CREDENTIALING ELIGIBILITY CRITERIA

SLHP/BrightPath maintains a Credentialing/Recredentialing Program to assist in selection and reevaluation of all providers within its delivery system. This application includes fields to enter race, ethnicity, language, and the type of insurance accepted. Providing this information is optional. SLHP/BrightPath does not discriminate on ethnicity, language, or the type of insurance accepted in which the provider specializes. All providers must successfully complete the credentialing process to be approved for SLHP/ BrightPath Participation. The provider has the right to review information obtained in the process of evaluating the credentialing and recredentialing application exclusive of peer review information.

Provider Criteria Consists of the Following:

1. Provider will have an executed Participating Provider Agreement with SLHP or BrightPath or be joining a group Tax ID who has an executed Agreement with SLHP/BrightPath.

2. Provider must participate in the initial credentialing process and will be required to recredential at least every three (3) years. The credentialing process requires verification of licensure, education, training experience of the Provider and other such information as may be required by SLHP/BrightPath and the established NCQA compliant process.

3. Must hold a current unrestricted license to practice for each state as applicable.

4. Providers, if they are Medical Doctors, Doctors of Osteopathy, Doctors of Podiatric Medicine, Nurse Practitioners or Physician Assistants shall either hold active Medical Staff admitting privileges at an in-network full-service hospital or use an admitting group or hospitalist service as designated by the participating hospital or make other suitable arrangements, as approved by SLHP. **Exceptions to this requirement are Anesthesiology, Pathology, Radiology, Emergency Medicine, Psychiatry, or Telemedicine.*

5. A current, unrestricted DEA and State Board of Pharmacy certificates as applicable. Multiple state locations will require individual DEA certificates.

6. Provider, if a physician, is either Board Certified, Board Admissible or is otherwise approved for credentialing by SLHP through its Participating Provider Committee. If not a physician, Provider shall be appropriately certified or credentialed.

7. Continuous work history of, at least, the most recent five (5) years including from and to dates MM/YYYY with an explanation of any gaps that exceed three (3) months.

8. Proof of Professional Liability insurance for at least the amount listed:
- $1,000,000 per occurrence and $3,000,000 aggregate.

9. Provider shall be, and remain, enrolled in the Medicare program unless granted an exception, by SLHP.

10. Provider will practice within the accepted community standards of care as deemed appropriate by the SLHP Participating Provider Committee.

11. The applicant has the right, upon request, subject to policies and procedures, to be informed of the status of their application. The Credentialing Department will make every effort to provide status at the time of request and, if unable, will respond by telephone or in writing with in three (3) working days.

12. Applicants have the right to revise, supplement or correct erroneous information to the Credentialing and Recredentialing Applications. This may be done at the provider's discovery or if deficiencies are discovered during the verification process by SLHP. Credentialing staff will provide notice to the Provider and must receive a response within 30 days of the date of the notification in order to correct, amend or provide the incorrect and/or omitted information. If no response is received from the Provider after 30 calendar days, a second attempt to contact the Provider is made by credentialing staff. If a second attempt to contact the Provider is unsuccessful, notification will be sent to the Provider that failure to respond within 15 business days will invalidate the application and the Provider will not be credentialed. All supplemental documents and correspondence is to be forwarded to the Credentialing Department at PO Box 1990 Boise, ID 83702 or faxed to (208) 381-9444.

13. If information is not received by the Credentialing Department within sixty (60) days of request, an updated Attestation may be required prior to final processing.

14. National Practitioner Identifier (NPI) Number.

15. Credentialing and Recredentialing is non-transferrable.

16. A copy of any portion/section of this Criteria Sheet and or Credentialing Application has the same force and effect as the original.

17. The applicant certifies by his/her signature on the application that the information in the entire application is complete, accurate, current and acknowledges that any misstatements in or omissions from this application constitute cause for denial of membership/participation or cause for summary dismissal by the entity to which this statement has been made. A photocopy of the application has the same force and effect as the original. The applicant confirms that he/she has reviewed this information as of the most recent date listed in the application.

