openmind HEALTH

Participating Provider Application

This application is submitted to Open Mind Mental Health, Inc. (OPMH)

1. INSTRUCTIONS

This form should be should be filled out electronically (typed) into the applicable form fields. If more space is needed than provided on this original document, please attached a word document with the additional information and an applicable reference. Current copies of the following documents must be submitted along with the application:

- State Professional License(s)
- DEA Certificate (if applicable)
- Physician Board Certification (if applicable)
- Up-to-date Curriculum Vitae

2. APPLICANT POSITION

Please check the box below for the position you are applying with OPMH:

☐ Psychiatrist ☐ Therapist ☐ Other If other, please give a brief description: _____

3. IDENTIFYING INFORMATION

Last Name	First Name	Middle
Is there any other name under which you have been known? Name(s)		
Home Mailing Address	Country	
City	State/Province	Zip
Home Phone Number	Mobile Phone Number	
Email Address		Zip
Date of Birth	Birthplace (City/State/Country)	Social Security Number
Citizenship (If not a United States citizen, please Include copy of Alien Registration Card).		
Specialty		
Sub Specialties		

4. PRACTICE INFORMATION

Practice Name (if applicable)	Department
Primary Office Street Address	Country
Phone Number	Fax Number
Office Manager/Administration	Phone Number
Name Affiliated with Tax ID Number	Federal Tax ID Number
Secondary Practice Name (if applicable)	Department
Office Street Address	Country
Phone Number	Fax Number
Supervisor /Administration	Phone Number
Name Affiliated with Tax ID Number	Federal Tax ID Number
Tertiary Practice Name (if applicable)	Department
Office Street Address	Country
Phone Number	Fax Number
Supervisor /Administration	Phone Number
Name Affiliated with Tax ID Number	Federal Tax ID Number

5. EDUCATION (Attach additional sheets if necessary. Reference this section.)

Institution		Degree Received	Date of Graduation (MM/YY)
Mailing Address	City	State	Zip
Institution		Degree Received	Date of Graduation (MM/YY)
Mailing Address	City	State	Zip
Institution		Degree Received	Date of Graduation (MM/YY)
Mailing Address	City	State	Zip

6. PROFESSIONAL EDUCATION (Attach additional sheets if applicable. Reference this section.)

School		Degree Received	Date of Graduation (MM/YY)
Mailing Address	City	State	Zip
Professional School		Degree Received	Date of Graduation (MM/YY)
Mailing Address	City	State	Zip
Professional School		Degree Received	Date of Graduation (MM/YY)
Mailing Address	City	State	Zip

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7. PRECEPTORSHIPS / INTERNSHIPS / RESIDENCIES / FELLOWSHIPS
(Attach additional sheets if necessary. Reference this section.)

Include preceptorships, internships, residencies, fellowships, teaching appointments (indicate whether clinical or academic), and post graduate education in chronological order, giving name, address, city, zip code, and dates. Include all programs you attended, whether or not completed.

Institution | Program Director

Mailing Address | City | State | Zip

Type of Training (e.g., residency, etc.) | Specialty | Dates (to/from) (MM/YY)

Did you successfully complete the program? ☐ Yes ☐ No If no, please explain in a separate document and reference this section.

Institution | Program Director

Mailing Address | City | State | Zip

Type of Training (e.g., residency, etc.) | Specialty | Dates (to/from) (MM/YY)

Did you successfully complete the program? ☐ Yes ☐ No If no, please explain in a separate document and reference this section.

Institution | Program Director

Mailing Address | City | State | Zip

Type of Training (e.g., residency, etc.) | Specialty | Dates (to/from) (MM/YY)

Did you successfully complete the program? ☐ Yes ☐ No If no, please explain in a separate document and reference this section.

Institution | Program Director

Mailing Address | City | State | Zip

Type of Training (e.g., residency, etc.) | Specialty | Dates (to/from) (MM/YY)

Did you successfully complete the program? ☐ Yes ☐ No If no, please explain in a separate document and reference this section.

