How to complete the County of Santa Clara Participating Practitioner (CSCPPA) Fillable Form

Section I. Instructions

This section describes general instructions and identifies the additional documents that need to be submitted with the CSCPPA. Please complete all applicable fields.

The completed packet must include:

1. CSCPPA
2. Copy of Liability Insurance
3. Resume
4. Mental Health Rehabilitation Specialist Certificate (if applicable)
5. Intern or trainee placement agreement (if applicable). The agreement must be with one of the schools that are on file for County and CCPS, as having agreements for placement.

The completed packet must be sent to BHSDCredentialing@vhp.sccgov.org with a copy to BHSDBusinessOffice@hhs.sccgov.org

I. INSTRUCTIONS
This form should be typed. If more space is needed than provided on the original, attach additional sheets andreference the question being answered. Please do not use abbreviations. Current copies of the following documents must be submitted with this application: • Face Sheet of Professional Liability Policy or Certification with a letter stating the applicant is covered by the Agency's insurance. • Curriculum Vitae or professional resume • For interns and trainees, a placement agreement or contract signed by the applicant, supervisor, or training coordinator and school placement liaison is required. The agreement must specify the duration of the contract. • For MHRS, provide a copy of MHRS Certificate

Section II. Identifying Information

This section requests the individual's demographic information.

1. Enter the legal name and any other names, if any.
2. Enter the mailing address.
3. Enter contact information such as e-mail address, mobile number, home telephone number (as applicable).
4. Enter Cultural Capabilities (Examples: Veteran's, Older adults, Transition Age Youth, Lesbian, Gay, Bisexual, Transgender)
5. Enter the Social Security Number.
6. Enter the NPI # and Taxonomy Code associated with the NPI # that is listed in NPPES. The legal name associated with the NPI should match.
7. Select one from the Specialty (drop-down) that the individual will be providing services as., i.e., Ph.D intern, MSW Intern, Psy.D Intern, MFT trainee, PCC trainee, paraprofessional < 2 years, paraprofessional > 2 years, or MHRS.
8. Select a gender type.
9. Enter additional languages spoken, if other than English.
10. Enter Race/Ethnicity (optional and used for consumer purposes only)
11. Enter provider Start Date (this can be the desired date or when they started)

II. IDENTIFYING INFORMATION			
Legal Last Name:	**Legal First Name:**	**Legal Middle Name:**	
Is there any other name under which you have been known? Name(s):			
Mailing Address:	**City:**		
Home Telephone Number:	**State:**	**Zip code:**	
Mobile Number: **Email Address:**	**Cultural Capabilities:**		
Birth Date: **Birthplace (City/State):**	**Country**		
Social Security No.: **NPI:**	**Gender:** ☐ Non-Binary ☐ Male ☐ Female		
Specialty: Select One **Taxonomy Code:**	**Race/Ethnicity (voluntary):**		
Languages Spoken (other than English):	**Provider Start Date:**		

Section III. Agency Information

1. Enter Agency Name, i.e. Contractor agency or County clinic
2. Select Agency Program Name (Check what services will be provided i.e. Mental Health or SUTS)
3. Enter the Supervisor Name, License, and NPI # (if applicable)
4. Enter Primary Office street address where the individual will provide services.
5. Enter the telephone number and fax number for that address.
6. Enter the name and contact information for the Office Manager/Administrator, such as the email address, telephone number, and fax number.
7. Enter the Agency's Tax ID # and the Agency Name affiliated with the Tax ID #.
8. Enter the Agency NPI # for the Primary Office street address
9. Enter the Agency Medi-Cal number for the Primary Office street address
10. If the individual provides services at additional locations, please complete the information for secondary and tertiary addresses.

