alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

MENTAL HEALTH PLAN FEE-FOR-SERVICE PROVIDER BRIEF APPLICATION

In order to meet the needs of Alameda County's diverse population, Alameda County Behavioral Health Care Services (ACBH) is seeking licensed mental health providers/practitioners to provide services to Alameda County residents and encourage those who meet the preference criteria on the next page to apply.

BRIEF APPLICATION INSTRUCTIONS:

1. Demonstrate that you meet with the Requirements to become a Mental Health Plan (MHP) Fee-for-Service (FFS) Provider with ACBH Provider Network:
   a. Have been licensed for at least two years[1];
   b. Have a breadth of clinical experience, including work with Medi-Cal beneficiaries;
   c. Cannot be a current Alameda County employee.
   d. If providing Telehealth Services, you must reside in California.

2. Fill out the MHP Brief Application below and indicate which Type of Service you provide.
   a. Please note: Phone Number(s) and Fax number(s) must be your own private line and **CANNOT** be shared with other practitioners in order to protect client confidentiality.

3. You must have a National Provider Identification (NPI) to contract with Alameda County Behavioral Health Care Services (ACBH). To apply or learn why you are required to have one, please visit: https://nppes.cms.hhs.gov.

4. You must have a CAQH ProView account set up in order to contract with ACBH.
   a. If you already have an account with CAQH, please provide your ID Number and ensure that your profile information is current.
   b. To create or update your account, please visit: https://proview.caqh.org/Login. If you have any questions about the registration process, please contact the **CAQH ProView Help Desk at (888) 599-1771.**

5. All payees must have an accurate W-9 on file in the Auditor-Controller's office in order to be paid. If you fail to furnish your correct TIN, you could be subject to a penalty. Please visit https://www.irs.gov/forms-pubs to obtain the current W-9.
   a. You must complete the W-9 Form Taxpayer Identification Number (TIN). The purpose of this form is to obtain or verify the accuracy of information regarding Alameda County's payees.

6. ACBH will access your **Certificate(s) of Insurance** for professional, commercial general[2], automobile, and workers' compensation liability insurance coverage as required in Exhibit C, County of Alameda Minimum Insurance Requirements through CAQH ProView.
   a. **You are required to submit proof of coverage annually prior to expiration as part of the contract agreement with Alameda County ACBH.**

7. Provide an **original or electronic signature** on the **Certification** page. **A signature is required to complete this application. ACBH will not accept stamped signatures.**

8. Provide a current resume or CV.

9. Email the Brief Application, W-9, and resume or CV to: MHproviders@acgov.org Subject: "MHP Provider Network Brief Application". The application can also be submitted by mail to:

Alameda County ACBH
Contracts Unit c/o MHP Fee-For-Service Providers
1900 Embarcadero Cove, Suite 205
Oakland, CA 94606
***OR** Fax: 510-567-8290*

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

[2] *Including an Additional Insured Endorsement Page: Commercial general liability shall be endorsed to name as additional insured: "County of Alameda, its Board of Supervisors, the individual members thereof, and all County officers, agents, employees, volunteers, and representatives."*

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MENTAL HEALTH PLAN PROVIDER NETWORK BRIEF APPLICATION

Name		***Pronouns***		***Social Security #***		***Date of Birth***	
NPI #			***License #***				
Licensure Type/Discipline		***Type of Service***	Individual Provider to take referrals from ACCESS	Murphy Conservatorship Assessor (Criminal Justice)*	Caregiver Competency Evaluator (Children and Family Services)		
City of Birth		***State of Birth***		***Country of Birth***			
Tax ID #		***Tax Address***					
CAQH ID #		***Billing Address***					

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***	

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 specify below

Please write in how you identify.

This is an optional section used to help match clients with providers that may reflect their sexual orientation and/or gender identify.

Sexual Orientation		Gender Identity	

Preferred Experience

	Have been licensed for at least two years[3]		**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**
			Not certified, but have a breadth of experience

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

Language and Other Experience

Please check if you can provide services in one or more of the following languages:

☐	ASL (American Sign Language)	☐	Cantonese	☐	Farsi	☐	Mandarin	☐	Spanish	☐	Vietnamese
☐	Other language, ***please specify***:										

Are you willing to work with an interpreter for a non-English speaking client?	☐	Yes	☐	No

Please describe your bi-cultural experience:

Clinical/Referral Profile

ACBH's ACCESS serves as a referral source for the MHP Provider Network. Referrals are normally made to best meet client needs and preferences.