18. Copy of W-9.

Provider Application Checklist

The following documentation is required when submitting a provider credentialing application. Please review and complete the information below and return this page with the application.

Required Documentation:
☐ Completed Initial Application
☐ Current medical malpractice insurance face sheet
☐ Provider Authorization and Release of Information page; signed and dated
☐ Complete Attestation (action history)
☐ DEA or prescription plan (MD, DO, DPM, DMD, DDS, PA, NP, CNS, CNM, CRNA)
☐ Completed hospital admitting privileges or admit plan (MD, DO, DPM, DMD, DDS, PA, NP, CNS, CNM, CRNA)
☐ Current and active license in the state of practice

**To avoid credentialing delays, please ensure all requested documents, as applicable, are attached when submitting the credentialing application.*

Universal Provider Credentials Verification Application

To use the Idaho Provider Application (IPA), follow these instructions

- ✓ Complete the application in its entirety using black or blue ink. **Keep an unsigned and undated copy of the application on file for future requests.** When a request is received, send a copy of the completed application, making sure that all information is complete, current and accurate. Please sign and date pages 12 and 13. Please document any YES responses on the Attestation Question page.
- ✓ Prior to submitting this application to any health care related organization, inquire with the organization, as you may need authorization (through a pre-application process) before the application is accepted. Identify the health care related organization(s) to which this application is being submitted in the space provided below.
- ✓ Attach copies of requested documents each time the application is submitted.
- ✓ If changes must be made to the completed application, strike out the information and write in the modification, initial and date.
- ✓ If a section does not apply to you, please check the provided box at the top of the section.

This application is submitted to: **St. Luke's Health Partners / BrightPath**

I. Instructions

This form should be **typed or legibly printed in black or blue ink**. If more space is needed than provided, attach additional sheets and reference the question being answered. *Please do not use abbreviations*. **Current copies of the following documents must be submitted with this application** (all are required for MDs, DOs; as applicable for other health providers). If not available, indicate why.

- State Professional License(s)
- DEA Certificate w/ current address
- ECFMG (if applicable)
- State Controlled Substance Certificate (if applicable)
- Passport photo (for hospitals only)
- Face Sheet of Professional Liability Policy or Certificate
- Curriculum Vitae (Not an acceptable substitute for completing the application.)

**** All sections must be completed in their entirety****

II. Provider Information

Last name (include suffix; Jr., Sr., III)	First (do not abbreviate)		Middle (do not abbreviate)
Other name(s) under which you have been known by reference, licensing and or educational institutions?			Degree(s)
Home telephone number	Pager number	Cell number	E-mail address
Home mailing address	City	State	Zip code
Birth date / Birthplace (city, state, country)	Social security number		Medicare Opt-Out - §1128 of the Social Security Act ☐ Yes ☐ No
Languages spoken other than English	Type of Provider ☐ PCP ☐ Specialist ☐ Urgent Care		Opt-Out Start Date / Opt-Out End Date
Individual NPI #	Individual Medicare Number	Individual Medicaid number(s)	Gender Identity ☐ Male ☐ Non-binary ☐ Female ☐ Transgender ☐ Prefer not to disclose
Specialty at the primary practice location:	Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to disclose		Race ☐ American Indian or Alaskan Native ☐ Asian or Asian Indian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other

III. Practice Information

Effective Date at Primary Practice location _____			**On average, how soon can a new patient get an appointment?** ☐ Within 48 hours ☐ Within 2 weeks ☐ 2-4 weeks ☐ 4-6 weeks ☐ Beyond 6 weeks
Name of practice, affiliation, or clinic name			Telehealth ☐ Yes ☐ No
Primary office street address	City	State	Zip code
Patient appointment telephone number	Fax number	Name affiliated with tax ID number	Federal tax ID number
Mailing address (if different from above)	City	State	Zip code

Modification to the wording or format of the Provider Application may invalidate the application.

