



Contra Costa County Mental Health
SHARECARE ID REQUEST FORM

PLEASE COMPLETE ALL SECTIONS AS APPLICABLE TO PREVENT DELAYS IN PROCESSING

Section I. To be completed by staff

FULL LEGAL NAME: _____
First Name Middle Name Last Name

DOB: _____ NPI: _____ Taxonomy: _____ Email Address: _____

Gender: Female Male Transgender Male to Female Transgender Female to Male Genderqueer Another Gender Identity Undisclosed

DISCIPLINE: _____ LICENSE #: _____
 EXP DATE: _____ STATE: _____
YOU MUST ATTACH A COPY OF YOUR LICENSE OR OTHER DOCUMENTATION REQUIRED FOR YOUR LICENSE

PHYSICIAN DEA#: _____ EXP DATE: _____
 PHYSICIAN UPIN: _____
YOU MUST ATTACH A COPY OF YOUR DEA REGISTRATION

Employment Start Date:

STAFF LANGUAGES	Please check one:
English	<input type="checkbox"/> Certified <input type="checkbox"/> Fluent
Other Languages:	
	<input type="checkbox"/> Certified <input type="checkbox"/> Fluent
	<input type="checkbox"/> Certified <input type="checkbox"/> Fluent

ETHNICITY:	<input type="checkbox"/> White	<input type="checkbox"/> Mexican American/Chicano	<input type="checkbox"/> Chinese	<input type="checkbox"/> Cambodian	<input type="checkbox"/> Other Non-White
	<input type="checkbox"/> Black	<input type="checkbox"/> Latin American	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Southeast Asian
	<input type="checkbox"/> Native American	<input type="checkbox"/> Other Spanish	<input type="checkbox"/> Laotian	<input type="checkbox"/> Filipino	<input type="checkbox"/> Unknown

STAFF SIGNATURE _____ Date: _____
 (Stamped or Electronic Signature Is Not Acceptable)

Section II. To be completed by supervisor/manager

Staff Type: Direct Service Provider TBS Worker TFC Parent Certified Peer Support Specialist Administrative Staff
 Contractor/Supervisor/Manager: _____ Program Name: _____
 Notification of Staff # Assignment to: _____ Phone Number: _____
 EMAIL: _____

Facility Authorization Requested for the following:

Facility ID # _____ Program ID # _____	Facility ID # _____ Program ID # _____
Facility ID # _____ Program ID # _____	Facility ID # _____ Program ID # _____

Section III. To be completed by Contra Costa Provider Services Unit

FOR CCC PROVIDER SERVICES USE ONLY APPROVED START DATE: _____	Psychiatrist: <input type="checkbox"/> DO <input type="checkbox"/> MD
	Nursing: <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Registered Nurse <input type="checkbox"/> Psychiatric Technician
	Licensed Mental Health Professional: <input type="checkbox"/> Marriage & Family Therapist <input type="checkbox"/> Social Worker <input type="checkbox"/> Psychologist [<input type="checkbox"/> PhD <input type="checkbox"/> PsyD] <input type="checkbox"/> LPCC
	Intern: <input type="checkbox"/> Associate Marriage & Family Therapist <input type="checkbox"/> Associate Social Worker <input type="checkbox"/> Psychologist Intern <input type="checkbox"/> Associate Prof Clinical Counselor
	Trainees: <input type="checkbox"/> Marriage & Family Therapist Trainee <input type="checkbox"/> Social Work Trainee <input type="checkbox"/> Psychologist Trainee
	<input type="checkbox"/> Mental Health Rehabilitation Specialist <input type="checkbox"/> Designated Mental Health Worker <input type="checkbox"/> TFC Parent <input type="checkbox"/> Certified Peer Support Specialist <input type="checkbox"/> Administrative Staff

SEND TO: Behavioral Health Administration 1340 Arnold Dr., Ste. 200, Martinez, CA 94553 FAX: (925) 957-5217 EMAIL: Provider.Services@cchealth.org