

College Health IPA Community Care Clinician Profile

Instructions:

Please complete the following application to the best of your ability. Should you need additional space to answer some of the questions, please attach a separate sheet.

If you have any questions, please contact Network at (800) 779-3825 Option 6, Option 3 or email to network@chipa.com.

You can return this profile via fax to (877) 349-1135 attention Network Department.

Provider Identification Information:

Last Name:		First Name:		Middle:
Social Security Number:	Degree/Designation:	NPI#	E-mail address:	

Mailing/Billing Information:

Street Address:				Suite Number:				
City:			State:	County:		Zip Code:		
Telephone Number:		Fax Number:			Cell Phone Number:			
Federal Tax ID Number:				Name Associated With Tax ID Number:				
Office Hours	From:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	To:							
Billing (if different):				City:		State:	Zip Code:	

Field Experience:

The second page is the Field Experience Questionnaire. It will ask you to provide further information about your experience in the field. Please be as descriptive as possible. Should you need additional space to answer the questions, please attach a separate sheet.

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Field Experience Questioner - Please briefly describe the following	
Experience with Care Management:	
Experience with assessing for medical/primary care issues	
Experience with coordinating BH care with other Health care providers	
Experience with providing home care:	
Experience with real-time crisis management	
Experience with motivational interviewing/coaching:	
Experience with Community Resource Development:	
Are you willing to travel out of your immediate area for assessments?	
If yes, which other cities would you be willing to travel to?	
What other cities or communities do you have familiarity with regarding resources?	
List all languages (including sign language) in which you are able to conduct treatment:	

Print Name

Signature

Date