III. AGENCY INFORMATION			
Agency Name (if applicable):	**Agency Program Name:** ☐ Mental Health ☐ SUTS		
Primary Office Street Address:	**City:**		
Supervisor Name: **License:** **NPI:**	**State:**	**Zip code:**	
Telephone Number:	**Fax Number:**		
Office Manager/Administrator Name/Title:	**Telephone Number:**		
Office Email Address:	**Fax Number:**		
Name Affiliated with Tax ID Number:	**Federal Tax ID Number:**		
Agency Medicare UPIN/National Provider Identifier (NPI):	**Agency Medi-Cal Number:**		

Section IV. College Education (if applicable)

1. Enter the college name and mailing address.
2. Enter the degree that the individual received at the college.
3. Enter the date (month and year) the individual graduated from the college.

IV. COLLEGE EDUCATION (Attach additional sheets if necessary and appliable. Reference this section number and title)			
College or University Name:	**Degree:**		**Date of Graduation: (mm/yy)**
Mailing Address:	**City:**	**State:** **Country:**	**Zip code:**

Section V. Graduate Education (if applicable)

1. Enter the professional school name and mailing address.
2. Enter the degree that the individual received at the school.
3. Enter the date (month and year) the individual graduated from the school.

V. GRADUATE EDUCATION (Attach additional sheets if necessary and applicable. Reference this section number and title)			
Professional School:	Degree:		Date of Graduation: (mm/yy)
Mailing Address:	City:	State:	Zip code:

Section VI. Internship/Experience (if applicable)

1. Enter the Agency or Institution that the individual is completing an internship or experience, i.e. Santa Clara University
2. Enter the Supervisor Name that is providing supervision, Supervisor License #, and Supervisor NPI#
3. Enter the mailing address of the Agency or Institution
4. Enter the type of internship.
5. Enter the Specialty that the individual will be providing services as., i.e., Ph.D intern, MSW Intern, Psy.D Intern, MFT trainee, or PCC trainee.
6. Enter the period (month and year) for the internship, i.e. August 1, 2022 to August 1, 2023

VI. INTERNSHIP/ EXPERIENCE (Attach additional sheets if necessary. Reference this section number and title)		
Agency/Institution:	Supervisor/Program Director: License Number: NPI Number:	
Mailing Address:		
City:	State: County:	Zip code:
Type of Internship:		
Specialty:	From: (mm/yy)	To: (mm/yy)

Section VII. Certification/Registration (if applicable)

1. Enter registration or certification number.
2. Enter type of registration or certification.
3. Enter issue and expiration date.

VII. CERTIFICATION/REGISTRATION (Remember to attach copies of documents)		
Registration/Certification Number:	Issue Date:	Expiration Date:
Type of /Registration/Certification:		

Section VIII. Attestation Questions

1. Please read the question carefully and select “yes” or “no” to each of the questions.
2. Print, sign, and date at the bottom of Page 3 to affirm the attestation.
3. Print, sign, and date at the bottom of Page 4 to affirm the information submitted in the application.

VIII. ATTESTATION QUESTIONS		
Please answer the following questions "yes" or "no." If your answer to questions A through F is "yes," please provide full details on a separate sheet. Provide an explanation of the incident(s), the date(s) it occurred, the results of the incident, and the date of the conclusion.		
A. Have you had a professional license/certification or privileges that were denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions, or have you been fined or received a letter of reprimand or is such action pending?		
	☐ Yes	☐ No
B. Have you ever been disciplined by a post-secondary educational institution or by any employer?		
	☐ Yes	☐ No
C. Have you ever had a license that was denied certification/recertification by a specialty board or has your eligibility, certification, or recertification status changed (other thanchanging from eligible to certified)?		
	☐ Yes	☐ No
D. Have you ever been convicted of a felony?		
	☐ Yes	☐ No
E. Do you presently use any drugs illegally?		
	☐ Yes	☐ No
F. Do you have any limitation on your ability to perform all the services required by your agreement with the Healthcare Organization to which you are applying, according to accepted standards of professional performance and without posing a direct threat to the safety of patients (other than a need for a reasonable accommodation)?		
	☐ Yes	☐ No