III. Practice Information (Continued)

Billing address (if different from above)	City	State	Zip code
Office manager / Administrator name	Administration telephone number	Fax number	E-mail address
Credentialing contact (if different from above)	Credentialing telephone number	Fax number	E-mail address

Effective Date at Secondary Practice location _____

On average, how soon can a new patient get an appointment?
☐ Within 48 hours ☐ Within 2 weeks ☐ 2-4 weeks
☐ 4-6 weeks ☐ Beyond 6 weeks

Name of secondary practice, affiliation, or clinic name			Telehealth ☐ Yes ☐ No
Secondary office street address	City	State	Zip code
Patient appointment telephone number	Fax number	Name affiliated with tax ID number	Federal tax ID number
Mailing address (if different from above)	City	State	Zip code
Billing address (if different from above)	City	State	Zip code
Office manager / Administrator name	Administration telephone number	Fax number	E-mail address
Credentialing contact (if different from above)	Credentialing telephone number	Fax number	E-mail address

List other office locations with above information on a separate sheet.

IV. Professional Licensure

State professional license/registration/certificate number			Status ☐ Active ☐ Inactive ☐ Temporary
Issue date	Expiration date	**Name of sponsor if required by licensure, (i.e. Physician's Assistant).**	
Drug Enforcement Administration (DEA) registration number	Issue date	Expiration date	
State controlled substance certificate number	Issue date	Expiration date	
ECFMG number (applicable to foreign medical graduates)		Date issued	

V. All Other Professional Licenses

State	License/registration/certificate number		Date issued
Expiration date	Year relinquished	Reason	
State	License/registration/certificate number		Date issued
Expiration date	Year relinquished	Reason	
State	License/registration/certificate number		Date issued
Expiration date	Year relinquished	Reason	

VI. Under-Graduate Education

Name of college or university			**Does Not Apply** ☐
Degree received	Start Date	Graduation date	
Mailing address	City	State	Zip code
Name of college or university			
Degree received	Start Date	Graduation date	
Mailing address	City	State	Zip code

(*Do not abbreviate*) **(Attach additional sheet if necessary)**

VII. MEDICAL/PROFESSIONAL EDUCATION

Medical/Professional school				
Start date	Graduation date	Degree received		
Mailing address		City	State	Zip code
		Phone	Fax	
Medical/Professional School				
Start date	Graduation date	Degree received		
Mailing address		City	State	Zip code
		Phone	Fax	

(*Do not abbreviate*) **(Attach additional sheet if necessary)**

VIII. GRADUATE EDUCATION

Institution **Does Not Apply** ☐			
Program or course of study	Faculty director		
Mailing address	City	State	Zip code
Dates attended ( ) - ( )	Phone	Fax	

(*Do not abbreviate*) **(Attach additional sheet if necessary)**

IX. INTERNSHIP/PGYI

Institution **Does Not Apply** ☐			
Program director			
Mailing address	City	State	Zip code
Start date / Completion date	Phone	Fax	
Type of internship	Specialty		
Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)			

(*Do not abbreviate*) **(Attach additional sheet if necessary)**

X. RESIDENCIES

Institution **Does Not Apply** ☐			
Program director			
Mailing address	City	State	Zip code
Start date / Completion date	Phone	Fax	
Type of residency	Specialty		
Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)			
Institution **Does Not Apply** ☐			
Program director			
Mailing address	City	State	Zip code
Start date / Completion date	Phone	Fax	
Type of residency	Specialty		
Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)			

Modification to the wording or format of the Provider Application may invalidate the application.

