**Optum TERM Network**

**Psychotherapy Treatment**

**Provider Application**

Prepared By:



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PRACTITIONER APPLICATION

San Diego County Mental Health Plan for TERM Network

**Optum TERM Network**

Optum TERM is a mental health program developed under the direction of the Board of Supervisors and managed by Optum Public Sector San Diego through a contract with the County of San Diego Health & Human Services Agency (HHSA) Behavioral Health Services. The Optum TERM mission is to improve the quality and appropriateness of mental health services provided to the clients of HHSA CWS and Juvenile Probation. In addition to contracting and credentialing providers Optum is responsible for monitoring the work of the TERM network providers through a quality review process. You can obtain additional information about Optum TERM at the website: <https://www.optumsandiego.com> or you can contact Optum TERM staff directly at 1-877-824-8376 (Option 4).

**Application Process** (*An Application Does Not Guarantee Acceptance to the Network)*

Enclosed is the Application for providers who want to join the Optum TERM Provider Network as a Therapist. An application checklist is included to assist you in collecting all the required documentation. Please ensure your curriculum vita is current and includes the clinical experience and training necessary to support the specialties requested on your application. To begin the application process, please submit the completed application and supporting documentation to:

Optum Public Sector

Attention: Provider Services

P.O. Box 601370

San Diego, CA 92160-1370

Fax: 877-309-4862

Email: [sdu\_providerserviceshelp@optum.com](mailto:sdu_providerserviceshelp@optum.com)

If you have any questions, please contact **Provider Services at 1-877-824-8376, Option 3.** We appreciate the opportunity to work with you in serving the clients of the County of San Diego.

**IMPORTANT NOTE:** All providers that render any service(s) that may be billable to Medi-Cal must also apply to the San Diego Fee For Service Medi-Cal Network. Only providers whose services cannot be billed under Medi-Cal may apply to be TERM Only Providers.

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|  |  |
| --- | --- |
|  | **Application Checklist** |
|  | **Curriculum Vitae (CV) -** It is very important that your CV be detailed including descriptions of populations, specialties, and disorders treated, as well as the theoretical orientation of the work. This detail is required to approve you to treat various age groups or specialties. Include the dates and locations of education and post-graduate training. |
|  | **Writing Sample** - is a required part of the application and must be submitted with your application in order for it to be considered complete; please ensure you have included a completed Therapist Writing Sample Packet available at [www.optumsandiego.com](http://www.optumsandiego.com)>BHS Provider Resources>TERM Providers>Applications. Please see Exhibit “A” for instructions. |
|  | **Certification –** Certificate must be submitted when required by the specialty criteria as stated in this application |
|  | **Specialty Criteria Requirement Section:** must include any training, education, supervision/consultation and/or experience that may not be included on your CV. If additional space is needed you may include a “Evaluator Documentation Addendum” available at <https://www.optumsandiego.com/content/sandiego/en/county-staff---providers/term-providers.html>. |
|  | **Attestation – Application Process Reviewed and Understood:** on page (3) must be signed and dated. |
|  | **TERM Clinician Specialty Requirements (TERM Therapist Applicants):** on page (13) must be signed and dated. |
|  | **Continuing Education**: Applicant understands that CEU certificates DO NOT need to be submitted with the original application, however, they may be required at the first (1st) and subsequent recredentialing (every 3 years). Applicant must be aware of the Continuing Education requirements for each of the specialties being requested and plan accordingly to complete them and maintain the certificates for possible future submittal if required. |
|  | **Child and Adolescent Needs and Strength Assessment (CANS):** Provider understands that all providers who render therapy services to clients ages 0 – 21 must become CANS certified and then be recertified every year. Provider may be reimbursed for training, certification, recertification and reports when the appropriate requirements are met. Additional information and instructions will be provided during the contracting process. |

**IMPORTANT: Review of the CV is completed by TERM clinicians based on the following:**

**Glossary of Application Terminology and Requirements**

**Training:** For the purpose of completing the TERM Panel Application, the word “training” refers to any Continuing Education Units (CEUs) that you acquire in effort to stay current with the specialty you are requesting approval for. Training can also include formal, didactic learning that is obtained by attending courses that are specific to the specialty.

**Supervision/Consultation:** For the purpose of completing the TERM Panel Application, “Supervision and/or Consultation” refer to obtaining clinical supervision and/or in consultation with peers who have experience with the specialty you are attesting to.

