health & Recovery Services

FAX (650-573-2841) OR EMAIL TO: LILIAN MONTALVO, LMontalvo@co.sanmateo.ca.us

Credentialing Confirmation for New BHRS Contracted Provider

APPLICANT & AGENCY INFORMATION

(To be completed by applicant and verified by Contract Provider 1-5)

☐ **New User** ☐ **Update to Current User**

1. **NAME and related information (If licensed, registered or waivered, exactly as it appears on license or registration.)**

Contracted Provider Lead Agency _____**(e.g., Caminar, Telecare, Star-Vista)**

Program Name/Worksite: _____ **Program Director/Supervisor:** _____

Work Phone:_____**Gender** ☐ **M** ☐ **F**

First _____ **Last** _____ **Middle** _____

Position _____ **Candidate's Discipline** _____

☐ **Therapy- Student/Trainee** (all documents need co-sign) ☐ **Administrative** ☐ **Clinical- Licensed/Registered**
☐ **Counselor** (Non-Licensed/Non-Registered- less than 2 years experience all doc need co-sign/ 2 years+ Treatment Plan/ Assessment need co-sign)
Applicant Requires co-signature ☐ **No** ☐ **Yes** **Co-Signer's Name:** _____

2. **NPI #.**

National Provider Identification Information **Therapist#**_____
10-digit NPI # _____ **10-digit Taxonomy Code** _____
***If ASW, must ALSO have a COUNSELOR taxonomy Code** _____

If Applicable
MediCare PIN Information ☐ **PIN** ☐ **U/PIN** **Effective Date** _____

3. **Contracted Provider Confirms Credentials for Licensed, Registered, Waivered Applicants.**

Clinical License Credentials					**Primary Source Verifications**	**Clear**	**Not Clear**
Profession	**Lic#**	**Issue date:**	**Missing**	**Expiration Date:**	Medical Board of California		
A.					Osteopathic Medical Bd of CA		
B.					Board of Behavioral Science		
C.					Board of Registered Nursing		
					Board of Occupational Therapy		
Registered/Waivered					Residency Verification		
					Medi-Cal S & I list Status		
DEA (or CDS) Lic.					Board Certification		
					NPDB Query		
					Medicare Opt Out		
Other-Incompl-Exp					OIG/LEIE		

NOTE: This Information MUST be verified by the Contracted Provider before submitting

_____**Certifies that this information is correct and up-to-date as of:** _____
Print Name Date

Program Director/Supervisor: _____ **Signature:** _____

4. DEMOGRAPHICS: (Please note that the Demographic Information is Optional)

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Language Data - ✓ all that apply. **Demographic Data ✓all that applies.**

Language	Read	Write	Speak	Ethnicity/Race		AVATAR Location User Roles	
American Sign Language	☐	☐	☐	African-American	☐	AARS	☐
Korean	☐	☐	☐	Amerasian	☐	Caminar	☐
Tagalog	☐	☐	☐	American Native	☐	Cordilleras	☐
Other Non-English	☐	☐	☐	Asian Indian	☐	Fred Finch	☐
English	☐	☐	☐	Cambodian	☐	Front Street	☐
Spanish	☐	☐	☐	Filipino	☐	Mateo Lodge	☐
Other Sign Language	☐	☐	☐	Guamanian	☐	Mental Health Association	☐
Cambodian	☐	☐	☐	Hawaiian Native	☐	Edgewood	☐
Armenian	☐	☐	☐	Japanese	☐	Telecare	☐
Llacano	☐	☐	☐	Korean	☐	StarVista	☐
Miehn	☐	☐	☐	Laotian	☐		☐
Hmong	☐	☐	☐	Latino	☐		☐
Lao	☐	☐	☐	Other	☐		☐
Turkish	☐	☐	☐	Other Asian/Pacific Islander	☐		☐
Hebrew	☐	☐	☐	Samoan	☐		☐
French	☐	☐	☐	Vietnamese	☐		☐
Polish	☐	☐	☐	White	☐		☐
Russian	☐	☐	☐	Unknown	☐		☐
Portuguese	☐	☐	☐				☐
Italian	☐	☐	☐				☐
Arabic	☐	☐	☐				☐
Samoan	☐	☐	☐				☐
Thai	☐	☐	☐				

5. The BHRS Avatar team sets up new and disables former Avatar and Infoscriber accounts. If the user is a Prescriber, you must notify Barbara Liang, BHRS Director of Pharmacy Services (bliang@co.sanmateo.ca.us)

MEDICAL STAFF ONLY – For Licensed MEDICAL User Only – Infoscriber

License Category ☐ MD ☐ NP ☐ RN ☐ Nursing Other ☐ Pharmacist ☐ Guest

Year of 1st Licensure _____

CA Lic # _____ **NPI #** _____

DEA # _____ **%Time work in SMC** _____ **Est # clients each wk** _____