(*Do not abbreviate*) **(Attach additional sheet if necessary)**

XI. Fellowships

Institution — **Does Not Apply** ☐

Program director

Mailing address	City	State	Zip code

Start date	Completion date	Phone	Fax

Course of study

Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)

Institution — **Does Not Apply** ☐

Program director

Mailing address	City	State	Zip code

Start date	Completion date	Phone	Fax

Course of study

Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)

(*Do not abbreviate*) **(Attach additional sheet if necessary)**

XII. Preceptorship

Institution — **Does Not Apply** ☐

Department chairman

Mailing address	City	State	Zip code

Start date	Completion date	Phone	Fax

Training

(*Do not abbreviate*) **(Attach additional sheet if necessary)**

XIII. Faculty Appointment

Institution — **Does Not Apply** ☐

Faculty director

Mailing address	City	State	Zip code

Start date	Completion date	Phone	Fax

Position

(*Do not abbreviate*) **(Attach additional sheet if necessary)**

XIV. Board Certification

Are you board or otherwise professionally certified? **Does Not Apply** ☐

☐ **Yes** If "Yes", please complete below ☐ **No** If "No", describe your intent for certification, if any, and dates of testing for Certification on separate sheet.

Issuing Board/Entity	Certificate Number	Specialty	Date Certified	Date Recertified	Expiration Date (if any)

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

If so, list certification and date

If you participate in a specialty which does not have board certification, please indicate specialty

(*Do not abbreviate*) (Attach additional sheet if necessary)

XV. Other Certifications

ACLS, BLS, ATLS, PALS, NRP, NALS (i.e., Fluoroscopy, Radiography, etc. – Attach certificate if applicable)		Does Not Apply ☐
Type	Number	Expiration date
Type	Number	Expiration date
Type	Number	Expiration date
Type	Number	Expiration date

XVI. Hospital and Other Institutional Affiliations

Does Not Apply ☐

Please list in **reverse chronological order (with the current affiliation(s) first)** all institutions where you (A) have current affiliations, (B) applications in process, (C) have had previous affiliations or, if no current affiliation, (D) have a current coverage plan. This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet(s). List only affiliations here, list employment in section XVII, Work History.

(*Do not abbreviate*) (Attach additional sheet if necessary)

A. Current Affiliations

Name of primary facility (Do you have admitting privileges? ☐ **Yes** ☐ **No**)			
Department	Department / Clinical Chair	Status (active, provisional, courtesy, temporary, etc.)	
Mailing address	City	State	Zip code
Phone number	Fax number	Appointment date	
Name of secondary facility (Do you have admitting privileges? ☐ **Yes** ☐ **No**)			
Department	Department / Clinical Chair	Status (active, provisional, courtesy, temporary, etc.)	
Mailing address	City	State	Zip code
Phone number	Fax number	Appointment date	
Name of other facility (Do you have admitting privileges? ☐ **Yes** ☐ **No**)			
Department	Department / Clinical Chair	Status (active, provisional, courtesy, temporary, etc.)	
Mailing address	City	State	Zip code
Phone number	Fax number	Appointment date	

(*Do not abbreviate*) (Attach additional sheet if necessary)

B. Applications In Process

Hospital/Institution			
Mailing address	City	State	Zip code
Phone number	Fax number	Date application submitted	
Hospital/Institution			
Mailing address	City	State	Zip code
Phone number	Fax number	Date application submitted	

(*Do not abbreviate*) (Attach additional sheet if necessary)

C. Previous Affiliations

Name of facility			**Does Not Apply** ☐
Department		Department / Clinical Chair	
Mailing address	City	State	Zip code
Phone number	Fax number	Previous status (active, provisional, courtesy, temporary, etc.)	
Reason for leaving		Appointment date (from– to)	
Name of facility			
Department		Department / Clinical Chair	
Mailing address	City	State	Zip code
Phone number	Fax number	Previous status (active, provisional, courtesy, temporary, etc.)	
Reason for leaving		Appointment date (from– to)	
Name of other facility			
Department		Department / Clinical Chair	
Mailing address	City	State	Zip code
Phone number	Fax number	Previous status (active, provisional, courtesy, temporary, etc.)	
Reason for leaving		Appointment date (from– to)	

D. Inpatient Coverage Plan

This Section only applicable for those without admitting privileges

Provider may attach signed letter of agreement from the physician or group representative that admits and manages the inpatient care for your patients. *Admit plan must be to an in network facility.

