Los Angeles County Department of Mental Health
Credentialing Application for Prescribing Practitioners
Delivering Services to DCFS Children

This application is exclusively for prescribing practitioners who provide services as sub-contractors to organizations that deliver treatment services to Los Angeles County DCFS patients, hereafter referred to the Los Angeles County DCFS Prescriber Network (LACDPN).

This application is not for prescribers seeking to join DMH's Fee for Service Network in order to independently bill for services or to provide services through a group practice that bills DMH.

Credentialing Application Instructions

- The credentialing application must be typed or printed legibly.
- Applicants must provide a phone number and an email address that allows direct contact
- The provider application must be completed in its entirety.
- If the answer to any professional liability question is "yes", provide full details on an attached separate sheet and include all pertinent documents from the court and/or attorneys.
- If the answer to any attestation question is "yes", provide full details on an attached separate sheet. Documentation is required from the professional licensing board if any action has been taken against your license. Additionally, documentation is required from Medi-Cal or Medi-Caid authorizing final disposition on any adverse actions.
- Psychiatrists are to include a copy of their current Drug Enforcement Agency (DEA) certificates, a current *curriculum vitae*, copies of their Medical Degrees, a *Certificate of Professional Liability Insurance*. Psychiatrists must be either board certified or have completed an ACGME, or equivalent, approved psychiatric residency training program in order to provider services under the LACDPN. Psychiatrists who are not board certified must include a copy of their certificate of completion of psychiatric residency training.
- Clinical nurse specialists and nurse practitioners are to include a *curriculum vitae*, a *Certificate of Professional Liability Insurance,* Proof of ANCC or AANP certification in behavioral health. Clinical nurse specialists are to submit proof of graduation from a master's degree in psychiatric/mental health nursing as a clinical nurse specialist. Nurse practitioners are to submit proof of graduation from a master's degree program in psychiatric/mental health nursing as a nurse practitioner and a DEA certificate.
- Malpractice insurance liability requirements are $1,000,000 per occurrence and $3,000,000 aggregate.
- Credentials will be renewed every 3 years.

- The Credentialing Unit will query the following websites to confirm licensure/certification, and obtain information regarding limitations or sanctions and malpractice claims.

    - State licensing boards and Medical Specialty Boards
    - National Provider Data Bank and Healthcare Integrity and Protection Data Bank
    - Office of the Inspector General exclusion list
    - Department of Health Care Services Medicaid/Medicare Suspended and Excluded List

Please mail or fax the completed application with the required documents to:

Department of Mental Health
Provider Credentialing Unit
550 S. Vermont Avenue, Room 703B
Los Angeles, CA 90020
Fax: (213) 487-9658
Credentialing Unit Telephone Numbers: (213) 738-2814 or (213) 738-2465

Application To Participate As A Provider in
The Los Angeles County Department of Mental Health
Local Mental Health Plan

PROVIDER INFORMATION

Last Name:	First Name:	Middle Initial:

Social Security Number: _____

Direct Contact Phone Number: _____ **Email Address:** _____

Is /are there any other name(s) under which you have been known?
Name(s):

Gender:	Birth date:	Ethnicity:	Degree:

Are you currently a County of Los Angeles employee? ☐ **Yes** ☐ **No**

If the answer is yes, please provide the following information: ☐ **Full-time** ☐ **Part-time** ☐ **Consultant**

Name of Department: _____

Work Location: _____

Position: _____

Job Responsibilities: _____

MAILING ADDRESS: Address to which all official notices will be mailed

Street:	Suite Number:	Post Office Box Number:
City:	**State:**	**Zip Code (9 digits required):**

E-Mail Address (Required):

PRACTICE LOCATIONS:

LOCATION #1 Name of Program/Facility: Street:	Suite Number:

City:		**State:**	**Zip Code:**
Phone:	**Fax Number:**	**Is this office wheelchair accessible?** ☐ **Yes** ☐ **No**	
LOCATION #2 **Name of Program/Facility:** **Street:**			**Suite Number:**
City:		**State:**	**Zip**
Phone:	**Fax:**	**Is this office wheelchair accessible?** ☐ **Yes** ☐ **No**	
LOCATION #3 **Name of Program/Facility:** **Street:**			**Suite Number:**
City:		**State:**	**Zip:**
Phone:	**Fax:**	**Is this office wheelchair accessible?** ☐ **Yes** ☐ **No**	

PROFESSIONAL EDUCATION

Educational Institution		Degree	From (mm/yy)	To (mm/yy)
Graduate School/ Medical School	**Institution:** **Address:** **City, State, Zip:**			
Internship	**Institution:** **Address:** **City, State, Zip:**			
Residency	**Institution:** **Address:** **City, State, Zip:**			

