

Public Sector San Diego

**Re: Optum Application Process for the County of San Diego TERM Network Intern**

Dear **Intern/Associate/Psych Assistant/Registered Psychologist**:

Thank you for your interest in joining the County of San Diego Treatment and Evaluation Resource Management (Optum TERM) provider network as an Intern/Associate/Psych Assistant. Optum is the County’s Administrative Services Organization and is responsible for contracting with individual providers who wish to join the Optum TERM provider 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 an Intern/Associate/Psych Assistant. An application checklist is included to assist you in collecting all the required documentation. Please ensure your resume is current and includes the clinical experience and training you have completed thus far. 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.

Sincerely,

Judy A. Duncan - Sanford, LMFT

Manager of Provider Services

Optum San Diego Public Sector

# COUNTY of SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY

# Checklist for TERM Intern Application

Please print or type your answers to all questions. If further space is needed for you to provide complete answers, please attach additional sheets of paper and indicate on the sheet the applicable question number.

Please use this checklist to confirm that you have included all of the following information in your application packet.

**Disclosure Questions** on pages 4 and 5 must be fully completed**.**

**Standard Authorization, Attestation and Release Form** on page 7 must be signed and dated

**Curriculum Vitae or Resume** It is very important that your resume or Vitae be detailed including descriptions of populations, specialties, and disorders treated, and the theoretical orientation of the work. Include the dates and locations of education and post-graduate training (If applicable).

**All pages of the application must be completed** Please do not write “refer to Curriculum Vitae/Resume” or attached documents as an answer to any questions on the application.

**Board of Psychology Supervision Agreement Form** Please attach a copy of the signed supervision form (If Applicable)

**Supervisor – Six-hour course in Supervision** Please include a copy of the supervisor’s certificate for most recent completion of the course (Must be within the past two years) ***NOTE: If the supervisor has never taken this course, it must be taken within 60 days of commencement of supervision***

**Optum TERM Intern Application**

**Optum Application Process for the County of San Diego TERM Network Interns**

**Note:** This application is to be used by Psych Assistances/Registered Psychologists/Licensed Psychologists who are applying to be Interns on the TERM Panel.

**Resume:** Must be current and include the clinical experience and training necessary completed thus far. Include descriptions of populations, specialties, and disorders treated, and the theoretical orientation of the work (If applicable).

**Application:**

* Review and complete the application in it’s entirely.
* Resume must be included with the application at the time of submittal.
* Signatures required on pages: 1, 7 and 8

**Supervisor Documentation:**

* Copy of the signed and dated Board Responsibility Statement or Supervisor Agreement Form
* Copy of the supervisor’s certificate for the most recent course completed (must be within the past two years)

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

Printed name of Supervisor: Click here to enter text.

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

Signature

Optum TERM Intern Application

Optum TERM defines an Intern as a pre-licensed professional who is currently:

(1) Registered with the California Board of Psychology as a Psychological Assistant or a Registered Psychologist (PA);

(2) A licensed psychologist, now completing additional training in a clinical specialty.

Interns who are providing treatment or evaluations to Child Welfare Services or the Juvenile Probation Department clients, under the supervision of an Optum TERM-approved provider, are required to complete this application. All items in this application must be completed. Email address is required for participation in the Optum TERM Network.

Intern Name: Click here to enter text. Gender: Click here to enter text.

Social Security Number: Click here to enter text. Date of Birth: Click here to enter a date.

Agency Name: Click here to enter text. Phone Number: Click here to enter text.

Address: Click here to enter text. Click here to enter text. Click here to enter text.

Street City, State Zip Code+4

Work Site Address (*If different from above*):

Click here to enter text. Click here to enter text. Click here to enter text.

Street City, State Zip Code+4

Phone: Click here to enter text. Fax: Click here to enter text.

Email: Click here to enter text. (Intern)

OPTUM TERM Approved Supervisor: Click here to enter text.

Supervisor Email: Click here to enter text.

Agency Director (*If different from Supervisor*): Click here to enter text.

Intern’s National Provider Identifier (NPI) Number: Click here to enter text.

**Education:**

Institution: Click here to enter text. Degree: Choose an item. Year: Click here to enter text.

Institution: Click here to enter text. Degree: Choose an item. Year: Click here to enter text.

Institution: Click here to enter text. Degree: Choose an item. Year: Click here to enter text.