Does Not Apply ☐

Name of participating admitting physician/practice/clinic/group	Hospital where privileged

(*Do not abbreviate*) (Attach additional sheet if necessary)

XVII. Work History

Chronologically list all work history activities since completion of professional training (use extra sheets if necessary). This information must be complete. A curriculum vita may be substituted as long as it is current and has exact dates of employment.

Name of current practice/employer				
Contact name	Telephone number	Fax number	From (mo/year)	To (mo/year)
Mailing address	City	State	Zip code	
Reason for leaving				
Name of practice/employer				
Contact name	Telephone number	Fax number	From (mo/year)	To (mo/year)
Mailing address	City	State	Zip code	
Reason for leaving				

XVII. Work History (Continued)

Name of practice/employer				
Contact name	Telephone number	Fax number	From (mo/year)	To (mo/year)
Mailing address	City	State	Zip code	
Reason for leaving				

Please account for all gaps in time between dates of medical / professional school graduation to present not covered elsewhere within this application. Include dates, activity, and names where applicable.

Activity / Name	From	To

XVIII. Professional Affiliations

Please list membership in all professional societies. Complete Name of Society	Date Joined	Current Member	
		Yes	No

XIX. Professional References

List **at least one** professional reference from your specialty area, not including relatives, who have worked with you in the past two years. Reference must be from an individual who through recent observation, is directly familiar with your work and can attest to your clinical competence in your specialty area.

Name of reference		Title and specialty	
Mailing address	City	State	Zip code
E-mail address	Telephone number	Fax number	Cell phone number

Name of reference		Title and specialty	
Mailing address	City	State	Zip code
E-mail address	Telephone number	Fax number	Cell phone number

Name of reference		Title and specialty	
Mailing address	City	State	Zip code
E-mail address	Telephone number	Fax number	Cell phone number

XX. Professional Liability

Current insurance carrier			Policy number
Mailing address	City	State	Zip code
Phone number	Fax number	Origination (retroactive) date	
Per claim amount	Aggregate amount	Effective date	Expiration date

Please list **ALL** professional liability carriers within the past ten years

Name of carrier			Policy number
Mailing address	City	State	Zip code
Phone number	Fax number	From	To
Name of carrier			Policy number
Mailing address	City	State	Zip code
Phone number	Fax number	From	To
Name of carrier			Policy number
Mailing Address	City	State	Zip code
Phone number	Fax number	From	To

XXI. Professional Liability Action Detail – Confidential

Provider name(print or type)

Does Not Apply ☐

Please list any past or current professional liability claim(s) or lawsuit(s), in which allegations of professional negligence were made against you, whether or not you were individually named in the claim or lawsuit. Please do not include patient names or other HIPAA protected health information (PHI). Photocopy this page as needed and submit a separate page for EACH claim/event. A legible signed provider narrative that addresses all of the following details is an acceptable alternative.

Date and clinical details of the incident, with preceding events	
Date	Details

Your role and specific responsibility in the incident

Subsequent events, including patient's clinical outcome

Date suit or claim was filed

Name and Address of Insurance Carrier that handled the claim

Your status in the legal action (primary defendant, co-defendant, other)

Current status of suit or other action

Date of settlement, judgment, or dismissal

If case was settled out-of-court, or with a judgment, settlement amount attributed to you? **$**

PROVIDER ATTESTATION QUESTIONS - *To be completed by the provider*

Please answer **all** of the following questions. If your answer to any of the following questions is '**Yes**", provide details as specified on a separate sheet. *If you attach additional sheets, sign and date each sheet.*

