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

Contra Costa County Behavioral Health

FACILITY/PROGRAM ASSIGNMENT FORM

This form can be used in lieu of the Credentialing Change Form to request that up to 10 providers within your organization be assigned to a specified facility and program. Please submit a copy of the attached 274 Report Provider Information Form (MHA22h) for each provider listed below.

Note: When requesting facility changes for an individual provider, please use the Credentialing Change Form (Form MHA22a) instead.

Section I: Facility and Program Information

Please list the Facility and Program where the providers should be authorized to bill for services.

Facility ID: __________ Facility Name: ____

Program ID: __________ Program Name: ____

Section II: Providers To Be Assigned

Please list all providers that should be assigned to the facility and program in section I. Include the provider's name, ShareCare ID, and the Start Date that should be used for the facility/program authorization.

	Provider Name (Last, First)	Credential Type (DMHW, LMFT, RN, etc)	ShareCare ID	Start Date for Authorization
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Section III: Contact Information and Signature

MANAGER APPROVAL REQUIRED FOR FACILITY ADDS & CHANGES:

Print Name: ______________________ Signature: ______________________ Date: __________
(Stamped or Electronic Signature Is Not Acceptable)

Send confirmation of change to: Name: ______________________ **Email:** ______________________

Section IV: For Provider Services Use Only

☐ Update ShareCare ☐ Update Provider Directory ☐ Add to Tracking Sheet ☐ Send Confirmation

Date Received: ____________ Completed by: ____________________ Date: ____________

Contra Costa County Behavioral Health

274 Report Provider Information

This form must be completed for each facility where the provider will be available to provide services.

Contra Costa County Mental Health Services must submit the 274 Report to DHCS to demonstrate that it complies with the network adequacy requirements. This form provides us with some of the provider information that is included in our monthly 274 Report submission. Please complete a copy of this form for each facility where the provider will be available to provide services. Additional copies of the form are available here: https://cchealth.org/mentalhealth/provider/

Section I: Provider and Facility Information

This form must be completed for each facility where the provider will be available to provide services.

Provider Name: ____ ShareCare ID *(if known)*: __________

Facility Name: ____ Facility ID: ____________

Section II: Contact Information

This form should be completed by the 274 Report Contact Person for the organization/clinic.

Please list the person we can contact for questions regarding the information you list in this form:

Name: ________________________________ Phone: __________________ Email: ______________________

Section III: Inclusion in 274 Report

Will the person listed in Section I be providing outpatient mental health services, targeted case management, crisis intervention, medication support services, intensive care coordination, or intensive home-based services on a regular basis at the facility listed in Section I?

Please select one:

☐ **Yes**- Provider will be available to provide direct services to beneficiaries on a regular basis at the facility above.
Please complete the remainder of this form and return to the Provider Services Unit.

☐ **No**- The person listed in Section 1 is an Administrative Staff Member, Supervisor, and/or member of leadership and will not have the capacity to serve clients on a regular and on-going basis at this facility.
You can stop here and return form to Provider Service Unit. You do not need to complete the remainder of the form.

☐ **No**- The person listed in Section 1 is only providing inpatient, hospital, and/or residential services at this facility.
You can stop here and return form to Provider Service Unit. You do not need to complete the remainder of the form.

☐ **No**- The person listed in Section 1 is ONLY providing substance use disorder services and is not providing outpatient mental health services at this facility.
You can stop here and return form to Provider Service Unit. You do not need to complete the remainder of the form.

☐ **No**- For a reason other than those listed above, the person should be excluded on the 274 Report (please specify reason): ____
You can stop here and return form to Provider Service Unit. You do not need to complete the remainder of the form.

Provider Name: ______________________________

Contra Costa County Behavioral Health

274 Report Provider Information

Section IV: Area of Expertise

Select all Areas of Expertise

☐ Child/Adolescent (ages 0-20)
☐ Adult (ages 21+)
☐ Geriatric
☐ Substance Abuse

Section V: Service Types

Select up to 5 Service Types the provider is qualified to provide

☐ **Mental Health Services-** assessment, evaluation, plan development, rehabilitation, individual psychotherapy, group psychotherapy, group rehab, or collateral.