**Experience:** Refers to any direct practice, therapeutic treatment, and/or psychological evaluations of children and/or adults in the areas of competence and/or diagnoses you are attesting to, as the *primary* focus of treatment and/or evaluation.

**Clarification:** Clarification of your experience, training and/or supervision/consultation may be requested during the application process. If “clarification” is requested under any area of competence and/or diagnoses, TERM is requesting specific, detailed information of your experience, training and/or supervision/consultation.

**Curriculum Vitae (CV):** A record of your academic and professional achievements. A CV is a thorough account of your professional training and experience. Please include a CV with your TERM Panel Application and ensure it includes detailed information of your training, supervision/consultation, and experience treating and/or performing psychological evaluations in each of the areas of competence and diagnoses to which you are attesting.*Confidential*

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**Last Name**: Click here to enter text. **First Name**: Click here to enter text. **MI**: Click here to enter text.

**License Type:**  MD/DO  PhD  PsyD  LCSW  LMFT  LPCC

**License Number**: Click here to enter text.

**Optum Application Process for the County of San Diego TERM Network (Therapist)**

**Curriculum Vitae (CV):** Must be current and include the clinical experience and training necessary to support the specialties requested on this application. Include descriptions of populations, specialties, and disorders treated, and the theoretical orientation of the work. This detail is required to approve you to treat various age groups or specialties. Include the dates and locations of education and post-graduate training. **Dates of employment must include the month and year.**

* **Important: The CV submitted with the application** will be reviewed for the education, clinical experience and training to support the specialties requested on this application.
  + If the CV does not support the education, clinical experience and training for the specialties requested on this application you will receive notification that your application has been removed from further consideration.
  + You are welcome to reapply in 6 months

**Application:**

* TERM Clinician Specialty Requirements (Therapist): on page (13) must be signed and dated.
* Optum will require documentation to verify you meet the criteria outlined under TERM Clinician Specialty Requirements pertaining to the specialty or specialties designated.
* Review and complete the application in it’s entirely. Only select the age ranges and specialties in which you have the experience and training and are willing to treat in your practice.
* CV must be included with the application at the time of submittal.
* Signatures required on pages: 3 and 12

Writing Sample(s):Please see Exhibit “A” for instructions; Writing Sample packets are located at [www.optumsandiego.com](http://www.optumsandiego.com)>BHS Provider Resources>TERM Providers>Applications.

* A Writing Sample is a required part of the application and must be submitted with your application in order for it to be considered complete.
* A TERM Team Clinician will review the Writing Sample and contact you if additional documentation is needed.
  + Only one (1) revision will be accepted
* If the Writing Sample revision does not meet TERM Documentation Guidelines you will receive a letter advising you that your application has been removed from further consideration.
  + You are welcome to reapply in 6 months

**Continuing Education**: CEU certificates DO NOT need to be submitted with your original application, however, they may be required at your first (1st) and subsequent recredentialing (every 3 years). Please ensure you are aware of the Continuing Education requirements for each of the specialties you are requesting and plan accordingly to complete them and maintain the certificates for possible future submittal if required..

We will notify you of the outcome within ten (10) business days of the decision.

I have read and understand the Optum Application Process for the County of San Diego TERM Network.

Printed name of Applicant: Click here to enter text. Date: Click here to enter a date.

Signature

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The **TERM** Network is a specialized panel focusing on evaluation and treatment of children and families referred through the dependency and delinquency systems. Due to the forensic and high risk nature of the referrals, specialized treatment and evaluation experience is required. While completing this application please **ONLY** check those specialties to which you meet the criteria.

**Curriculum Vitae:** It is very important that your Curriculum Vitae be detailed including; descriptions of populations served, clinical specialties, diagnoses treated, and the theoretical orientation of the work. This detail is required to approve you to treat various age groups or specialties. Include the dates and locations of education and post-graduate training and employment. Please note that you may be asked to testify in Court to support the treatment you have provided. At that time, your Curriculum Vitae will be used by the Court to determine your expertise to treat and/or evaluate clients in the Juvenile Court System.

**Individual and Group Treatment Specialty Criteria:**

Please document below any other relevant information pertaining to your qualifications for the specialty criteria below.