Area of Expertise

Please check ALL areas of expertise/specialty you have.

Diagnosable Mental Disorders

☐	Adjustment Disorders	☐	Bipolar Disorder	☐	Gender Identity	☐	Psychotic Disorders
☐	Anxiety Disorders	☐	Conduct Disorders	☐	Obsessive Compulsive Disorder	☐	Schizophrenic Disorders
☐	Asperger's Disorders	☐	Depressive Disorders	☐	Oppositional Defiant Disorder		
☐	Attachment Disorders	☐	Dissociative Disorders/MPD	☐	Personality Disorder		
☐	Attention Deficit Disorder	☐	Eating Disorders (ED)	☐	Phobias		

Demographic Factors

☐	Children (0-5)	☐	Transitional Age Youth (18-25)	☐	Court Dependents	☐	Developmental Disability
☐	Children (6-12)	☐	Adults (18-64)	☐	Physical Disability	☐	LGBTQIA+
☐	Adolescents (13-17)	☐	Older Adults (80+)				

Psychosocial Problems

☐	Adoption	☐	Family Relations/Parenting	☐	Physical Abuse Survivor	☐	Substance Abuse
☐	Assaultive Behavior/Anger Management	☐	HIV/AIDS	☐	Pregnancy Issues	☐	Suicide History
☐	Co-Occurring Disorder (SA & MH)	☐	Medical Conditions	☐	Sexual Abuse Survivor	☐	Trauma/PTSD
☐	Developmentally Disabled *with* MH problems	☐	Neurological Conditions	☐	Sexual Perpetrators (Adults)		
☐	Domestic Violence	☐	Occupational Stress	☐	Sexual Perpetrators (Juvenile)		

Services

☐	Case Management	☐	Crisis	☐	Groups	☐	Individual Therapy	☐	Medication Support
☐	Couples Counseling	☐	Family Counseling	☐	Home Visits	☐	Inpatient Experience	☐	Psychological Testing

Modality

Select all that you are trained AND qualified to provide:

☐	Cognitive Behavioral Therapy	☐	Eye Movement Desensitization and Reprocessing	☐	Motivational Interviewing
☐	Dialectical Behavioral Therapy	☐	Hypnotherapy	☐	Other:

Office Hours							
Please list hours:							
ADA Access Yes No	Monday	Tuesday	Wednesday	Thursday	Friday	Weekend availability? No Yes - Please list hours	
	to	to	to	to	to	Saturday	Sunday
						to	to
Evening availability?						Please list evening availability in the boxes to the left if applicable.	

Do you offer Telehealth?	Yes No	If yes, approximately what percentage of services are telehealth vs. in-person?	_____ % Telehealth	_____ % in person
Do you transport clients?	Yes No			

Additional								
How many ACBH-referred individuals can you see at any given time? [4]			I have worked in an ACBH County-operated clinic		I have worked for an ACBH contracted organization		I am willing to work with clients with a limited benefit		I am willing to work with Social Services Children and Family Services (CFS)
Please insert any relevant clinical experience and/or notes that ACBH should consider when evaluating your Brief Application.									
Are you currently working for a group or organization? If yes, please indicate name.									

[4] ACBH prefers providers/practitioners that can provide services to three or more ACBH clients at any given time.

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MENTAL HEALTH PLAN PROVIDER NETWORK BRIEF APPLICATION

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

1. Attend trainings to gain knowledge about:
   - ACBH 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;
2. 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;
3. Check client's benefit status to ensure they are still eligible for benefits under Alameda County's MHP, such as Medi-Cal;
4. Submit claims for service rendered on appropriate claim forms following the claiming rules;
5. Submit a Request for Extended Service (RES) form or Request for Concurrent Review (RCR) to continue seeing a beneficiary;
6. Submit proof of professional liability and general liability insurance coverage meeting the minimum of $1,000,000 per incident and $3,000,000 aggregate;
7. 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 Contracts Unit immediately;
8. Complete and submit the re-credentialing application and required documents;
9. Update ACCESS when open slots for beneficiary referrals are available; and
10. Update the Contracts Unit 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 ACBH requirements. I certify that this information is true and accurate.

_____

Name ***Date***