8. PROFESSIONAL LICENSE(S) / NPI / DEA (if applicable) (Attach copies of documents)

State License Number	Issue Date	Expiration Date
State License Number	Issue Date	Expiration Date
State License Number	Issue Date	Expiration Date
NPI Number	Expiration Date	
DEA Registration Number	Expiration Date	

9. PROFESSIONAL LIABILITY (Attach a copy of liability policy or certification sheet).

Current Insurance Carrier	Policy Number	Original Effective Date	
Mailing Address	City	State	Zip
Per Claim Amount	Aggregate Amount	Expiration Date	

Please explain any surcharges to your professional liability coverage in separate document. Reference this section and title number.

Please list all of your professional liability carriers within the past seven years, other than the one listed above.

Name of Carrier	Policy Number	Dates (From/To)	
Mailing Address	City	State	Zip
Name of Carrier	Policy Number	Dates (From/To)	
Mailing Address	City	State	Zip

10. BOARD CERTIFICATION (if applicable) (Attach copies of documents)

Name of Issuing Board	Specialty	Date Certified/Recertified	Expiration Date (if any)
Name of Issuing Board	Specialty	Date Certified/Recertified	Expiration Date (if any)
Name of Issuing Board	Specialty	Date Certified/Recertified	Expiration Date (if any)

Have you applied for board certification other than those indicated above? ☐ Yes ☐ No

If so, list board(s) and date(s)

If not certlfied, describe your intent for certlficatlon, if any, and date or eligibility for certification on separate sheet.

11. AFFILIATIONS

Please llst In reverse chronologieal order (with the current affiliation(s) first) all institutions you have current affiliations (A) and have had previous affiliuations, including hospital privileges (B) during the past ten years. (If additional space needed for listings, please attach a separate page.)

A. Current Affiliations (Attach additional sheets if necessary. Reference this section)

Affiliation Name		Appointment Date	
Address	City	State	Zip
Affiliation Name		Appointment Date	
Address	City	State	Zip
Affiliation Name		Appointment Date	
Address	City	State	Zip

B. Previous Affiliations (Attach additional sheets if necessary. Reference this section)

Affiliation Name		Appointment Date	
Address	City	State	Zip
Affiliation Name		Appointment Date	
Address	City	State	Zip

12. REFERENCES

List three professional rererences, preferably from your specialty area, not including relatives, current partner, or associates in practice. If applicable, Include at least one member from the Medical Staff of each facility at which you have privileges.

NOTE: References must be from individuals wbo are directly familiar with your work, either via direct clinical observation or through close working relations

Name of Reference	Specialty	Telephone Number	
Address	City	State	Zip
Name of Reference	Specialty	Telephone Number	
Address	City	State	Zip
Name of Reference	Specialty	Telephone Number	
Address	City	State	Zip

13. WORK HISTORY

Chronologically list all work history activities since completion of post graduate training (use extra pages if necessary). This information must be complete. A curriculum vitae is only sufficient provided it is current and contains all information listed below. Please explain any gaps in work history on a separate page.

Current Practice	Contact Name	
Telephone Number	Email	Date Started
Address	City	State	Zip
Practice/Employer	Contact Name	
Telephone Number	Email	Dates (From/To)
Address	City	State	Zip
Practice/Employer	Contact Name	
Telephone Number	Email	Dates (From/To)
Address	City	State	Zip

14. ATTESTATION QUESTIONS

Please answer Ihe following questions “yes• or “no.” If your answer to question A Ihrough K is •yes,” or your answer to “L” is “no” please provide full details on a separate page.

A. Has your license to practice in any jurisdiction, your Drug Enforcement Administration (DEA) registration or any narcotic registration (if applicable) in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involutarily 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

☐ Yes ☐ No

B. Have you ever been charged, fined, disciplined, or otherwise sactioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, Medicaid, Medicare, or any public program, or is any such action pending?

☐ Yes ☐ No

C. Have you ever been denied, for possible incompetence or improper professional conduct, or breach of contract, clinical privileges, membership, contractual participation or employment by any medical organization (e.g., hospital medical staff, medlcal group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position, or other health delivery entity or system) or have your clinical privileges, membership, contractual participation, or employment at any such organization ever been suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed, or is any such action pending?