**CEU certificates DO NOT need to be submitted with your original application, however, they may be required at your first (1st) and subsequent recredentialing (every 3 years). Please ensure you are aware of the Continuing Education requirements for each of the specialties you are requesting and plan accordingly to complete them and maintain the certificates for future submittal if required.**

**Specific Criteria for Age Ranges:**

|  |  |
| --- | --- |
| **Infant –Toddler: 0 months – 3 years**   Yes  No | |
| * Licensed psychologist, LMFT, LCSW or LPCC * Completion of didactic training and supervised clinical experience treating infants and toddlers * Experience to include EITHER: * Post-licensure certification as an infant-family and early childhood mental health specialist prenatal to 3 years endorsement or prenatal to 5 years endorsement   OR   * A minimum of two (2) years treating infants and toddlers within the last five (5) years * Minimum of twelve (12) hours of continuing education in topics relevant to infant/early childhood mental health and/or child development within the last three (3) years | |
| **Experience** | * Click here to enter text. * Click here to enter text. * Click here to enter text. |
| **Supervision/**  **Consultation** | * Click here to enter text. * Click here to enter text. * Click here to enter text. |

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| --- | --- |
| **Preschool: 3 - 5 years**  Yes  No | |
| * Licensed psychologist, LMFT, LCSW or LPCC * Completion of didactic training and supervised clinical experience treating children between the ages of 3-5 years * Experience to include EITHER: * Post-licensure certification as an Infant-Family and Early Childhood Mental Health Specialist prenatal as 3 - 5 years endorsement or prenatal to 5 years endorsement   OR   * A minimum of two (2) years treating children between the ages of 3 - 5 years within the last five (5) years * Minimum of twelve (12) hours of continuing education in topics relevant to infant/early childhood mental health and/or child development within the last three (3) years | |
| **Experience** | * Click here to enter text. * Click here to enter text. * Click here to enter text. |
| **Supervision/**  **Consultation** | * Click here to enter text. * Click here to enter text. * Click here to enter text. |

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| --- | --- |
| **Children: 6 - 12 years**  Yes  No | |
| * Licensed psychologist, LMFT, LCSW or LPCC * Completion of didactic training and supervised clinical experience treating children between the ages 6-12 years * A minimum of two (2) years within the last five (5) years of practice treating children ages 6-12 * Minimum of twelve (12) hours of continuing education in topics relevant to child mental health and/or child development within the last three (3) years | |
| **Experience** | * Click here to enter text. * Click here to enter text. * Click here to enter text. |
| **Supervision/**  **Consultation** | * Click here to enter text. * Click here to enter text. * Click here to enter text. |

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| --- | --- |
| **Adolescents: 13 - 17 years**  Yes  No | |
| * Licensed psychologist, LMFT, LCSW or LPCC * Completion of didactic training and supervised clinical experience treating children between the ages 13-17 years * A minimum of two (2) years within the last five (5) years of practice treating children ages 13 and older * Minimum of twelve (12) hours of continuing education in topics relevant to child/adolescent mental health and/or child/adolescent development within the last three (3) years | |
| **Experience** | * Click here to enter text. * Click here to enter text. * Click here to enter text. |
| **Supervision/**  **Consultation** | * Click here to enter text. * Click here to enter text. * Click here to enter text. |

|  |  |
| --- | --- |
| **Older Adults: 60 years and older**  Yes  No | |
| * Licensed psychologist, LMFT, LCSW or LPCC * Completion of didactic training and supervised clinical experience treating older adults * A minimum of two (2) years within the last five (5) years of practice treating older adults * Minimum of twelve (12) hours of continuing education in topics relevant to geriatrics/gerontology and/or older adult mental health within the last three (3) years | |
| **Experience** | * Click here to enter text. * Click here to enter text. * Click here to enter text. |
| **Supervision/**  **Consultation** | * Click here to enter text. * Click here to enter text. * Click here to enter text. |

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**Specific Criteria for Clinical Specialties:** (Prerequisite: *Must meet age range specialty criteria*)