			Yes	No
A.	**PROFESSIONAL SANCTIONS**			
1.	Have you ever been, or are you now in the process of being denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation, monitored, or not renewed for any of the following? Or have you voluntarily or involuntarily relinquished, withdrawn, or failed to proceed with an application for any of the following in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct?			
	a.	License to practice any profession in any jurisdiction	☐	☐
	b.	Other professional registration or certification in any jurisdiction	☐	☐
	c.	Specialty or subspecialty board certification	☐	☐
	d.	Membership on any hospital medical staff	☐	☐
	e.	Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc.	☐	☐
	f.	Medicare, Medicaid, FDA, governmental, national or international regulatory agency or any public program	☐	☐
	g.	Professional society membership or fellowship	☐	☐
	h.	Participation/membership in an HMO, PPO, IPA, PHO or other entity	☐	☐
	i.	Academic Appointment	☐	☐
	j.	Authority to prescribe controlled substances (DEA or other authority)	☐	☐
2.	Have you ever been subject to review, challenges, and/or disciplinary action, formal or informal, by an ethics committee, licensing board, medical disciplinary board, professional association or education/training institution?		☐	☐
3.	Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?		☐	☐
4.	Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?		☐	☐
B.	**CRIMINAL HISTORY**		**Yes**	**No**
1.	Have you ever been charged with a criminal violation (felony or misdemeanor) resulting in either a plea bargain, conviction on the original or lesser charge, or payment of a fine, suspended sentence, community service or other obligation?		☐	☐
	a.	Do you have notice of any such anticipated charges?	☐	☐
	b.	Are you currently under governmental investigation?	☐	☐
C.	**AFFIRMATION OF ABILITIES**		**Yes**	**No**
1.	Do you presently use any drugs illegally?		☐	☐
2.	Do you have any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or could affect your current ability to practice with or without reasonable accommodation? If reasonable accommodation is required, specify the accommodations required. If the answer to this question is yes, please identify and describe any rehabilitation program in which you are or were enrolled which assures your ability to adhere to prevailing standards of professional performance.		☐	☐
3.	Are you unable to perform any of the services/clinical privileges required by the applicable participating provider agreement/hospital agreement, with or without reasonable accommodation, according to accepted standards of professional performance?		☐	☐
D.	**LITIGATION AND MALPRACTICE COVERAGE HISTORY**			
1.	Have allegations or claims of professional negligence been made against you at any time, whether or not you were individually named in the claim or lawsuit?		☐	☐
2.	Have you or your insurance carrier(s) ever paid any money on your behalf to settle/resolve a professional malpractice claim (not necessarily a lawsuit) and/or to satisfy a judgment (court-ordered damage award) in a professional lawsuit?		☐	☐
3.	Are there any such claims being asserted against you now?		☐	☐
4.	Have you ever been denied professional liability coverage or has your coverage ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged)?		☐	☐
5.	Are any of the privileges that you are requesting not covered by your current malpractice coverage?		☐	☐
E.	**ATTESTATION**			

I warrant that all the statements made on this form and on any attached information sheets are complete, accurate, and current. I understand that any material misstatements in, or omissions from, this statement constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been submitted.

Typed or printed name _____ Signature _____ Date _____

Modification to the wording or format of the Provider Application may invalidate the application.

Provider Credentials Verification Addendum

Supplemental Provider Authorization and Release of Information

XXII. PROVIDER AUTHORIZATON TO RELEASE INFORMATION

I hereby authorize the presenter of this Release and/or its representatives to consult with others who have information bearing on my professional competence, character, professional practice or ethical qualifications. I authorize all malpractice carriers to release coverage and/or claims history information which may exclude direct patient identification including name, address or telephone numbers to the presenter of this Release and/or its representatives. I hereby further consent to the inspection by the presenter, and/or its representatives, of all documents, including medical records, which may be relevant to evaluation of my professional competence, character, professional practice or ethical qualifications. *The presenter complies with the Health Insurance Portability and Accountability Act of 1996 "HIPAA" (as defined in 45 CFR § 160 et seq.) as well as other state and federal statutes, rules and regulations relating to confidentiality and privacy.* I understand that I have the right to review any information submitted in support of this Provider Application.

I hereby release from liability any and all individuals and organizations that provide information to the presenter concerning my professional competence, practices, ethics, character or ethical qualifications for participating provider status, and hereby consent to the release of such information. I further agree to release and hold harmless from any liability the presenter and/or its representatives who participate within the scope of their duties in review of any information obtained under this Release. I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, professional practice or ethical qualifications for resolving any doubts regarding such qualifications. A copy of any portion/section of the Authorization and Release, Criteria Sheet and or Application has the same force and effect as the original.