Fellowship	**Institution:** **Address:** **City, State, Zip:**			

If you are an international medical school graduate, are you certified by the Education Commission for Foreign Medical Graduates (ECFMG)? ☐ Yes ☐ No
For Non-Board Certified Physicians please include Residency completion Certificate

PROFESSIONAL LICENSE (S):
Include a copy of your license(s) with your application materials

Licensing Board Name	State	Specify Active or Inactive	License Number	Expiration Date

DEA CERTIFICATE: M.D.s'/D.O.'s/Nurse Practitioners
Include a copy of your current certificate with your application materials

DEA Certificate Number:	Expiration Date:

BOARD CERTIFICATION: M.D.'s/D.O.'s/R.N.s

Name of Board	Certification Date	Expiration Date (If Applicable)

HOSPITAL PRIVILEGES: List all hospitals at which you have privileges

Hospital	City	Appointment Date

PROFESSIONAL LIABILITY COVERAGE:

Insurance Carrier	Per claim amount	Aggregate amount	Expiration Date

Please answer either "yes" or "no" after each question. If you answer "yes" to any question, please provide a detailed explanation on a separate sheet. Documentation is required if you have any malpractice actions pending or settled within the past five years. The documentation must be from an attorney or the entity that issued the judgment.

Have you ever been denied professional liability insurance?	☐ **Yes**	☐ **No**
Has your professional liability insurance ever been canceled, denied renewal or subject to restriction (e.g. reduced limits, surcharged)?	☐ **Yes**	☐ **No**
Within the past seven years have you been a party to any malpractice actions?	☐ **Yes**	☐ **No**
Within the past seven years has any malpractice action been settled or has there been an unfavorable judgment(s) against you in a malpractice action?	☐ **Yes**	☐ **No**
To your knowledge, is any malpractice action against you currently pending?	☐ **Yes**	☐ **No**

ATTESTATION QUESTIONS:

Please answer "yes" or "no" after each question. If you answer yes to any question, please provide a detailed explanation on a separate sheet. Documentation is required from the professional licensing board if any action has been taken against your license.

LICENSURE

1. **Has your professional license in any state ever been limited, suspended, revoked or subjected to probationary conditions or have proceedings toward any of those ends ever been instituted against you?..... ☐ Yes ☐ No**
   - **a. Have you ever voluntarily surrendered your license?..... ☐ Yes ☐ No**
   - **b. Are formal charges pending against you at this time?..... ☐ Yes ☐ No**

HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS

2. **Have you ever had an application for membership or privileges at a hospital or other health care facility denied, granted with limitations, suspended, revoked, not renewed or subjected to probationary conditions or have proceedings toward any of those ends ever been instituted against you, or ever been recommended by a standing medical staff committee or governing board of a hospital, other health care facility or any medical organization? …… ☐ Yes ☐ No**
3. **Have you ever voluntarily or involuntarily relinquished a medical staff membership, your clinical privileges, a professional license, or a narcotics permit under threat of disciplinary action, threat of censure, restriction suspension or revocation of such privileges?..... ☐ Yes ☐ No**
4. **Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?..... ☐ Yes ☐ No**

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5. **Have your medical staff membership, your clinical privileges, a professional license, or a narcotics permit ever been limited or subjected to disciplinary action of any kind?..... ☐ Yes ☐ No**
6. **Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency? …….. ☐ Yes ☐ No**
7. **Are you currently the subject of any investigation by any hospital, licensing authority, DEA, or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?..... ☐ Yes ☐ No**
8. **Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever be revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending?..... ☐ Yes ☐ No**

EDUCATION, TRAINING AND BOARD CERTIFICATION

9. **Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?..... ☐ Yes ☐ No**
10. **Has your specialty board certification or eligibility ever been limited, suspended, revoked, denied, relinquished, not renewed, or reduced or subjected to probationary conditions, or have proceedings toward any of those ends ever been instituted? (M.D.s/O.D.s only)…….. ☐ Yes ☐ No**

DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION

11. **Has your DEA certificate or any other controlled substances authorization, ever been suspended, revoked, limited, denied renewal, or have any proceedings toward any of those ends ever been instituted against you?(M.D.' s/D.O.'s/ nurse practitioners only)…… ☐ Yes ☐ No**

MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PARTICIPATION

12. **Do you have any pending disciplinary action, or are you currently sanctioned, expelled, or suspended from any federally funded programs, including but not limited to, Medi-Cal, or Medicare?..... ☐ Yes ☐ No**
13. **Have you ever been fined, had an arrangement suspended, been expelled from participation or had criminal charges brought against you by Medicare or Medicaid?..... ☐ Yes ☐ No**
14. **Have you ever been sanctioned, expelled, suspended from, or had criminal charges brought against you by any federally**

funded programs, including but not limited to, Medi-Cal, or Medicare?..... ☐ Yes ☐ No

PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY

15. **Has your professional liability insurance ever been terminated, or not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your liability insurance or its coverage of any procedure? ……. ☐ Yes ☐ No**

MALPRACTICE CLAIMS HISTORY

16. **To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data bank or Healthcare Integrity and Protection Data Bank?..... ☐ Yes ☐ No**
17. **Has any malpractice lawsuit and/or arbitration been filed against you in the last 10 years?..... ☐ Yes ☐ No**
18. **To your knowledge, do you have any pending malpractice suite, arbitrations or judgments?..... ☐ Yes ☐ No**

CRIMINAL/CIVIL HISTORY

19. **Have you ever been court-martialed for actions related to your duties as a medical professional?(M.D.s/O.D.s /N.P.s only) …… ☐ Yes ☐ No**
20. **Have you ever been a subject of charges related to moral or ethical turpitude?..... ☐ Yes ☐ No**
21. **Have you ever been convicted of any crime, other than a traffic violation, or pled nolo contendere? ☐ Yes ☐ No**
22. **Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g. CLIA, OSHA, etc.)?..... ☐ Yes ☐ No**
23. **Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last 10 years for sexual harassment or other illegal misconduct?..... ☐ Yes ☐ No**

ABILITY TO PERFORM JOB

24. **Do you have a history of alcohol and/or chemical dependency/substance abuse?..... ☐ Yes ☐ No**
25. **Do you have a current problem with alcohol and/or chemical dependency/substance abuse?..... ☐ Yes ☐ No**
26. **Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?..... ☐ Yes ☐ No**
27. **Do you have any physical or mental impairment which would render you unable, with or without reasonable accommodations, to provide professional services within your areas of practice, without posing a direct threat to the health and safety of others?..... ☐ Yes ☐ No**
28. **Are you able to perform all the services required by your agreement with, or professional bylaws of, the Healthcare Organization to which you are applying, with or without reasonable accommodations, according to accepted standards of professional performance and without posing a direct threat to the safety of patients?..... ☐ Yes ☐ No**

PRIOR LOS ANGELES COUNTY EMPLOYMENT

29. **Have you ever been employed in any capacity by Los Angeles County?..... ☐ Yes ☐ No**
30. **If yes, were you terminated of did you resign because of a performance issue or in the midst of any kind of investigation?..... ☐ Yes ☐ No**
31. **Have you ever been terminated from employment anywhere?..... ☐ Yes ☐ No**
    If yes, please describe the circumstances _____
    _____

I do hereby certify that the information contained in this application is accurate and complete to the best of my knowledge and belief. I fully understand that any misstatement in or omission from this application constitutes cause for denial of credentialing and enrollment as a network provider in the LACDPN. I agree to notify the LACDPN promptly if there are any material changes in the information provided in this application.

I authorize the LACDPN to consult orally, electronically, and in writing with the state licensing board(s), the American Medical Association, the National Technical Information Service, educational institutions, malpractice insurance carriers, specialty boards, Educational Commission for Foreign Medical Graduates, hospitals, the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, and any other person or entity from whom/which information may be needed to complete the credentialing process or to obtain and verify information concerning my professional competence and qualifications. Applicants are hereby advised that the LACDPN participates in the National Practitioner Data Bank, The Office of the inspector General, California Licensing Boards, American Board of Medical Specialties, and the Department of Health Care Services Medi-Cal Suspended and ineligible Provider list, and the Healthcare Integrity and Protection Data Bank. Applicants acknowledge that adverse actions taken by the

LACDPN may be reported to these agencies and/or other disciplinary boards/authorities as necessary.
I consent to the release by any person to the LACDPN of all information that may be relevant to an evaluation of my professional competency and qualifications, including any information relating to any disciplinary action, suspension or curtailment of privileges. I release the LACDPN and all those whom the LACDPN contacts from any and all liability for their acts performed in good faith in obtaining and verifying such information and in evaluating my application.

I agree to obtain and maintain in effect all licenses, permits, registration, accreditations and certificates as required by all Federal, State and local laws, ordinances, rules and regulations, and policies of the LACDPN. I agree to immediately notify the LACDPN upon any investigation, revocation, reduction, termination, denial, limitation or suspension of my DEA number, furnishing certificate, professional license, professional liability insurance, participation in federally funded programs such as Medi-Cal or Medicare or other certification and/or other credentials authorizing me to practice my profession. I also agree to immediately notify the LACDPN upon termination, suspension or revocation of my staff privileges at any hospital or health care facility.

I understand that I must meet any requirements set forth in this credentialing application and that this credentialing application implements the LACDPN credentialing policy, all of which apply to the application and any decision made by the LACDPN with respect to it.

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Signature of Applicant **Date**