☐ **Targeted Case Management-** placement, linkage, or case management plan development.

☐ **Crisis Intervention-** crisis intervention.

☐ **Medication Support-** evaluation/RX, RN/LPT injection, education, medication plan development, or medication group.

☐ **Intensive Care Coordination-** Check this box if this facility is approved to provide Katie-A services and the services are within the provider's scope of practice.

☐ **Intensive Home-Based Services-** Check this box if this facility is approved to provide Katie-A services and the services are within the provider's scope of practice.

Section VI: Practice Focus

Select up to 5 Practice Focus Areas

☐ Disorders usually first diagnosed in infancy, childhood, or adolescence (1D)
☐ Delirium, Dementia, and Amnestic and other Cognitive Disorders (CD)
☐ Mental Disorders Due to a General Medical Condition Not Elsewhere Categorized (GM)
☐ Substance-Related Disorders (SR)
☐ Schizophrenia and Other Psychotic Disorders (PS)
☐ Depressive Disorders (DS)
☐ Bi-Polar Disorders (BP)
☐ Mood Disorders (MD)
☐ Anxiety Disorders (AD)
☐ Somatoform Disorders (SD)
☐ Factitious Disorders (FD)
☐ Dissociative Disorders (DD)
☐ Sexual and Gender Identity Disorders (SG)
☐ Eating Disorders (ED)
☐ Sleep Disorders (SL)
☐ Impulse-Control Disorders not otherwise elsewhere categorized (IC)
☐ Adjustment Disorders (AJ)
☐ Personality Disorders (PD)

Section VII: FTE

FTE is dedicated time available to serve the Medi-Cal beneficiaries (including assessment, plan development, treatment, documentation, chart review, etc). For Administrative Staff, do not include percent of time spent on administrative functions. For example, if a Program Manager is needed for administrative functions 90% of the time, they can only be included in the 274 Report at a maximum of 10% FTE.

100% = 40 hours/week
87% = 35 hours/week
80% = 32 hours/week
75% = 30 hours/week
62% = 25 hours/week
50% = 20 hours/week
40% = 16 hours/week
37% = 15 hours/week
25% = 10 hours/week
20% = 8 hours/week

FTE % Children's Services (0-20): ______%   **FTE % Adult Services (21+): ______%**

Total FTE at all facilities for an individual provider should not exceed 100% (40 hours/week).

Section VIII: Caseload

Enter the Maximum & Current Caseload for each age group. Or, enter "N/A" if the provider does not work with the specified age group.

For providers that do not carry a caseload (such as nursing staff and staff at mobile crisis units and transitional teams), estimate the Max Caseload based on the maximum number of beneficiaries the provider could serve during the amount of time specified in the FTE section above. Estimate the Current Caseload based on average/range of encounters per month.

Current Caseload (Children 0-20): _______   **Maximum Caseload (Children 0-20): _______**

Current Caseload (Adult 21+): _____   **Maximum Caseload (Adult 21+): _____**

Section IX: Telehealth

How are the services provided for this provider at this facility?

☐ Services provided through telehealth only
☐ Services provided both in-person & through telehealth
☐ Services provided in-person only

Section X: Field Based Services

Does provider travel to beneficiaries' home and/or community settings to deliver services?

☐ Yes - Maximum miles provider will travel: _______
☐ No

Section XI: Cultural Competency Training

Has the provider completed Cultural Competency Training in the past 12 months?

☐ Yes- Total Training Hours in Last 12 Months: ______
☐ No

Prov. Serv. Unit Use Only: Provider Start Date: ___________ ☐ S.P. 274 Record Created ☐ S.P. 274 Monthly Record Created Date Complete: ___________