CONTRA COSTA
HEALTH

Submit completed packet to: Office of Provider Services
Email: bhrecredentialing@cchealth.org - or - Fax: (925) 608-6794

Contra Costa County Behavioral Health

LEGAL NAME CHANGE FORM

This form is used to request a change to your legal name. *Note: This form is only for active providers and should not be used for providers that have been inactivated, termed, or away from CCMHP for 30 days or more.*

Section I: Provider Information

Current Legal Name: ______________________ (*Last*) ______________________ (*First*) ______________________ (*Middle*)

Prior Legal Name: ______________________ (*Last*) ______________________ (*First*) ______________________ (*Middle*)

ShareCare ID: ___________ NPI Number: ________________________

Classification: MD NP RN LPT Licensed Psychologist LMFT LCSW LPCC
Waivered Psychologist AMFT ASW APCC Trainee
MHRS DMHW TFC Parent

Section II: Required Documentation

Please attach copies of the following documentation **with your new legal name**.

- ☐ Driver's License or Passport
- ☐ NPI Registration Printout
- ☐ Professional License or Registration (if applicable)
- ☐ DEA Certificate (MD/DO/NP only)

Section III: Requester Information

Requester/Contact Person: ____________________________ Email: ________________________________

Section IV: Signature

I hereby affirm that the information submitted in this application and any addenda hereto is true, current, correct, and complete and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges or employment.

Print Name: __________________________ **Signature:** ____________________________ **Date:** ___________
(Stamped or Electronic Signature Is Not Acceptable)

Note: the attached Attestation Questions must be completed and signed must be included with this form.

Section V: For Provider Services Use Only

- ☐ Verify name on Identification, NPI, and other documents
- ☐ Notify Requester/Contact Person
- ☐ Update Name in ShareCare
- ☐ Add to Tracking Sheet
- ☐ Update name in Staff Sheets and on waiver list (if applicable)
- ☐ Update Provider Directory *(N/A for DMHW, MHRS, and Trainees)*

Date Received: _____________ Completed by: ______________________ Date: ______________

Section X: Attestation Questions: *To be completed by all providers*	
Please answer the following questions. ***If your answer is "yes" to any of the questions A-M, please provide full details on a separate sheet of paper.***	
A. Has your license to practice in any jurisdiction, your Drug Enforcement Administration (DEA) registration or any applicable narcotic registration in any jurisdiction ever been 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 charged, suspended, fined, disciplined, or otherwise sanctioned, 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, by Medicare, Medicaid, or any public program, or is any such action pending?	☐ Yes ☐ No
C. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g. hospital medical staff, medical 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), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract 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 employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (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 relinquish 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, subjected to probationary conditions, or not renewed, or is any such action pending?	☐ Yes ☐ No
G. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank?	☐ Yes ☐ No
H. Have you been denied certification/recertification by a specialty board, or has your admissibility, certification or recertification status changed (other than changing from admissible to certified)?	☐ Yes ☐ No
I. Have you ever been convicted of any crime (other than a minor traffic violation)?	☐ Yes ☐ No
J. In the past (5) years, have you had a history of chemical dependency or substance abuse that might adversely affect your ability to competently and safely perform essential functions of a practitioner in your area of practice?	☐ Yes ☐ No

Section X: Attestation Questions (continued): *To be completed by all providers*	
K. Do you have an ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without direct threat to the health and safety of others?	☐ Yes ☐ No
L. Have any judgments/arbitration or claims been entered against you, or settlements been agreed to by you within the last (7) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitration's against you pending?	☐ Yes ☐ No
M. Are you currently engaged in the illegal use of drugs? ("Illegal use of drugs" means the use of controlled substances, obtained illegally, as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed health care practitioner. "Currently" does not mean on the day of or even the weeks preceding the completion of this application, rather, it means recently enough so that the illegal use may have an impact on one's ability to practice).	☐ Yes ☐ No
N. Have you reviewed and completed the Contra Costa County Mental Health Plan Beneficiary Protection Training within the last 3 years? *The training must be completed at the time of initial credentialing and again every 3 years at recredentialing. If you have not yet completed the training, please complete it before submitting your credentialing/ recredentialing application. The training is available on the Provider Services Website.* *https://cchealth.org/mentalhealth/provider/*	☐ Yes ☐ No
O. Do you always meet the continuing education requirements of your license as prescribed by the governing board of your discipline? Check N/A if not applicable. *Unlicensed providers (DMHW & MHRS), Trainees, and Waivered Psychologists should select "N/A" here. Also, licensed providers and registered interns in their first year of licensure can check "N/A."*	☐ Yes ☐ No ☐ N/A
P. FOR UNLICENSED THERAPEUTIC BEHAVIORAL SERVICES (TBS) WORKERS ONLY *(check N/A if not applicable)* Have you completed ongoing training related to providing TBS?	☐ Yes ☐ No ☐ N/A
Q. FOR THERAPEUTIC FOSTER CARE (TFC) PARENTS ONLY *(check N/A if not applicable)* Have you completed twenty-four hours of annual, ongoing training, related to providing TFC services? *This ongoing, annual training includes an emphasis on skill development and Specialty Mental Health Services knowledge acquisition, and can be provided in a variety of formats (video, readings, internet training, and webinars).*	☐ Yes ☐ No ☐ N/A

I hereby affirm that the information submitted in the Attestation Questions, and any addenda thereto is true, current, correct and complete to the best of my knowledge and belief and is furnished in good faith. I understand that intentionally withholding or omitting material information or intentionally submitting material false or misleading information may result in denial of my application or termination of my privileges or employment.

I understand and agree that I, as an 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.

Print Full Name: ____

Signature: ________________________________ **Date:** ____________

(Stamped or Electronic Signature Is Not Acceptable)