Optum TERM Intern Application

**PLEASE COMPLETE THE AREA BELOW** **FOR THE LICENSE YOU PLAN TO PURSUE:**

**Psychological**

**Assistance:** Registration Number: Click here to enter text.

Expiration Date: Click here to enter a date.

**Registered**

**Psychologist:** Registration Number: Click here to enter text.

Expiration Date: Click here to enter a date.

**List ALL Languages other than English** in which you are able to conduct treatment **fluently:**

**CRITERIA:** Fluent means that you are able to effectively and effortlessly speak and conduct a clinical evaluation and treatment in the language(s) checked below. For most individuals, formal classes in school or university will not produce this level of competence without other experience with the language.

|  |  |  |  |
| --- | --- | --- | --- |
| American Sign Language | French | Laotian | Samoan |
| Arabic | Hebrew | Mandarin Chinese | Somali |
| Armenian | Hmong | Mien | Spanish |
| Cambodian | Ilocano | Other Sign Language | Tagalog |
| Cantonese Chinese | Italian | Polish | Thai |
| Chinese | Japanese | Portuguese | Turkish |
| Farsi | Korean | Russian | Vietnamese |
| Filipino Dialect |  |  |  |
| Other Click here to enter text. | |  |  |

**Ethnic/Cultural Identity: *Optional*** – Intern’s self-identified information

|  |  |  |  |
| --- | --- | --- | --- |
| African America | Filipino | Laotian | Samoan |
| Amerasian | Guamanian | Mexican American /Chicano | Somali |
| Asian Indian | | Hawaiian Native | Native American | Sudanese |
| Cambodian | Hmong | Other Asian | Vietnamese |
| Chinese | Iranian | Other Latin American | White |
| Cuban | Iraqi | Pacific Islander | Unknown |
| Dominican | Japanese | Puerto Rican |  |
| Ethiopian | Korean | Salvadoran |  |
| Other Click here to enter text. | |  |  |

**DISCLOSURE QUESTIONS**

**Disclosure Questions** Answer all questions. For any “Yes” response, provide an explanation on page19. If you believe a question is not applicable to you, you should answer the question No”

|  |  |
| --- | --- |
|  | **Disclosure Questions** |
| 1. Yes  No | **LICENSURE**  Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board? |
| 2. Yes  No | Has there been any challenge to your licensure, registration or certification? |
| 3. Yes  No | **HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS**  Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board including TERM – approved or Juvenile Court panels? |
| 4. Yes  No | Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation? |
| 5. Yes  No | Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMO’s, PPO’s, or provider organizations such as IPAs, PHOs)? |
| 6. Yes  No | **EDUCATION, TRAINING AND BOARD CERTIFICATION**  Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign? |
| 7. Yes  No | Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program? |
| 8. Yes  No | Have any of your board certifications or eligibility ever been revoked? |
| 9. Yes  No | Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation? |
| 10. Yes  No | **DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION**  Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished? |
| 11. Yes  No | **MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PROGRAM PARTICIPATION**  Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs? |
| 12. Yes  No | **OTHER SANCTIONS OR INVESTIGATIONS**  Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or sexual offense or sexual misconduct? |
| 13. Yes  No | To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank? |
|  | **Disclosure Questions - Continued** |
| 14. Yes  No | Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)? |
| 15. Yes  No | Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchanged for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct? |
| 16. Yes  No | Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchanged for no investigation by a hospital or healthcare facility or any military agency? |
| 17. Yes  No | **PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY**  Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history? |
| 18. Yes  No | Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history? |
| 19. Yes  No | **MALPRACTICE CLAIMS HISTORY**  Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years? If yes, provide information for each case. |
| 20. Yes  No | **CRIMINAL/CIVIL HISTORY**  Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony? |
| 21. Yes  No | In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct? |
| 22. Yes  No | Have you ever been court-martialed for actions related to your duties as a medical professional? |
| 23. Yes  No | Has a true finding ever been made against you, your spouse, or an adult member of your household in a Juvenile Court dependency action? |
| 24. Yes  No | Have you, your spouse, or an adult member of your household ever been investigated by a Child Protective Agency? |
| 25. Yes  No | **ABILITY TO PERFORM JOB**  Are you currently engaged in the illegal use of drugs?  (“Currently” means sufficiently recent to justify a reasonable belief that the use of drugs may have any ongoing impact on one’s ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. “Illegal use of drugs” refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C.§ 812.22. It “does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal Law.” The term does include, however, the unlawful use of prescription controlled substances.) |
| 26. Yes  No | Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety? |
| 27. Yes  No | Do you have any reason to believe that you would pose a risk to the safety or wellbeing of your patients? |
| 28. Yes  No | Are you unable to perform the essential functions of a practitioner in your area even with reasonable accommodation? |

