CONTRA COSTA
HEALTH SERVICES

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	☐ Certified ☐ Fluent
Other Languages:	
	☐ Certified ☐ Fluent
	☐ Certified ☐ Fluent

ETHNICITY:

	White		Mexican American/Chicano		Chinese		Cambodian		Other Non-White
	Black		Latin American		Vietnamese		Japanese		Other Southeast Asian
	Native American		Other Spanish		Laotian		Filipino		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:
☐ DO ☐ MD

Nursing:
☐ Nurse Practitioner ☐ Registered Nurse ☐ Psychiatric Technician

Licensed Mental Health Professional:
☐ Marriage & Family Therapist ☐ Social Worker ☐ Psychologist [☐ PhD ☐ PsyD] ☐ LPCC

Intern:
☐ Associate Marriage & Family Therapist ☐ Associate Social Worker ☐ Psychologist Intern ☐ Associate Prof Clinical Counselor

Trainees:
☐ Marriage & Family Therapist Trainee ☐ Social Work Trainee ☐ Psychologist Trainee

☐ Mental Health Rehabilitation Specialist ☐ Designated Mental Health Worker ☐ TFC Parent
☐ Certified Peer Support Specialist ☐ Administrative Staff

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