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| --- | --- |
| **Adults with Serious Mental Illness (SMI): CWS - Involved Parents**  Yes  No | |
| * Licensed psychologist, LMFT, LCSW or LPCC * Completion of didactic training and supervised clinical experience treating adults with serious mental illness * A minimum of two (2) years within the last five (5) years of practice treating adults with serious mental illness * Minimum of twelve (12) hours of continuing education in topics relevant to with serious mental illness within the last three (3) years | |
| **Below mark age groups you are willing to treat in your practice:**  18-22 years old  23 – 59 years old  60+ years old | |
| **Experience** | * Click here to enter text. * Click here to enter text. * Click here to enter text. |
| **Supervision/**  **Consultation** | * Click here to enter text. * Click here to enter text. * Click here to enter text. |

|  |  |
| --- | --- |
| **Child Physical Abuse: Individual Treatment**  Yes  No | |
| * Licensed psychologist, LMFT, LCSW or LPCC * Minimum of two (2) years practice experience working in Child Physical Abuse Treatment in the last five (5) years * Documentation of completion of forty (40) hours of initial training that include topics related to child abuse and neglect, parenting, maladaptive client response styles such as denial and cognitive distortions, substance abuse, domestic violence, anger management, law and ethics, psychopathology including personality disorders, differential diagnosis, and risk assessments related to suicidality, homicidality, and training in actuarial risk assessment tools, if validated for intended purpose. This requirement may be satisfied by graduate level training or BBS/BOP approved continuing education units (CEUs). * Minimum of twenty-one (21) hours of continuing education in topics related to child maltreatment and its prevention or amelioration within the last (3) years | |
| **Below mark age groups you are willing to treat in your practice:**  18-22 years old  23 – 59 years old  60+ years old | |
| **Experience** | * Click here to enter text. * Click here to enter text. * Click here to enter text. |
| **Supervision/**  **Consultation** | * Click here to enter text. * Click here to enter text. * Click here to enter text. |

|  |
| --- |
| **Child Physical Abuse: Group Treatment**  Yes  No |
| * Approved by County of San Diego Adult Probation Department as a Child Abuse Group Treatment Provider |
| **Below mark age groups you are willing to treat in your practice:**  18-22 years old  23 – 59 years old  60+ years old |

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| --- | --- |
| **Domestic Violence Treatment – Victim: Group & Individual Treatment**  Yes  No | |
| * + Licensed psychologist, LMFT, LCSW or LPCC   + Completion of an approved (40) hour training program in Domestic Violence that fulfills California State’s requirement for domestic violence victim counselors   + Minimum of six (6) months supervised training experience working with Domestic Violence Victims and topics relevant to the CWS population   + Evidence of a minimum of two (2) years practice experience in Domestic Violence Victim treatment within the last five (5) years   + Minimum of fifteen (15) hours continuing education in topics relevant to Domestic Violence Victim treatment in the last three (3) years | |
| **Below mark age groups you are willing to treat in your practice:**  18-22 years old  23 – 59 years old  60+ years old | |
| **Experience** | * Click here to enter text. * Click here to enter text. * Click here to enter text. |
| **Supervision/**  **Consultation** | * Click here to enter text. * Click here to enter text. * Click here to enter text. |

|  |
| --- |
| **Domestic Violence Treatment – Offender: Group Treatment**  Yes  No |
| * Approved by County of San Diego Adult Probation Department as a Domestic Violence Offender Group Treatment Provider |
| **Below mark age groups you are willing to treat in your practice:**  18-22 years old  23 – 59 years old  60+ years old |

|  |  |
| --- | --- |
| **Domestic Violence Treatment – Offender: Individual Treatment**  Yes  No | |
| * Licensed psychologist, LMFT, LCSW or LPCC * Completion of the forty (40) hour basic domestic violence training from Facilitator Training Committee (FTC) approved provider, pursuant to PC1203.098(a)(1) * Minimum of three (3) years practice experience working in Domestic Violence Offender Treatment in the last five (5) years * Attendance at the San Diego Domestic Violence Council Treatment and Intervention Committee meetings; minimum attendance is three (3) per calendar year. * Minimum of twenty-four (24) hours of continuing education in topics related to Domestic Violence Offender Treatment within the last (3) years | |
| **Below mark age groups you are willing to treat in your practice:**  18-22 years old  23 – 59 years old  60+ years old | |
| **Experience** | * Click here to enter text. * Click here to enter text. * Click here to enter text. |
| **Supervision/**  **Consultation** | * Click here to enter text. * Click here to enter text. * Click here to enter text. |