☐ Yes ☐ No

D. Have you ever surrendered, allowed to expire voluntarily or involuntarily withdrawn a request for membership or clinical privileges terminated contractual participation, or resigned from any medical organization (e.g., medical staff, medical group, independent practice associate (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), medical society, professional association, medical school faculty position, or other health delivery entity or system while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?

☐ Yes ☐ No

E. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to reliquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?

☐ Yes ☐ No

F. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subject to probationary conditions, or not renewed, or is any such action pending?

☐ Yes ☐ No

G. Have you ever been denied certification/recertification by a specialty board, or has your eligibility, certification, or recertification changed (other than changed from eligible to certified?

☐ Yes ☐ No

H. Have you ever been convicted of any crime (other than a traffic violation)?

☐ Yes ☐ No

I. Do you presently use any drugs illegally?

☐ Yes ☐ No

J. Have any judgements been entered against you, or settlements been agreed to by you within the last seven years in professional liability cases, or are there any filed and served professional liability lawsuits/arbitrations pending against you?

☐ Yes ☐ No

K. Has your professional liability insurance ever been terminated, 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 professional liability insurance or its coverage of any procedures?

☐ Yes ☐ No

L. Are you able to perform all services required by your agreement with the Healthcare Organization to which you are applying, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients?

☐ Yes ☐ No

14. ATTESTATION QUESTIONS (continued)

I hereby affirm that the information submltted in this section # 14, Attestation Questions and any addenda thereto is true, current, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that any material omission or misrepresentation may result in denial of my application or termination of any/all contractual agreements with OPMH.

Print Name Here

Signature

Date

15. INFORMATION RELEASE / ACKNOLEDGEMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualificatlons and performance ("credentialing information') by and between "this Healthcare Company" and other Healthcare Organizations (e.g., hospital medlcal staffs, medical groups, independent practice associations (IPAs), health maintenance organizations {HMOs), preferred provider organizations (PPOs), other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies (with respect to certification of coverage and claim history), licensing authorities, and businesses and individuals, acting as their agents collectively "Healthcare Organizations,") for the purpose of evaluatlng this application and any recondentialing application regarding my professional training, experience, character, conduct and judgment, ethics and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect credentialing information from being further disclosed.

I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, engaged In quality assessment, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities providing credentialing information to such representatives of this Healthcare Organization, from any liability Ibey might incur for their acts and/or communications in connection with evaluation of my qualifications for particlpatlon In this Healthcare Organization to the extent that those acts and/or communications are protected by state or Federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Healthcare Organization as may be required by state and federal law and regulation, includlng but not limited to, California Business and Professional Code Section 809 et seq., if applicable.

I the understand and agree that I, as the applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications. During such time as this application is being processed, I agree to update the application should there be any change in the Information provided.

In addition to any notice required by any contract with Open Mind Mental Health, Inc. (OPMH), I agree to notify OPMH immediately in writing of the occurrence of any of the following: (i) the unstayed suspenslon, revocation or nonrenewal of my professional license; (ii) any suspension, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellation or nonrenewal of my professional liability insurance coverage.

I further agree to notify (OPMH) in writing, promptly and no later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me by any professional licensing authority taken or pending, including but not limited to, any accusation filed, temporary restraining order, or imposltion of any interim suspension, probation, or limitations affecting my license; or (ii) any adverse action against me by any Healthcare Organization, including which has resulted in the filing or a Section 805 report with the Medical Board of California (if applicable), or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, limitation, nonrenewal or voluntary relinqulshment by registration of any staff membership or clinical privileges at any Heallhcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, and filed and served malpractice suit or arbitration action; or (vi) my conviction of any criminal law (excluding minor traffic violations); or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

Print Name Here

Signature

Date

15. INFORMATION RELEASE / ACKNOWLEDGEMENTS

I hereby affirm that the information submitted in this application and any addenda hereto including my curriculum vitae if attached) is true, current, correct and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of any/all agreements with OPMH. A photocopy of thls document shall be as effective as the origlnal, however, original signatures and current dates are required on pages 10 and 11.

Print Name Here

Signature

Date