**Purpose:**

In order to meet the needs of Alameda County’s diverse population, BHCS is seeking licensed mental health providers/practitioners to provide office-based services who meet the preferred criteria under A. and at least one criterion under B. Please see the Provider Responsibilities section of the FAQ page for more information: <http://www.acbhcs.org/providers/network/docs/2013/MHP_Provider_Network_FAQ.pdf>

**Instructions:**

1. Read the Preferred, Required and Additional sections to see if you are eligible to provide services. Please note BHCS is seeking providers/practitioners that have offices located in the listed areas
2. Fill out the following and indicate which of the following criteria you meet
3. Attach a current resume
4. Submit this Brief Application and resume to: [procurement@acbhcs.org](mailto:procurement@acbhcs.org) Subject “MHP Provider Network Brief Application”

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name | | | |  | | | | | | | | | | | | | | | | ***Tax ID#*** | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| Licensure Type/Discipline | | | |  | | | | | | | | | | | | | | | | | Type of Service | | | | | | | Individual Provider to take referrals from ACCESS | | | | | | |  | | ERMHS Assessor | | | | | |  | | Murphy Conservatorship Assessor (Criminal Justice)\* | | | | | | | |  | Caregiver Competency Evaluator (Children and Family Services) |  | |
| Race/Ethnicity ***Please select the categories that most closely match how you identify*** | | | | | | | | | | | | | | | | | | | | | | | | Asian  Black  Caucasian | | | | | | | | | Filipino  Latino | | | | | | Middle Eastern  Native American  Pacific Islander | | | | | | | | | | | South Asian  Other | | | | | | |
| ***Please select the categories that most closely match how you identify. This is an optional section.*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | Lesbian | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | Queer | | | | | | | | | | | | | | | | |
|  | | | | | Gay | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | Intersex | | | | | | | | | | | | | | | | |
|  | | | | | Bisexual | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | Two-Spirited | | | | | | | | | | | | | | | | |
|  | | | | | Transgender | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | Straight | | | | | | | | | | | | | | | | |
| ***Gender*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | Female | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | Male | | | | | | | |  | | | | Other | | | | |
| ***Primary Office Address*** | | | |  | | | | | | | | | | | | | | | | ***City/Zip*** | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| ***Phone*** | | | |  | | | | | | | | | | Fax | | | |  | | | | | | | | | | | | | | ***Email*** | | | | | | | | | |  | | | | | | | | | | | | | | |
| ***Secondary Office Address*** | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | ***City/Zip*** | | | | | | | | | |  | | | | | | | | | | | | | | |
| ***Phone*** | | | |  | | | | | | | | | | Fax | | | |  | | | | | | | | | | | | | | ***Email*** | | | | | | | | | |  | | | | | | | | | | | | | | |
| ***Mailing Address (if different from Office Address)*** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | ***City/Zip*** | | | | | | | | | |  | | | | | | | | | | | | | | |
| Preferred Experience | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | **Have been licensed for at least two years[[1]](#footnote-1)** | | | | | | | | | | | | | |  | | | | **Have a breadth of clinical experience, including working with consumers with Medi-Cal** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | **Have experience providing eating disorder (ED) treatment** | | | | | | | | | | | | | |  | | | | **Certified in eating disorder treatment *(Eating Disorder certified providers receive a higher rate)*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | **Not certified, but have a breadth of experience *(In order to receive the higher rate, provider applicant will be prompted to complete the Supplemental Questionnaire on Eating Disorders when they complete their MHP Provider Network Application. BHCS will determine if provider meets the criteria to receive a higher rate. )*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Required Geographic Area/Language | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Have an office and provide services in one or more of the following areas *(note, your office address must match the checked area)*:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Alameda | | | | | | |  | | Ashland | | | | | |  | | | | | Castro Valley | | | | | | | |  | | | | | | Cherryland | | | | | | | |  | | | | | Dublin | | | | | | |
|  | | Fairview | | | | | | |  | | Fremont | | | | | |  | | | | | Hayward | | | | | | | |  | | | | | | Livermore | | | | | | | |  | | | | | Newark | | | | | | |
|  | | Oakland (East in zip codes 94621, 94603 & 94605) | | | | | | |  | | Oakland (West in zip codes 94607 &94625) | | | | | |  | | | | | Pleasanton | | | | | | | |  | | | | | | San Leandro | | | | | | | |  | | | | | San Lorenzo | | | | | | |
|  | | Sunol | | | | | | |  | | Union City | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Provide services in one or more of the following languages:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | ASL (American Sign Language) | | |  | | | Cantonese | | | |  | | | Farsi | | | | | | | | |  | | | | Mandarin | | | | | | | | |  | | | Spanish | | | | | |  | | | | Vietnamese | | | | |
|  | | | Other language, ***please specify***: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | ***Please describe your bi-cultural experience***: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Additional** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| How many BHCS-referred individuals can you see at any given time? [[2]](#footnote-2) | | | | | | |  | | |  | | I have worked in a BHCS County-operated clinic | | | | | | | | | | | | | | | | | | |  | | | I have worked for a BHCS contracted organization | | | | | | | | | | | |  | | | | I am willing to work with clients with a limited benefit (12 sessions per year) | | | | | | |
| Please insert any relevant clinical experience and/or notes that BHCS should consider when evaluating your Brief Application. | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

As a condition of contracting with BHCS’ MHP Network providers must meet BHCS requirements; provide information and submit particular forms to continue to be contracted with and be in compliance with the Agreement with BHCS. Providers must:

1. Attend trainings to gain knowledge about:

* BHCS and the various units that co-manage the MHP Provider Network
* Your obligation of how and when to check beneficiary eligibility for coverage, such as Medi-Cal
* Receiving referrals and the importance of keeping ACCESS informed of your availability
* How to obtain authorizations for ongoing services
* Required Quality Assurance (QA) documentation standards
* How to successfully meet the claims requirements for reimbursement

1. Seek Prior Authorization from ACCESS for individuals who are under 18 and over 64 and/or require psychological testing and for any other benefits plan other than Medi-Cal
2. Check client’s benefit status to ensure they are still eligible for benefits under Alameda County’s MHP, such as Medi-Cal
3. Submit claims for service rendered on appropriate claim forms following the claiming rules
4. Submit a Request for Extended Service (RES) form or Request for Concurrent Review (RCR) to continue seeing a beneficiary
5. Submit proof of professional liability and general liability insurance coverage meeting the minimum of $1,000,000 per incident and $2,000,000 aggregate
6. Submit a photocopy of all applicable state license(s) with a clearly visible expiration date; if your license is revoked or suspended you must inform the Network Office immediately
7. Complete and submit the re-credentialing application and required documents
8. Update ACCESS when open slots for beneficiary referrals are available
9. Update the Network Office on all changes to contact information, addresses, phone/fax numbers and email addresses

**If approved to be part of the MHP Provider Network, I agree to adhere to BHCS requirements. I certify that this information is true and accurate.**

|  |  |
| --- | --- |
|  |  |
| Name | Date |

1. This can be replaced with equivalent experience serving the Medi-Cal population during an internship.

   [↑](#footnote-ref-1)
2. BHCS prefers providers/practitioners that can provide services five or more BHCS clients at any given time. [↑](#footnote-ref-2)