Beacon Health Options
CLINICIAN INFORMATION FORM

Site Name:				Beacon ID#:	
Address:		Tax ID:		Accepting new referrals? Yes ☐ No ☒	
Clinician First:		Clinician Last:			Middle Initial:
Gender: Male ☐ Female ☒	Date of Birth:	Clinician License #:		Clinician NPI #:	
Medicaid ID/TPI#:		Medicare#:		Taxonomy:	
DEA # *(MD & NP)*		CANS *(MA Only)*:			

Licensure:

☐ MD	☐ DO	☐ APRN / NP	☐ RNCS	☐ PHD	☐ PSYD
☐ EDD	☐ LICSW	☐ LCSW	☐ LMHC	☐ LMFT	☐ LPC
☐ LADAC	☐ BCBA	☐ Other (specify):			

Ethnicity:

☐ African American	☐ Asian	☐ Caucasian	☐ Latino / Hispanic
☐ Native American	☐ Other (specify):		

Language(s):

☐ American Sign Language	☐ Cambodian	☐ English	☐ French
☐ Haitian Creole	☐ Laotian	☐ Portuguese	☐ Russian
☐ Spanish	☐ Vietnamese	☐ Other (specify)	

Specialties: Please indicate top 10 areas of expertise. **Shaded** specialties require submission of attached **Specialty Verification Form**. To qualify as "disability competent" in RI, at least one asterisked (*****) specialty must be checked.

Minimum Age: _____ Maximum Age:_____ Practice Limitations: ☐Male only ☐Female only

☐ Abuse (Physical)	☐ CSN (Children w/Special Health Care Needs)	☐ Low Income Populations*
☐ Abuse (Sexual) *	☐ Cultural Diversity*	☐ Medical Co-Morbidity
☐ Addiction Psychiatry	☐ DBT (Please include certification)	☐ Mood Disorders
☐ Addictions/Substance Abuse	☐ Depression	☐ Neuropsychological Testing
☐ ADHD	☐ DID/MPD	☐ OCD
☐ Adolescents	☐ Disabilities – Developmental/MR*	☐ Pastoral Counseling
☐ Adoption	☐ Disabilities – Hearing Impaired*	☐ Personality Disorders
☐ Affective Disorders	☐ Disabilities – Learning*	☐ Post-Partum / Pre-Partum Depression
☐ Agoraphobia	☐ Disabilities – Physical*	☐ Psychiatry & Neurology
☐ Alzheimer/Dementia	☐ Disabilities- Visually Impaired*	☐ Psychiatry
☐ Anger Management	☐ Domestic Violence*	☐ Psychological Testing
☐ Anxiety Disorder	☐ Dual Diagnosis (MH/SA)*	☐ Psychology
☐ Applied Behavioral Analysis	☐ EAP	☐ Psychopharmacology
☐ Asperger's Syndrome	☐ Eating Disorder	☐ Psychotherapy
☐ Attachment/Reactive Attachment Disorder	☐ ECT	☐ Psychotic Disorders
☐ Autism Spectrum Disorders	☐ EMDR (Please include certification)	☐ PTSD
☐ Bariatric Counseling	☐ Family	☐ Refugees
☐ Bereavement	☐ Fire-Setting	☐ School Based
☐ Borderline Personality Disorder	☐ Forensic	☐ Sex Offenders
☐ Certified Drug/Alcohol Counselor	☐ Gambling	☐ Sexual Addictions
☐ Certified Social Worker	☐ Gay/Lesbian/Bisexual	☐ Sexual Disorders
☐ Child Abuse	☐ Gender Identity	☐ Sexual Dysfunction
☐ Child Oppositional Defiant	☐ Geriatric	☐ Sleep Disorders
☐ Child Psychiatry	☐ Group Therapy (Specify type) _____	☐ SPMI (Severe & Persistently Mentally Ill)
☐ Child Psychopharmacology	☐ Head Injury/Traumatic Brain Injury	☐ Suboxone / Buprenorphine (prescribing)
☐ Child/Pediatric	☐ HIV/AIDS	☐ Terminal Illness
☐ Chronic Pain	☐ Home Visits*	☐ Transgender
☐ Cognitive Behavioral Therapy	☐ Homeless/Outreach	☐ Veteran's Issues
☐ Couples	☐ Immigrant Populations	☐ Victim Awareness

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SPECIALTY VERIFICATION

Clinicians who have indicated specialties in: **Abuse (Physical), Abuse (Sexual), Addictions/Substance Abuse, Child Abuse, DID/MPD, Eating Disorder, Fire-Setting, Forensics, Geriatrics, Neuropsychological Testing, Post-Partum Depression, Psychological Testing, Sex Offenders,** and **Sexual Addictions; must attest to the following criteria:**

- Independent licensure
- 10-20 hours of documented training (continued education, etc) in past 1-2 years (and/or internship or postdoctoral fellowship in specialty)
- 200 hours of direct clinical contact in past 5 years
- Access to (*check one or both of the following*):
  - ☐ supervision with a professional in the field.
  - ☐ supervision with a peer supervision group.
- Access to a prescribing provider (network or out-of-network).

Clinicians who have indicated a specialty in **Applied Behavior Analysis** must be certified by the BACB or licensed. Clinicians who have indicated a specialty in **Eating Disorders**, please answer the following Questions:

1) What percentage of your practice involves eating disorders? 0% %
2) Are you a member of a state or national Eating Disorders provider network? If so, please indicate which organization(s):_____
3) Are you prepared to do the necessary collateral work required for this population? (Work with this population requires coordination and collaboration with client's medical provider, dietician, family therapist, etc.) N/A

Specialty Attestation Statement

The undersigned hereby certifies that the above information requested by BEACON HEALTH Options, LLC is truthful, correct and complete in all respects, and the undersigned further understands that the intentional submission of false or misleading information or the withholding of relevant information is grounds for termination as a participating practitioner with BEACON HEALTH Options, LLC. The undersigned hereby agrees to notify BEACON HEALTH Options, LLC of any changes in the above information.

_____ _____
Signature (Original Signature Required) **Date**

_____
Printed Name/Title