I also understand that to participate, this application must be verified and I must be notified in writing whether this application has been approved or denied. I agree to immediately notify the entity to which this authorization has been given, in accordance with executed Agreements, of any change in submitted information. Failure to notify the entity of changes in the information contained in this application may result in immediate termination from participation with the entity to which this Release is given.

XXIII. ATTESTATION

I certify the information in this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been made. A photocopy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

Print Name Here _____

Signature _____

(Stamped signature is not acceptable)

Date _____

St. Luke's Health Partners

Application Addendum: Behavioral Health Provider Expertise

This addendum applies only to providers with a Mental Health / Behavioral Health specialty

Provider Name _____ **NPI** _____

Clinic Name _____ **Tax ID** _____

Provider Gender Identity:

☐ Male ☐ Female ☐ Non-Binary ☐ Transgender ☐ Prefer Not to Disclose

Provider Race/Ethnicity:

☐ American Indian ☐ Asian ☐ Black or African American ☐ Hispanic or Latino
☐ Native Hawaiian or Pacific Islander ☐ White ☐ Two or More Races ☐ Prefer Not to Disclose

Which population do you specialize in providing services to? (Please mark all that apply)

- ☐ Adults
- ☐ Children (ages 0-12)
- ☐ Elder (65+)
- ☐ Immigrants and/or Refugees
- ☐ LGBTQ+
- ☐ Men
- ☐ Racial or Ethnic Minorities
- ☐ Teenagers (ages 13-17)
- ☐ Veterans
- ☐ Women
- ☐ _____

Do you offer telehealth or virtual visit capabilities with both audio/visual components?

- ☐ Yes
- ☐ No

On average, how soon can a new patient get an appointment to see you?

- ☐ Within 48 hours
- ☐ Within 2 weeks
- ☐ 2 - 4 weeks
- ☐ 4 - 6 weeks
- ☐ Beyond 6 weeks

Do you provide any of the following? (Please mark all that apply)

- ☐ Couples Counseling
- ☐ Family Counseling
- ☐ Group Counseling
- ☐ Individual Counseling
- ☐ Psychiatric Medication Management

Which therapeutic models, theories or practices are you trained to provide? (Please mark all that apply)

- ☐ Acceptance and Commitment Therapy (ACT)
- ☐ Attachment-based Therapy
- ☐ Cognitive Behavioral Therapy (CBT)
- ☐ Dialectical Behavioral Therapy (DBT)
- ☐ EMDR
- ☐ Mindfulness-Based (MBCT)
- ☐ Motivational Interviewing
- ☐ Psychodynamic
- ☐ Solution Focused Brief Therapy (SFBT)
- ☐ Trauma Focused Therapy

Which do you specialize in? (Please mark all that apply)

- ☐ ADHD
- ☐ Addiction
- ☐ Anger Management
- ☐ Anxiety
- ☐ Autism
- ☐ Bipolar Disorder
- ☐ Borderline Personality Disorder
- ☐ Chronic Illness
- ☐ Chronic Pain
- ☐ Alzheimer's
- ☐ Depression
- ☐ Divorce
- ☐ Domestic Abuse
- ☐ Dual Diagnosis
- ☐ Eating Disorders
- ☐ Grief
- ☐ Infertility
- ☐ Life Transitions
- ☐ Obsessive Compulsive Disorder
- ☐ Pregnancy, Prenatal or Postpartum
- ☐ Racial Identity
- ☐ Self Esteem
- ☐ Self-Harming
- ☐ Sex Therapy
- ☐ Spirituality
- ☐ Stress
- ☐ Substance Use
- ☐ Suicidal Ideation
- ☐ Testing and Evaluations
- ☐ Thought Disorders
- ☐ Trauma and PTSD
- ☐ Traumatic Brain Injury
- ☐ Weight loss