**Standard Authorization, Attestation and Release**

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as “Participation”) at or with each healthcare organization indicated on the “List of Authorized Organizations” that accompanies this Provider Application (hereinafter, each healthcare organization on the “List of Authorized Organizations” is individually referred to as the “Entity”), and any of the Entity’s affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

**Authorization of Investigation Concerning Application for Participation:**  I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity’s affiliated entities and their representatives, employees, and/or designated agents; and the Entity’s designated professional credentials verification organization (collectively referred to as “Agents”), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

**Authorization of Third-Party Sources to Release Information Concerning Application for Participation:** I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data bank, and the Health Care Integrity and Protection Data Bank, and Child Protection Agencies to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

**Authorization of Release an Exchange of Disciplinary Information:** I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party’s agents to release “Disciplinary Information,” as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, “Disciplinary Information” means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have acknowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

**Release from Liability**: I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, is Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity’s medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide consent may be grounds for termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration: denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Intern Signature Name (print) Date Signed

|  |
| --- |
| The National Practitioner Data Bank requires Health Care Entities to report: (1) professional review actions that are based on reasons related to professional competence or conduct and that adversely affect clinical privileges for a period longer than 30 days; or, (2) the voluntary surrender or restriction of clinical privileges while under investigation, or to avoid investigation. If you suspect you may not be accepted through our credentialing process for the reasons listed above, you may not want to apply since a denial of you application may require a report to the National Practitioner Data Bank if the denial is for reasons related to profession competence or conduct. |

If you answered “yes” to any Disclosure Questions, please provide an explanation here: Click here to enter text.

**Optum TERM Intern Application**

The following items are required to be registered with Optum TERM. Please **initial** each item. As a TERM approved Intern I AGREE TO:

|  |  |
| --- | --- |
| **[ ]** | **Submit** a copy of current Board registration or proof of academic status with this registration; and **re-submit** this information **annually** or earlier if changes occur. |
| **[ ]** | Participate in peer review and quality review. |
| **[ ]** | Participate in continuing education as deemed appropriate by the Juvenile Court or Optum TERM. |
| **[ ]** | Obtain my site supervisor's signature on any documents sent to Optum TERM, CWS, Probation or the Courts, and append the word "Intern" to my own signature, as my status is designated by Optum TERM. |
| **[ ]** | Observe all ethical standards of the profession for which I am preparing. |

**I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE FOREGOING IS TRUE AND CORRECT.**

Printed name of Applicant: Click here to enter text.

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

Signature

**SUPERVISOR:**

**I have reviewed and approved this intern’s application and will comply with Optum TERM’s STANDARDS for USE of INTERNS:**

Printed name of Supervisor: Click here to enter text.

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

Signature

Please return the signed and dated agreement to Optum Provider Services:

Fax - 877-309-4862; or

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

**Note:** This application will be processed only if fully completed, signed and the appropriate documentation attached

**OPTUM TERM STANDARDS FOR THE USE OF EVALUATOR INTERNS**

Optum TERM has developed specific standards for the use of post-doctoral psychology (pre-licensed) trainees and post-licensed medical/psychological professionals to complete evaluations for the Juvenile Court. Our purpose is to ensure that clients receive fair, objective and appropriate evaluations in both Court-ordered and voluntary, Child Welfare Services and Juvenile Probation cases. The results of every evaluation must meet Court expectations, with the understanding that Court testimony may be required of the intern and supervisor. Please give careful attention to each of the following standards:

1. Definition of intern:
2. An **intern** is a post-doctoral trainee or post licensed medical/psychological professional who is currently:
   1. Registered with the Board of Psychology as a Psychological Assistant or Registered Psychologist; **or**,
   2. A licensed psychologist, now completing additional training in a clinical specialty.