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|  |  |
| --- | --- |
| **Domestic Violence Treatment – Offender: Individual Treatment**  Yes  No | |
| * Licensed psychologist, LMFT, LCSW or LPCC * Completion of the forty (40) hour basic domestic violence training from Facilitator Training Committee (FTC) approved provider, pursuant to PC1203.098(a)(1) * Minimum of three (3) years practice experience working in Domestic Violence Offender Treatment in the last five (5) years * Attendance at the San Diego Domestic Violence Council Treatment and Intervention Committee meetings; minimum attendance is three (3) per calendar year. * Minimum of twenty-four (24) hours of continuing education in topics related to Domestic Violence Offender Treatment within the last (3) years | |
| **Below mark age groups you are willing to treat in your practice:**  18-22 years old  23 – 59 years old  60+ years old | |
| **Experience** | * Click here to enter text. * Click here to enter text. * Click here to enter text. |
| **Supervision/**  **Consultation** | * Click here to enter text. * Click here to enter text. * Click here to enter text. |

|  |  |
| --- | --- |
| **Child Sexual Abuse Victim Treatment: CWS - Involved**  Yes  No | |
| * + Meet criteria for specific age group(s) 0 through 17 as outlined within the age category section above   + Supervised training experience working with Child Sexual Abuse Victims and topics relevant to the CWS population   + Training in evidence-supported treatment for sexual victimization   + Evidence of a minimum of two (2) years practice experience in Child Sexual Abuse Victim treatment within the last five (5) years   + Minimum of twelve (12) hours of continuing education in topics relevant to Child Sexual Abuse Treatment within the last three (3) years | |
| **Below mark age groups you are willing to treat in your practice:**  0-3 years old  3-5 years old  6-12 years old  13-17 years old | |
| **Experience** | * Click here to enter text. * Click here to enter text. * Click here to enter text. |
| **Supervision/**  **Consultation** | * Click here to enter text. * Click here to enter text. * Click here to enter text. |

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| --- | --- |
| **Youth with Sexual Behavior Problems Treatment: CWS - Involved Youth**  Yes  No | |
| * + Meet criteria for specific age group(s) 0 through 17 as outlined within the age category section above   + Supervised training experience working with Youth with Sexual Behavior Problems   + Training in evidence-supported treatment for sexual behavior problems   + Evidence of a minimum of two (2) years practice experience in youth with Youth with Sexual Behavior Problems treatment within the last five (5) years   + Minimum of twelve (12) hours of continuing education in topics relevant to Youth with Sexual Behavior Problems within the last three (3) years | |
| **Below mark age groups you are willing to treat in your practice:**  6-12 years old  13-17 years old | |
| **Experience** | * Click here to enter text. * Click here to enter text. * Click here to enter text. |
| **Supervision/**  **Consultation** | * Click here to enter text. * Click here to enter text. * Click here to enter text. |

|  |
| --- |
| **Sexual Offender Treatment: Group & Individual Treatment**  Yes  No |
| * Approved by California State Sex Offender Management Board (CASOMB) <http://www.casomb.org> **AND** continue to meet CASOMB requirements for treating sex offenders at the independent or Associate level |
| **Below mark age groups you are willing to treat in your practice:**  13-17 years old  18-22 years old  23 – 59 years old  60+ years old |

|  |  |
| --- | --- |
| **Sexual Abuse Non Protecting Parent Treatment; Group & Individual Treatment  Yes  No** | |
| **Below mark age groups you are willing to treat in your practice:**  18-22 years old  23 – 59 years old  60+ years old | |
| * + Approved by California State Sex Offender Management Board (CASOMB) <http://www.casomb.org>   OR   * Licensed psychologist, LMFT, LCSW or LPCC   + A Minimum of three hundred (300) hours within the preceding two years treating Sexual Abuse Non-Protective Parents; two hundred (200) of those hours were provided face to face or providing supervision, OR two-thousand (2000) hours over lifetime   Minimum of twenty (20) hours of continuing education units in CASOMB approved training topics, with fifteen (15) of those hours in CASOMB required core topics, in the last two (2) years | |
| **Experience** | * Click here to enter text. * Click here to enter text. * Click here to enter text. |
| **Supervision/**  **Consultation** | * Click here to enter text. * Click here to enter text. * Click here to enter text. |

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Please complete the following grids. Only check areas in which you specialize, have experience andare willing to treat in your practice.