2. Psychiatry intern evaluators must meet one these criteria:

1. A licensed Medical Doctor/Doctor of Osteopathic Medicine who is enrolled in a psychiatry residency training program; or,
2. A licensed Medical Doctor/Doctor of Osteopathic Medicine who has completed psychiatry training and is Board-certified or Board-eligible in adult psychiatry, now receiving additional training in a child and adolescent specialty; or,
3. A Board-certified psychiatrist receiving additional training in child forensic evaluations.

3. Each Intern applicant is required to submit the following documents:

1. A fully completed Optum TERM Intern Application, co-signed by the supervisor
2. A copy of the Board of Psychology “Supervisor Agreement Form” signed by both the applicant and supervisor
3. A copy of the supervisor’s certificate for the most recent course completed (must be within the past two years)
4. A Writing Sample is encouraged: To be supervised, reviewed and signed by supervisor

* If submitting a writing sample it should be sent with the Applicant’s application.

4. Supervisors are required to be in good standing on Optum TERM’s evaluator panel and approved for the specialties relevant to the case at hand.

5. Supervisors are to be licensed in the intern’s respective discipline. Supervision is required to conform to state laws, the standards of the intern’s training program requirements, and the standards of practice in the profession.

6. Supervisors are to provide the intern with specific information regarding the Dependency and/or Delinquency programs, the Juvenile Court system, the role of the evaluator in these systems, relevant national and professional standards for court ordered evaluations, and the limits of the evaluator’s special expertise in the case. This may be accomplished in lecture format or face to face supervision. Interns also are required to review and be familiar with all sections of the Optum TERM provider *Handbook*.

7. Supervision is required to include the following:

* 1. Knowledge of the case and careful case selection for each intern;
  2. Assistance for the intern in preparing for the evaluation, including selection of interview questions, appropriate tests (psychology interns), and other methods based on the nature of the referral and client’s presentation;
  3. Review and oversight of the trainee’s work product;
  4. Co-signature of the intern’s evaluation report.

8. To prepare for the possibility of Court testimony, **all supervisors for pre-license psychology intern evaluators must be present during the client interview**. This allows the supervisor to form an independent, clinical opinion. Supervisors of psychiatry interns and post-license psychologists who have a current professional license, may interview the client as needed.

9. Pre-license psychology intern evaluators may not be assigned juvenile or adult competency evaluations.

10. Prior to assigning the client to an intern, supervisors are required to discuss the case with the PSW to ensure assignment to an intern is appropriate. PSWs must approve assignment of clients to interns. In addition, supervisors are required to inform the client and/or attorney of the planned use of an intern, a minimum of three (3) days prior to the evaluation, so that, if preferred, the client and/or attorney can request an evaluator who is not an intern.

11. **Interns may not receive a direct referral for services and shall not provide direct services to CWS Medi-Cal funded cases.** In all cases, the referral and the reimbursement must be made to the clinical supervisor. Claims are required to indicate that services were rendered by an intern. The supervisor retains clinical and legal responsibility for each case.

12. **Newly Licensed Optum TERM Interns:**

It is the policy of Optum TERM to allow a ninety (90) day grace period for Optum TERM interns who are newly licensed to continue to be Optum TERM interns pending submission, review and approval of their application to render services as a. independent provider on the Optum TERM approved provider panel. This grace period will allow for continuity of client care. These procedures must be followed in order for this grace period to be in effect.

**Procedure:**

1. An individual who has completed her/his period of state registration as an intern, has passed the licensure exam and is waiting receipt of the professional license, is eligible to be listed by TERM for a ninety (90) day grace period. This grace period is to allow time for this professional to submit the TERM application and thus, to ensure continuity of care for the client.
2. Within 5 business days of notification by the respective professional licensing board, the individual’s agency must inform TERM in writing that the intern is newly licensed.
3. Within three (3) business days TERM will forward an application to this individual.
4. The agency must attest that this individual will:

a) Continue to be an employee of the agency;

b) Submit proof that the appropriate malpractice insurance coverage is in effect;

c) Continue to receive professional consultation; and

d) Submit the completed application to TERM within thirty (30) days of receipt of the license.

1. During the grace period and pending approval for serving on the TERM panel(s) as an independent provider, the individual may not receive any new TERM-referred cases at this or another agency, or in private practice.
2. Services for continuing clients must be billed by the agency supervisor at the specified intern rate for the services provided.