**Clinical Experience:** *(Not included under the Specialty Criteria)*

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Modality:** | **Infants**  **0 - 3** | | **Preschool**  **3 - 5** | **Children**  **6 - 12** | **Adolescents**  **13 - 17** | **Transitional Youth**  **18 - 22** | **Adults 23- 59** | **Older Adults**  **60+** |
| Conjoint |  | |  |  |  |  |  |  |
| Family |  | |  |  |  |  |  |  |
| Individual |  | |  |  |  |  |  |  |
| **Areas of Clinical Expertise:** | **Infants**  **0 - 3** | | **Preschool**  **3 - 5** | **Children**  **6 - 12** | **Adolescents**  **13 - 17** | **Transitional Youth**  **18 - 22** | **Adults 23- 59** | **Older Adults**  **60+** |
| Adoption Related Issues |  | |  |  |  |  |  |  |
| Attachment Issues |  | |  |  |  |  |  |  |
| Autism Spectrum |  | |  |  |  |  |  |  |
| Blind/Vision Impaired | |  |  |  |  |  |  |  |
| Chemical Dependency/ Substance Abuse Treatment | |  |  |  |  |  |  |  |
| Deaf Hearing Impaired | |  |  |  |  |  |  |  |
| Developmentally Delayed | |  |  |  |  |  |  |  |
| Co-Occurring Disorders-Mental Health/Substance Abuse | |  |  |  |  |  |  |  |
| LGBTQIA | |  |  |  |  |  |  |  |
| Medically Fragile | |  |  |  |  |  |  |  |
| Depressive Disorders | |  |  |  |  |  |  |  |
| Parenting Skills | |  |  |  |  |  |  |  |
| Post-Traumatic Stress Disorder (PTSD) | |  |  |  |  |  |  |  |
| Serious Emotional Disturbance (SED) | |  |  |  |  |  |  |  |
| Born Positive Toxicity (Pos Tox) | |  |  |  |  |  |  |  |

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**Safety Threats and Risk Factors:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Infants**  **0 - 3** | **Preschool**  **3 - 5** | **Children**  **6 - 12** | **Adolescents**  **13 - 17** | **Transitional Youth**  **18 - 22** | **Adults 23- 59** | **Older Adults**  **60+** |
| Domestic Violence – Exposed |  |  |  |  |  |  |  |
| Emotional Abuse Victim - Due to Exposure to Domestic Violence |  |  |  |  |  |  |  |
| Emotional Abuse – Non-Protector |  |  |  |  |  |  |  |
| Neglect – Offender |  |  |  |  |  |  |  |
| Neglect - Non-Protector |  |  |  |  |  |  |  |
| Neglect – Victim |  |  |  |  |  |  |  |
| Child Physical Abuse – Victim - |  |  |  |  |  |  |  |

**Evidence Based Practices:**

|  |  |  |
| --- | --- | --- |
| **\* Proof of CEU’s and/or training certificate may be requested** |  | **Certification** |
| Behavioral |  |  |
| \* CBT |  | Yes Date: Click here to enter a date.  No |
| \* Child Parent Psychotherapy (CPP) |  | Yes Date: Click here to enter a date.  No |
| \* DBT (Certification attests the ability to provide individual/group services) | Ind  Grp | Yes Date: Click here to enter a date.  No |
| \* EMDR |  | Yes Date: Click here to enter a date.  No |
| \* PCAT |  | Yes Date: Click here to enter a date.  No |
| \* PCIT |  | Yes Date: Click here to enter a date.  No |
| \* Play Therapy |  | Yes Date: Click here to enter a date.  No |
| \* TF-CBT |  | Yes Date: Click here to enter a date.  No |

**Signature on this page is required of all TERM Network applicants. Failure to sign this form will cause a delay in the processing of your application.**

I hereby attest that all of the information in this application is true and accurate to the best of my knowledge.

I shall maintain proficiency in all specialty areas I selected on my application to the TERM network.

I understand that Optum may require documentation to verify that I meet the criteria outlined under the TERM Clinical Specialty Requirements pertaining to the specialty or specialties I have selected on this application. I agree to cooperate with an Optum TERM Network audit, if requested, to verify that I meet the required criteria.

Printed name of Applicant: Click here to enter text.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: Click here to enter a date.

Signature

**Exhibit “A”**

[**https://www.optumsandiego.com/content/sandiego/en/county-staff---providers/term-providers.html**](https://www.optumsandiego.com/content/sandiego/en/county-staff---providers/term-providers.html)

